INTRODUCTION  (For your information only)
The hematopoietic system is composed of a wide range of lymphoid tissues and all the fixed and circulating blood cells originating from the bone marrow. For convenience it is often divided into discrete systems even though there are extensive interactions between these components:

<table>
<thead>
<tr>
<th>Myeloid Tissues</th>
<th>Lymphoid tissues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Marrow</td>
<td>Lymph node</td>
</tr>
<tr>
<td>Blood cells</td>
<td>Thymus</td>
</tr>
<tr>
<td>Monocyte-macrophage system</td>
<td>Spleen</td>
</tr>
<tr>
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<td>Accessory lymphoid tissues (MALT, tonsils)</td>
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CLINICAL EVALUATION OF THE HEMATOPOIETIC SYSTEM
Evaluation can provide valuable information about the health status of the patient. Some portions of the hematopoietic system, such as circulating blood, are easily accessible to clinicians. In many cases antemortem laboratory evaluation of the blood via complete blood counts (CBC) and blood smears ± lymph node and/or bone marrow aspirates provides better information than necropsy in understanding diseases of the hematopoietic system. Consequently, many diseases affecting this system will be covered with more detail in your Clinical Pathology course.

MYELOID TISSUES
BONE MARROW AND BLOOD CELLS
Normal Structure and Function (for your information only)

HEMATOPOIESIS (Hemopoiesis) = the process through which all blood cells are made.

Development of Hematopoiesis
• In the embryo, hematopoiesis begins as clusters of stem cells, called blood islands, within the yolk sac.
• In the fetus, hematopoietic activity is found mostly in the liver and spleen.
• In neonates, hematopoiesis is confined primarily to the bone marrow involving both flat
(vertebrae, pelvis, skull, sternum, ribs) and long bones.

- As the animal grows hematopoietic activity in the central areas of long bones regresses and is replaced by fat.
- In adults, hematopoiesis occurs in the flat bones and in the marrow of the extremities of the long bones. The medullary cavity in the diaphyseal region of the long bones contains mostly fat.
- In adults, when hematopoiesis occurs anywhere other than the marrow, it is referred to as extramedullary hematopoiesis (EMH) – this is most common in the spleen.

**BONE MARROW – Normal structure**

- Bone marrow is supported by trabecular bone with a periosteum that anchors the stromal scaffolding of the marrow spaces.
- In the marrow spaces, there is a network of stromal cells: adipocytes and reticular cells.
- Bone marrow is highly vascularized and contains venous sinusoids that deliver nutrients, remove waste, and allow blood cells to enter circulation.
- Hematopoietic tissue occurs in the intestitium between the vascular sinuses.
- The islands of hematopoietic tissue consist of: erythroid (RBCs), granulocytic (neutrophils, eosinophils), monocytic, and thrombocytic (megakaryocytes and platelets) series cells.
- Fewer macrophages, lymphocytes, plasma cells and mast cells are scattered amongst the developing blood cells.

**Basic Concepts in Hematopoiesis**

- Hematopoietic tissue is highly prolific: all blood cells are derived from a common pluripotential hematopoietic stem cell capable of both self-renewal and further differentiation into committed stem cells.
- The cells undergo sequential divisions as they mature and the mature cells have limited life spans.
- Production and turnover of blood cells are balanced in health (steady-state kinetics).

**Examination of Bone Marrow**

Bone marrow is located in multiple sites, but responds as a single tissue (whole-body homogeneity); the assumption is that a bone marrow sample taken anywhere in the body will represent the marrow as a whole.

Bone marrow samples are typically taken from the proximal humerus, trochanteric fossa of the femur and the iliac crest in dogs and cats; from the proximal ribs in cattle; and from the sternum in horses.

Bone marrow examination is indicated for certain abnormal hematology findings:

- Unexplained cytopenias (= decreased cells in circulation) (eg non-regenerative anemia)
- Maturation defects or morphologic abnormalities in blood cells
- Suspected myeloproliferative diseases
- Examination is also indicated to evaluate for malignancies metastatic to marrow.

**Microscopic evaluation:**

Microscopic evaluation of hematopoietic cells is performed on cytology samples (bone marrow...
smears/aspirates) and on histology samples (core biopsies).

- Bone marrow smears/aspirates are typically interpreted by clinical pathologists and are the best samples for evaluating:
  - Cellular morphology
  - Ratio of white cell lineage to red cell lineage (myeloid:erythroid or M:E ratio); this gives a rough estimate of where the marrow replicative energies are directed.

- Core biopsies are often interpreted by morphologic pathologists and are the best samples for evaluating:
  - bone marrow cellularity, which is measured as the ratio of hematopoietic cells to adipose tissue (altered ratio is seen with aplasia/hypoplasia or hyperplasia/neoplasia)

- Please note: thorough evaluation of the bone marrow should always include a **CBC**, a bone marrow aspirate and a bone marrow biopsy.**

**Pathology of the Bone Marrow and Blood Cells**  
(Alterations / Damage to Hematopoiesis)

The end result is dependent on the type of cells damaged:

- **Pluripotent stem cells**: multiple cell lines affected.
- **Committed stem cells**: one or more lines affected.
- **Differentiated cells**: one cell line affected

Alterations in hematopoiesis are reflected in the peripheral blood as deficiencies (cytopenias) or increases in different cell lines. Such changes are apparent on a CBC and are therefore covered in clinical pathology. In the bone marrow, they are reflected as increased or decreased cellularity and/or alterations in the myeloid to erythroid ratio.

**I) Bone Marrow: Hereditary disorders** — most are reflected in the peripheral blood and will be covered in clinical pathology

**II) Bone Marrow: Degeneration/necrosis**

Since hematopoietic cells are in general very active metabolically, a variety of insults can affect their viability leading to cell degeneration and necrosis:

**Main causes of bone marrow degeneration include:**

- **A) Radiation**
- **B) Toxins / Drugs**
  - Antineoplastic / Immuno-suppressive Drugs
  - Idiosyncratic Drug Reactions
  - Idiopathic drug toxicity
  - Toxic chemicals
- **C) Infectious agents**
  - Feline parvovirus (panleukopenia)
  - Feline leukemia virus (FeLV)
  - Equine infectious anemia (EIA)
  - Canine parvovirus
  - Feline immunodeficiency virus (FIV)
D) Immune-mediated
   Specific immune-mediated disorders, eg systemic lupus erythematosus (SLE)
   Altered surface cell antigens caused by drugs or infectious agents

E) Idiopathic
   In many cases the cause is not identified

III) Bone Marrow: Inflammation (Covered in pathology of the skeletal system)
   • Myelitis usually occurs as part of localized osteomyelitis (inflammation of bone & medullary cavity)

IV) Bone Marrow: Adaptations of growth*

1) Bone Marrow Hypoplasia/Aplasia*
   Bone marrow hypoplasia (decreased proliferative activity) can be represented in one cell line or multiple cell lines (resulting in pancytopenia).

