

## ***CLINICOPATHOLOGICAL CONFERENCE -BY 4th MEDICAL UNIT***

A 20-year-old male had presented with complaints of recurrent swelling over the right side of the neck for the past 4 years. The swelling had appeared insidiously, increased gradually in size, and then regressed partially, only to recur again after variable intervals. During the periods of enlargement, he had experienced episodes of low-grade fever, which were not associated with chills, rigors, or systemic upset. The fever had subsided spontaneously as the swelling regressed. There had been no history of significant constitutional symptoms such as loss of weight, loss of appetite, or night sweats. He denied history of cough with expectoration or hemoptysis. There had been no complaints of chest pain, dyspnea, or palpitations.

He did not report abdominal pain, vomiting, loose stools, or abdominal distension. He had not noticed swelling of the lower limbs or generalized edema. There had been no skin rashes, pruritus, or mucocutaneous lesions. He did not complain of easy fatigability, joint pain, or bone pains. There was no history of bleeding manifestations such as epistaxis, gum bleeding, petechiae, or ecchymoses. No other systemic complaints were reported.

The patient had experienced similar neck swellings in the past for which he had been treated with antibiotics, following which the swellings had partially subsided but never completely disappeared. Fine Needle Aspiration Cytology (FNAC) done 4 years earlier had shown features of reactive lymphadenitis.

An excision biopsy performed around the same time had revealed lymphoid follicular hyperplasia with

prominent eosinophilic infiltration in the background.

In view of persistent and recurrent lymphadenopathy, he had been started empirically on anti-tubercular therapy (ATT) one year ago. He had completed a 6-month course of ATT, but the swelling had not resolved significantly.

There was no past history of tuberculosis, jaundice, diabetes, hypertension, or other chronic illnesses. He had no history of any major surgery or blood transfusion in the past.

There was no family history of tuberculosis, malignancy, or similar swellings. There was no history of hereditary or chronic illnesses such as diabetes mellitus, hypertension, or asthma among family members.

The patient was IT professional by occupation. His diet had been mixed and adequate. His appetite and sleep pattern had been normal. Bowel and bladder habits had been regular. There was no history of addictions to tobacco, alcohol, or any other substances. There was no history of recent travel, exposure to sick contacts, or pets at home.

The patient was conscious, oriented, and afebrile. There was no pallor, icterus, cyanosis, clubbing, or pedal edema. Oral cavity examination revealed bilateral enlarged tonsils (Grade I).

In the right cervical region, lymph nodes measuring 2.0 × 1.5 cm and 1.5 × 1.5 cm were palpated; both were firm, mobile, nontender, and matted. On the left side, a lymph node measuring 1.0 × 1.0 cm

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Blood pressure was 110/70 mm Hg (right upper limb, sitting), pulse 96/min, respiratory rate 16/min, and SpO<sub>2</sub> 98% on room air.

Cardiovascular system revealed normal S1 and S2 with no murmurs. Respiratory system showed bilateral air entry with normal vesicular breath sounds. Abdomen was soft with no organomegaly. Central nervous system examination was normal with no focal deficits.

### **Investigations**

Hematology: Complete blood count and differential count were within normal limits. Peripheral smear showed no atypical cells.

Mantoux test: Negative.

Viral Studies: VCTC and viral markers were nonreactive.

Microbiology: Sputum CBNAAT – MTB not detected.

ESR was found to be 45 mm/hour and CRP was 20 mg/dl.

FNAC (USG-Guided): Cellular smear showing sheets of mature lymphocytes admixed with ill-defined granulomas.

CECT Chest: No lung parenchymal abnormalities, no hilar lymphadenopathy.

CECT Neck: Multiple prominent bilateral cervical lymph nodes involving levels IB and II (right > left). Some nodes showed

tiny non-enhancing areas suggestive of necrosis; others enhanced well. Few enlarged bilateral level IV and supraclavicular nodes were seen with homogeneous enhancement. Bilateral prominent intraparotid nodes were noted, with the right parotid gland showing heterogeneous enhancement and subcutaneous stranding.

CECT Abdomen: Normal liver, spleen, gallbladder, pancreas, and kidneys. No abdominal lymphadenopathy or free fluid.

Another investigation was done and diagnosis was reached.