



Collar stud abscess an interesting case report

Kameshwaran Kannappan Punniyakodi * Balasubramanian Thiagarajan*

*Stanley Medical College
Chennai, Tamilnadu

Abstract – Cervical Lymphadenopathy with collar stud abscess of tuberculous etiology is uncommon nowadays. This case is being reported for clinical interest and for the purpose of documentation.

Introduction

Tubercular Lymphadenopathy is a common extra pulmonary manifestation of tuberculosis. Collar stud abscess are rarely seen in OPD nowadays. Tuberculosis remains a problem throughout the world and is still a common cause of cervical lymphadenopathy.

Portals of Entry of infection:

- Pharyngeal lymphoid tissue like tonsils ‘Bovine type’.
- Secondary to pulmonary tuberculosis.
- Hematogenous-rare

Tuberculous lymphadenitis¹ is caused by Mycobacterium tuberculosis. The basic pathology is a granulomatous inflammation with tubercles which undergoes caseation necrosis and destruction of the lymph node. Spread of infection to the adjacent nodes causing periadenitis results in these nodes getting adherent to each other. This gives the characteristic physical sign of early matting of the node. Where the node lies deep to the deep fascia as in the neck, the caseous node perforates through the deep fascia and the caseous matter escapes into the superficial fascia resulting in the characteristic collar stud abscess.

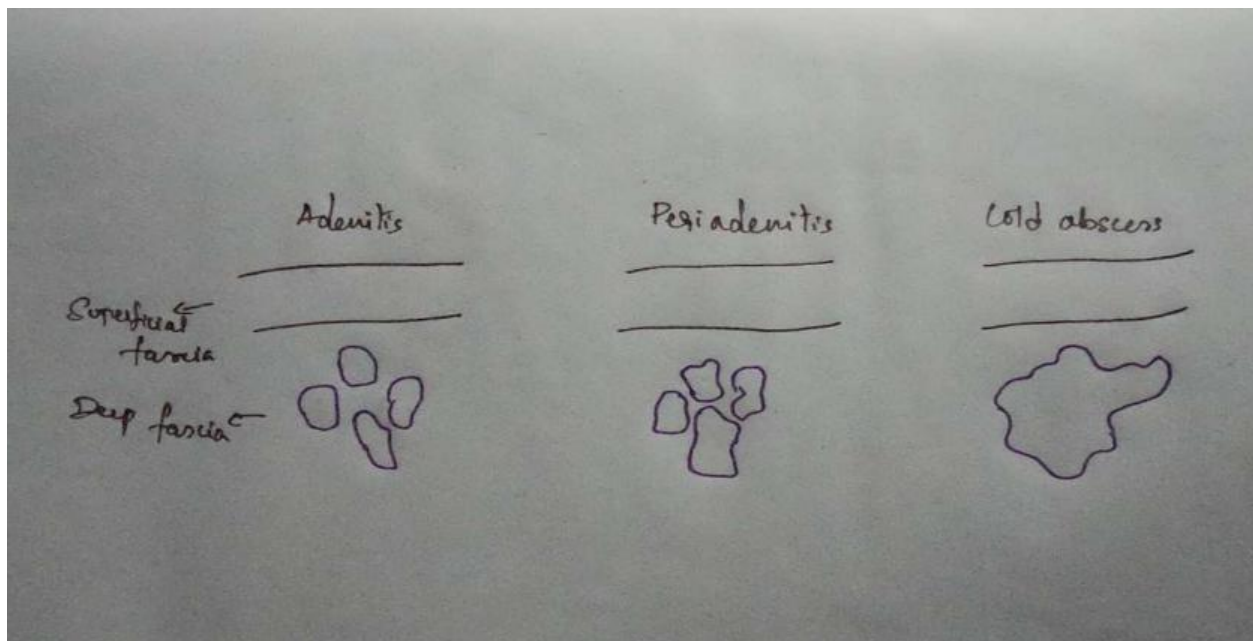
The condition most commonly affects children and young adults but can occur at any age. Clinically three stages are recognized².

