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A Rare Presentation Of Generalized Lymphadenopathy In A Case Of Lepromatous Leprosy

KEYWORDS

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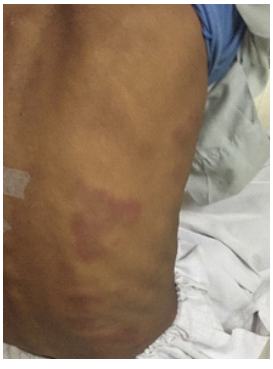
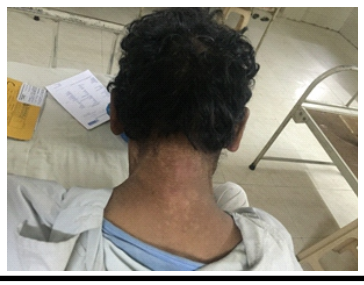
Introduction:
Leprosy, first described in ancient texts from the 6th century B.C., is a non-fatal, chronic infectious disease caused by mycobacterium leprae. Mycobacterium leprae is a unique organism with capacity to invade not only Schwann cells but also other parenchymal tissues such as testes, lymph node, larynx, liver, spleen, bone marrow, bone and muscle. The prevalence of leprosy in India is reported to be 0.7/10,000 populations. The disease should be suspected when a patient from an endemic area has suggestive skin lesions or peripheral neuropathy. However, this disease can also present with generalised lymphadenopathy.

Case Detail: A 45 year old male presented with low to moderate grade fever with chills, dry cough, decreased appetite, tingling and numbness in bilateral palms and soles associated with painless swelling over both inguinal regions, both axillary and neck regions since 25-30 days. On clinical examination multiple erythematous plaques and nodules were seen over hands, legs, back and abdomen. Bilateral cervical, supraclavicular, axillary and inguinal lymph nodes were palpable.

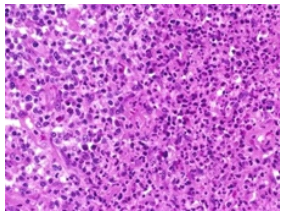


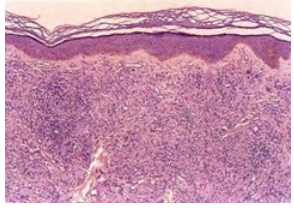
Bilateral periauricular, supraorbital and ulnar nerves were palpable, thickened and tender. Touch and temperature sensations were altered over glove and stocking areas. Patient was chronic bidi smoker since last 20 years.



The patient did not have any documentary evidence of his past medical history.

Investigation:
CBC: Hb-9.7 gm%, TLC -22800 cell/cumm, plt-4.84lacs/cumm.
PBS: RBC- microcytic hypochromic RBCs are seen, target cells and fragmented RBCs also seen, WBC- leucocytosis with neutrophilia, platelets- adequate on the smear.
ESR- 20mm
LDH: 803u/l
C-REACTIVE PROTEIN: 215.63 mg/l
RFT: urea-22mg%, creatinine- 1.0%
LFT: total bilirubin – 0.4 mg%, SGPT-20IU/l.
ELECROLYTE: sodium-129mmol/L, potassium- 4.9mmol/l, clorides- 98mmoll.
SEROLOGY (ELISA): HIV-negative, HBsAg –negative, HCV- negative.





SPUTUM AFB: negative.
TUBERCULIN SKIN TEST: Montoux test- negative

CHEST X RAY (PA): old healed in left upper zone.

FNAC OF LEFT CERVICAL LYMPH NODE: suggestive of acute suppurative inflammation.

SKIN BIOPSY FROM LESION OVER BACK: showed borderline lepromaotus with erythema nodosum.

USG NECK WITH AXILLA: multiple enlarged lymph nodes noted in neck along jugular chain both sides (largest of 10x4 mm on left side and 11x4.4mm on right side.), bilateral multiple enlaged lymph nodes noted in axillary region (3.4x1.4cm on right side and 2.3x1.4cm on left side).

USG INGUINAL REGION: there are enlarged multiple lymph nodes noted in bilateral inguinal regions (largest of size measuring 2.3x0.7cm on right side).

Discussion: multiple site lymph nodes involvement is rare presentation in leprosy patient and very few cases have been reported till now. Enlargement of lymph nodes confined to phases of

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lepra reaction followed by marked swelling and tenderness, especially of femoral and inguinal groups of lymphnodes. Major causes of lymphadenopathy are tuberculosis, secondary syphilis, AIDS, infective mononucleosis, histoplasmosis, leukemia, lymphoma, metastatic carcinoma, SLE and other miscellaneous condition like amyloidosis and sarcoidosis. Mycobacterium leprae infection usually presents with cutaneous and neurological involvement. However very few cases reported generalized lymphadenopathy in a case of lepromatous leprosy. So clinicians practicing in endemic areas should bear this fact in mind.

Conclusion: in this case, clinical suspicion lymphoma is more likely but detailed history, clinical examination, investigations may avoid misdiagnosis and mismanagement in such cases of generalised lymphadenopathy in lepromatous leprosy.