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Lesson of the Week

Acute tuberculous lymphadenopathy in an immunosuppressed patient

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Patients who receive immunosuppressive drugs for non-malignant disorders develop mycobacterial infections more often than untreated individuals.¹ Active pulmonary tuberculosis has been found in patients with systemic lupus erythematosus (SLE) who are treated with high doses of corticosteroids.² We report on a patient with SLE who was receiving immunosuppressive treatment and presented with an acute tuberculous cervical lymphadenitis.

Case report

A 53-year-old woman was admitted with a two-day history of swelling in the left side of the neck and a one-day history of pain on swallowing. SLE had been diagnosed in 1960 and had mainly affected the skin and to a lesser extent the joints. She had been receiving prednisolone 15 mg daily and azathioprine 100 mg daily for several years with no problem. She was a smoker and had mild shortness of breath on exertion; there was no history of cough, sputum, night sweats, weight loss, or contact with tuberculosis.

The physical examination showed a large, erythematous exquisitely tender swelling of the left side of the neck, and vitiligo secondary to skin destruction related to SLE over the face (figure). Her temperature was 38°C and pulse rate 80 per min. Examination of the chest was normal. The results of investigations showed haemoglobin 11.3 g/dl; white cell count $5.7 \times 10^9/l$ ($5700/mm^3$), with a differential count of neutrophils 82%, lymphocytes 14%, and monocytes 4%; platelet count $233 \times 10^9/l$ ($233\,000/mm^3$). Many acid-fast bacilli were seen in a sample of fluid aspirated from the swelling in the neck. *Mycobacterium tuberculosis* was cultured from this specimen and was

Tuberculosis lymphadenitis in an immunosuppressed patient may be acute and resemble an acute pyogenic bacterial infection

The patient on the second day after admission to hospital, showing an erythematous swelling on the left side of the neck and skin destruction on the face.

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sensitive to streptomycin, aminosalicylic acid, isoniazid, rifampicin, thiacetazone, cycloserine, pyrazinamide, and prothionamide. A chest x-ray examination showed patchy diffuse consolidation in the right upper zone and a dense area of consolidation just below the left first rib with an area of possible cavitation. X-ray films of the neck showed no evidence

of retropharyngeal abscess or bony destruction. Sputum was negative for acid-fast bacilli on microscopy and culture. The results of blood cultures were negative. No other organism was seen on microscopy or cultured from the fluid aspirated from the neck.

Treatment with azathioprine was stopped and prednisolone was continued at a dose of 15 mg a day. Treatment with daily intramuscular streptomycin and oral rifampicin, isoniazid, and ethambutol was started. The swelling in the neck and the temperature gradually diminished over the first week in hospital. Two weeks after she was admitted to hospital a tablespoonful of pus was expressed from the neck; azathioprine 100 mg daily was reintroduced because of increasing joint stiffness. The patient was discharged receiving prednisolone, azathioprine, ethambutol, rifampicin, and isoniazid. Five months after admission she remained well, the neck swelling had settled, and her chest x-ray films showed improvement.

Comment

Tuberculous lymphadenopathy commonly presents as a painless, progressive swelling. In this patient the onset was

acute over two days, and the swelling was very tender and erythematous. Symptoms of the pulmonary tuberculosis had been fully suppressed by this patient's treatment before the veritable explosion of inflammation in the neck. Fortunately, the characteristic features of pulmonary tuberculosis seen on the chest x-ray films led us to examine the fluid aspirated from the neck for acid-fast bacilli. This experience suggests that pathological samples from patients receiving immunosuppressive treatment who develop acute lymphadenitis should be examined for acid-fast bacilli.

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Letters to a Young Doctor

Choosing to become a general practitioner

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More than half of the doctors in the United Kingdom are general practitioners. Numerically, therefore, general practitioners are the most important group. They deal with perhaps 90% of all illness for which patients decide that medical help is needed. Their range of work is immense and on a very broad front, as opposed to the relatively narrower range of the hospital specialist. The specialist's knowledge is deep and his skills are esoteric, covering every aspect of his subject. The GP's knowledge is wide, with skills to match so that they cannot normally be complete in any one branch of medicine.

This generalisation is mainly true but has many obvious exceptions in individuals, both general practitioners and specialists. The best physicians, for instance, may seem to be closely similar to general practitioners, and vice versa. Many GPs have trained as physicians, surgeons, and obstetricians and have higher qualifications in many specialist subjects, so that there may be much overlap between general and hospital practice. Indeed, many general practitioners undertake work in hospitals as clinical assistants and hospital practitioners so that they have and retain specialist knowledge and skills. And outside major urban centres many general practitioners care for inpatients in hospital beds in what used to be called cottage hospitals.

Dividing lines are therefore often far from clear, and every specialist is aware that in his outpatient clinics he may be carrying out much that might be classified as being the work of a general practitioner. It is probably ridiculous to try to categorise in this fashion. Medicine is medicine and covers the whole human condition and is therefore not to be broken up into watertight compartments. There is a continuous spectrum running from what is manifestly general practice to what is obviously specialist, with a large intermediate part which may be either the one or the other. Making the distinctions is unproductive.

Nevertheless, there are differences between consultants and general practitioners. GPs tend to be fiercely independent and entrepreneurial. They are indeed independent contractors to the National Health Service, earning from various practice payments, capitation fees for each patient on their lists, and fees for items of service. In short, they are not salaried staff as the hospital staff are. This makes it possible for them to shape and mould the content of their work in a way which is not open to specialists. Every specialist is in some sense a bureaucrat, since he takes his responsibilities from the office that he holds, and nowadays there is a job description for him which will not vary much throughout the UK for those holding appointments in his subject.

This is not so for general practitioners. Each practice has its own nuances, kinds of responsibility, and organisation. Urban practices differ from suburban ones, and rural ones are different again. There are single-handed GPs and practices with many partners. In group practices there may be some degree of specialisation. Some partners will undertake obstetrics or minor

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