Diagnostic Dilemma: Disseminated TB mimicking Lymphoma & CLD

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INTRODUCTION

Tuberculosis in India poses to be a significant public health problem, accounting for ~25% of the global burden. The high mortality of extra-pulmonary and disseminated TB continues to be an issue, attributed to the non-specific and varied presentation mimicking other systemic diseases leading to a delayed diagnosis. Here is a case of one such patient who presented with findings s/o alcoholic liver disease, which later pointed towards a more ominous diagnosis.

CASE PRESENTATION

A 31yo alcoholic male, labourer by profession, presented with C/O :

- Fever since 1.5y, with night sweats, exhaustion, weight loss and a loss of appetite. Not associated with any rash or joint pain.
- B/L lower limb swelling & abdominal distention since 2mo, painless & gradually progressing, with 3-4 episodes of black tar-like stools. Not associated with yellow discoloration of eyes, nausea, vomiting, or blood in vomitus.
- Cough since 15d, with scanty sputum, with 2 episodes of expectoration of blood-tinged sputum 1wk ago. Dyspnea on exertion for the past 1wk.
- N/H/O chronic illness - TB/DM/HTN. His family has N/H/O TB or undiagnosed chronic cough.
- H/O Alcohol consumption daily (1-2 drinks) for the past 10y

O/E he was A/C/O, febrile to touch, cachectic and ill-looking, with a distended abdomen, moderate pallor, but no icterus.

- Palpable nodular swellings in the left anterior cervical, left posterior cervical, left supraclavicular and B/L axillary regions.
- The nodes were painless, mobile, firm in consistency, with smooth surface and well-defined margins.
- Pitting edema was present in B/L lower limbs.
- Abdominal examination revealed shifting dullness and fluid thrill but there was no palpable enlargement of the liver or spleen.

INVESTIGATIONS

Lab investigations :

- Severe anemia (Hb: 6g/dL) with a RPI of 1.96. ESR - 60mm/1st hour.
- RFT & LFT were WNL, except for Hypoalbuminemia (2.24g/dL). UACR WNL.
- Viral serologies for HIV, HBsAg & Anti-HCV Ab were non-reactive.
- Ascitic fluid : clear, straw colored, lymphocyte predominant (85%, WBC: 101 cells/mm3), high SAAG (1.44) ascites with protein of 1.7g/dL, glucose of 95mg/dL, ADA of 32U/L. Aerobic Culture, AFB, CBNAAT & cytological examination for Malignant cells were negative.
- Sputum examination for AFB and CBNAAT were negative as well.

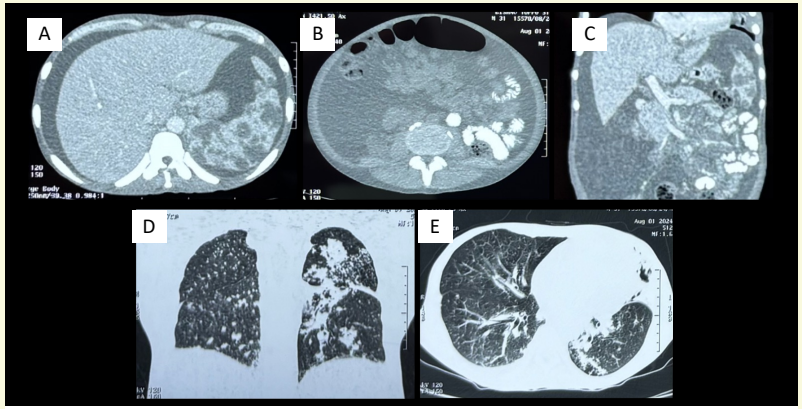

Figure 1 : CECT-W/A (A,B : Axial & C : Coronal) showing ascites, splenic hypodense lesions & multiple enlarged, confluent abdominal lymph nodes with loss of fatty hilum s/o Lymphoma; HRCT-Thorax (D & E) with lesions s/o Tubercular infection

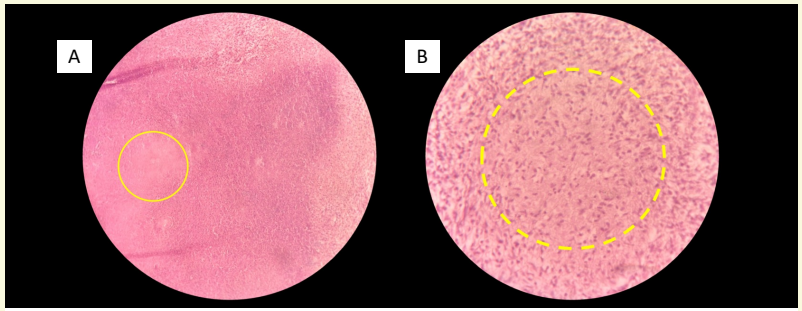

Figure 2 : Histopathology of excisional biopsy of left axillary lymph node showing Necrotising Granulomatous lesion (A: Necrosis, B: Granuloma with Epithelioid cells); No Malignant cells present

Imaging :

- USG-WA and CECT-WA (Fig1.A,B,C) reported normal hepatic and renal dimensions, borderline splenomegaly (13.2cm) with multiple hypoechoic/hypodense lesions, & multiple enlarged, confluent abdominal lymph nodes with loss of fatty hilum.
- HRCT-Thorax (Fig1.D,E) had lesions s/o tubercular infection.
- UGI-Endoscopy reported no esophageal or gastric varices, or ulcerative lesions. Echocardiography was WNL

Excisional Biopsy of Lymph Node : Findings in Fig 2.

MANAGEMENT

Conservatively managed with anti-pyretics, diuretics, albumin infusion & transfusion of 4 units PRBC. Therapeutic paracentesis of ascitic fluid on 3 occasions ~1L each day. Patient started on 1st Line ATT, based on the clinical, radiological & histological suspicion of Disseminated TB.

DISCUSSION

Although the initial presentation & history were in part s/o decompensated alcoholic liver disease, the imaging studies (normal liver parenchyma and absence of varices) questioned the diagnosis. Moreover, the prolonged period of fever, night sweats & presence of lymphadenopathy, could not be explained by it, which were rather s/o Lymphoma or Tuberculous Lymphadenitis among other diagnoses, but the distinction could not be made via imaging studies due to the shared characteristics. Presence of infective lesions in lung parenchyma and necrotizing granulomas in lymph nodes, makes the diagnosis of TB much more likely, given its endemicity. In an otherwise immunocompetent host, such dissemination of TB is rather rare & depending upon the response to ATT, further workup may be necessary if symptoms persist.

CONCLUSION

A thorough workup & a high index of suspicion is necessary for the prompt diagnosis of Disseminated TB, given its varied presentation.