   Main causes of bone marrow hypoplasia/aplasia:
   A) Bone marrow suppression
      • Estrogen in the dog; exogenous (therapeutic) or endogenous (Sertoli cell tumor)
      • Anemia of chronic disease
      • Anemia of chronic renal disease
   
   B) Lack of nutrients
      • Inadequate iron, vitamin B12, folate, etc
   
   C) Endocrine dysfunction
      • Hypothyroidism
   
   D) Bone marrow degeneration/necrosis (see previous section)

   Gross findings: characterized by increased yellow marrow (fat) and decreased red marrow.
   Microscopic findings: increased proportion of adipose tissue to hematopoietic cells (despite peripheral demand). Please note: in a normal adult the marrow is ~ 50:50 fat:cells.

2) Bone Marrow Hyperplasia*
   Pathogenesis: Proliferation (hyperplasia) of hematopoietic cells in response to increased peripheral demand or hypofunction of blood cells. One or multiple cell lines may be hyperplastic depending on the stimulus.

   A) Erythroid hyperplasia → response to decreased RBC number/function (anemia): due to hemorrhage, immune or parasitic RBC destruction, immune mediated hemolytic anemia, etc

   B) Megakaryocytic hyperplasia → response to decreases in platelet number/function: due to consumptive coagulopathies, immune-mediated destruction of platelets, etc.
C) Myeloid (granulocytic or monocytic cell lines) hyperplasia (other than megakaryocytes)

- Neutrophilia → response to most bacterial infections, tissue necrosis, etc.
- Eosinophilia → response to parasites, hypersensitivities, etc.
- Monocytosis → response to chronic infections, specific infectious agents, etc.

Gross findings: Initially red marrow replaces yellow marrow (fat) in the metaphyses and along the endosteal surface of diaphysis; with progression can occupy the entire marrow cavity.

Microscopic findings: Decreased proportion of adipose tissue to hematopoietic cells (ie increased cellularity). Along with the proliferation of one or more cell lines, you may see a shift toward immaturity in those cell lines. If severe, it can revert to extramedullary hematopoiesis (especially in spleen and liver).

3) Bone Marrow Atrophy?

- The term atrophy (decrease in cell size) is seldom used to describe bone marrow.
- An exception is a condition referred to as serous atrophy of fat = gelatinous transformation of fat within the marrow due to catabolism of fat associated with starvation from malnutrition or chronic disease.

V) Primary Hematopoietic (Hemic) Neoplasia**

Primary hematopoietic neoplasia results from clonal expansion of hematopoietic cell types. These tumours primarily affect the bone marrow, the blood (leukemia: to be covered in clinical pathology) and the lymphoid tissues (lymph node, spleen, etc.)

Common Features of Primary Bone Marrow Neoplasia:

- Hypercellular marrow: reflects uncontrolled proliferation of the neoplastic hematopoietic cells.
- Anemia: non-regenerative anemia due to ineffective erythropoiesis. When the bone marrow is occupied by neoplastic hematopoietic cells there is competition for nutrients &/or space (myelophthisis). Additionally, inhibitory factors may be released from neoplastic cells.
- Thrombocytopenia +/- Neutropenia: not present in all myeloproliferative diseases.
- Leukemic cells in peripheral blood: immature stages of hematopoietic cells in peripheral blood are commonly seen in hematopoietic neoplasia.

Hematopoietic tumours are broadly divided into:

- Lymphoproliferative disease: neoplastic transformation of a lymphoid cell line (ie lymphocytes)
- Myeloproliferative disease: neoplastic transformation of one or more bone marrow cell lines (myeloid cells), including: granulocytes (neutrophils, basophils, and eosinophils), erythrocytes, megakaryocytes and monocytes

<table>
<thead>
<tr>
<th>Primary Hematopoietic Neoplasia</th>
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<tbody>
<tr>
<td><strong>Lymphoproliferative Diseases</strong></td>
</tr>
<tr>
<td>Lymphoma</td>
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<tr>
<td>Lymphoid leukemia¹</td>
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V) Lymphoproliferative Diseases
Defined as a neoplastic proliferation of lymphocytes causing a spectrum of disease from pure lymphoid leukemia (neoplastic lymphocytes primarily in bone marrow and circulation) to lymphoma (neoplastic lymphocytes in lymph nodes / tissues / organs).

Lymphoid leukemia will often invade tissues and lymphoma can involve marrow / circulating cells (ie leukemic lymphoma) - so separating these disease states from one another can be difficult, but in some cases can be important for prognosis and treatment options.

1). Lymphoid Leukemia (covered in Clinical Pathology)
- Leukemia refers to malignant hematopoietic neoplasms that originate in bone marrow (or spleen) and typically have significant numbers of neoplastic cells circulating in the blood.
- Lymphoid leukemia is lymphocytic (T-lymphocyte or B-lymphocyte) in origin and may be acute or chronic in nature

2). Lymphoma (lymphosarcoma)**
***Lymphoma is one of the most common malignant neoplasms in domestic animals***
It can be sporadic, hereditary (porcine lymphoma) or viral (FeLV in cats, BLV in cattle) in cause.

A) Several classifications systems exist, with classification by:
   a) Anatomical Classification
      - Multicentric: generalized involvement of lymph nodes, +/- liver, spleen, marrow or other organs.
      - Alimentary: nodular to segmental involvement of the GI tract, especially intestine.
      - Mediastinal / thymic: involvement of the cranial mediastinum / thymus.
      - Cutaneous: both epitheliotropic (mostly T-cell) and non-epitheliotropic forms.
      - Miscellaneous: renal, ocular, cardiac, neural, etc.
      - Leukemic lymphoma: when lymphoma invades marrow and occurs in blood (recall difficulty in separating from lymphoid leukemia).

   b) Cellular morphology
      - Based on size, nuclear features, mitotic rate
      - Multiple classifications are based on the cytologic features of neoplastic lymphocytes.
      - Two prognostic assumptions of this method of classification are:
        - Small cell lymphomas with low mitotic rates: slowly progress and show poor response to chemotherapy.
        - Large cell lymphomas with high mitotic rates: progress rapidly but respond to chemotherapy.
c) **Immunophenotype**
- Use immunohistochemistry/flow cytometry to determine the origin of the lymphoblasts (B-lymphocyte: CD79a, T-lymphocyte: CD3, or non-T/B-lymphocyte).
- In animals: B-cell lymphomas generally have better survival profiles and response to treatment when compared to T-cell lymphoma.

d) **Biologic behavior**
- Low-grade (indolent)
- Intermediate
- High grade (aggressive)

e) **Histologic pattern**
- Diffuse versus follicular

B) **Clinical signs of lymphoma:**
- Most common sign of lymphoma is painless enlargement of one to multiple lymph nodes (lymphadenopathy).
- Multitude of additional signs are dependent upon the organ system involved, for example:
  - Retrobulbar lymph node involvement may result in exophthalmos.
  - Thymic lymphoma may induce jugular vein engorgement, dyspnea and/or esophageal obstruction.
  - Enteric lymphoma often results in diarrhea, intestinal obstruction or melena.

