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Generalized BCG Tuberculosis

Fatal generalized BCG tuberculosis in association with BCG vaccination is extremely rare. Congenital agammaglobulinemia was used to be considered as one of the conditions associated with disseminated BCG infection(1). Immune system abnormalities associated with dissemination of live vaccines include thymocytic deficiency without agammaglobulinemia or hypogammaglobulinemia, and leukocyte and monocyte deficiency disease(2). We report a case of generalized BCG tuberculosis.

A 3-month-old boy was brought to this hospital with swelling on the left side of neck about 20 days after receiving BCG vaccination. The patient had fever, irritability, poor feeding and excessive crying for the last 2 months. There was no history of contact with tuberculosis and he was breastfed. The antenatal, natal and postnatal history was insignificant. On examination BCG scar was present about 2.5 cm from the acromion tip. Eight lymph nodes of the left upper cervical group were palpable, measuring 0.5-2 cm, they were firm, mobile, not-matted and non-tender. Abdominal examination showed a hepatomegaly of 5 cm, firm, smooth, non-tender and splenomegaly of 6 cm, firm with round margin and non-tender. The hemoglobin, total and differential counts were within normal limits; SGPT was 292 IU/l. The chest roentgenogram showed bilateral miliary mottling (*Fig.*). Lymph node biopsy revealed tubercular granuloma consisting of areas of caseation surrounded by epitheloid cells, lymphocytes and Langhans giant cells. The child was treated with rifampicin 10 mg/kg, INH 10 mg/kg and ethambutol 20 mg/kg along with steroid 1 mg/kg. He came back after about 5 months with progressive enlargement of swelling in the neck and abscess was drained with excision of some caseating lymph nodes.

Fig. Chest X-ray showing diffuse miliary mottling suggestive of miliary tuberculosis.

Progressive BCG infection is extremely

rare and is associated with vaccination soon after birth and in children with immune deficiency(3). In the present case there was no evidence of immune deficiency as indicated by the family history, history of recurrent infections and abnormal lymphocyte count. This case presented with evidence of chronic infection in the form of fever, poor feeding, irritability and crying. A similar case reported by Marks *et al.*(4) did not have history of recurrent infections. This child did not respond to treatment with INH, rifampicin and ethambutol along with steroid and continued to show enlargement of cervical lymph nodes with cold abscess formation. The poor response could be explained due to drug resistance or an underlying immune deficiency(1).

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Lymphangioma of Scrotum

An 8-year-old boy was admitted with a gradually increasing painful scrotal swelling of 2 weeks duration (*Fig.*). Examination revealed a tense cystic, transilluminant

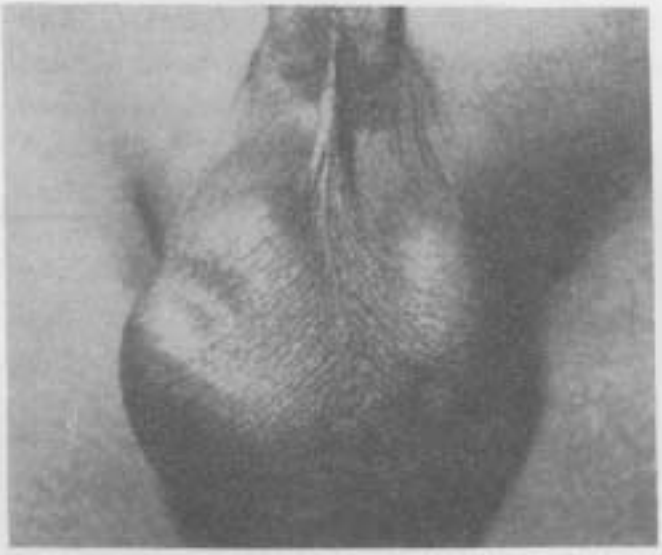

Fig. Clinical photo showing the scrotal swelling.

swelling 5 cm in size involving the right scrotal sac. Testis could be felt separate from the swelling. At exploration the swelling was found to be multiloculated cystic lesion with hemorrhage into some of the loculi. It was adherent to the skin and extended up to the urethra. It was excised *in toto*. Histopathology of the excised specimen confirmed it to be a lymphangioma.

About 95% of lymphangiomas occur in the neck and axilla and the remaining are scattered at various sites like mediastinum, mesentery, retroperitoneum, *etc.* The scrotal location is quite uncommon and only 25 cases were reported in the literature till 1979(1,2). The mass is usually separate from the testis and the spermatic cord, but can be adherent to the overlying skin(2). Hydrocele and spermatocele are the usual