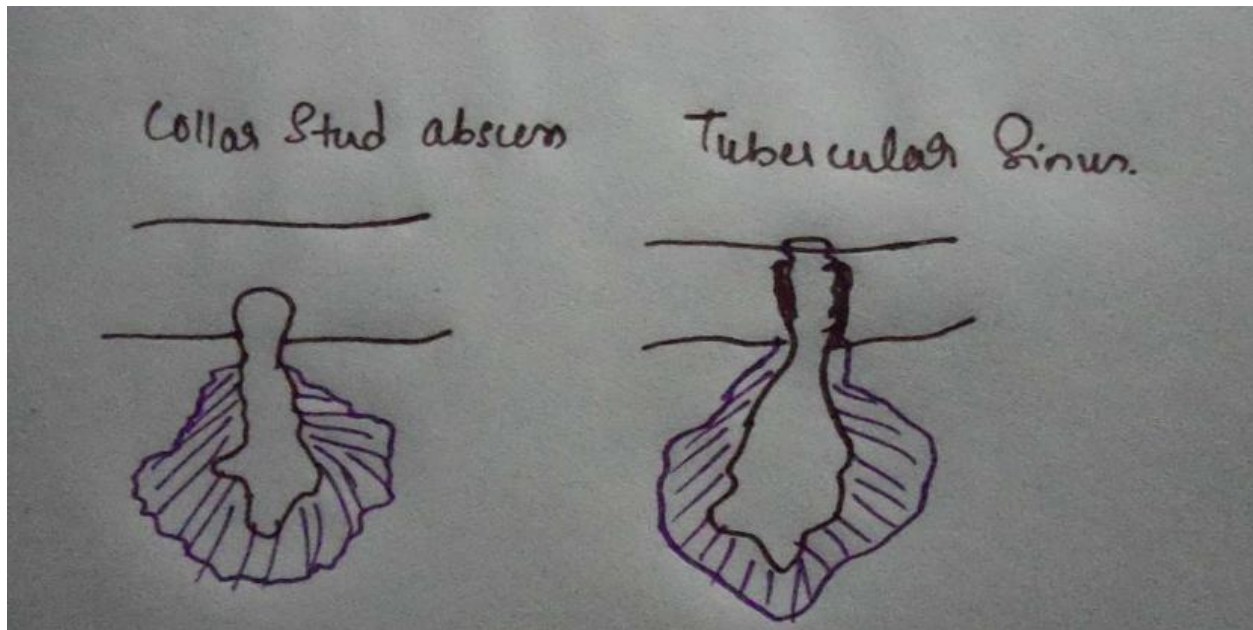
First stage- The nodes become enlarged without matting. This is known as lymphadenoid type and its differentiation from chronic septic lymphadenitis becomes difficult.

Second stage- In periadenitis the enlarged nodes become adherent to one another (matted). This is the most characteristic feature of tuberculous lymph nodes.

Third stage- caseation takes place in the interior of the nodes so that the nodes become softer with formation of cold abscess. Gradually the cold abscess makes its way towards the skin and ultimately bursts out forming a tubercular ulcer or sinus which refuses to heal.

Pathologically 5 stages of lymphadenitis are recognized:





Stage I – The glands are enlarged, mobile, firm and slightly tender. Histologically this stage shows nonspecific relative hyperplasia.

Stage II – The nodes are enlarged, firm and fixed to surrounding tissue and to each other. Histologically they show periadenitis.

Stage III – The caseation occurs within the lymph node which burst out and collects beneath the deep fascia.

Stage IV – The caseous material perforates the deep fascia and escapes into the superficial fascia resulting in collar stud abscess formation.

Stage V – The cold abscess burst out and gives rise to a persistent discharging sinus.

Case report:

A 38 year old female belonging to lower socio economic class came with chief complaints of left sided swelling in the neck for the past 3 months, Insidious in onset, Progressive in nature and attained its present stage, No Aggravating /Relieving factors. H/o fever on & off for past 3 months, Evening rise of temperature+ , No h/o Cough/Hemoptysis/Breathlessness/Loss of weight. No h/o Contact. Rest of the family members were normal and healthy.



Clinical image showing neck swelling

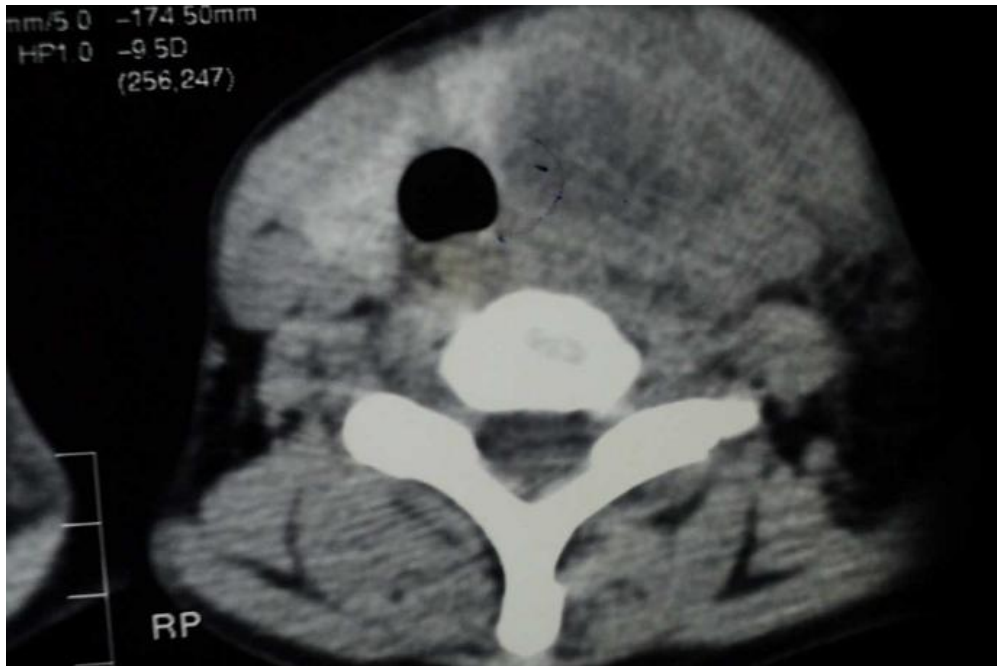
On General examination, patient is moderately built. Pallor+. Temperature-100F, PR-102/min, BP-110/70 mmHg, Respiratory system and other system within normal limit.

