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Case Report *Medical research*

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.

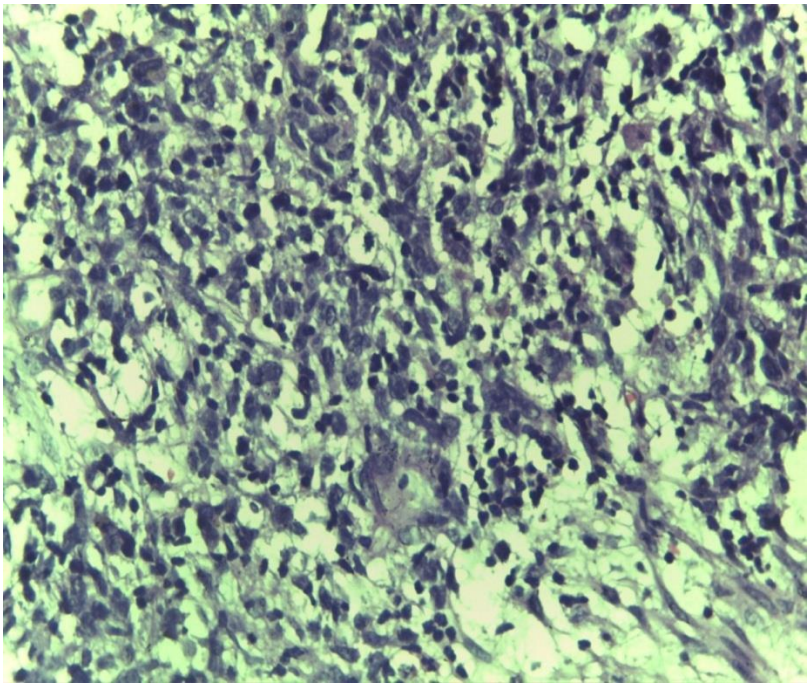
On examination vitals are stable. General physical examination- pallor , clubbing present. A 5*4 hard left supraclavicular lymph node, lower boarder is not palpable. A palpable 8*7 bony swelling present at the medial end of clavicle. No nuerocutaneous markers.

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 ,beevers 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.

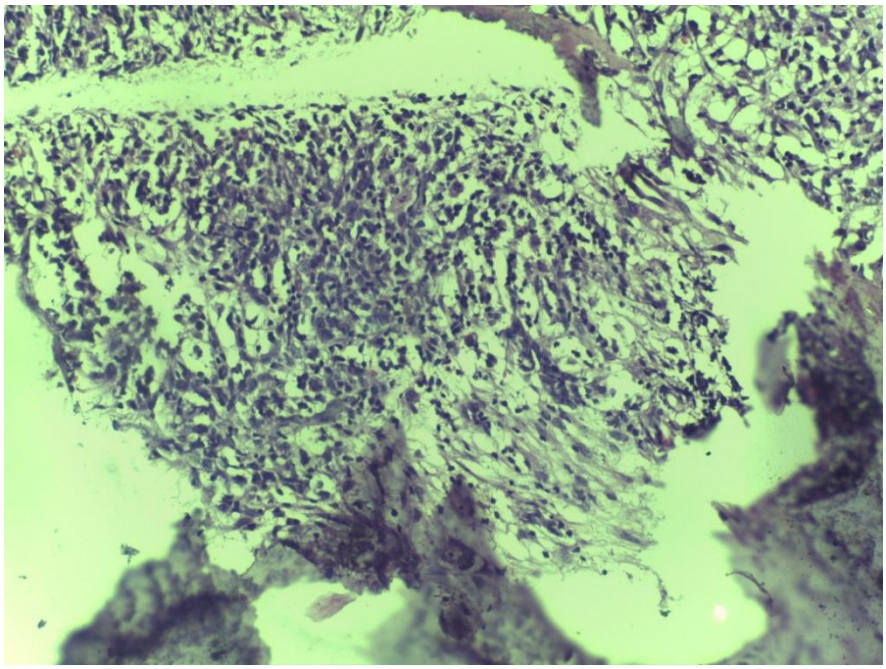
Examination of abdomen -hepatomegaly, 4cm below the right costal margin. Massive spleenomegaly of firm to hard mass ,10 cm below left costal margin .No other mass palpable . No bruit or rub over liver or spleen. Examination of chest showing crepitation over right upper lobe. Other systems with in normal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

