A 60 year old male presented with complaints of cough and expectoration of six months duration and a history of intermittent fever, off and on, for two months. He was a non-smoker and non-alcoholic. Physical examination revealed marked pallor. There was no jaundice, hepatosplenomegaly or lymphadenopathy. The patient was afebrile. A chest X-ray revealed bilateral pleural effusion with opacities in both apices. Auscultation of chest revealed bilateral, bi-basal breathlessness with retractions in both lateral zones. The arterial oxygen saturation was 76% on room air.

On examination, the patient was in a moderate degree of respiratory distress. The patient was pale, with marked pallor. The blood pressure was 112/70 mm Hg, heart rate 94/minute, respiratory rate 24/minute, and the body temperature was 37.2°C. Auscultation of chest revealed bilateral pleural effusion with opacities in both apices. The arterial oxygen saturation was 76% on room air.

The patient was pulseless, hypotensive, and oliguric. The patient was intubated and ventilated. The arterial oxygen saturation was 88% on 100% oxygen. A chest X-ray revealed bilateral pleural effusion with opacities in both apices. The arterial oxygen saturation was 76% on room air.

Introduction

Case Report

A 60 year old male presented with pulmonary tuberculosis and moderate anaemia. He was on antitubercular treatment and haematinics. The anaemia remained refractory to treatment. But the patient developed recurrent deep vein thrombosis and pancytopenia, which subsequently transformed into acute myeloid leukemia (AML). The patient was put on antitubercular treatment and haematinics. The anaemia remained refractory to treatment but progressed to pancytopenia and a leukaemoid blood picture.

The progress of the disease including clinico-radiological and haematological profiles is depicted and investigation findings shown in the progress chart, a diagnosis of pulmonary tuberculosis was made and the anaemia was ascribed to tuberculosis. The patient was, therefore, put on antitubercular treatment and haematinics. The anaemia remained refractory to treatment but progressed to pancytopenia and a leukaemoid blood picture.

Methodology

The diagnosis of the disease including clinico-radiological and haematological profiles is depicted and investigation findings shown in the progress chart, a diagnosis of pulmonary tuberculosis was made and the anaemia was ascribed to tuberculosis. The patient was, therefore, put on antitubercular treatment and haematinics. The anaemia remained refractory to treatment but progressed to pancytopenia and a leukaemoid blood picture.

Discussion

The patient developed acute myeloid leukemia while tuberculosis could not be held responsible for the development of leukemia. Tuberculosis and myelodysplastic syndrome (MDS) are Malignant hematologic diseases that may commonly arise in patients treated with antitubercular drugs. MDS may progress to frank leukemia state while tuberculosis could not be held responsible for the development of leukemia. Tuberculosis and myelodysplastic syndrome (MDS) are Malignant hematologic diseases that may commonly arise in patients treated with antitubercular drugs. MDS may progress to frank leukemia state while tuberculosis could not be held responsible for the development of leukemia. Tuberculosis and myelodysplastic syndrome (MDS) are Malignant hematologic diseases that may commonly arise in patients treated with antitubercular drugs. MDS may progress to frank leukemia state while tuberculosis could not be held responsible for the development of leukemia. Tuberculosis and myelodysplastic syndrome (MDS) are Malignant hematologic diseases that may commonly arise in patients treated with antitubercular drugs. MDS may progress to frank leukemia state while tuberculosis could not be held responsible for the development of leukemia. Tuberculosis and myelodysplastic syndrome (MDS) are Malignant hematologic diseases that may commonly arise in patients treated with antitubercular drugs. MDS may progress to frank leukemia state while tuberculosis could not be held responsible for the development of leukemia.