

Tubercular Inguinal Lymphadenopathy

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Citation

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Abstract

Bilateral tubercular inguinal lymphadenopathy is very uncommon presentation of lymphadenopathy. This case is being reported for their rarity and for the purpose of documentations.

INTRODUCTION

Tubercular Lymphadenopathy is a common extra pulmonary manifestation of tuberculosis. This disease most commonly occurs in children. Primary tubercular inguinal lymphadenopathy is a very uncommon presentation of tuberculosis.

This case is being reported for its clinical interest and for the purpose of documentation.

CASE REPORT 1

A 28 years old female, house wife presented with history of pain, off and on fever and swelling in bilateral inguinal region for the last 18 month. His parents, brother, sisters are alive and healthy. General examination revealed that patient is of thin built with bilateral matted, palpable lymph nodes in bilateral inguinal region. There were no sign of anaemia. Her resting pulse rate was 92/min and blood pressure was 112/68mmHg. Respiratory system examination was within normal limit. Her others system were also within normal limits. His Haemoglobin was 12 Gm%; Total Leucocyte count was 8,900/cmm: Neutrophils 17%, Lymphocytes 72%, Monocytes 1%. Her chest x-ray was normal. Her Ultrasonography abdomen was. Her PPD was done showed 20 mm induration. FNAC on both side of inguinal lymph node revealed tubercular etiology.

She was put on antitubercular drugs RHZ (Rifampicin, Isoniazid, Pyrazinamide) for 2 months, followed by 4 months of RH (Rifampicin, Isoniazid). At this regimen she improved.

DISCUSSION

Tuberculosis is a chronic granulomatous infection caused by *Mycobacterium tuberculosis*, which is an acid-fast bacillus.

It commonly presents as pulmonary tuberculosis. A common extra pulmonary manifestation of tuberculosis is lymphadenopathy. Tubercular Lymphadenopathy often affects children and young adults^{1,2,3}. Tuberculous lymphadenopathy most commonly involves the cervical group of lymph nodes. Tuberculous infection of inguinal group of lymph nodes occurs rarely⁴. A review of literature shows cervical lymphadenopathy to be the commonest site for tuberculous lymphadenitis followed by axillary lymphadenopathy and rarely inguinal lymphadenopathy. Incidence wise the cervical group is involved in 74% - 90% cases, the axillary group in 14% - 20% cases and inguinal group in 4% - 8% of cases.^{5,6} An Indian study done in Orissa showed that the inguinal lymphnode involvement was more common than axillary lymphadenopathy⁷. Female predilection has been reported in some studies^{8,9}. Primary inguinal lymphadenopathy shows a male preponderance in presentation.⁷ However; our case was a female patient.

Patients usually present with slowly enlarging lymph nodes and may otherwise be asymptomatic. Some patients with Lymph node tuberculosis, may manifest systemic symptoms and these include fever, Weight loss, fatigue and occasionally night sweats. Peripheral tuberculosis lymphadenopathy has been classified into five stages¹⁰. These include: (i) stage 1, enlarged, firm mobile discrete nodes showing, non-specific reactive hyperplasia; (ii) stage 2, large rubbery nodes fixed to surrounding tissue owing to peradenitis; (iii) stage 3, central softening due to abscess formation; (iv) stage 4, collar-stud abscess formation; and (v) stage 5, sinus tract formation. Physical findings depend upon the stage of the disease. The enlarged lymph nodes may be of varying size, are usually firm and may be discrete or matted. If necrosis and abscess formation have taken

place they may become cystic in consistency.

Fine needle aspiration cytology (FNAC) is an important diagnostic tool to establish the diagnosis. But gold standard is excisional biopsy of the lymph nodes. Treatment includes standard antituberculosis drugs for six months or category-III under RNTCP. Our case responded very well to 2 RHZ X 4 RH.

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