C) **Lymphoma, gross findings:**
- Affected lymph nodes are moderately to markedly enlarged, soft to firm, often bulge on cut surface and have a homogenous pale tan to white appearance ± focal areas of necrosis or hemorrhage. Often the nodes are firmly attached to surrounding tissue due to peri-nodal invasion and subsequent fibrosis.
- Lymphoma in other organs cans cause:
  - Diffuse organomegaly (usually splenomegaly/hepatomegaly)
  - Single to multiple discrete tan nodules within any affected organ
  - Localized to generalized thickening of the walls of tubular organs (intestine, stomach, uterus)

D) **Lymphoma, microscopic findings:**
- Effacement of the normal architecture due to proliferation of a homogeneous population of lymphocytes with variable degree of anaplasia, mitosis, and apoptosis.

E) **Species Differences:**
  a) **Canine lymphoma:**
  Lymphoma is the most common canine hematopoietic neoplasia. Affected animals are often middle-aged and older. Clinical signs are often nonspecific or absent at diagnosis. Ninety percent of dogs with lymphoma have a normal leukogram. Most have a multicentric distribution (about 80 - 85%) with prominent peripheral lymph node involvement and the majority of cases are intermediate or high-grade tumors. Other forms include alimentary, cutaneous, mediastinal (thymic), and miscellaneous. The alimentary form is often thought to
be preceded by lymphoplasmacytic enteritis (Inflammatory Bowel Disease - IBD). There are no known causes of lymphoma in dogs and no known viral associations. Hypercalcemia of malignancy is sometimes associated with canine lymphoma due to the production of parathyroid hormone-related peptide (PTHrP) by neoplastic cells.

b) Feline lymphoma:
This is the most common malignant neoplasm of cats. In decreasing order of frequency, the tumors may be alimentary, multicentric, mediastinal (thymic) or miscellaneous (renal, ocular, etc). Unlike dogs, there is often no peripheral lymph node involvement in cats and leukemia and bone marrow involvement are common. Feline lymphoma is characterized by a short clinical course - approximately 75% of affected cats are dead within 8 weeks of diagnosis if untreated. Approximately 10 – 20% of cats with lymphoma are infected with Feline Leukemia Virus (FeLV). FeLV-associated lymphoma often affects young cats, and most commonly leads to mediastinal or multicentric T cell lymphoma (80% of young cats with mediastinal lymphoma are FeLV +). Clinical signs are often non-specific and include weight loss, anorexia, poor grooming habits, or are referable to the affected organ system: diarrhea, vomiting, dyspnea.

c) Bovine Lymphoma:
i) Enzootic bovine lymphoma (bovine enzootic leukosis): This is primarily a multicentric disease of adult cattle (average age 5 – 8 years old). The etiologic agent is Bovine Leukemia Virus (BLV), an oncogenic retrovirus. The virus is transmitted by transfer of viral infected lymphocytes; mostly horizontally by arthropods, natural breeding and accidental transmission by needles, ear tagging equipment, etc. Once infection is established, it is lifelong. The target cell for BLV is the B-lymphocyte. Approximately 30% of BLV-infected animals develop non-neoplastic persistent lymphocytosis and, of these, less than 5% develop lymphoma. Dairy cattle are more commonly affected than beef cattle, likely because of management practices and average age. BLV may cause lymphoma in sheep and goats (experimentally).
In addition to the lymph nodes, the commonly affected organs include the heart (right atrium), abomasum, uterus, and the vertebral canal. Clinical signs depend on the organ involved but include lymphadenopathy, diarrhea, vagal indigestion, congestive heart failure, and posterior paresis/paralysis.

ii) Sporadic bovine lymphoma: Occurs in young cattle and is not associated with BLV infection. There are three forms of sporadic lymphoma:
• Calf form - multicentric lymphoma in calves from 3 to 6 months of age. Symmetrical lymph node enlargement, often with leukemia and bone marrow involvement.
• Juvenile form/thymic lymphoma - mediastinal lymphoma, usually yearling beef breeds. Characterized by large cranial thoracic/lower cervical masses, respiratory distress, and weight loss in cattle less than 2 years of age.
• Cutaneous form – usually 2 to 3 yr-old cattle. Characterized by plaque-like, round raised skin lesions, often with ulceration. Typically located on the head, sides, and perineum. Lesions may wax and wane and animals may survive for 12 – 18 months. Ultimately there is deep organ involvement indistinguishable from multicentric lymphoma.
d. Porcine lymphoma:  
Lymphoma is considered to be the most common neoplasm of swine. The lesions are usually multicentric (visceral lymph nodes, spleen, liver, stomach, intestine, kidney, and bone marrow involvement are common) or mediastinal and affected animals are often less than one year old. Females are affected more often than males. A familial form of multicentric lymphoma has been described in Large White pigs (autosomal recessive heritability).

e. Equine lymphoma: Has a lower incidence than in cats, cattle and dogs. Multicentric lymphoma is the most common form. Cutaneous, subcutaneous, alimentary, abdominal, splenic, and leukemic forms also occur. Lymphoma in horses is often intermediate or low grade and frequently is of mixed cell type (B lymphocytes and T lymphocytes). Concurrent leukemia is not uncommon.

3) Plasma cell tumours
A. Cutaneous plasmacytoma: Solid tumour of plasma cell originating in the skin (pinna, digit). Occur in mature animals, most frequently dogs (rarely in cats). Usually a solitary benign lesion; surgical excision is often curative. Microscopically, masses may be composed of a uniform population of well-differentiated plasma cells or, more commonly, may have marked anisocytosis and anisokaryosis (anaplastic plasmacytoma).

