This finding indicates that it is important to treat patients with inappropriate ADH secretion with fluid restriction and antibiotics, as on occasions they will be found to have this type of treatable disorder.

We thank Dr. J. M. Holt under whose care the patient was admitted and Dr. Rhees, St. Bartholomew's Hospital, who carried out the urine ADH estimations.

Two Cases of Tuberculous Lymphoedema

SHAISTA HODA, S. M. RAB

British Medical Journal, 1974, 3, 786

Tuberculous lymphoedema is rare because inguinal lymph nodes are not often affected. We report two cases of disseminated lymphatic tuberculosis, one of which presented with elephantiasis and the other with unilateral lymphoedema.

Case 1

A 35-year-old woman was admitted to hospital with a nine-month history of massive, non-pitting oedema of the feet and low grade pyrexia and complaining of pain and stiffness of the legs. On admission she had a fever of 99-100°F (37.2-37.8°C) and palpable cervical, supraclavicular, and inguinal lymph nodes, which were firm and matted. There was non-pitting oedema of the feet and ankles (fig. 1). Her total leucocyte count was 7,600/mm³ with neutrophils 65%, lymphocytes 28%, eosinophils 4%, and monocytes 3%. The E.S.R. was 100 mm in the first hour. The tuberculin test result was positive and x-ray examination of the chest showed tuberculous infiltration at the left apex. Lymph node biopsy showed chronic granulomatous inflammation with caseation necrosis compatible with tuberculosis. Direct smear and culture of the pus from the node was positive for *Mycobacterium tuberculosis*. The lymph nodes and pulmonary lesion regressed with antituberculous treatment but the lymphoedema still persisted after 10 months.

Case 2

A 24-year-old woman was admitted to hospital with a three-month history of pain and non-pitting oedema of the right leg, low grade pyrexia, weight loss, and malaise. On admission she had a fever of 100°F (37.8°C), the cervical, iliac, and superficial inguinal lymph nodes were palpable, and there was a discharging sinus in the neck. The right leg was swollen with non-pitting oedema (fig. 2). The liver was enlarged. Blood examination showed: W.B.C. 12,000/mm³ (neutrophils 80%, lymphocytes 18%, monocytes 2%), E.S.R. 85 mm/1 hr, serum bilirubin 0.9 mg/100 ml,

References

- Bartter, F. C., and Schwartz, W. B. (1967). *American Journal of Medicine*, 42, 790.
British Medical Journal. (1972). 2, 489.
 Bryant, D. H. (1972). *Medical Journal of Australia*, 1, 1285.
 Miller, M., and Moses, A. M. (1972). *Annals of Internal Medicine*, 77, 715.
 Stormont, J. M., and Waterhouse, C. (1962). *Metabolism*, 11, 1181.
 Utz, J. P., et al. (1969). *New England Journal of Medicine*, 280, 264.
 Rosenow, E. C., Segar, W. E., and Zehr, J. E. (1972). *Mayo Clinic Proceedings*, 47, 169.

FIG. 1—Case 1. Elephantiasis of the legs. FIG. 2—Case 2. Unilateral oedema.

serum alkaline phosphatase 3.1 Bassey-Lowry units, and SGOT 9 U/ml. Thymol turbidity was 11.5 units. X-ray examination of the chest showed bilateral tuberculous infiltration. The histology of the lymph nodes was compatible with the diagnosis of tuberculosis. Culture of the caseous material from the lymph nodes showed *M. tuberculosis*. Liver biopsy showed fatty changes with granulomas. After eight months of antituberculous therapy all the lesions improved except the lymphoedema.

Comment

Tuberculosis may present in various ways (Rab and Rahman, 1967). The two cases reported here show the mechanical effects of lymphatic obstruction by enlarged subinguinal and deep iliac tuberculous glands. Awareness of this manifestation of the disease is important in developing as well as in developed countries. In the former these cases would probably be diagnosed as filariasis while in the latter tuberculosis is now so uncommon that it might not be thought of.

We thank Professor N. A. Jaffery, professor of pathology, Jinnah Postgraduate Medical Centre, Karachi, and the photographic department of the hospital for their co-operation and help.

Reference

- Rab, S. M., and Rahman, M. (1967). *British Journal of Diseases of the Chest*, 61, 90.

Department of Medicine, Jinnah Postgraduate Centre, Karachi, Pakistan

SHAISTA HODA, M.B., B.S., Senior House Physician
 S. M. RAB, M.B., F.R.C.P., Professor of Medicine