

- A 63 year old male Mr.mani, who is a farmer by occupation presenting with chief complaints of multiple swellings in both sides of neck and axilla for 2 months

History of presenting illness

- Patient was apparently normal 2 months back after which he developed multiple swellings in both sides of neck and axilla

insidious in onset, initially small in size, gradually progressive and to attain current size,

not associated with discharge and pain

- h/o fever for 2 days, low grade, continuous, not associated with chills and rigor, relieved by medication
- No h/o night sweats
- No h/o loss of weight and loss of appetite
- No h/o itching
- No h/o chronic cough , swelling of face , breathlessness
- No h/o abdominal pain , swelling of legs
- No h/o evening rise of temperature

- No h/o oral ulcers
- No h/o ear pain, ear discharge,
- No h/o bleeding from nose, nasal block
- No h/o abdominal pain, hematemesis, melena
- No h/o swollen testis
- no h/o hoarseness of voice
- No h/o difficulty in turning head
- No h/o deviation of tongue
- No h/o frequent fainting
- No h/o difficulty in shrugging of shoulders
- No h/o swelling elsewhere in the body

Past history

- No h/o similar complaints in the past
- No h/o TB ,DM , HT, asthma, epilepsy, jaundice , IHD, STD
- No h/o any drug allergy
- No h/o previous surgeries

Personal history

- Patient consumes non-veg diet
- No addictive habits
- Normal bowel and bladder habits
- Patient denies h/o extra marital contact

Family history

- No relevant family history

General examination

- Patient is conscious ,oriented , moderately built , moderately nourished
- pallor+
- No icterus
- No cyanosis
- No clubbing
- No pedal edema
- Significant lymphadenopathy (neck ,axilla , inguinal)

Vital signs:

- PR-76/min, regular in rhythm, normal volume, no specific character, no radiofemoral, radioradial delay, equally felt on both sides in all palpable peripheral vessels, no vessel wall thickening
- RR-18/min, abdominothoracic type
- BP-130/80 mm Hg in right upper limb, sitting posture
- Afebrile.

Examination of neck nodes:

- Inspection
 - Multiple neck nodes involving cervical nodes upto level V, on both sides , which includes submental , submandibular, upper,middle and lower deep cervical and posterior cervical nodes
 - Each node measuring 2x2cm, hemispherical in shape, largest node in upper deep cervical node of 3x3 cm.
 - Smooth surface
 - No scars ,sinuses,dilated veins,visible pulsations
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Palpation

- Not warm, not tender,
- Inspectory findings of site , size, shape are confirmed
- Rubbery in consistency ,
- Freely mobile,
- Discrete,
- Not fluctuant
- Skin over the swelling pinchable
- Plane of swelling – deep to deep fascia

Examination of axillary nodes:

Inspection

- Multiple axillary nodes involving central group of nodes on both sides
- Each node measuring 2x2cm, hemispherical in shape
- Smooth surface
- No scars ,sinuses,dilated veins,visible pulsations

Palpation

- Not warm, not tender,
- Inspectory findings of site , size, shape are confirmed
- Rubbery in consistency ,
- Freely mobile,
- Discrete,
- Not fluctuant,
- Skin over the swelling pinchable
- Plane of the swelling- deep to deep fascia

Examination of inguinal nodes:

Inspection

- Multiple inguinal nodes involving superficial horizontal group of nodes on both sides
 - Each node measuring 2x2cm, hemispherical in shape
 - Smooth surface
 - No scars ,sinuses,dilated veins,visible pulsations
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Palpation

- Not warm, not tender,
- Inspectory findings of site , size, shape are confirmed,
- Rubbery in consistency ,
- Freely mobile,
- Discrete,
- Not fluctuant,
- Skin over the swelling pinchable.

- No other palpable lymph nodes elsewhere in the body (epitrochlear, para-aortic, popliteal)
- Oral cavity- no tonsillar enlargement

OTHER SYSTEMS

- Examination of abdomen : soft,not tender, no palpable mass, no organomegaly , no free fluid , hernial orifices are free ,external genetalia normal.
- Examination of RS : Normal vesicular breath sounds heard. No added sounds
- Examination of CVS:S1 S2 heard,no murmurs
- Examination of CNS:No focal neurological deficit
- Examination of Spine and Cranium:Normal
- Perrectal examination to be done

Diagnosis

- Generalised lymphadenopathy for evaluation involving cervical group of lymph nodes from level I to level V ,central group of axillary lymph nodes, superficial horizontal group of inguinal lymph nodes probably Hodgkin's lymphoma of stage IIIB

Differential diagnosis

- Non hodgkin's lymphoma
- Tuberculous lymphadenitis
- Secondaries neck
- HIV(AIDS Complex)
- Leukemia
- syphilis

MANAGEMENT

INVESTIGATIONS

- Routine:
- Blood: TC, DC ,ESR ,Hb%, Blood grouping/typing ,urea ,sugar ,creatinine.
- Urine: sugar ,albumin ,deposits
- X ray chest
- ECG

Specific investigations:

- USG Neck
- FNAC of lymph node
- Excision biopsy of lymph node
- Mantoux test
- CT head and neck
- MRI
- PET scan
- Triple endoscopy
- Colonoscopy

Treatment

- Since it belongs to stage IIIB Hodgkin's lymphoma(according to cotswold's staging), the treatment is chemotherapy-ABVD regimen