Correspondence

Cervical Lymphadenopathy: A Rare Presentation of Malaria

Sir,

Plasmodium infection is associated with myriad presentations, which ranges from simple febrile illness to fatal complications. Various atypical clinical features of malaria are cough, malarial paroxysm, migraine, urticarial rash, bradycardia, postural hypotension, jaundice, cerebral involvement, anemia, thrombocytopenia, pancytopenia, splenic rupture due to splenomegaly and acute abdomen. We report a case of mixed malaria infection who presented with fever, cervical Lymphadenopathy and hepatosplenomegaly. After anti-malarial treatment, the cervical Lymphadenopathy regressed. A search of the existing literature revealed only one case report of abdominal lymphadenopathy in malaria. To our knowledge, we have described the first case of significant cervical lymphadenopathy caused by mixed malarial infection.

A 25 year old lady presented with 15 days history of high grade fever (up to 103°F) along with multiple swellings of neck for 10 days. On examination patient was conscious, oriented and toxic. General physical examination revealed bilateral cervical multiple enlarged lymph nodes; largest lymph node was 2×4 cm size, while smallest was 1×1cm size. One 2×2 cm lymph node was also present in right axilla. Lymph nodes were soft to firm in consistency and mild tenderness was present. On abdominal examination liver was palpable 3 cm and spleen was 1.5 cm below subcostal margins. Sternal tenderness was absent. Other systemic examination was normal.

Investigations showed Hemoglobin 10.6 gm/dl, TLC 9.4×10^9/L, platelets 256000/mm3, ESR 50 mm at the end of 1 hour. Peripheral smear revealed plasmodium vivax with index 0.1%. There was no evidence of falciparum parasite on blood film examination but antigen for falciparum (histidine-rich protein 2 kit assay) was positive. Leptospira antigen, Hepatitis B, Hepatitis C, and HIV were negative. Urine examination, renal function test, liver function test were within normal limits. Chest radiography was unremarkable. USG of abdomen showed hepatomegaly (span of 15.8 cm) normal in echo texture, spleen was enlarged (span of 13.5 cm). USG of abdomen did not show any abdominal lymph node. Fine needle aspiration cytology of cervical lymph node showed reactive hyperplasia. In view of positivity of falciparum and vivax malaria patient was started on Artesunate and Doxycycline. On third day of initiation of therapy fever subsided and lymph nodes started regressing. Within 5 days patient was totally asymptomatic, her lymph nodes almost disappeared.

This patient presented with history of fever and on examination she had significant cervical and axillary lymph nodes enlargement with hepatosplenomegaly. Common differential diagnosis of this clinical presentation is viral infection, tuberculosis, leukemia or lymphoma. Routine blood film examination revealed plasmodium vivax which was an incidental finding. Lymphadenopathy caused by malaria is not a known phenomenon and extensive literature search revealed only one case report of abdominal lymphadenopathy in malaria. Lymphadenopathy is a manifestation of variety of disorders which range from benign reactive lymphadenopathy to malignancy. One study showed that ablation of lymphoid sites greatly impairs subsequent development of protective immunity against malaria. Our patient belonged to hyper endemic area and had mixed malaria infection, which might have precipitated exaggerated T and B cell response and lymphadenopathy but further study is required to support this theory.

References


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