**Non hodgkin lymphoma and TB: a together co existence.-Case report**

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**ABSTRACT**

Non hodgkin lymphoma may be preceded by chronic inflammatory disease like tuberculosis. Its rare for a lymphoma to present as acute. Here we present a case of combined infection of non Hodgkin Lymphoma and tuberculosis and unusual presentation of lymphoma. A high index of clinical suspicion led to the correct diagnosis in this atypical presentation.

**INTRODUCTION**

Metastatic epidural spinal cord compression (MESCC) will be defined as compression of the spinal cord or cauda equina nerve roots from a lesion outside the spinal dura. The most common tumors causing epidural compression are breast, lung, prostate, lymphoma, sarcoma, and kidney, accounting for over 70% of cases. The thoracic spinal column is most commonly involved; exceptions are metastases from prostate and ovarian cancer, which occur disproportionately in the sacral and lumbar vertebrae. The epidural space is a true space which lies between spinal cord dura and the bony spinal canal. It contains fat, connective tissue and a rich para vertebral venous plexus which drains the vertebrae and intervertebral spaces. Non Hodgkins lymphoma is a group of blood cancers that include all types of lymphoma except hodgkin lymphomas. Symptoms include enlarged lymph nodes, fever, night sweats, weight loss, and tiredness. Other symptoms may include bone pain, chest pain, or itchiness. Diagnosis by bone marrow or lymphnode biopsy. Treatment include chemotherapy, radiation, immunotherapy, targeted therapy, stem cell transplantation, surgery or watchfull waiting.

Non-Hodgkin’s lymphoma (NHL) may be preceded by chronic inflammatory diseases and furthermore has been related to immune deficiency. Tuberculosis (TB), on the other hand, is a chronic infectious disease whose presentation and reactivation is known to be promoted by cell mediated immunodeficiency. The coexistence of NHL and TB in the same organ is rather rare. It has been reported that the risk of NHL is increased in individuals with a history of TB.
CASE REPORT

A 70 year old male patient with no significant past history and family history presented with acute onset of weakness of both lower limb of 4 days duration. History suggestive of radicular pain for last two weeks. History of chronic cough for 3 months, productive yellowish coloured sputum. On and off treatment with antibiotics. Smoker not an alcoholic.

On examination vitals are stable. General physical examination- pallor , clubbing present. A 5*4 hard left supraclavicular lymph node, lower boarder is not palpable. A palpable 8*7 bony swelling present at the medial end of clavicle. No neurocutaneous markers.

Systemic examination - Higher mental functions normal, cranial nerves including Fundus normal. Motor system -Tone both lower limb hypertonia. Power 0 grade. DTR bilaterally absent ,b/l plantar extensor, abdominal reflexes absent , absent cremasteric reflex ,beever's sign positive. upper limbs normal .No involuntary movement. Superficial sensation decreased below t 10, posterior column sensation decreased below T10.T10 spinal tenderness. Skull normal.

Examination of abdomen - hepatomegaly, 4cm below the right costal margin. Massive splenomegaly of firm to hard mass ,10 cm below left costal margin .No other mass palpable . No bruit or rub over liver or spleen. Examination of chest showing crepitation over right upper lobe. Other systems with in normal limit.

In view of sudden onset of spinal paraplegia with a motor, sensory, reflex level at t10 level.Tenderness over the vertebra along with lymphadenopathy, pallor, clubbing, and firm to hard hepatosplenomegaly. We clinically suspect extradural extramedullary compressive paraplegia due to non hodgkins lymphoma is considered. In view of chronic cough and lung signs in right upper lobe possibility of TB is considered even though there is no constitutional symptoms.

Bone marrow biopsy showing atypical lymphocyte cells. 40x and 20x view

Clavicle head left supraclavicular LN Enlarged.
Nuerological manifestation of non Hodgkin lymphoma includes direct invasion of spinal cord, leptomeningeal metastasis, plexopathies, direct infiltration of plexus, paraneoplastic, and finally chemotherapy induced nuerological manifestations. Atypical manifestation presents like dual persistence of sputum positive TB with NHL, malnutrition, vitD deficiency, altered immunue system, epidural spina cord secondaries, reciprocal activation of one over another.

CONCLUSION
NHL and tuberculosis seen in same patient is vere rare. In this patient NHL was acute in onset with metastatic compression at the level of L5.In our case a supraclavicular lymphnode with hepatospleenomegaly ,chronic cough ,raised ESR,X ray findings triggered a high clinical suspicion of NHL association with TB. Routine investigations, pathological studies along with IHC, imaging studies aid in proper diagnosis.

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