**Tuberculous Cervical Lymphadenopathy in Babylon**

Mahmoud M. J. Hamad Abeer Leteef Hamza

College of Medicine, University of Babylon, Hilla, Babylon, Iraq

Email: almukhtar2010@yahoo.com

****

**Received 28 October 2013**  **Accepted 25 November 2013**

**Abstract**

**Objectives :**The aim of this study is to evaluate the frequency of Tuberculosis (TB) presenting as cervical lymphadenopathy (LAP), to describe the clinical picture with which the patient may present, and to evaluate the most yielding laboratory investigations to be recommended.

**Patients and Methods :**The study included all patients more than 13 years old presenting with the complaint of cervical LAP of both genders for the period from September 2008 to September 2012 who had been managed in Hilla General Teaching and Merjan Teaching Hospitals. All of them were submitted to Fine Needle Aspiration Cytological examination (FNAC). Excisional/incisional lymph node biopsy was undertaken when this procedure had been required.

**Results :**We reviewed a total of220patientspresented with cervical LAP. The study revealed tuberculous cervical LAP in 155(70.45%), 30(13.63%) cases were suffering from reactive hyperplasia cervical LAP, 25(11.3%) cases were due to secondary metastatses, 10(4.54%) proved to be lymphoma cases while only 5(2.27%) cases were due to non-specific chronic LAP. Family history and suggestive constitutional symptoms were undetectable in most of the cases of cervical LAP. TB affected the lymph nodes located in the posterior triangle of the neck in most of the cases.

**Conclusion :**The most common aetiology of cervical LAP was TB process. The aetiology behind this should be investigated in more depth. While most of the laboratory investigations commonly used were not so much helpful in confirming the diagnosis, FNAC exam was so sensitive in settling the diagnosis.

**Keywords :**Tuberculosis, cervical lymphadenopathy, lymphoma, Babylon.

**تضخم العقد اللمفاوية التدرني المنشأ في محافظة بابل**

**الخلاصة**

**الأهداف :**تهدف هذه الدراسة الى محاولة تقييم أنتشار مرض التدرن في العقد اللمفاوية في الرقبة و وصف الصورة السريرية للمرضى المصابين مع محاولة معرفة أنع و أدق الفحوص المختبرية التي يمكن ان يوصى بها لتشخيص هذا من أصابات مرض التدرن.

**الطريقة :**شملت الدراسة كل المرضى الذين يشكون من تضخم العقد المفاوية في الرقبة ممن هم فوق سن الثالثة عشر لكلا الجنسين و للفترة من أيلول 2008 الى أيلول 2012 و الذين تمت معالجتهم في مستشفى الحلة التعليمي العام و مستشفى مرجان التعليميز تم أجراء الفحص الخلوي بطريقة الشفط الأبري على أنه قد تم أيضا فحصهم بأخذ الخزعة من العقد اللمفاوية عند وجود دواعي لهذا الفحص.

**النتائج :**تمت دراسة 220 حالة لتضخم العقد اللمفاوية في الرقبة. وجدنا 155(70.45%) حالة تدرن في هذه العقد , 30(13,63%) كانت بسبب تضخم العقد التفاعلي. أوضحت الدراسة وجود نقائل سرطانية في تلك العقد في 25(11,3%) حالة. كان هناك 5(2,27%) حالة بينما هناك 10(4,54%) حالة امرض ورم العقد اللمفاويةز وجدت الدراسة 5(2,27%) حالة لمرض التهابا العقد اللمفاوية اللا نوعي. ام يكن أي تأريخ عائلي للمرض كما لم يكن هناك أعراض بدنية ملحوظة. بينت الدراسة أن أغلبية العقد اللمفاوية المصابة كانت واقعة في المثلث الرقبي الخلفي.

**الاستنتاج :**أن أغلب حالات تضخم العقد اللمفاوية هو من النوع التدرني . أكثر الفحوص المختبرية الشائعة غير ذات قيمة نفعية في التشخيص المرضي لهذه الحالة بينما كان الفحص الخلوي بالشفط بالابرة ذو قيمة تشخيصية عالية.