B. Extramedullary plasmacytoma: Solid tumour of plasma cell origin arising in sites other than the bone marrow and skin. These are rare tumours which occur more often in dogs (Cocker Spaniels are predisposed) than in other species (cat and horse). Most often arise in the gastrointestinal tract but may also occur in the trachea, spleen, kidney, uterus, etc. Tend to be more aggressive than cutaneous plasmacytoma with occasional metastasis to the lymph nodes.

C. Multiple myeloma (plasma cell myeloma)*  
Relatively uncommon in domestic animals; seen most often in dogs and cats. These are malignant tumours of plasma cell origin arising within the bone marrow. The neoplastic plasma cells (derived from one clone) secrete immunoglobulins or immunoglobulin fragments of one class leading to hypergammaglobulinemia. Hypergammaglobulinemia is detected by serum protein electrophoresis as a monoclonal spike in the globulin fraction (monoclonal gammopathy\(^9\)). It can lead to hyperviscosity syndrome (resulting in sludging of blood cells, hypotension, and shock) and light-chain (Bence-Jones) proteinuria\(^9\). Bence Jones proteins are free immunoglobulin light chains which pass through the glomerulus into urine – they are detected using electrophoresis and immunoprecipitation.

Gross lesions: Sections of affected bone exhibit multiple dark-red soft / gelatinous tissue nodules filling areas of bone resorption / lysis. Approximately 2/3 of dog cases have radiographic “punched out” lesions in skeleton\(^9\). Lesions can be found in any hematopoietically active bone, but are most common in the vertebrae. Affected dogs may have hypercalcemia\(^9\) (due to osteoclastic activity in the bone lesions).

Histology: Masses composed of sheets of neoplastic plasma cells are present in the bone marrow\(^9\).
Clinical signs: Lameness, ill-defined pain and lethargy. Paraplegia can occur due to direct spinal cord compression by protrusion of tumor masses into the vertebral canal or secondary to a pathologic vertebral fracture. The clinical course is often slowly progressive and neoplastic cells may metastasize to spleen, liver, lymph nodes and kidneys. (Diagnosis of multiple myeloma is often based on a minimum or 2 or 3 of these findings)

Vb) Myeloproliferative Diseases
1) Myeloid Leukemia (covered in Clinical Pathology)
- Erythroid, granulocytic, monocytic, or megakaryocytic in origin

2) Myelodysplastic Diseases (covered in Clinical Pathology)
- Group of myeloid proliferative disorders characterized by ineffective hematopoiesis.
- Rare in veterinary medicine: most often seen in FeLV-infected cats.

3) Histiocytic Neoplasia/Proliferative Disorders
Histiocytic proliferative diseases occur most commonly in dogs. Canine proliferative histiocytic diseases include a wide range of disorders which vary in clinical behavior. This group of disorders includes the following:

A. Cutaneous histiocytoma (covered in Dermatopathology)

B. Canine Reactive Histiocytosis (Cutaneous and Systemic reactive histiocytosis)
Canine reactive histiocytosis is either limited to the skin (cutaneous histiocytosis) or simultaneously affects the skin and other organs (systemic histiocytosis). It is considered an immunoregulatory disorder rather than true neoplasia with lesions responding (somewhat) to immunosuppressive therapy. The cell of origin is thought to be an activated dermal dendritic cell (an antigen presenting cell). Disease is characterized by multifocal skin masses which wax and wane. Bernese Mountain dogs are predisposed to developing the systemic form which often involves the skin, peripheral lymph nodes, ocular/nasal mucosa, liver, spleen etc.

C. Histiocytic Sarcoma and Disseminated Histiocytic Sarcoma (malignant histiocytosis)*
Rare malignant tumours of histiocytic origin which occur most often in dogs. Breed predilections include Bernese Mountain dogs, Rottweilers and Flat-coated Retrievers. Histiocytic sarcomas may occur as solitary nodules or as multiple lesions that rapidly disseminate. Solitary masses often arise in the subsynovium of the joints or in the subcutis; however other primary sites have been reported (spleen, lymph nodes, etc). Disseminated histiocytic sarcoma (malignant histiocytosis) is an aggressive multisystemic disease characterized by the presence of multiple tumour masses in several organ systems. Primary sites include spleen, lung, bone marrow, lymph nodes, skin and subcutis. This disease (especially the disseminated form) has a guarded to poor prognosis and often responds poorly to routine chemotherapy. Masses are composed of sheets of round cells (histiocytes; these tumours may arise from dendritic cells or less often from macrophages). Those arising from macrophages may be avidly hemophagocytic (hemophagocytic histiocytic sarcoma) causing rapidly progressive anemia.

4) Mast cell tumours (often not included in myeloproliferative disease)
A) **Cutaneous mast cell tumours** (covered in dermatopathology)

B) **Alimentary mast cell tumours** (covered in pathology of the alimentary system)

C) **Systemic mastocytosis/visceral mast cell tumours** *
Primarily affects the hematopoietic system, especially the spleen. Most commonly occurs in cats. Grossly splenomegaly is evident (diffuse or nodular). Microscopically there is effacement of the splenic architecture by dense sheets of mast cells. Mast cells can be identified on histology by using toluidine blue staining. Other viscera which may be affected include the intestine and liver.

**VI) Secondary Bone Marrow Neoplasia**
- Secondary neoplasia of the bone marrow is the result of metastasis of non-marrow origin neoplastic cells to the bone marrow.

**VII) Myelopthisis**
- Myelopthisis = the replacement of hematopoietic tissue within the bone marrow by abnormal tissue.
  - Usually replaced by fibrous tissue (= myelofibrosis) or malignant cells.
  - May be reflected in the peripheral blood as pancytopenia

**LYMPHOID SYSTEM**
**LYMPH NODES**
Normal Structure and Function: *for your information only*
• Lymph nodes are oval to bean shaped organs which are distributed throughout the body along lymphatic vessels (all lymph filtered by at least one lymph node prior to returning to blood).
• The lymph nodes help co-ordinate and direct the body’s immune response, via immune cells (B & T lymphocytes, macrophages, and dendritic cells)
• Constantly responding to antigenic stimuli, even in the absence of clinical disease.