Local examination- 5*6cm swelling seen in the left sided anterior neck region, extending up to thyroid cartilage superiorly, 1cm above the sterna notch, Just crossing the midline medially, up to the anterior border of Sternocleidomastoid laterally, Tender on touch, Warmth, No dilated veins, Skin Pinchable, No sinus/scar.

Investigations- Hb-11.2gms%, TC-9300/cmm Neutrophils-25%, Lymphocytes-73%, Eosinophils-2%, ESR-20/30, CXR- NAD, Mantoux – REACTIVE.

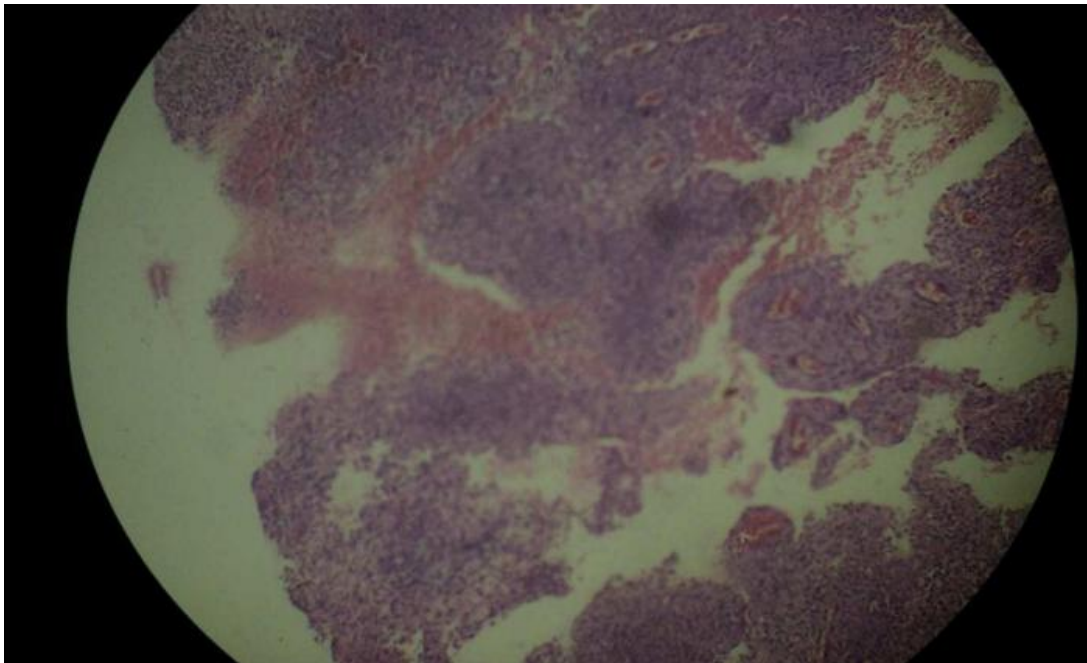
FNAC³

– Granulomatous lesion with epithelial cells. Chest physician opinion obtained-Advice to start ATT Category I.



CT NECK IMAGE ^{4,5}

Histology Image



HPE Report- Granulation tissue with Haemorrhage and Ill defined Epitheloid granuloma, features consistent with partially treated with ATT.

TREATMENT

Standard anti tuberculosis drugs for six months .our case responded well to 2 RHZ X 4 RH.
UNDER GA, NON DEPENDENT INCISION AND DRAINAGE DONE.

CONCLUSION

In conclusion, TB is still a common and important disease. It may present in a myriad of ways depending on the organ(s) involved. One should be aware of the various clinical presentations of both pulmonary and extra pulmonary TB. This case is being reported for clinical interest and for the purpose of documentation.

REFERENCES

- 1.Seth V, Kabra SK, Jain Y, Semwal OP, Mukhopadhyaya S, Jensen RL Tubercular lymphadenitis: clinical manifestations. *Indian J Pediatr* 1995; 62: 565.
- 2.Diagnostic standards and classification of tuberculosis in adults and children September 1999, *Am J Respir crit care med* 2000 161 (4): 1376-1395
- 3.Bezabih M, Mariam DW, Selassie SG. Fine needle aspiration cytology of suspected tuberculous lymphadenitis. *Cytopathology* 2002; 13: 284-90.
- 4 .Engin G, Acunas B, Acunas G, et al. Imaging of extrapulmonary tuberculosis. *Radiographics* 2000; 20:471-88.
5. Sharma SK, Mohan A. Extrapulmonary tuberculosis. *Indian J Med Res* 2004; 120:316-53.