Published online: 2021-08-16

A Giant Lymph Node—Liver Imposter

Sagar Dembla[1] Shujaath Asif[2] Aniruddha P. Singh[2] Anuradha Sekaran[3] Sundeep Lakhtakia[4] D. N. Reddy[4]

[1]Department of Medical Gastroenterology, Narayana Medical College Hospital, Nellore, Andhra Pradesh, India
[2]Department of Medical Gastroenterology AIG Hospitals, Gachibowli, Hyderabad, Telangana, India
[3]Department of Pathology, Asian Institute of Gastroenterology, Hyderabad, Telangana, India
[4]Asian Institute of Gastroenterology, AIG Hospitals, Hyderabad, Telangana, India

Address for correspondence Sundeep Lakhtakia, Asian Institute of Gastroenterology, AIG Hospitals, Hyderabad, Telangana, India (e-mail: drsundeeplakhtakia@gmail.com).

J Digest Endosc 2021;12:112–113.

Abstract

Abdominal tuberculosis has insidious course and is a diagnostic challenge. Tubercular lymphadenitis is associated with constitutional symptoms and multiple enlarged lymph nodes. Isolated giant lymph nodes are rare in tuberculosis and are common in lymphoma or malignancy. Peripancreatic mass on endosonography are commonly lymph node less than 4 cm. Isolated giant nonnecrotizing lymph node can mimic liver architecture on endoscopic ultrasound but lack a biliary connection.

Keywords
- giant lymph node
- peripancreatic mass
- tubercular lymphadenitis

Introduction

A 27-year-old male was presented with discomfort in the upper abdomen for 2 months. There was no associated weight loss, cough, or fever. He had history of acute necrotizing pancreatitis with uncomplicated walled-off-necrosis 2 years ago. There were no further episodes of pancreatitis. Patient had a family history of tuberculosis.

Laboratory investigations were unremarkable (complete blood count and liver and renal function test). Serum amylase and lipase were normal. Ultrasound showed a 63 mm × 55 mm hypoechoic peripancreatic lesion. Pancreas was normal. MRI showed a large homogenous hyperintense mass encasing left gastric artery (69 mm × 63 mm × 54 mm) located near neck and body of pancreas. Pancreas was normal.

On endoscopic ultrasound, a large solid well-defined hypoechoic lesion (80 mm × 50 mm) was observed in sub-hepatic or peripancreatic region (**Video 1**; available in the online version). The mass had close visual resemblance with liver, but biliary communication was absent. Liver was mildly hyperechoic. Pancreas and pancreatic duct were normal. EUS-guided core biopsy with 22-g needle was performed from the mass.

Histopathology confirmed granulomatous inflammation with well-defined noncaseating granulomas in the background of lymphoid tissue. There was no evidence of dysplasia or malignancy. Mantoux test and QuantiFERON-TB Gold were strongly positive. Workup for sarcoid was negative (angiotensin-converting enzyme [ACE] levels normal, calcium: 9.8). The patient was started on an antitubercular four-drug regimen. He showed improvement in clinical condition at 4 weeks.

Abdominal tuberculosis has insidious course, involves intestine, peritoneum, lymph node, and solid organs.[1,2] Tubercular lymphadenitis presents with multiple enlarged lymph node in association with constitutional symptoms. Peripancreatic mass on endosonography are commonly enlarged lymph node of less than 4 cm.[3,4] Isolated giant lymph nodes are common in lymphoma or malignancy.[5] An isolated giant nonnecrotizing lymph node can mimic liver architecture on endoscopic ultrasound but lack a biliary connection.

DOI https://doi.org/10.1055/s-0041-1731585
ISSN 0976-5042

Thieme Medical and Scientific Publishers Pvt. Ltd. A-12, 2nd Floor, Sector 2, Noida-201301 UP, India

Video 1

A giant lymph node liver imposter.Online content including video sequences viewable at: https://www.thieme-connect.com/products/ejournals/html/10.1055/s-0041-1731585

Conflict of Interest
None declared.

References

1 Dalal A, Puri AS, Sachdeva S, Sakuja P. Nonsurgical management of gastroduodenal tuberculosis: nine-year experience from a tertiary referral center. Endosc Int Open 2019;7(10):E1248–E1252
2 Singh A, Sahu MK, Panigrahi M, et al. Abdominal tuberculosis in Indians: still very pertinent. J Clin Tuberc Other Mycobact Dis 2019;15:100097
3 Anand D, Barroeta JE, Gupta PK, Kochman M, Baloch ZW. Endoscopic ultrasound guided fine needle aspiration of non-pancreatic lesions: an institutional experience. J Clin Pathol 2007;60(11):1254–1262
4 Boujaoude J-D, Honein K, Yaghi C, Ghora C, Abadjian G, Sayegh R. Diagnosis by endoscopic ultrasound guided fine needle aspiration of tuberculous lymphadenitis involving the peripancreatic lymph nodes: a case report. World J Gastroenterol 2007;13(3):474–477
5 Massaro M, Valencia MP, Guzman M, Mejia J. Accessory hepatic lobe mimicking an intra-abdominal tumor. J Comput Assist Tomogr 2007;31(4):572–573