• Lymph nodes are divided into an outer cortex, inner cortex and medulla (in swine this arrangement is reversed with the cortex at the center and the medulla at the periphery):
  o The outer cortex includes follicular structures (primary follicles) which, when antigenically stimulated, develop into secondary follicles. This area is populated mostly by B lymphocytes, but also by macrophages and dendritic cells.
  o The inner cortex (paracortical region) contains primarily T lymphocytes.
  o The medulla contains medullary cords (mostly macrophages, B cells and plasma cells) and medullary sinuses (surrounded by macrophages which phagocytose foreign material/bacteria)

• Lymph circulation: lymph enters via afferent lymphatic vessels → subcapsular sinuses → trabecular sinuses → medullary sinuses → efferent lymphatics → thoracic duct

PATHOLOGY OF THE LYMPH NODES:
Two basic changes can be appreciated grossly: the lymph nodes may be increased in size or decreased in size. The differentials for these two changes are listed in the following table:

<table>
<thead>
<tr>
<th>Enlarged Lymph Nodes*</th>
<th>Small Lymph Nodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphadenitis*</td>
<td>Lymphoid atrophy</td>
</tr>
<tr>
<td>Lymphoid Hyperplasia*</td>
<td>Lymph node degeneration</td>
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<tr>
<td>Hyperplasia of</td>
<td>Lymph node hypoplasia</td>
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<tr>
<td>monocyte/macrophage system</td>
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<tr>
<td>Primary neoplasia*</td>
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<td>Metastatic neoplasia*</td>
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Small Lymph Nodes:
I) Lymph Node Atrophy/Degeneration
  • Senile atrophy – seen in aged dogs, cats and primates
  • Cachectic atrophy – common, especially old sheep and goats with dental attrition
  • Toxins
  • Chemotherapy/Irradiation
  • Many viral infections cause degenerative changes of the lymph nodes (lymphocytolysis)
    o Egs. feline panleukopenia virus, canine parvovirus, canine distemper virus, bovine viral diarrhea virus, feline immunodeficiency virus
    o With chronicity, often results in lymph node atrophy
  • Gross: Lymph nodes are decreased in size (very difficult to appreciate)
  • Histology: Overall reduced cellularity/lymphoid depletion ± lymphocytolysis
Enlarged Lymph Nodes:
*Lymphadenopathy or lymphadenomegaly = lymph node enlargement of unknown or unspecified cause.*
- Can be localized or generalized:
  - Local enlargement usually reflects a pathological process limited to the drainage area
  - Generalized enlargement is seen with sepsis, certain infectious diseases (tuberculosis, brucellosis), and with lymphoma

II) Inflammation (Lymphadenitis)*
Lymphadenitis = an inflammatory response to an infectious agent within the node
(can able to differentiate this from reactive lymphoid hyperplasia in which the node is immunologically reactive but free of local infection).
Lymphadenitis can be acute or chronic:

1) Acute lymphadenitis
- Usual the result of a regional lymph node draining a site of inflammation and subsequently becoming infected. Examples:
  - Infection of the tracheobronchial lymph nodes in pneumonia
  - Infection of the mesenteric lymph nodes with enteritis
  - With sepsis, many nodes will be involved.
- Gross: Affected lymph nodes are enlarged / swollen, soft, moist, hyperemic, and often bulge on cut surface.
  - Swelling is due to edema, exudate and proliferation of the lymphoid / monocyte-macrophage system components of the node.
  - Exudates are usually serous, but may be hemorrhagic or suppurative.

2) Chronic lymphadenitis
- Characteristic features are increased size and firm texture due to fibrosis; lymph node may become irregularly shaped, dry and indurated with prolonged inflammation.

A) Chronic suppurative lymphadenitis (ie. lymph node abscess): Swollen lymph node with a necrotic / pus- filled center (can have fistulous tract draining to the skin surface), in response to pyogenic bacteria.
  - Equine strangles: *Streptococcus equi* subsp. *equi* causes inflammation of the upper respiratory tract and results in abscesses in the mandibular, retropharyngeal, and parotid lymph nodes.
  - Porcine jowl abscess: *Streptococcus porcinus* colonizes the oral cavity and tonsils and spreads to the regional lymph nodes (usually the mandibular lymph node).
  - Streptococcal adenitis in dogs: *Streptococcus sp* (*Lancefield group G*). Occurs in minor endemics in kennels. Characterized by pharyngitis, fever, conjunctival discharge, and enlargement of the submaxillary nodes with abscessation.
Caseous lymphadenitis*: Common disease of sheep and goats caused by Corynebacterium pseudotuberculosis. The etiologic agent is also responsible for ulcerative lymphangitis of horses and cattle and pectoral abscesses in horses. In sheep, the organism usually penetrates the body via cuts (shear wounds) or rarely enters the body by inhalation and drains to the regional lymph nodes. In young animals the disease tends to be confined to the superficial lymph nodes, of which the cervical (prescapular) and subiliac (prefemoral) are most frequently affected. In goats, it often affects the lymph nodes of the head, and neck and may be acquired through the buccal mucosa in addition to skin wounds. In both species there may be slow spread of disease with time to produce abscesses in the internal organs (lung, liver, spleen, etc).

  o **Gross**: Chronic suppurative inflammation and caseous necrosis of the lymph nodes. Concentric laminations within these areas (when present) are considered characteristic of the disease. They are the result of progressive necrosis and reformation of a connective tissue capsule.

B) Granulomatous lymphadenitis*: May be nodular or diffuse; characterized by large, firm solid nodes that may exhibit areas of caseous necrosis and/or discrete granulomas with mineralization

• **Nodular (focal to multifocal) granulomatous lymphadenitis:**
  o *Mycobacterium bovis* (bovine tuberculosis)*
    o Single to multiple discrete white to yellow nodules with central caseous necrosis
    o Initially in regional lymph nodes (eg tracheobronchial lymph nodes in the case of pulmonary tuberculosis) but can become disseminated affecting lymph nodes throughout the body
    o **Gross**: Enlarged lymph nodes with single to multiple (coalescing) pale caseous nodular lesions. Often have gritty (mineralized) centers.
    o **Histology**: Nodular aggregates of epithelioid macrophages, multinucleated giant cells, fewer lymphocytes and plasma cells surrounding central regions of necrosis +/- mineralization. Acid-fast bacilli are located in lesions.
  o *Mycobacterium avium* subsp. *paratuberculosis* (Johnne’s disease)
    o Several non-caseating granulomas in the mesenteric lymph nodes
  o *Actinobacillus lignieresii* (wooden tongue)
  o Migrating parasitic larvae

• **Diffuse granulomatous lymphadenitis**: Generally see enlarged, dry firm nodes
  o Porcine Circovirus type-2* (PCV-2) – Postweaning multisystemic wasting syndrome (PMWS): granulomatous inflammation with large botryoid intracytoplasmic viral inclusions within macrophages.
  o *Histoplasma capsulatum* is a facultative intracellular pathogen of macrophages. Therefore disease is characterized by diffuse involvement of the mononuclear phagocyte system.
    o Marked proliferation of macrophages in the spleen, lymph nodes, liver, lungs and intestine → enlarged lymph nodes, spleen and liver
  o *Blastomyces dermatitidis* and *Cryptococcus neoformans*
Affects regional lymph node draining the affecting areas (skin, lungs, etc)

III) Lymph Node Hyperplasia*
• Hyperplastic changes lead to lymph node enlargement (lymphadenopathy)
• Hyperplastic changes may involve lymphoid tissue (lymphoid hyperplasia) and/or cells of the monocyte-macrophage system (sinus histiocytosis)
• Lymph node hyperplasia is a common reactive lesion; it can be localized or generalized and occurs in response to presentation of foreign material / antigen or in response to circulating interleukin levels.
• One classical example of reactive hyperplasia is seen in local lymph nodes draining a site of local infection or a site of vaccination.
• Reactive hyperplasia also occurs during early lymphadenitis

Gross: Moderate enlargement of affected lymph nodes, may bulge on cut section.

