



Unusual presentation of tubercular unilateral cervical lymphadenitis: A case report

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Abstract:

A case of tubercular lymphadenitis in a 19 year old is reported here for its unusual presentation and to create awareness regarding uncommon manifestations of lymph node tuberculosis, so as to diagnose the condition early for better management.

Case Report:

A 19 year old female presented to ENT OPD with swelling in preauricular region on the left side since 2 months .The swelling was small in size initially progressed over the 2 months to the present size of 2×2cm .The swelling was painless , there was no associated history of fever , toothache , earache , ear discharge, pain while swallowing .There was no history of cough or loss of weight or loss of appetite. There was no history of tuberculosis in the past. There was no history of tuberculosis in the family.

On examination she was found to be afebrile, with pulse rate of 86beats/min, respiratory rate of 19/min.

She had received BCG vaccine and the scar was present .

On physical examination multiple lymph nodes were palpated on the left side.

1.Left preauricular region single lymph node of size 2×2cm

2.Left jugulodigastric region single lymph node of 1×0.5cm

3.Left submandibular region single lymph node of 0.5×1cm

4.Left posterior triangle multiple lymph nodes largest measuring 1×1.5cm

5.Left supraclavicular region multiple lymph nodes largest measuring 0.5×1cm.

All the lymph nodes were firm in consistency , non tender with no local rise of temperature, mobile , with no scars or sinuses.

Surprisingly there were no palpable lymph nodes on the right side. Examination of the ear , nose , oral cavity and throat was normal. Indirect laryngoscopy was within normal limits . General physical examination did not reveal any palpable lymph nodes in the body. Facial nerve was intact , the movements of cervical spine was normal.

On investigation her haemoglobin was 9.2g%, total leucocyte count 9900/cum, differential leucocyte count neutrophils 69%, lymphocytes 24%, eosinophils 1%, monocytes 6%, ESR 90mm/hr. Peripheral smear showed microcytic hypochromic anemia. Rest of the blood investigations were normal. Chest x ray was normal. Usg neck showed multiple enlarged level 1, 2, 3 and 4 on left side largest measuring 8 to 14mm in size with hypoechoic echopattern. Few of lymph nodes showed partial necrosis .

FNAC of left submandibular and preauricular lymph nodes was done which was reported as reactive lymphadenitis. Mantoux test was done which was positive with 23mm induration. With high clinical suspicion of tuberculosis , positive mantoux, elevated ESR, USG neck showing partial necrosis in few lymph nodes FNAC was repeated .FNAC of left preauricular and left submandibular lymph nodes showed ill formed granulomas of epithelial cells, mature lymphocytes, plasma cells, histiocytes , centrocytes , centroblasts and immunoblasts against a background of caseous necrosis , stromal fragments and lymphogranular bodies suggestive of tubercular lymphadenitis. Patient was started on anti tubercular treatment category 1 under the Directly Observed Treatment Short course (DOTS) strategy as per RNTCP guidelines .There was marked response with this treatment and swellings subsided after 2 months of treatment.

Patient is presently in 4th month of treatment and there is disappearance of swelling , and has gained 3 kgs during treatment. Patient is also being treated for anemia her haemoglobin is 10.4g% at present.

Discussion:

Extrapulmonary TB is defined as TB of organs other than lungs such as lymph nodes , pleura, genitourinary tract , skin , joints , bones etc Tuberculosis of superficial lymph nodes called scrofula is very common in India with cervical lymph nodes most commonly involved .The clinical picture is often non descriptive in EPTB , symptoms such as fever , loss of weight and failure to thrive are usually associated .In our case , patient had swelling in preauricular region with no other symptoms.

Tuberculosis needs to be suspected in every case of asymptomatic cervical swelling in India due to high prevalence of tuberculosis in India especially in rural settings . The reason why only left side lymph nodes alone were affected still remains unanswered.

The gold standard for diagnosis of EPTB is the direct demonstration of acid fast bacilli in the biopsy. It is difficult to see AFB in such cases due to low bacterial load .FNAC showing features of granulomatous lymphadenitis is still valid for diagnosis of tubercular lymphadenitis

Four drug regimen (rifampicin , isoniazid , ethambutol and pyrazinamide) in the intensive phase followed by two drugs (rifampicin and isoniazid) in continuation phase is recommended treatment regimen.

Conclusion:

EPTB often poses a diagnostic delay due to the non descriptive clinical picture and low burden of organisms. The increased awareness of uncommon manifestations of lymph node tuberculosis at atypical sites may help in diagnosing the condition early.

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