

Primary tuberculous lymph cyst of the axilla – a rare case report

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Abstract: Isolated axillary tuberculosis lymph cyst is rare and described in patients without evidence of previous or ongoing tuberculosis anywhere in the body. Presented is a 32-year-old female with tuberculosis lymphatic cyst, clinical examination and investigations revealed no evidence of tuberculosis elsewhere. Diagnosis was confirmed by microscopy and histology. Tuberculosis should be considered in patients residing in endemic areas with axillary swelling.

Keywords: axillary cyst, tuberculosis

INTRODUCTION:

Tuberculosis is a public health problem worldwide. India has the highest burden of tuberculosis in the world, with approximately 1.8 million people developing the disease annually extra pulmonary tb accounts for about 7-30% of TB cases and lymphadenitis accounts for 17-43% of cases [1]. Cervical lymph nodes constitute the most common site of involvement with axillary nodes affected in 3.8-20.3% of tuberculosis lymphadenitis. In patients with or without systemic symptoms and signs, chest radiograph is required to confirm or rule out pulmonary tb, diagnosis may be difficult at times necessitating biopsy [2]. We report our recent experience with a 32 year old presenting with a primary tuberculosis lymph cyst in the axilla, without any cervical node involvement, withno evidence of previous or active pulmonary TB and no evidence of TB detected elsewhere in the body [3].

CASE REPORT:

A case report of a 32-year-old female who presented in the outpatient clinic with a history of swelling in the left axilla of 3 months duration. The swelling gradually increased in size and was painless. There was a history of occasional low-grade fever with cough treated symptomatically at peripheral centres. No history of anorexia, weight loss, loss of appetite, drenching night sweats; no breast changes or left upper limb lesions. There was no family or past history of tuberculosis. Examination revealed a female in good health, a solitary bilocular left axillary swelling that measured 7×7 cm in diameter, non tender, and fluctuant with brilliant transillumination. The skin over the swelling and surrounding region was normal; the contra lateral axilla was unremarkable, breasts, upper limbs and other regions were essentially normal.

Investigations revealed haemoglobin of 10.3g/dl, ESR of 100 mm at the end of one hour, other routine blood investigations were found to be normal. Mantoux test was negative. Chest x-ray showed clear lung fields; HIV I & II screening negative. Patient underwent excision biopsy of the lesion. Intraoperatively a cyst was found (fig 1) between the interpectoral muscles with thick wall and clear cystic fluid, the specimen and fluid were sent for histopathological and microbiological examination respectively. HPE showed caseous necrosis surrounded by inflammatory cells and giant cells, suggestive of granulomatous inflammation, consistent with tuberculosis (fig 2).acid fast bacilli seen on microscopy with ziehl –nielson staining. Diagnosis of tuberculous lymph cyst made, on follow up patient had normal wound healing at the post op site except for a mild induration. She commenced anti-tuberculosis chemotherapy with satisfactory therapeutic response.



Fig-1

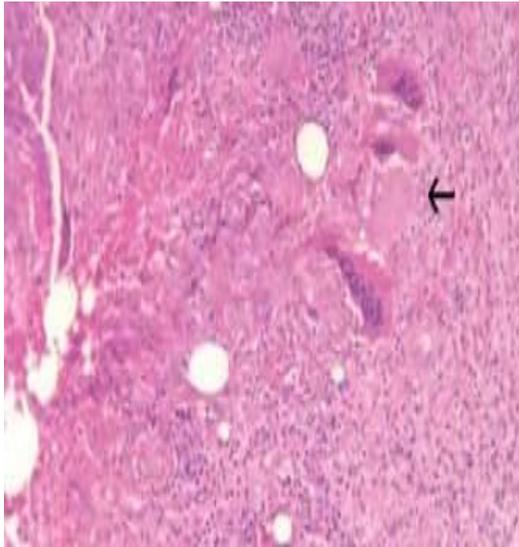


Fig-2

DISCUSSION:

Tuberculosis (TB) is responsible for a high burden of disease and estimated to affect one third of the world population with most in developing countries [1]. The proportion of extra pulmonary cases of TB, with their principal subset lymphadenitis has increase extra pulmonary tb accounts for about 7-30% of TB cases and lymphadenitis accounts for 17-43% of cases [4]. Cervical lymph nodes constitute the most common site of involvement with axillary nodes affected in 3.8-20.3% of tuberculosis lymphadenitis [5]. Axillary tuberculosis lymphadenopathy is rare, presents a problem of differential diagnosis with breast carcinoma metastasis, and has a major prevalence between 20-50 years old, which was in keeping with our patient aged 32 years[5]. Other differential diagnosis should include nodular fibromatosis, ectopic breast ,lipoma, hydatidic cyst , hematoma, soft tissue sarcomas [6]. Rates of systemic symptoms vary depending on the geographic origin and case selection, we did not record any convincing systemic symptoms in this patient. Definitive diagnosis is by culture or nucleic amplification of mycobacterium tuberculosis; demonstration of acid fast bacilli and granulomatous inflammation may be helpful [7]. Excisional biopsy has the highest sensitivity at 80%, but fine-needle aspiration is less invasive and may be useful, especially in immunocompromised hosts and in resource-limited settings. Antimycobacterial therapy remains the cornerstone of treatment, but response is slower than with pulmonary tuberculosis; persistent pain and swelling are common, and paradoxical upgrading reactions may occur in 20% of patients [8]. The role of steroids is controversial. Initial excisional biopsy deserves consideration for both optimal diagnosis and management of the otherwise slow response to therapy [4]. Axillary tuberculosis lymphadenopathy remains a rare condition, and should be considered in patients living in endemic areas of TB. [9]

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