Histologically: Proliferation of the lymphoid follicles with prominent germinal centers, increased T-cells in the paracortex, and increased plasma cells in the medullary cords.

IV) Neoplasia*
1) Primary Neoplasia – Lymphoma: See primary neoplasia of the hematopoietic system

2) Secondary Neoplasia (metastatic)
Lymph node metastasis is commonly seen with carcinoma, malignant melanoma (especially of the oral cavity of dogs) and mast cell tumors. Grossly, the lymph nodes may be enlarged. Histologically, there may be few cells within the peripheral/medullary sinuses or there may be effacement of the normal node architecture by neoplastic cells.

Lymph node involvement is one basis for the clinical staging of tumor malignancy. This is done as part of the World Health Organization TNM classification of tumors.

T: Tumour size or extent (T0 – T4)
N: Lymph node involvement (N0 – N3 depending on extent)
M: Metastasis (M0 or M1)

THYMUS
Normal Structure and Function – for your information only
• The thymus is a white to tan, lobulated organ, found in the anterior mediastinum; ruminants and pigs have a large cervical lobe which extends along the cervical trachea.
• Composed of epithelial tissue (from endodermal branchial pouches) and lymphoid tissue (T lymphocytes).
• It is divided into lobules, each lobule having a cortex (immature T cells) and a medulla (mature T cells).
• The thymus provides the necessary microenvironment required for T lymphocytes to proliferate and mature.
• The thymus is large at birth and begins involution at or near puberty (although it remains active throughout life). The involuting organ is gradually replaced by loose connective
tissue and fat.

I) Miscellaneous Disorders
1) Lymphocytolysis/Thymic atrophy
   • Lymphocytolysis in the thymus (as in other organs) is caused by:
     o Malnutrition
     o Drugs/Toxins
     o Viral infections
   • Results in varying degrees of immunodeficiency (ie secondary/acquired immunodeficiency)
     o see increased severity of infectious diseases and an increased susceptibility to opportunistic pathogens.
   • Thymic atrophy is normal with advancing age.

2) Thymic aplasia/hypoplasia
   • Aplastic or hypoplastic thymic disorders occur with loss or functional impairment of T cells and impaired cell-mediated immunity → primary/congenital immunodeficiency:
     o Many deficiencies involve failure of both T and B cells (= combined immunodeficiency) with morphologic changes including lymph node hypoplasia, lack of splenic white pulp, and thymic hypoplasia.
       ▪ SCID (severe combined immunodeficiency) in foals, mice, dogs (jack Russell terriers, Bassett hounds).

3) Thymic hemorrhage/hematoma
   • Reported in dogs: sudden death due to hypovolemic shock resulting from massive thymic and mediastinal hemorrhage. A variety of causes have been implicated: trauma (HBC), ruptured aortic aneurysms, ingestion of anticoagulant rodenticide.

II) Neoplasia*
1) Thymic (mediastinal) lymphoma* (also see primary hematopoietic neoplasia)
   • T-cell neoplasm, usually younger animals (calves, cats, dogs).
     o In cats: wide age distribution, but in young cats - often associated with FeLV.
     o In cattle: yearlings, usually beef: no viral association.
   • Gross: Large space occupying mass in the cranioventral mediastinum (may see dyspnea).
     o Thoracic effusion is common and thoracic aspirates are often used for diagnosis.
   • Histology: Sheet-like infiltrates of neoplastic lymphocytes.

2) Thymoma*
   • Less common than lymphoma; seen most commonly in dogs, sheep and goats
   • Tend to be slow-growing, heavily encapsulated tumours that rarely metastasize.
   • Gross: Large space occupying mass in the cranioventral mediastinum (may see dyspnea).
   • Histology: Neoplastic proliferation of thymic epithelial elements accompanied by varying amounts of non-neoplastic lymphoid tissue.
   • In dogs and humans can result in a paraneoplastic syndrome of myasthenia gravis (ie autoimmune attack of the acetylcholine receptors of the neuromuscular junction).
SPLEEN

Normal Structure – for your information only
• The spleen, which is located in the left cranial abdomen within the omentum, is covered by a fibromuscular capsule and the parenchyma is incompletely dissected by trabeculae.

Structure: The splenic parenchyma consists of red pulp and white pulp:
• Red pulp consists of fenestrated vascular spaces and splenic cords (reticular cells/fibers) supporting macrophages, lymphocytes, plasma cells and blood cells (granulocytes, platelets, red blood cells).
• White pulp consists of periarteriolar lymphoid sheaths = PALS (T cells), appended lymphoid nodules (B cells), and a peripheral marginal zone (rich in phagocytic macrophages and dendritic cells

Function: Just as the lymph nodes filter lymph, the spleen filters blood:
• Red Pulp
  • Removal of foreign material, microorganisms, and senescent or altered erythrocytes by splenic macrophages via phagocytosis (→ part of the monocyte macrophage system).
  • Storage of mature red blood cells in some species (eg horse); spleen size may decrease by contraction of the fibromuscular capsule / trabeculae to release stored blood into circulation in response to hypovolemia, or epinephrine stimulation.
  • Extramedullary hematopoiesis (EMH) is found in the red pulp under certain circumstances in the adult; EMH in red pulp is normal in the fetus and neonate and also in adults of some species (rodents, mink).

• White Pulp (secondary lymphoid organ)
  • Plays a role in the immune response, with production of B lymphocytes and plasma cells to produce antibody and memory lymphocytes.
  • The response starts in the red pulp where macrophages / dendritic cells trap and process blood borne particles / viruses / bacteria / protozoa and present them as processed antigen → T and B cells → production of antibody, memory cells, etc.
  • Note: splenectomized animals are more susceptible to hemoparasites, eg Mycoplasma haemofilis.

