

HAEMATOLOGIC MASKS OF TUBERCULOSIS

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Recently certain changes in the clinical course and pathomorphology of tuberculosis (TBC) are reported to be a definite difficulty in diagnosing the disease (Struckov, A. I. — 1971; Rabuchin, A. E. — 1974; Jacques, J. et al. — 1970). TBC (the way most infectious diseases do) causes bone-marrow hypo- and aplasia, which converts its morphologic development very close to that of an acute leucosis, myelogenous leucosis, etc. (Reich, P. et al. — 1978). Most considerable are the differentiative-diagnostic problems due to the haematogenic disseminated TBC-form in adults being the most often reason for haematologic masks of this disease (Kassirskii, I. A. — 1970).

Concerning bibliography and our own data in diagnosing TBC with haematological disorders we demonstrate 6 patients admitted to the Clinic of Pulmology and Phthisiatry, Higher Institute of Medicine, Varna city, initially suspected to be haematological cases but later proved to be definite TBC-cases:

1) P. V. K., age 49, female; initial diagnosis (ID): Hypoplastic anaemia, TBC-lymphadenitis; final pathohistologic diagnosis (FPHD): Acute millitary TBC.

2) I. A. T., age 53, female; ID: Aggranulocytosis, sepsis. FPHD: Productive TBC of periphery lymph nodes.

3) T. I. T., age 54, female; ID: Nondifferentiative leucosis, aleucosic form; FPHD: Acute millitary TBC.

4) Y. I. B., age 59, female; ID: Morbus Hodgkin; FPHD: Subacute haematogenic disseminated TBC.

5) P. A. G., age 23, female; ID: Aggranulocytosis; FPHD: Productive TBC of periphery lymph nodes.

6) M. I. H., age 30, male; ID: Autoimmune haemolytic anaemia; FPHD: Productive TBC of testicles.

All patients had an expressed intoxicative syndrome (adynamia, febrility, fever) and leucocytosis. Two women shew a heavy-degree anaemia. Physical examination revealed out considerably affected status of the patients. 5 female patients had enlarged lymph nodes; 4 female+1 male patients had enlarged liver. The haematologic indexes of those patients admitted with ID: Aggranulocytosis, hypoplastic anaemia or leucosis can be seen on the following table:

Haematologic indexes of patients with leucopenia:

Patients:	Hb:	Leuco:	Bone marrow:
P. B. K.	9,5 g %	2000—2300	hypoplastic
I. A. T.	10,6 g %	1600—2000	no maturation of white cells
T. I. T.	6,5—7,5 g %	1000—1700	reticular
Y. I. B.	6,2—8,1 g %	700—1200	maturation towards myelocytes

Serum iron was lowered with all patients. Positive liver tests, dislocated transaminases, increased alkaline phosphatase, etc. were registered. These data coincided with those of bibliography concerning patients with haematogenic disseminated TBC (C. Can et al. — 1974). The haemocultures of banal (ordinary) flora with our cases were all negative. After X-rays investigation of the lungs no pathological disorders were established. Differentiative-diagnostic analysis of aggranulocytosis, hypoplastic anaemia, sepsis, TBC, neoplastic processes, etc. was done. Concerning the present lymphadenomegalia, positive Mantoux (diluted 1:10 000) and persistent febrility we directed our investigations towards a possible TBC-process. Bacteriological examination of sputum (Coch-method) and smear of lymph nodes was negative. Cytological study of punctured lymph nodes of 3 patients was performed; epitheloid cells and single multinuclear cells with a Langhans-like appearance were registered with 1 of our patients. No histologic proof for TBC was established in biopsy-investigation of periphery lymph nodes of 2 patients. The disorders were considered to be resultant of lymphogranulomatosis and nonspecific inflammatory process. Several months later the second biopsy proved TBC with 1 female patient. Specific treatment cured the disease successfully whereas the rest 3 cases had a lethal end 4—5 months later.

Our cases shew certain diagnostic problems concerning TBC with aggranulocytosis or pancytopenia. The difficult diagnosis is due to the morphologic masks established in bone-marrow smears (acute leucosis or hypoplastic anaemia) as well as the difficulties in histological study (no specific changes in lymph nodes under biopsy-investigation were registered). This makes the obligation of suggesting a TBC-process in all patients with aggranulocytosis and pancytopenia in order to treat the disease thoroughly.

Our patient M. I., age 30, clin. rec. No. 21 844/28th September, 1977, is a worth-reported example: he was admitted to the clinic with adynamia, febrility, pains, swelling of left testicle and laboratory proved haemolytic anaemia. His complaints had a 4-month duration. Physical examination: hepatosplenomegalia, icterus, constant subfebrility; considerably enlarged left testicle with a red skin over, hydrocele. Laboratory investigations: low Hb values — 6,2 g %; leucocytosis — 16 000; toxic granulations in neutrophiles, slightly increased Sedimentation Test. Immunologically: positive antibodies IgA and IgM, erythroantibodies with specificity anti-I and positive direct Coombs. Total bilirubin 5,3 mg % with an increase of its indirect (mainly) fraction. Laboratory proved intrahepatic cholestasis. X-rays investigation of lungs: no pathological disorders. Differentiative diagnosis: neoplasia (testicle seminoma) with metastases in liver; symptomatic autoimmune haemolytic anaemia; specific epididimitis. The testicle biopsy shew nonspecific inflammatory process. Regardless to the applied antibiotics the patient's status was worse and worse, his subfebrility persisted. Abdominal aches and ascitis appeared additionally. Laparoscopia was performed: it established single scattered nodules on the peritoneum which were considered to be metastases. Mantoux was strongly positive (1:10 000) which required a second testicle biopsy: histological signs of productive TBC (B. I. No. 6300/8th December, 1977). Specific anti-TBC treatment was recommended and the patient slowly recreated; liver and spleen reduced their sizes, icterus disappeared. Patient was discharged and directed to sanatorium.

No bibliographic data could be found showing an autoimmune haemolytic anaemia resultant of TBC. The demonstrated patient manifested exclusive differentiative-diagnostic problems and difficulties in proving his TBC which shew its main symptoms related to autoimmune haemolytic anaemia.

The extraordinary location and considerably enlarged lymph nodes were also a certain diagnostic problem. To our clinic was directed and admitted a pregnant patient in her VIIth lunar month, age 28, initial diagnosis: Morbus Hodgkin (enlarged lymph nodes, egg-like, located in axillar and supraclavicular region) and X-rays detected disorders of the right lung hillus. Morbus Hodgkin, TBC of tracheobroncheal and periphery lymph nodes, lymphoma, etc. were considered, discussed and analysed. Mantoux: positive — 30×30 mm. Biopsy of lymph nodes: productive TBC. Specific treatment was applied and the patient had later normal pregnancy and labour.

Our demonstrated patients are undoubtedly interesting for the clinical practice with their extraordinary developing disease and initially manifested haematological symptoms.

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ГЕМАТОЛОГИЧЕСКИЕ МАСКИ ТУБЕРКУЛЕЗА

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РЕЗЮМЕ

Авторами наблюдались 6 больных различными формами туберкулеза, прошедших с начальными клиническими и лабораторными данными агранулоцитоза, аутоиммунной гемолитической анемии и болезни Ходжкина. Туберкулезное заболевание диагностировано после нескольких биопсий лимфатических узлов у трех больных, а у остальных — патологоанатомически. Обсуждаются значительные трудности диагностирования туберкулеза с начальными проявлениями гематологического заболевания, както и необходимость в целенаправленных и систематических поисках туберкулезного процесса, в особенности у больных с агранулоцитозом.