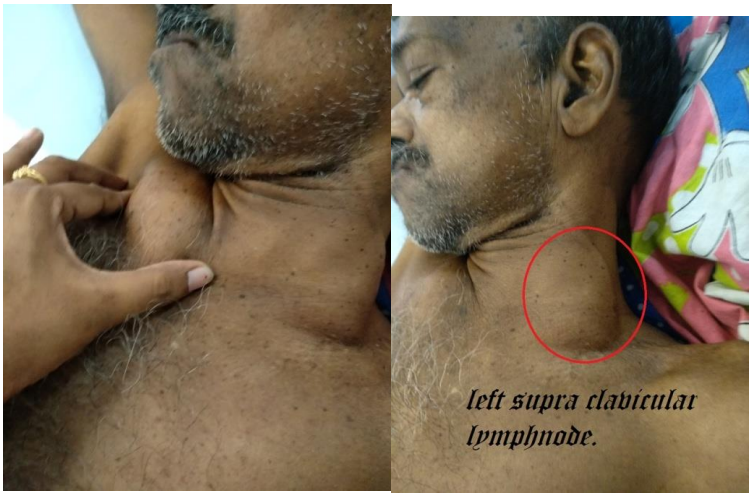
INVESTIGATIONS revealed Hb-11.1GM%,WBC-2500,PLT-45000. ESR-120.PCV normal. LFT –Total protein 7.5.Albumin 3 .Globulin 4.5.OT 120 PT 140 ALP-314.S bilurubin - 1 . Pt -13 .Aptt- 32.RFT- normal. Sodium Pottassium normal. serum Uricacid , calcium-normal .Peripheral smear- microcytic hypochromic anaemia. Sputum AFB-2 samples positive.CB NAAT-positive.Mantoux –negative.Routine C/S negative. AFB and fungal culture sent result awaiting. Lipid profile normal. Viral markers negative. VDRL negative. TFT normal.Serum Electrophoresies –normal ANA profile normal. Tumour marker profile not done due to financial problems. Chest xray-rightupper lobe infilteration. USG Abdomen- Hypoechoic nodules lesions noted in retro peritoneum in paracaval and postcaval locations possibly retroperitoneal lymph nodes. spleenomegaly. Enlarged perisplenic lymph nodes. Mild ascites and right sided pleural effusion. Echo normal study. MRI Spine –reduced height of D2 vertebral body. The epidural soft tissue causing mild compression of dorsal spine cord at D2,D3 level.compression of cauda equina nerve root at L5,L5 level. The paraspinal soft tissue infiltrates to psoas ,posterior para spinal muscles and lumbo sacral nerve roots.nodular retroperitoneal lesions at L1 and L2 Vertebral levels. nodular lesion in left supraclavicular region –lymph nodal mass. Lymph node FNAC-reactive lymphocytosis , Lymph node biopsy suggestive of non hodgkin lymphoma. Bone marrow biopsy-bone marrow space seperated by trabeculae, focal areas of fibrous tissue, also hypercellular areas of atypical cells seen. IHC cells shows strong diffuse CD20 positivity. Histology and IHC compatible with a high grade non Hodgkin lymphoma B cell type.

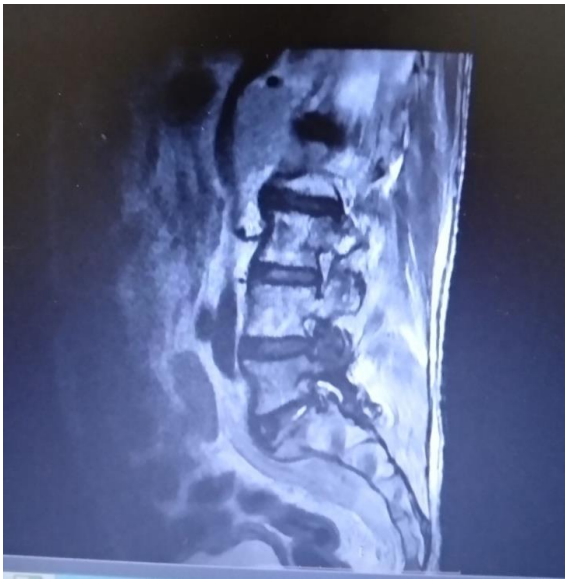


Bone marrow biopsy showing atypical ymphocyte cells.40x and 20 x view



Clavicle head left supraclavicular LN Enlarged.





Compression at the level of L5

DISUSSION

Nuerological manifestation of non Hodgkin lymphoma includes direct invasion of spinal cord, leptomeningeal metastasis, plexopathies, direct infilteration 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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