Tuberculous adenitis

Tuberculous adenitis

This condition most commonly a ff ects children or young adults but can occur at any age. The deep upper cervical nodes are most commonly a ff ected, but there may be a widespread cervical lymphadenitis with matted nodes. In most cases, the tubercular bacilli gain entrance through the ipsilateral tonsil. - In approximately 80% of patients, the tuberculous process is limited to the clinically a ff ected group of lymph nodes, but a primary focus in the lungs must always be suspected. Rarely , the patient may develop a natural resistance to the infection and the nodes may be detected at a later date, as evi - denced by calcification on radiography . This can also be seen after appropriate general treatment of TB adenitis. If treat - ment is not instituted, the caseated node may liquefy and break down with the formation of a cold abscess in the neck. The pus is initially confined by the deep cervical fascia, but after weeks or months this may become eroded at one point and the pus flows through the small opening into the space beneath the superficial fascia. T he process has now reached the well-known stage of a ‘collar-stud’ abscess. The superficial abscess enlarges steadily and, unless suitably treated, a discharging sinus results. Fine-needle aspirate taken from neck nodes with a suspicion of TB should be tested for the presence of acid-fast bacilli. Systemic investigation should not be neglected, with a chest radiograph and tuberculin skin test (Mantoux) useful as first-line investigations. The drawback of the Mantoux test is the poor sensitivity in immunocompromised patients and low specificity in patients with prior bacille Calmette–Guérin (BCG) vaccination. The interferon- γ release assay (QuantiFERON Gold In-Tube; QFT-GIT; Cellestis, Carnegie, Australia) with ® T-SPOT . TB (Oxford Immunotec, Abingdon, UK), in con trast, is more specific than a Mantoux test as the results are not confounded by previous BCG vaccination. This blood test measures the cellular immune response to antigens derived from Mycobacterium tuberculosis . Although active or latent infec tion cannot be specifically di ff erentiated with this test, a pos itive test in a patient with negative clinical and radiological evidence of TB indicates latent TB infection. Depending on the country of origin, where TB is diagnosed or suspected, the coexistence of other infectious diseases such as HIV and malaria should not be ov erlooked. Treatment The patient should be treated using appropriate chemotherapy , dependent on the sensitivities derived from the abscess contents. If an abscess fails to resolve despite appropriate chemotherapy and general measures, occasionally excision of the abscess and its surrounding fibrous capsule is necessary , together with the relevant lymph nodes. If there is active TB of another system, for example pulmonary TB, then removal of tuberculous lymph nodes in the neck is inappropriate. The matted nodes are associated with significant fibrosis, making surgery di ffi cult to the extent that the sacrifice of adjacent structures such as the internal jugular vein or sternocleidomastoid muscle may be necessary . The resected nodes should be sent for both histology and microbiology . Tuberculous adenitis

This condition most commonly a ff ects children or young adults but can occur at any age. The deep upper cervical nodes are most commonly a ff ected, but there may be a widespread cervical lymphadenitis with matted nodes. In most cases, the tubercular bacilli gain entrance through the ipsilateral tonsil. - In approximately 80% of patients, the tuberculous process is limited to the

clinically a ff ected group of lymph nodes, but a primary focus in the lungs must always be suspected. Rarely , the patient may develop a natural resistance to the infection and the nodes may be detected at a later date, as evi - denced by calcification on radiography . This can also be seen after appropriate general treatment of TB adenitis. If treat - ment is not instituted, the caseated node may liquefy and break down with the formation of a cold abscess in the neck. The pus is initially confined by the deep cervical fascia, but after weeks or months this may become eroded at one point and the pus flows through the small opening into the space beneath the superficial fascia. T he process has now reached the well-known stage of a ‘collar-stud’ abscess. The superficial abscess enlarges steadily and, unless suitably treated, a discharging sinus results. Fine-needle aspirate taken from neck nodes with a suspicion of TB should be tested for the presence of acid-fast bacilli. Systemic investigation should not be neglected, with a chest radiograph and tuberculin skin test (Mantoux) useful as first-line investigations. The drawback of the Mantoux test is the poor sensitivity in immunocompromised patients and low specificity in patients with prior bacille Calmette–Guérin (BCG) vaccination. The interferon- γ release assay (QuantiFERON Gold In-Tube; QFT-GIT; Cellestis, Carnegie, Australia) with ® T-SPOT . TB (Oxford Immunotec, Abingdon, UK), in con trast, is more specific than a Mantoux test as the results are not confounded by previous BCG vaccination. This blood test measures the cellular immune response to antigens derived from Mycobacterium tuberculosis . Although active or latent infec tion cannot be specifically di ff erentiated with this test, a pos itive test in a patient with negative clinical and radiological evidence of TB indicates latent TB infection. Depending on the country of origin, where TB is diagnosed or suspected, the coexistence of other infectious diseases such as HIV and malaria should not be ov erlooked. Treatment The patient should be treated using appropriate chemotherapy , dependent on the sensitivities derived from the abscess contents. If an abscess fails to resolve despite appropriate chemotherapy and general measures, occasionally excision of the abscess and its surrounding fibrous capsule is necessary , together with the relevant lymph nodes. If there is active TB of another system, for example pulmonary TB, then removal of tuberculous lymph nodes in the neck is inappropriate. The matted nodes are associated with significant fibrosis, making surgery di ffi cult to the extent that the sacrifice of adjacent structures such as the internal jugular vein or sternocleidomastoid muscle may be necessary . The resected nodes should be sent for both histology and microbiology .

Revision #1
Created 2025-12-31 15:20:07 UTC by Omar Ayman
Updated 2025-12-31 15:20:07 UTC by Omar Ayman