

MDT case discussion

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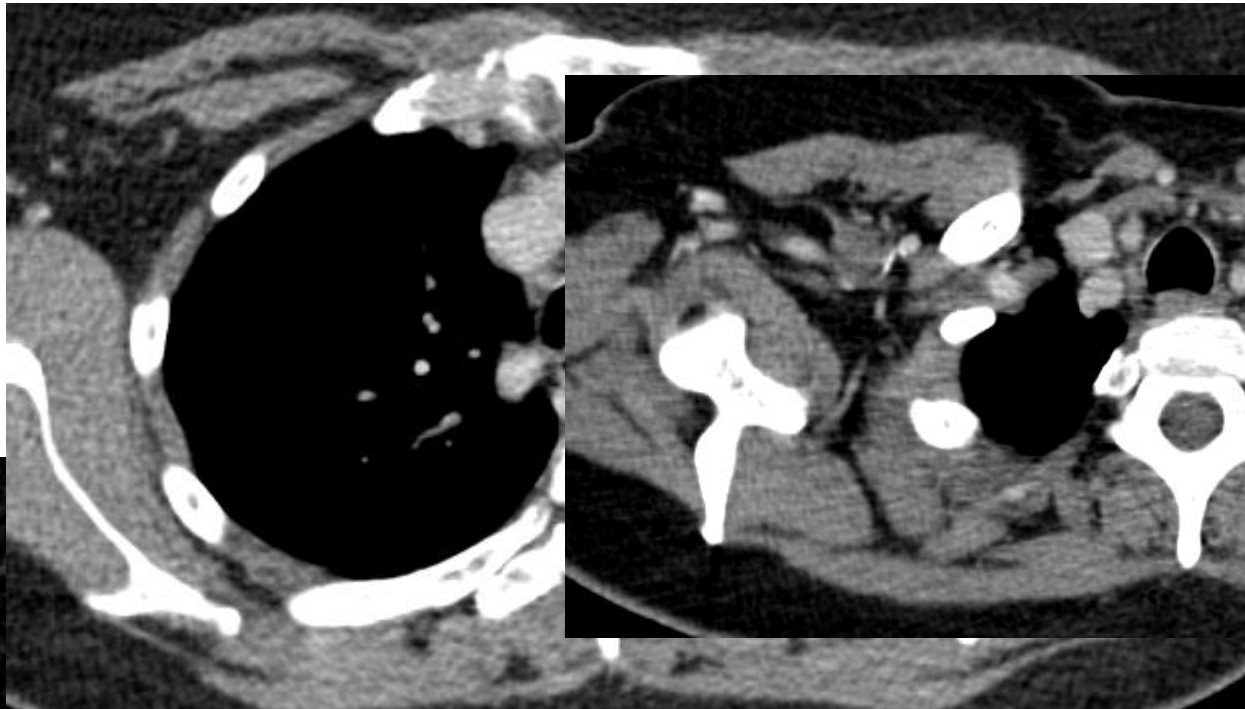
NW TB Conference 12 November 2018

Initial presentation

- 46 F
- Cough, unintentional weight loss, tired, sweats – several months
- Cough with copious white sputum
- Anaemic, raised ESR
- GP requested CXR (Withington Hospital) and referred end July on HSC205 pathway to lung cancer diagnostic team
- CXR automatically led to CT thorax (Wythenshawe Hospital)

Her background

- No PMH
- Rx: ferrous sulphate; no allergies
- Never smoked
- Unemployed, no significant occupational history
- Single
- Born in UK to Pakistani parents
 - Father well; mother died pancreatic cancer
- No known contact with TB



Initial plan

- Routine blood tests
 - HIV, HBsAg, HCV negative
- 3x sputum for AFB/TB culture
- US neck and FNA neck nodes
 - PUS
 - Sent for TB culture and cytology

Initial results

- Sputum x3
 - AFB smear-negative
- Pus from neck
 - AFB smear-negative
- FNA cytology
 - Inflammatory
 - No obvious granulomata
 - Possible atypical cells (consultants can't agree), advised to carry out excision biopsy

What would you do now?

- 1. Start TB treatment empirically
- 2. Wait for TB culture
- 3. Refer for excision biopsy of neck node
- 4. Bronchoscopy/EBUS
- 5. Medical thoracoscopy

Next steps

- Referred to TB clinic
- I advised that, because of cavitating lung lesion and pus in lymph node, very likely to be TB
- I recommended empirical TB treatment (standard regimen)
- Warned diagnosis not confirmed yet

4 weeks into treatment

- Feeling slightly better
- Cough less productive, down from 5 pots to 1 pot of sputum per day; sleeping sitting up
- Sweats continue (no better)

What would you do now?

- 1. Continue TB treatment
- 2. Stop TB treatment
- 3. Refer for excision biopsy of neck node
- 4. Bronchoscopy/EBUS
- 5. Medical thoracoscopy

Next steps

- Discussed excision biopsy
 - Refused
- Had bronchoscopy (reluctantly)
 - Washings: AFB smear negative
 - Endobronchial biopsies and brushings: atypical cells, suspicious for lymphoproliferative disease
 - Referred to Leeds Cancer Centre for tertiary opinion

2 months into treatment

- No significant clinical or radiological improvement
- 6 sputum samples
- 1 pus sample
- All culture negative for TB
- Again refused referral for cervical lymph node biopsy
- Haematologists confirmed could not offer chemotherapy without a biopsy

What would you do now?

- 1. Advise to complete course of standard TB treatment
- 2. Switch to MDR-TB treatment
- 3. Arrange biopsy under Mental Capacity Act
- 4. ...

11 weeks into treatment

- Histopathology report from FNA back from Leeds
 - There is a monotypic plasma cell proliferation
 - plasmacytoma and marginal zone lymphoma the main differential diagnoses
- Again refused to have cervical lymph node biopsy
- We phoned and wrote to her to say that the biopsies had confirmed cancer,
- And stopped TB treatment

Subsequently

- A further 3 months later
- Presented to ED: neck pain unbearable, ongoing constitutional symptoms
- Agreed to excision biopsy

Subsequently

- Biopsy confirmed diffuse large B-cell lymphoma
- Started R-CHOP chemotherapy same admission
- Complete response on PET-CT
- Recent relapse with recurrence in stomach
- Plan for further chemotherapy followed by autologous stem cell transplant

Summary

- Cavities and pus = TB
- But need to assess response to treatment and keep an open mind
- Proportion of patients with fluctuant lymph nodes who have TB is anecdotally very high