COEXISTENCE OF LYMPHADENOMA AND TUBERCULOSIS.

BY

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The possibility of lymphadenoma and tuberculosis coexisting is well recognized. Ewing has pointed out that tuberculosis follows in the wake of lymphadenoma, and Ziegler estimated that 20 per cent. of these patients died of miliary tuberculosis. It has, indeed, been held that the two diseases are identical. Sternberg first put forward the view that Hodgkin's disease was a form of tuberculosis, due, probably, to infection with an attenuated form of the tubercle bacillus. Clinically, cases occur in which the two diseases are almost indistinguishable. In the morbid histology of tuberculous adenitis a type is recognized without definite giant cell systems and in which endothelial hyperplasia is the characteristic feature. It is well known that an endothelial hyperplasia may be the sole feature of early lymphadenoma, a point which is emphasized by Christian and Warthin. Even Andrews, though he denies the identity of the two diseases, considers it is difficult to distinguish atypical lymphadenoma from a typical tuberculosis.

We do not intend to lay any great stress on this view, but the occurrence of tuberculosis in cases of Hodgkin's disease is of great interest, since both may present lesions which are difficult to allocate. This is particularly so since there occur in lymphadenomatous glands in the late stages certain yellowish-white areas which are referred to by Ewing as "necrotic foci" and by Longcope as "areas of necrosis." The difficulty arises in distinguishing them from areas of caseation, and the question may be asked
whether these necrotic foci are really due to a mixed infection with the tubercle bacillus, or whether there is in lymphadenitis a type of "caseation" similar in certain aspects but differing in others. This latter view is supported by the fact that abscess formation is often accompanied by necrosis, and that the necrosis may be a part of the process of caseation. The lesion may be due to an infective granuloma like syphilis, tuberculosis, and actinomycosis, which becomes more striking for, in all these conditions we have alteration of the normal structures by endothelial and lymphoid tissue with the presence of giant cells, for an lesion is "caseation" by sclerosis.

The presence of myocytes in the blood is of interest and unusual. It will be remembered that the earlier authors have described cases of lymphadenitis in which the blood contained myocytes. The disease is termed "pseudo-leukemia," and to this term the case must be assigned. The presence of myocytes indicates that the bone marrow is involved, and that the process is not far removed from a leukaemic hyperplasia. It may be added that Fabian has recorded a few myocytes in cases of Hodgkin's disease, though they were few in number. The presence of myocytes may indicate involvement of the bone marrow, since some cases of Hodgkin's disease have been reported, in which the bone marrow was found to contain myocytes.

The occurrence of an abscess in one of the glands in the neck is unusual, and raises the question whether these cases are due to the blood stream or to the lymphatics. In this case, again, may suggest the view that lymphadenitis is a secondary infection—a view which is emphasized by Horder—an infection supervening on some other chronic condition.

With regards to the eosinophilia, Longeboe holds that it is more common where there are necroses in the glands. Bunting, on the other hand, contends that eosinophils are low in the blood in the active stages of the disease, seeming that they all emigrate into the lymphatic glands, the destruction of the lymphocytes there apparently serving as a stimulus. In this case it is conceivable that eosinophilia in the glands is well marked, but not so in the blood.

### Literature


Bunting, J.: Neoplastic Diseases, 1913.

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Horder, Sir T.: Medical Notes.
T. K. MENON AND T. B. MENON: COEXISTENCE OF LYMPHADENOMA AND TUBERCULOSIS.

Fig. 1.—Photograph of the intra-thoracic glands with the foci of necrosis. (By the courtesy of Captain Barnard, Radiologist, General Hospital, Madras.)

Fig. 2.—Showing the lymphoid areas surrounded by dense fibrous tissue. (x 22.)

Fig. 3.—Showing the endothelial giant cells and multinucleate endothelial cells. (x 220.)

Fig. 4.—Showing an endothelial giant cell with large nuclei arranged round the periphery. (x 220.)

B. MORTON: RAPID HEALING OF A GASTRIC ULCER.

Fig. 1.

Fig. 2.

Fig. 3.