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Therapeutic controversy in a case of extrapulmonary lymph nodes tuberculosis in a hemodialysed patient

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Introduction: Tuberculosis lymphadenitis is the most common form of extrapulmonary tuberculosis. 50% of extrapulmonary location is represented by tuberculosis of lymph nodes. In the absence of pulmonary tuberculosis, ganglionary involvement makes the diagnosis to be difficult and tardive, delaying the onset of the treatment. Mediastinum lymph nodes location compels us to the differential diagnosis with sarcoidosis, carcinoma, sarcoma, lymphomas and infectious adenitis, collagen or systemic diseases.

Case Presentation: A 63-years-old female with insulin dependent type-2 diabetes, chronic hepatitis B, diabetic nephropathy and Chronic Kidney Disease (CKD) in Hemodialysis (HD) was referred one year ago with nonspecific pulmonary symptoms (cough, dyspnea) and dysphagia. The X-ray detected large left superior mediastinum and chest CT scan highlighted polylobulate left para-aortic mass with necrosis tendency, in relation to large mediastinum vessels. Multiple tumoral biopsy emphasized sarcoidosis (Ziehl-Nielsen initial coloration was negative). After initiation of corticosteroids (preceded by treatment with Lamivudine), the clinical evolution was unfavorable and we decided reevaluating the histological sections (positive for tuberculosis) and another CT scan was made. The angiotensin converting enzyme was in normal limits. The diagnostic was reconsidered, establishing rare extrapulmonary lymph node tuberculosis. After 6 months of tuberculostatics, the clinical and paraclinical evolution was favorable with significantly decrease of mediastinal tumor (from 7/5 cm till 2/1 cm) and significant reducing symptoms. The corticosteroid doses were gradually excluded.

Discussion: The case particularity is represented by disease association (diabetes mellitus, CKD in HD, chronic hepatitis B and mediastinum lymph nodes tuberculosis). Differential diagnosis between sarcoidosis and extrapulmonary tuberculosis was very important, because corticosteroids administered for sarcoidosis could decompensate liver function (replication of hepatitis B virus) and glycemic status. On the other hand, the tuberculostatic treatment could decompensate liver and eye function and doses must be reduced for CLcr <15 ml/min/1,73 m2. In addition to this, the polylobulate mass in relation with large and vital mediastin vessels compel to closely monitor and relatively reserved prognosis.

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