

Tuberculous lymphadenopathy mimicking sarcoidosis

예수병원 내과¹, 예수병원 호흡기·알레르기내과²

조은섭¹, 최경화^{1,2}

Sarcoidosis and tuberculosis are granulomatous disorders that share many clinical manifestations. Tuberculosis should always be ruled out before the diagnosis of sarcoidosis. However, the diagnosis is often complicated, particularly in extra-pulmonary cases. Here, we present a case of tuberculosis lymphadenopathy clinically mimicking sarcoidosis. A 45-year-old man presented to the outpatient department with an episode of febrile sensation and a palpable mass in the left neck for 5 days. He had suffered from recurrent uveitis after surgery in his right eye 10 years before and had been treated with steroids and cyclosporin. Physical examination revealed a palpable non-tender irregular mass in the left supraclavicular area. Needle biopsy of the neck node revealed non-caseating granulomatous inflammation. Tissue stain and culture for acid-fast bacilli and fungi revealed no organisms. Chest computed tomography showed unilateral lymphadenopathy without central necrosis in the left supraclavicular and left pectoralis muscle areas [Fig 1]. Additional tests were performed to identify granulomatous lymphadenitis of various causes, such as serum angiotensin-converting enzyme and calcium level, which results were normal except the interferon-gamma release assay was positive. So we performed further excisional lymph node biopsy, showed multiple non-caseating epithelioid granulomas [Fig 2]; tissue *Mycobacterium tuberculosis* polymerase chain reaction was positive. The patient was diagnosed with tuberculosis lymphadenopathy and treated with anti-tuberculosis drugs for 6 months. His symptoms subsided, and there was improvement in lymphadenopathy. No recurrence has occurred in the 15-month follow-up period. Granulomatous lymphadenitis is not a specific histopathological diagnosis and may be associated with several underlying causes. The precise diagnosis is important because these diseases have different types of treatment. To that end, we require a high index of clinical suspicion for both diseases, clinical acumen, and a detailed evaluation including a thorough evaluation of radiologic, laboratory, and pathology findings.

