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Letter to the Editor Open Access

Non Hodgkins Lymphoma Masquerading as Tuberculosis

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In the past few months, we have come across a few patients being given Anti Tubercular Drugs which on further detailed evaluation have turned out to have all together different diagnosis like Lymphomas, Connective tissue disease, Vasculitis and so on. As in India and other developing countries, tuberculosis is quite rampant and concept of Empirical Anti tuberculosis is also being followed the following correspondence highlights the point that we need to be extra vigilant and cautious in diagnosing a case of Tuberculosis and insist on Tissue or Pathological confirmation if we really want to halt the spread of Multi Drug Resistant (MDR Tuberculosis).

We report a case of a 42 year old woman who presented to our hospital with fever for two month and jaundice for 8-10 days with malaise and apparent weight loss over the preceding 3-4 months. Patient was taking anti-tubercular therapy (ATT) for 3 weeks in view of investigations done which were suggestive of abdominal tuberculosis with multiple intrabdominal Lymphnodes with central necrosis on CECT Abdomen.

On presentation to us she had total bilirubin was 3.2 mg/dl with conjugated hyperbilirubinemia of 2.0 mg/dl; SGOT, SGPT were mildly raised with marked elevation of alkaline phosphatase (832). HBs antigen, HIV and anti HCV antibodies were negative. Monteux test was strongly positive with ESR of 72. Chest X ray (PA view) was normal. Abdominal ultrasonography revealed multiple necrotic lymph nodes in periportal and peripancreatic regions. Provisional diagnosis of abdominal tuberculosis with ATT induced hepatitis was made. Hepatosafe ATT was started. CECT of the abdomen showed periportal, peripancreatic, gastrohepatic, and retroperitoneal lymphadenopathy with caseation and thick walled caecum and terminal ileum suggestive of abdominal Koch's. Overtime her jaundice worsened with appearance of generalized pruritus and clay colored stools In view of development of cholestasis features and worsening of liver function tests during hospital stay, an MRCP was done which revealed confluent lymph-nodal mass showing necrotic areas in the hepatogastric, portal, peripancreatic, retropancreatic, portocaval region pushing the pancreas and portal vein anteriorly. Mass was encasing and compressing the extra-hepatic CBD just beyond the porta, beyond which CBD was not visualized with resultant proximal mild bilobular intrahepatic biliary radical dilatation. The mass measured approx. 8.3 × 5.8 × 5.1 cm in its maximum dimension. Few discrete lymph nodes were also noted at porta, periaortic, and portocaval region. Percutaneous ultrasonography-guided fine needle aspiration of the confluent lymph nodal mass was performed and pathologic examination showed diffuse sheets of large malignant lymphoid cells. These cells were positive for CD20 and CD79a and negative for CD3, CD4, CD5, and CD8. Final pathologic diagnosis was diffuse large B-cell type non-Hodgkin lymphoma. Patient was transferred to the Department of Hematology and Oncology for chemotherapy.

Obstructive jaundice is an extremely rare presentation of both non-Hodgkin lymphoma (NHL) as well as abdominal tubercular lymphadenitis. Obstructive jaundice secondary to abdominal TB can be caused by TB enlargement of the head of the pancreas, TB lymphadenitis, TB stricture of the biliary tree, or a TB mass of the retro-peritoneum [1]. Non-Hodgkin lymphoma is a rare cause of biliary obstruction [2,3]. Incidence of obstructive jaundice as an initial presentation of NHL is only seen in 1-2% of patients. In this case, despite various imaging and biochemical investigations being supportive of tubercular pathology, the final pathologic diagnosis turned out to be hematological malignancy. Therefore, though tuberculosis is rampant in our country and other developing countries, still alternate possibilities should be considered before ruling in tuberculosis in atypical case presentations.

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