Hodgkin’s Disease and Tuberculosis

Carl Mulky, M.D., F.A.C.P.
Albuquerque, New Mexico

Hodgkin’s Disease is one of several disorders that is accompanied by progressive enlargement of the lymph glands. Opinions differ as to whether it should be classified with the neoplasms as lympho-sarcoma, with the blood dyscrasias such as the leukemias, or with the infectious granulomata as tuberculosis and syphilis.

 Clinically, it closely resembles glandular tuberculosis with which it is often confused. Nearly every case of Hodgkin’s Disease that has come under the observation of the writer in the past few years has been referred because of a previous diagnosis of tuberculosis or as a tuberculosis suspect. Next to tuberculosis, Hodgkin’s Disease is the most common cause of progressive glandular enlargement. To make the picture more confusing, it is quite possible for tuberculosis and Hodgkin’s Disease to co-exist in the same patient. In fact a considerable number of patients with Hodgkin’s Disease develop frank pulmonary tuberculosis with positive sputum as a terminal stage of their disease.

Hodgkin’s Disease usually occurs in the same age group as tuberculosis, i.e., in early adult life. There is a similar insidious onset, with loss of weight, increasing fatigue and weakness, a low grade fever and secondary anemia. However the glandular enlargement of Hodgkin’s Disease is usually somewhat different from that of tuberculosis. The swelling is painless, and progresses from one group of glands to another. The glands remain firm, discreet and freely movable and do not tend to fuse together and break down and suppurate as tuberculous glands so frequently do.

Occasionally groups of internal lymph nodes, such as the tracheo-bronchial or retroperitoneal glands, are involved before any external enlargements are noted, and in such cases the diagnosis is difficult. When the thoracic group is primarily affected the resemblance to tuberculosis is often striking. Along with the debility there is an irritating cough and frequently dyspnoea from pressure on the trachea or bronchi. There may be hoarseness or complete loss of voice from pressure on the recurrent laryngeal nerve. Dyspnoea from pleural effusion is often the first symptom that brings the patient to the physician. Difficulty in swallowing from pressure on the esophagus is not uncommon. Examination of the chest does not reveal much abnormality unless there is pleural effusion or massive enlargement of the mediastinal glands. There may be noticeable dyspnoea or displacement of the heart from pressure. The spinal and para-ternal areas of dullness may be widened and there may be some rales due to the associated bronchitis. The x-ray will show an irregular mass in the mediastinum, which may be concealed by the heart shadow unless viewed obliquely. There are often patches of infiltration throughout the lung areas when scattered bronchial nodes are involved.

When Hodgkin’s Disease involves the retro-
peritoneal glands it may closely simulate tuberculous peritonitis. There is abdominal pain and tenderness with various digestive disturbances, such as anorexia, flatulence, nausea or diarrhea, and frequently there is jaundice or ascites. A definite diagnosis is almost impossible without an exploratory laparotomy until the superficial glands begin to enlarge.

Like tuberculosis the blood picture of Hodgkin's Disease varies with the severity and stage of the disease. Essentially it is a progressive secondary anemia which in the later stages may become extreme. The number of white cells may be within normal limits in the early stage, but later there may be marked leukocytosis. The differential count is variable, but an increase in the number of eosinophiles is significant.

The final diagnosis of Hodgkin's Disease depends on microscopical examination of an affected gland. Preferably, an isolated gland should be excised for this purpose. The histological changes need not be described here, but they are quite characteristic, and in the hands of an experienced pathologist a positive diagnosis can usually be made.

For prognostic reasons it is extremely important to differentiate Hodgkin's Disease from glandular tuberculosis as early as possible. While glandular tuberculosis is comparatively mild and usually curable, Hodgkin's Disease invariably has a fatal termination. Surgical removal of isolated groups of enlarged glands or deep x-ray therapy may stay the progress of Hodgkin's Disease for a time, but death ordinarily occurs in from two to five years in spite of any form of treatment yet discovered.

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Artificial Pneumothorax in Clinic Cases

JOHN L. ELLIOTT, M.D.
Savannah, Georgia

The treatment of pulmonary tuberculosis without transplantation of the patient has always been a much more difficult task than treatment with institutional care. In fact, removal of the patient from his normal environment has proved so beneficial that until recent years physicians thought that the change of climate was responsible. It is now felt by most workers that climate plays a less important role, but, as pointed out by many writers the patient is unable to relax at home. The unvarying routine, better nourishment, and the force of precept and example are very important factors and not to be overlooked. These factors can be supervised a little more carefully in clinic work with good results.

Until recent years care of the tuberculous patient in the home and clinic has been a rather desultory procedure with a hopeless attitude on the part of the physician and all attendants. This was disastrous to the morale of the patient and endangered his recovery. The use of artificial pneumothorax has changed this attitude somewhat and is proving very beneficial to the patient mentally and physically as well as eliminating some of the danger to contacts. Pneumothorax has already been discussed at great length; its advantages and disadvantages, its dangers and contraindications have been reviewed thoroughly by those conversant with the subject and most of them agree, I believe, that the induction of pneumothorax in a new patient in the clinic is an undertaking fraught with many hazards.

It is better for the patient to have a few weeks of strict bed rest in an institution with careful supervision to determine whether the disease is progressing or regressing before pneumothorax is attempted. However tuberculosis is notoriously progressive and though small cavities may sometimes heal without collapse therapy this is the exception rather than the rule and some eighty-five per cent of all patients with open tuberculosis die within a period of five years under conservative treatment alone. In communities where there are no beds for those suffering with tuberculosis nearer than the State Sana-