I) Miscellaneous diseases
1) Siderofibrosis of the splenic capsule (= siderotic nodules or Gamma-Gandy bodies)*
  • Very common incidental finding in dogs, likely represent residual effects of prior hemorrhage.
  • Gross: Granular, white to yellow-tan deposits within the splenic capsule.
  • Histology: Accumulations of hematoidin (yellow pigment), hemosiderin/iron (gold-brown pigment), mineral (blue deposits) and fibrosis within the affected capsule.

2) Splenic amyloidosis
  • In animals, the most common form of amyloidosis is “secondary amyloidosis”, which is associated with the deposition of amyloid protein AA (an acute phase protein) secondary to chronic inflammation.
• **Gross:** Splenomegaly (not always), beige to orange discolouration, +/- firm prominent white pulp areas.

• **Histology:** There is deposition of amyloid around follicular arteries (detect with Congo red).

3) Splenic contraction

• Due to contraction of smooth muscle in the capsule/trabeculae. Induced by catecholamine release, circulatory shock, and acute splenic rupture.

• **Gross:** Small spleen, wrinkling of the capsular surface, tissue is dry on cut surface

• Can see **incomplete contraction** - due to failure of contraction of the smooth muscle in some areas.
  
  o **Gross:** Numerous dark red to black, raised, soft, blood filled areas of various size with intervening areas of depression. May be indistinguishable from acute splenic infarcts.

4) Splenic rupture*

• Most often seen in dogs and cats: can be primary, due to trauma (eg hit by car) or may occur secondary to splenomegaly or splenic neoplasia (eg, hemangiosarcoma, lymphoma) which cause thinning of the capsule.

• The result may be death by exsanguination or healing by scarring

• Occasionally following rupture there may be seeding of splenic explants on peritoneal / serosal surfaces forming accessory spleens (‘splenosis’).

• **Accessory spleens:**
  
  o **Gross:** One or more small red nodules within the omentum (looks similar to hemangiosarcoma implants/metastases)
  
  o **Histology:** Identical to normal spleen

5) Torsion of the spleen*

• Torsion of the spleen, with or without torsion of the stomach, occurs mainly in pigs and dogs.

• If the whole spleen is twisted around the gastrosplenic ligament, there is severe congestion and hemorrhagic (venous) infarction due to occlusion of the splenic vein; may lead to hemodynamic shock.

• **Gross:** splenomegaly, blue-black, and often folded back on itself (C-shaped).

II) Circulatory disturbances

1) Active hyperemia*

• Seen with acute systemic infection and bacterial sepsis.

2) Passive congestion*:

• Caused by disturbances in systemic and portal circulation; can be seen with shock (vascular pooling), **barbiturate administration** (especially horses, dogs), and hemolytic anemia

• **Gross:** the spleen is enlarged/swollen and red-purple to black because of increased amounts of blood (unoxgenated) and **oozes blood on cut surface**.

• **Histology:** Vascular spaces are dilated and contain erythrocytes. The germinal centers are widely separated and the trabeculae are thinned.
3) Splenic Infarction* - due to thrombosis or embolism

- **Thrombosis and infarction**
  - Seen with diseases causing vascular damage: certain viruses (Classical swine fever), bacterial sepsis
  - Seen with hypercoagulable states: nephrotic syndrome, IMHA, steroid therapy/Cushing’s disease, neoplasia, pancreatitis
  - Splenomegaly (regardless of the cause) makes the spleen prone to thrombosis and infarction

- **Embolism and infarction** is usually the result of septic emboli: eg. endocarditis of the left heart, vena caval thrombosis of cattle.

- **Gross**: Acutely, infarcts are discrete, slightly raised, dark red areas usually located at the margins of the organ. With time (chronicity) they become depressed, pale and firm (fibrosis)

4) Splenic hematoma*

- Splenic hematoma is one of the more common canine splenic “masses”.
- Usually the result of trauma. Can be associated with nodular hyperplasia or splenic vascular neoplasia.
- **Gross**: Red nodular mass(es), bloody consistency, often very large
- Histopathology necessary to rule-out underlying neoplasia, especially hemangiosarcoma.

III) Inflammation

1) Acute Spleatitis*:

A) Spleens of relatively normal size may contain multifocal small (1 to 2 mm diameter) foci of necrosis / suppurative infiltration.

- Tularemia (*Franciscella tularensis*) – especially seen in wild rodents, can affect most species; zoonotic
  - Tularemia is found world-wide and is abundant in nature as an infection of rodents. In humans, it causes severe systemic disease. The organism can penetrate intact skin and mucous membranes, but is also infective by ingestion, inhalation, and inoculation by biting insects and ticks.

- Yersiniosis (*Yersinia pseudotuberculosis*) – especially wild rodents and birds, can affect many species; zoonotic.

- **Gross**: Small white miliary foci scattered throughout the spleen. Similar lesions may be present in the lymph nodes and liver. Slightly larger older lesions may resemble granulomas.

B) In other septicemias there is marked splenomegaly = “septicemic splenitis” → the spleen is soft, dark and engorged with viscous blood:

- African swine fever
- Erysipelas
- Anthrax**
Anthrax is caused by Bacillus anthracis, a gram-positive bacillus. In horses, pigs, and dogs, localization to the throat or intestine is more common and may be fatal before invasion of the blood occurs. In ruminants, Anthrax tends to be a brief septicemic disease. With sepsis, the blood swarms with vegetative organisms; these form spores when exposed to air. Spores of Bacillus anthracis may survive for decades in certain soil types and ruminants are frequently infected following soil excavation (probably via ingestion of contaminated food or water, inhalation, or entry through traumatized mucous membranes). Following infection there is a lymphangitis and local lymphadenitis. Sepsis ensues and bacterial toxins (edema factor, protective antigen, lethal factor) are secreted resulting in increased capillary permeability, impaired coagulation, and injury and inactivation of phagocytes.

**Gross:** In cattle, characteristic findings are a carcass that bloats and autolyses rapidly and blood oozing from body orifices. Internally there is marked splenomegaly, multiple hemorrhages and edema of the soft tissues. The blood is thick and dark (frequently described as tarry) and either is not clotted or the clots are very soft and friable. In pigs and dogs, splenomegaly is not characteristic; they tend to have pharyngeal inflammation with cervical lymphadenitis or localized necrotizing enteritis. Dogs and pigs acquire infection by eating infected carcasses.  
*You are not supposed to necropsy animals suspected to have died from anthrax!*

Diagnosis should be based on the identification of organisms in blood smears—usually from the ear or tail. These bacilli have a distinct capsule that stains pink with old methylene blue.

