Virchow's Node or Scrofula? A Lesson Learned

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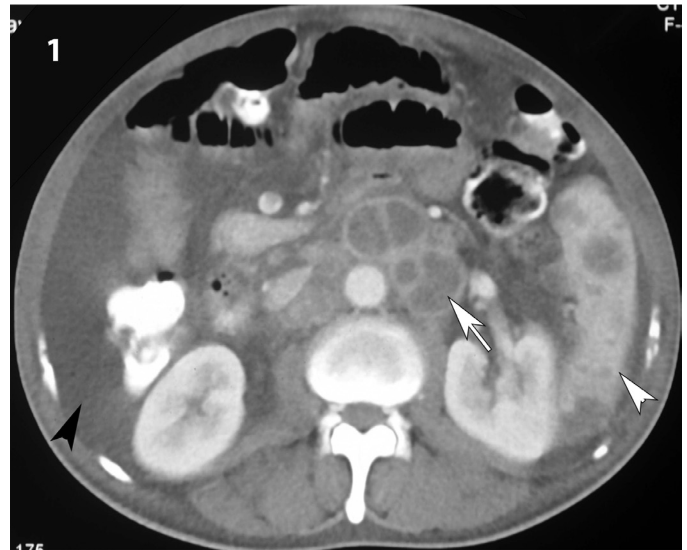

Figure 1: Contrast-enhanced computed tomography abdomen showing multiple confluent necrotic abdominal lymph nodes (white-arrow), multiple splenic granulomas (white arrow head), and ascites (black arrow head).

Extra-pulmonary tuberculosis (EPTB) is often misdiagnosed, mistreated or underestimated because of the nonspecific clinical manifestations as well as the lack of familiarity with protean presentations.[1] We have recently had the opportunity of observing a teachable case of EPTB.

A 46-year-old gentleman presented with epigastric mass and abdominal distension of three months duration along with intermittent fever, anorexia, and weight loss. Physical examination revealed left supraclavicular lymphadenopathy, a slightly tender epigastric mass, moderate hepato-splenomegaly, and a tense ascites. The clinical possibility of malignant etiologies such as metastatic gastrointestinal cancer and high-grade lymphoma were kept by the MD resident during the bedside case presentation in the ward rounds.

Basic laboratory investigations showed bicytopenia (hemoglobin 98 g/L, thrombocytopenia 63×10^9/L), high blood sugars and cholestatic liver injury pattern (total and conjugated bilirubin, 44.46 and 22.57 μmol/L respectively; aspartate aminotransferase, alanine aminotransferase and alkaline phosphatase of 1.54 μkat/L, 0.85 μkat/L, and 8.28 μkat/L respectively). Fine needle aspiration cytology (FNAC) from the left supraclavicular node showed acid-fast bacilli and extensive necrosis. Subsequently, a computed tomography of chest and abdomen showed enlarged necrotic lymph nodes in neck, mediastinum, retroperitoneum, and periportal location; hypodense lesions in spleen and left adrenal; mild ileocaecal thickening; gross ascites; and few nodules in the left upper lobe of the lung (**Figure 1**). The ascitic fluid examination did not reveal malignant cells. With a diagnosis of disseminated tuberculosis and diabetes mellitus, the patient was started on anti-tubercular treatment and metformin. Four weeks into the treatment, the patient improved significantly.

All Virchow's node, abdominal mass, and ascites are not always malignancy; tuberculosis may be a mimic. Lymphadenitis is the most common form of the EPTB. Cervical lymph nodes (particularly posterior chain) are the most commonly affected. Supraclavicular lymphadenopathy is uncommon. FNAC is a minimally invasive procedure and gives an excellent bacteriological yield.[2]

References

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