Case Report

TUBERCULOSIS OF CYSTIC LYMPH NODE OF LUND - A RARE PRESENTATION

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Abstract

Tuberculosis is one of the major infectious diseases in Bangladesh. After respiratory system, lymphatic and gastrointestinal tracts are the commonest sites of development of this pathology. However, hepatobiliary tuberculosis is rare, seen in approximately 1% of all abdominal cases. Reporting of tuberculosis of the cystic duct lymph node is very uncommon. Its diagnosis is difficult because of the absence of characteristic symptoms and signs. In this case report, we present a case of tuberculosis of cystic duct lymph node.

Case Report

A 24 year old male medical student was presented with anorexia and weight loss (8 kg) over 2 months. He also complained of vague upper abdominal pain, postprandial fullness and afternoon fever. On clinical examination there was no jaundice. Chest X-ray was normal. ESR was 71 mm in 1st hour (Westergren). Abdominal ultrasound showed the gallbladder wall mildly thickened with calcified polyps. Large lymph nodes were present in epigastric, para-aortic and porta hepatis areas, with prominent spleen. At CT scan of Abdomen multiple intra-abdominal Lymphadenopathy involving porta-hepatis and peripancreatic region were present. CT guided FNAC showed reactive lymphadenitis. Laparoscopic cholecystectomy with cystic lymphadenectomy was done (Figure 1). Cystic lymph node was fairly large. Histopathological examination of the cystic duct lymph node showed granuloma formation, caseating necrosis and Langerhans-type giant cells (Figure 2). The gallbladder showed chronic cholecystitis with cholesterolosis. AFB staining of the lymph node showed M. tuberculosis (Figure 3). Anti Koch treatment was started immediately with isoniazid, rifampicin, pyrazinamide, ethambutol. After 2 months of beginning treatment the patient's general condition was improved.

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Fig.-1: Gross section of the gall bladder with attached cystic lymphnode
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Discussion

Till date two cases of tubercular cystic lymph node were reported\(^1\),\(^2\) where the patients presented with affected gallbladder also\(^3\). High concentrations of bile acids provide protection against the tubercle bacillus\(^4\). The presence of gallstone is the cause of gallbladder tuberculosis in more than 90% of the reported cases, which may also play an important role in the development of tuberculosis of cystic duct lymph node\(^5\),\(^6\). Our patient had no gallstone. We can thus conclude that gallstone had no association with this particular case. It was difficult for us to diagnose the patient from his presenting features like fever, weight loss, and postprandial abdominal discomfort. Raised ESR was in favor of this disease but CT guided FNAC misled the diagnosis as reactive lymphadenitis. Finally the diagnosis was confirmed by microscopic appearance of caseating granulomas and isolation of *M. tuberculosis*\(^7\). A suitable technique to detect the presence of the pathogen is the PCR method, especially when its culture is difficult\(^7\). Skilled dissection while preserving architecture of lymph nodes is mandatory to get a good histopathological report.

References


