Journal of Surgical Sciences (2013) Vol. 17 (1) : 62-63
© 2012 Society of Surgeons of Bangladesh

JOURNAL OF SURGICAL SCIENCES

Case Report

TUBERCULOSIS OF CYSTIC LYMPH NODE OF LUND - A RARE PRESENTATION

TK Paul[1], MN Baqui[2], R Parveen[3]

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.

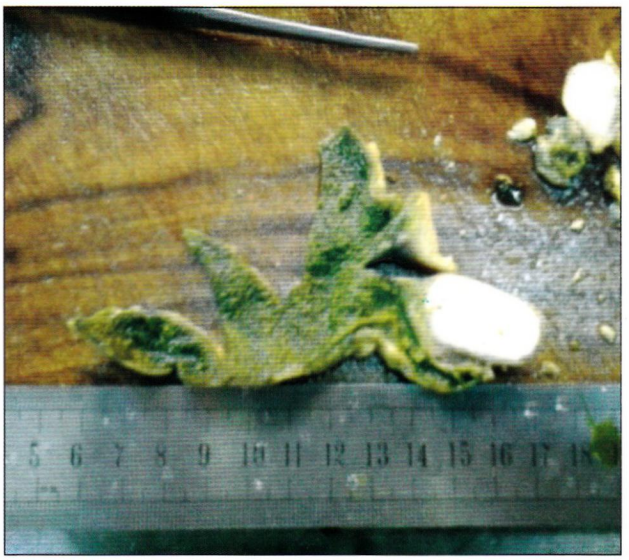

Fig.-1: *Gross section of the gall bladder with attached cystic lymphnode*

1. Associate Professor of Surgery, Delta Medical College
2. Assistant professor of Pathology, Bangladesh Institute of Health Science
3. Assistant professor of Radiology & Imaging, Delta Medical College

Correspondence to: Dr. Paul TK, Associate Professor of Surgery, Delta Medical College

Received: 24 April 2013 **Accepted:** 05 December 2013

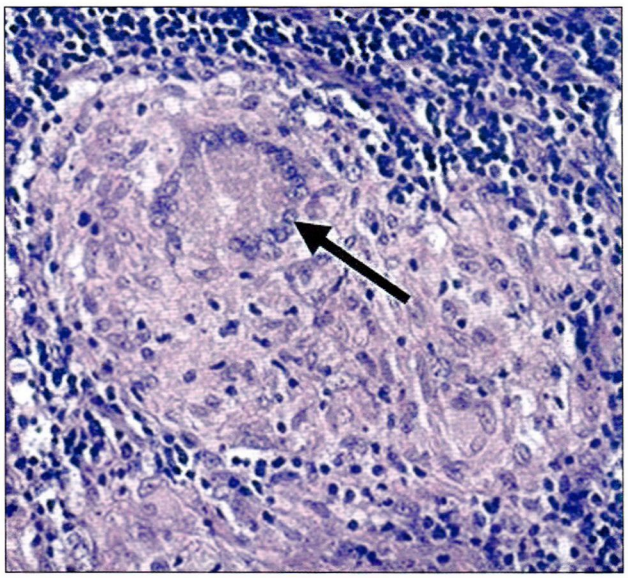

Fig.-2: *Histopathological section of the cystic lymphnode showing epithelioid granuloma and giant cell (arrow). (H&E 400X)*

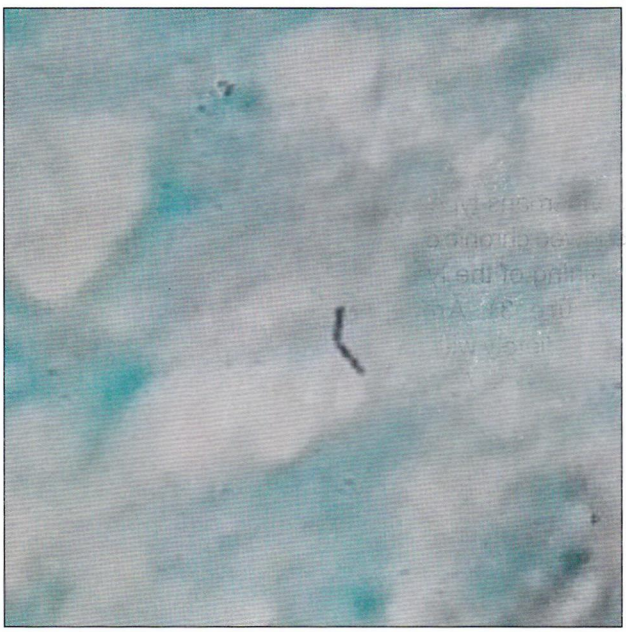

Fig.-3: *Smear from the lymphnode scrapping show AFB positive Mycobacterium tuberculosis. (100X)*

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

1. Goyal S.C., Goyal R., Malhotra V., Kaushik K. Tuberculosis of the gall bladder. Indian J Gastroenterol 1998;17:108.
2. Melo VA, Melo GB, Silva RL, Piva N, Almeida MLD. Tuberculosis of the Cystic Duct Lymph Node. The Bra J of Inf Dis 2004;8(1):112-114.
3. Prasad A., Pandey K.K. Tuberculous biliary strictures: uncommon cause of obstructive jaundice. Australas Radiol 2001;45:365-8.
4. Autio V., Virtanen S., Antila L. Biliary tract tuberculosis. Ann Chir Gynacol Fenn 1963;52:50-7.
5. Bergdahl L., Boquist L. Tuberculosis of the gallbladder. Br J Surg 1972;59:289-92.
6. Ziarek S., Deddouche M., Zoubir Y., Taleb M. Tuberculose de la vésicule biliaire. A propos de trois cas. Med Chir Dig 1975;4:219-22.
7. Ben R.J., Young T., Lee H.S. Hepatobiliary tuberculosis presenting as a gall bladder tumor. Scand J Infect Dis 1995;27:415-7.