**الكلمات المفتاحية:** مرض التدرن, تدرن العقد اللمفاوية, الرقبة, محافظة بابل.

ــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــــ

**Introduction**

I

t is well recognized that LAP is the most frequent presentation of extrapulmomary manifestation in cases of pulmonary TB. Nevertheless, TB LAP still presents botha diagnostic and therapeutic challenge because can be well confused with other pathological processes and at the same time the physical findings and laboratory investigations are not so conclusive in most of the cases. Thereby, making an accurate diagnosis is somewhat a difficult one and so may require excisional/incisional biopsy. Complete clinical history with thorough physical examination, staining for acid-fast bacilli(AFB), FNAC and polymerase chain reaction(PCR) are so helpful in making a correct diagnosis[1]. The most common presentation of extapulmonary TB may be cervical swellings (92%), pyrexia, cold abscess, discharging sinus, chronic non-healing ulcers.anorexia and weight loss[2]. FNAC of cervical LAP has a high diagnostic accuracy. It provides important clues in subsequent guiding regarding the clinical management. However, for diagnosing other aetiologies of cervical LAP e.g. metastatic LAP, various types of lymphomas surgical biopsy and immunohistopathology may be required.It is recommended that there should be a free access for all patients with cervical LAP to Weekly Neck Lumps Clinic with standardized protocols for lymphoma diagnosis[4].FNAC and PCR are commonly employed for detection of Mycobacterium Tubercculosis and should be used for the differential diagnosis of TB LAP [5]. It should well remembered that Hodgkins lymphoma, squamous cell carcinoma, metastasis from papillary thyroid carcinoma can coexist in cervical LAP[6]. The aim of study is an attempt to find out the frequency of TB cervical LAP, to assess other variables e.g. age, sex distribution, the value of clinical assessment and the most useful laboratory investigations to be used in diagnosis regarding its sensitivity, accuracy and cost-effective.

**Patients and Methods**

This study was conducted for the period from 8/2/2008-8/2/2013 in Hilla General Teaching and Merjan Medical Teaching Hospital . It included recording of patients age, sex and clinical distribution of proven TB cervical LAP. The family history and the clinical presentation were reviewed. Related investigation e.g. complete blood picture, erythrocytes sedimentation rate and chest X-ray. FNAC was undertaken in all the cases. Cluture for acid-fast bacilli and excisional/incisional biopsies were conducted whenever there were a non-conclusive FNAC results.Biostatistical analysis was done using SPSS version 13. The proportions of the causative aetiology were compared using Chi-square test and a value of more than 0.05 had been considered as insignificant in this report.

**Results**

The study included a 220 cases complaining of cervical LAP.Therewere150 (68.2%) females versus 70 (31.8%) males. Majority of patients were between 15-53 years old. TB cervical LAP was the most dominant histological diagnosis (70.45%). Ninety per cent of the cases presented without any evident constitutional symptoms whereas only (10%) exhibited suggestive symptoms. TB cervical LAP predominantly affected lymph nodes located in the posterior triangle of the neck. Three cases of mediastinal LAP with associating complaint of dysphagia had been observed together with TB cervical LAP. We observed also two cases of postauricular LAP due to TB. FNAC proved to be the most effective diagnostic test with a sensitivity of (93%).

**Discussion**

TB is a common clinical problem and is the commonest infectious disease affecting the lymph nodes in the body[7-8]. In a study conducted in Eygpt, aetiology of cervical LAP was TB in (54%), reactive hyperplasia (33%) while metastatic LAP were (11%).The study revealed that FNAC was found to be highly effective diagnostic procedure in (95%) and that lymph nodes in the posterior triangle of the neck were most commonly involved[8,11]. Our study also revealed that TB is the main aetiology of cervical LAP but the results were relatively higher in comparison to other reports from different parts of the world. We should look carefully to the source of TB bacilli as there was no significant positive family history. In one reportthe most affected age group was 11-22 years and constitutional were absent in most of the cases. The upper deep jugular nodes were most commonly affected. Discharging sinus and abscess formation were uncommon. Chest radiological lesions were evident in (10%) of cases[9, 12,13]. As compared to that study the age group mostly affected was14-45 years and the posterior triangle of the neck was the most involved area whereas other findings were nearly the same. Males were predominantly affected with TB cervical LAP in our study in contrast to an Indian report which showed more female affection with TB cervical LAP[10-13]. This study showed that Cervical TB LAP usually presents with multiple lymph nodes involvement but without any constitutional signs and symptoms characteristic of TB infections. Clinically, the diagnosis of TB behistopathological investigations. It can be easily diagnosed depending on FNAC and PCR tests. Accordingly, if no improvement is observed in patients on anti-TBan excisional/incisional biopsy is recommended. This was dectected in this study. ESR, Chest X-rays were not reliable in most of the patients so FNAC and excisional/incisional biopsy is the gold standard in any doubtful case.

