Primary Kochs Inguinal Lymphadenopathy Presenting as a Mass

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Abstract

Lymphadenopathy is a common manifestation of Tuberculosis. This disease most commonly occurs in children. Involvement of cervical nodes is the most common presentation of tuberculous lymphadenopathy. Isolated or primary inguinal tuberculous lymphadenopathy has been described but is a very rare presentation of tuberculous lymphadenopathy.

We present a case report and review of literature of isolated or primary tuberculous inguinal lymphadenopathy.

Introduction

Tuberculosis is a chronic granulomatous infection caused by Mycobacterium tuberculosis, which is an acid-fast bacillus. It commonly presents as pulmonary tuberculosis. A common extra pulmonary manifestation of tuberculosis is lymphadenopathy. Tuberculous lymphadenopathy most commonly involves the cervical group of lymph nodes. Tuberculous infection of inguinal group of lymph nodes occurs rarely and is usually associated with cutaneous tuberculosis, scrofuloderma or lupus vulgaris. Primary or isolated inguinal lymphadenopathy without any other focus of tuberculosis is a very rare presentation.

We present a case of inguinal tuberculous lymphadenopathy in a 30-year-old female without pulmonary or cutaneous involvement by the tuberculous pathology, a rare presentation.

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Case Report

Present case is a 30 year old married female who presented to us with a swelling in the right thigh of 8 years duration which was associated with dull aching continuous pain without any associated fever or painful lesions on the lower limb on the same side. The patient had a similar swelling twelve years back in both the groins, which resolved on its own after bursting spontaneously. On local examination the patient had a soft tissue swelling in the right groin measuring 10 cms by 8 cms, which was in the subcutaneous plane, had well defined margins, was firm to feel which was not tender and had restricted mobility. No other visible or palpable lumps were evident in the other lymph node regions. The rest of the right lower limb was unremarkable on local examination (Fig. 1). The femoral pulses were slightly diminished in comparison with its fellow but a colour Doppler of the right thigh ruled out any involvement of the femoral vessels. A chest X-ray done did not show any evidence of pulmonary tuberculosis.

A provisional diagnosis of a soft tissue tumour was made. An FNAC done to confirm the diagnosis showed Langhan’s giant cell, lymphocytes and few polymorphocytes over a caseous necrotic background giving the impression of tuberculous lymphadenitis. The patient was started on anti-tuberculosis treatment and surgical excision of the lump was done after careful dissection from femoral vessels (Fig. 2). The histopathology of the specimen showed the swelling to be a lymphnode with disrupted architecture due to extensive area of caseous necrosis.
with epitheloid cell granulomas, Langhan’s giant cells and lymphocytes confirming the diagnosis of tuberculous lymphadenopathy. On follow up the patients was symptomatically relieved on the anti-tuberculosis treatment. Follow up of one year has shown the patient to be disease free.

**Discussion**

A review of literature shows cervical lymphadenopathy to be the commonest site for tuberculous lymphadenitis followed by axillary lymphadenopathy and very rarely inguinal lymphadenopathy. Incidence wise the cervical group is involved in 74% - 90% cases, the axillary group in 14% -20% cases and inguinal group in 4% - 8% of cases. An Indian study done in Orissa showed that the inguinal lymphnode involvement was more common than axillary lymphadenopathy. Involvement of the inguinal group of lymphnodes is also common in the Igbo's ethnic group in Nigeria. Primary inguinal lymphadenopathy shows a male preponderance in presentation. However, our case was a female patient. FNAC is a reliable diagnostic tool in helping to avert the more invasive surgical procedures undertaken in the diagnosis of tuberculous adenitis. The Ziehl Neelsen stain for identification of acid-fast bacilli should be incorporated as an adjunct to increase the diagnostic accuracy of tuberculous lymphadenitis. FNAC may also provide antibiotic sensitivity for appropriate anti-tuberculosis treatment.

The patient is started on a regular course of anti-tuberculosis treatment appropriate for extrapulmonary tuberculosis and a clinical response is awaited. In the event of a non-response clinically or a large mass initially, a decision may be taken to excise the affected lymphnodes for histopathology and antibiotic sensitivity which will guide further anti-tuberculosis treatment. In the present case we simultaneously started the patient on anti-tuberculosis treatment and carried out surgical excision.

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**References**