Case Report

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Tubercular lymphadenitis presenting with facial palsy: a rare case report

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ABSTRACT

India has a very high prevalence of tuberculosis (TB). Incidence of extrapulmonary tuberculosis is on the rise and at times it presents with uncommon features. We reported a case of 27 year old female presented with an irregular scar mark in the submandibular region along with an asymmetric smile. She was on treatment for tuberculosis as diagnosed by an earlier aspiration cytology report. Examination showed irregular non tender scar along with an underlying 2×2 cms swelling. Repeat fine needle aspiration was inconclusive and the patient was thus taken up for excision biopsy. Final report turned out to be tubercular lymphadenopathy and treatment was thus started accordingly. We conclude that tubercular lymph nodes presenting with facial nerve paresis are extremely rare entity. A high degree of suspicion should be maintained in a country like India where prevalence of TB is significantly high.

Keywords: Tubercular lymphadenitis, Facial palsy, Fine needle aspiration

INTRODUCTION

India has the highest burden of tuberculosis (TB). The World Health Organization (WHO) statistics of India for 2015 gave an estimated incidence of 2.2 million cases of Kochs, out of a global incidence of 9.6 million. The estimated prevalence of TB for 2015 is around 2.5 million. It is the second ranked cause of death resulting from an infectious disease, next only to the human immunodeficiency virus. Tubercular lymphadenitis was earlier considered a disease of childhood, but it is now frequently seen in the young to middle-aged adult population. An increased prevalence has been noted in Asian women from TB endemic areas. In rural India, the prevalence of tuberculous lymphadenitis in children up to 14 years of age is approximately 4.4 cases per 1000.

CASE REPORT

A 27 year old lady from a middle socio economic status, presented with an irregular scar on the left submandibular region. It appeared to be a keloid and was associated with an asymmetric smile. Detailed history revealed, existence of a swelling which developed a year back insidiously and gradually enlarged in size and then spontaneously ruptured through the neck tissues. She then underwent fine needle aspiration cytology (FNAC), as suggested by a physician. The report was positive for tuberculosis and she was thus started on Anti Tubercular therapy as per category 1. The lesion healed with an irregular keloid formation.

On examination the scar was 5 cm in length, reddish brown in color, irregular, non-tender, horizontally

oriented in the left submandibular region. There was asymmetry of the face when the patient smiled and when asked to show her teeth, suggestive of paresis of the mandibular branch of the facial nerve. The remaining branches of the facial nerve were normal in function. Moreover, there was a 2×2 cms circumscribed swelling palpated just inferior to the keloid. The swelling was not adherent to the overlying skin and was freely mobile over the underlying tissues (Figure 1).





Figure 1: Preoperative picture showing facial paresis and submandibular keloid.

Magnetic resonance imaging of the neck revealed a well-defined, 1.7×1.4 cms lymph node appearing heterogenously hyperintense on T1w images and hypointense on T2W in left submandibular region causing focal disruption of platysma and reaching up to the subcutaneous fat with irregularity and thickening of overlying skin.

A repeat FNAC showed extensive necrosis amidst reactive lymphoid cells. Neither epitheloid cell granuloma nor malignant cells were noted. In view of inconclusive FNAC, she was worked up in detail and planned for excision biopsy.

Elliptical incision was marked over the previous scar. Scar tissue was resected and the lymph node identified and removed in toto (Figures 2 and 3). Cheesy material was seen oozing from the lymph node. Injection Kenacort was injected in the incision margins and the wound was sutured with unabsorable material.





Figure 2: Excision of Keloid and lymph node.





Figure 3: 2×1.5 cms lymph node after excision.

Final histopathology report was suggestive of tuberculosis and the patient was thus managed accordingly on a 6 month therapy; 2 month intensive and 4 month continuous phase was initiated.

DISCUSSION

Extrapulmonary tuberculosis refers to any microbiologically confirmed or clinically diagnosed case of TB involving tissues other than the lung parenchyma like the pleura, lymph nodes, skin, intestines, genitourinary tract, bones etc.

Lungs are the most commonly affected site by TB, second being the lymph nodes which are seen in 25% of all TB cases and 51% of TB cases with extrapulmonary involvement. Tuberculous lymphadenitis usually presents as an insidious onset and gradually increasing painless swelling of one or more groups of lymph nodes. The duration usually ranges from weeks to months. Systemic symptoms like fever, weight loss, fatigue and night sweats may or may not be always associated with the lymphadenopathy. In the initial stages, the nodes are firm, discrete and mobile with no attachment to the underlying skin. In general, multiplicity, matting and caseation are features of tuberculous lymphadenitis but these are neither specific nor sensitive. Later on, the nodes become matted and the overlying skin may be inflamed. In more advanced stage, the nodes may soften and form abscesses and sinus tracts which may be difficult to heal. Unusually large nodes may compress or invade the adjoining structures complicating the course of the disease.^{2,4}

Epidemiologically, a 1.4:1 female-to-male ratio is seen with peripheral tubercular lymphadenitis with a peak age ranging from 30-40 years.⁵

Treatment of EPTB under RNTCP is carried out in 2 months intensive phase +4 months continuation phase. Four drugs are given at thrice-weekly schedule for 2 months in the intensive phase while two drugs at thrice-weekly schedule are given for remaining 4 months as continuation phase 2H3R3Z3E3+4H3R3 [H: Isoniazid (300 mg), R: Rifampicin (450 mg), Z: Pyrazinamide

(1500 mg), E: Ethambutol (1200 mg), S: Streptomycin (750 mg)].⁶

CONCLUSION

There should be a high suspicion of tuberculosis in patients presenting with cervical lymphadenopathy considering the high incidence in our country. Such lymph nodes presenting with facial paresis are extremely rare and should be managed as per the histopathological confirmation of diagnosis.

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