2) **Granulomatous splenitis:**
   - Can lead to multiple pale nodules or a diffusely swollen and firm spleen (grossly it may be difficult to differentiate from neoplasia). Causes include: Mycobacterium spp. (eg. Tuberculosis), Brucella spp, systemic mycotic diseases (eg Histoplasmosis and Blastomycosis) and Leishmania.

3) **Splenic abscesses:**
   - Relatively rare, but can follow sepsis with pyogenic bacteria: Arcanobacterium pyogenes in cattle, Rhodococcus equi in horses.

IV) **Disturbances of Growth**

*Splenomegaly = enlarged spleen*

1) **Aplasia, malformation, atrophy**
   - These tend to have little pathological significance.

2) **Nodular hyperplasia**
   - Common incidental finding in aged dogs and occasionally old bulls.
   - The cause is unknown, however they may predispose to splenic hematomas and cannot be grossly distinguished from neoplasia.
   - **Gross:** Single or multiple raised nodules, gray to reddish pink or variegated red and white. Usually < 2 cm, but can reach >5 cm in diameter.
   - **Histology:** Unencapsulated nodules are composed of aggregates of lymphoid tissue +/- extramedullary hematopoiesis, separated by congested red pulp
3) **Lymphoid hyperplasia***
   - Hyperplasia of the lymphoid follicles and the PALS
   - Response to blood-borne antigens/chronic antigenic stimulation.
   - **Gross:** lymphoid follicles are visible as 1–3 mm white foci scattered throughout the spleen

4) **Hyperplasia of monocyte/macrophage population / Hypersplenism**
   **Hypersplenism** = a spleen that is overactive in cell destruction.
   - Any cause of splenomegaly has the potential to stimulate the phagocytic population of the spleen to proliferate and fill all available splenic space.
   - Often leads to phagocytic hyperactivity (hypersplenism) with resultant anemia and/or thrombocytopenia.
   - Hyperplasia of the macrophages can also be caused by infectious agents (*Histoplasma, Leishmania*).

5) **Extramedullary hematopoiesis (EMH)**
   - In response to increased demand (eg anemia, infection) there is proliferation and maturation of normal erythroid and/or myeloid and/or megakaryocytic cell lines in the red pulp of the spleen (expansion of marrow production). Normal in fetuses and neonates.
   - Can cause splenomegaly or mass-like nodules

V) **Splenic Neoplasia***
In dogs, nodular tumors must be differentiated from nodular hyperplasia and splenic hematomas; often requires histologic/cytologic examination.

1) **Primary Neoplasms**
   A) **Lymphoma / Lymphoid Leukemia:**  *See primary neoplasia of the hematopoietic system*
      - **Gross:** May see nodules or diffuse splenomegaly

   B) **Myeloproliferative Diseases**
      - Most myeloproliferative diseases (eg mast cell tumor, histiocytic sarcoma) will involve the spleen and liver as the disease progresses.
      - **Gross:** May see nodules or diffuse splenomegaly

   C) **Hemangioma**
      - Benign tumour of endothelial cell origin.
      - **Gross:** Single, soft, nodular, dark red mass.
      - **Histology:** Composed of cavernous blood-filled spaces lined by well-differentiated endothelium.

   D) **Hemangiosarcoma**
      - Malignant tumour of endothelial cell origin.
      - Most common malignant neoplasm of canine spleen (German shepherds predisposed).
      - **Gross:** Single to multiple, discrete to coalescing, dark red masses in the spleen (+/- metastasis).
      - **Histology:** Composed of blood filled vascular spaces lined by anaplastic endothelial
cells.

- **Sequelae:** Splenic hematomas, splenic rupture (leading to internal hemorrhage and death), neoplastic implants in the peritoneum (looks like splenosis), widespread metastasis.

**E) Others**
- Fibrosarcoma, leiomyosarcoma, fibrohistiocytic nodules/ malignant fibrous histiocytoma.

2) **Primary Neoplasms**
- Lymphoma, hemangiosarcoma, osteosarcoma, fibrosarcoma, leiomyosarcoma, fibrohistiocytic nodules/ malignant fibrous histiocytoma.

2) **Secondary Neoplasms**
- Metastases in the spleen are not as common as expected; the functional efficiency of the sinusoidal macrophages are thought to prevent the establishment of metastatic foci.

The following two tables include important differentials for splenomegaly and splenic nodules:

<table>
<thead>
<tr>
<th>Splenic nodules with a bloody consistency</th>
<th>Splenic nodules with a firm consistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematoma</td>
<td>Nodular hyperplasia</td>
</tr>
<tr>
<td>Hemangiomia</td>
<td>Primary Neoplasia</td>
</tr>
<tr>
<td>Hemangiosarcoma</td>
<td>Metastatic Neoplasia</td>
</tr>
<tr>
<td>Acute splenic infarct</td>
<td>Abscess</td>
</tr>
<tr>
<td>Incompletely contracted area of spleen</td>
<td>Granuloma</td>
</tr>
</tbody>
</table>

Diffuse splenomegaly with a bloody consistency “Bloody Spleen”

- Congestion
- Due to proliferation of cells

Septicemia (Anthrax, Salmonella)  
Hemolytic disease  
Splenic torsion  
Barbiturate euthanasia**  
- Mast cell neoplasia  
- Histiocytic sarcoma  
- Granulomatous disease (Histoplasmosis)  
Amylloidosis

OTHER SECONDARY LYMPHOID ORGANS *(for your information only)*
Including tonsils, pharyngeal lymphoid follicles, Mucosal-associated lymphoid tissue (MALT) (including BALT, GALT, and Peyer’s patches)

Pathology: Subjected to a range of pathologic processes similar to that of lymph nodes.
- Some degree of constant stimulation/inflammation is not surprising since they tend to occur on mucosal surfaces and serve as immunologic sentinels for the body.
- Often the portal of entry for pathogens *(Mycobacterium avium subsp. paratuberculosis,*
Listeria monocytogenes, Salmonella).

- Please note, lymphoma may arise from MALT (especially in aged cats and dogs). MALT lymphoma tends to be low-grade, of B-cell origin, and is thought to arise in a background of chronic inflammation.

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**BURSA OF FABRICIUS** *(for your information only)*

- Located along the dorsal aspect of the cloaca; like the thymus it atrophies as the bird matures.
- It is the location of proliferation, maturation and removal of self-reactive B lymphocytes.
- A specific viral infection of chickens, infectious bursal disease (IBD), causes severe damage to the bursa in young chicks and results in immunodeficiency.
- Lymphoid leukosis (due to avian leukosis virus) is a neoplastic proliferation of B cells which involves many organs, including the bursa.