**Conclusion**

This study revealed that the frequency of cervical TB LAP is high in our region. The real reason for this should moer carefully investigated. A high index of clinical suspicision is required as most of the affected cases can present without any suggestive constitutional signs and symptoms which are classically known to be secondary to TB infections in particular. We observed that ESR and chest radiography has a limited role in diagnosis of TB cervical LAP while FNAC was the procedure of choice althoughexcisional/incisional biopsy may be indicated to settle the diagnosis in some cases.

**References**

1. Whang AS, Li JW, Wiu GE et al. Tuberculous lymphadenitis. J Assoc Path Ind 2008; 61 :84-90.
2. Simpolous CF, Bottin HI, Toman VU. Clinical presentation of enlarged lymph nodes. J Indsurg 2009; 37: 41-6.
3. Ibrahim SR, Heanin FE, Donald GR et al. Fine Needle Aspiration Cytology and its accuracy in management of cervical lymphadenopathy. Scand J Inf Dis 2007; 67 : 93-9.
4. Alponti ZE, Kumen SD, Rajankova OH. Lymphoma Diagnosis in cervical lymphadenopathy. Jap J Med 2008; 66: 23-7.
5. Merdolin BD. Tuberculous cervical lymphadenopathy mimicking metastatic lymphadenopathy in thyroid papillary carcinoma. Br j Radiol 2010; 112 ; 201-5.
6. Johan CW, Sulaimmov NS, BaseckentG et al. Cervical tuberculosis and metastatic squamous cell carcinoma in a single lymph node group. Ear Nose Throat J 2007; 69:95-9.
7. Minwa YD, Ishizaki UB, Sugo FJ et al. An audit of lymph node biopsy in suspected malignancy. Med Turk J Assoc 2006;79 : 931-7.
8. Livingstone DD, Rege RF, Peter VS et al. Incidence of cervical tuberculous lymphadenitis. Cairo Univ Med J 2010; 78: 45-9.
9. Davis MH, Wayland JW, Shmo ST et al. Diagnosis and management of tuberculous cervical lymphadenopathy. Scand j Otolaryngol 2009; 61: 215-5.
10. Lewis BF, Malek SP, Deham LG et al. Clinicopathological study of tuberculous cervical adenitis in 230 patients. Ind J Inf Dis 2009; 55 :115-7.
11. Sunbor BM, Savage CD, Yale DCet al. Cervicaladentis and diagnosis of lymphoma. Scot J Inf Dis 2008; 74 : 67-72.
12. Agawal HJ, Sethio ZA, Mishra CK et al. Astudy of 180 cases of tuberculous cervical adenitis. Eup J Inf Dis 2009; 38: 91-6.
13. Zehan QA, Harry NM, Exter VA et al. Cervial lymph nodes tuberculosis: diagnosis and treatment. Jap J Head Neck Surg 2008; 59: 101-6.

**Table 1** demonstrating freqenuecy of different cervical LAP aetiologies.

|  |  |  |
| --- | --- | --- |
| Aetiology | Patients Number | Percentage |
| TB cervical LAP | 155 | 70.45 |
| Reactive LAP | 30 | 13.63 |
| Cervical metastatic LAP | 25 | 11.63 |
| Cervical lymphoma | 10 | 4.54 |
| Non-specific LAP | 5 | 2.27 |