Reply

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Reply From the Author

Madam, The very idea of presenting these two cases and the review was to emphasize the atypical way in which tuberculosis can present and being in the endemic area it should always be considered in differential diagnosis. As far as question of Addison's disease in first case is concerned, there was no pigmentation, history was rather short and on admission initially no hyponatremia, hypeikalemia, azotemia, hypotension or postural hypotension was noted. On initial presentation she was not anemic and her ESR was 30. In other hospital she was given dexamethasont for a presumed diagnosis otviral encephalitis as per the attending physician. Again on readmission, she had a serum potassium of 3.3 mEq/l, against a diagnosis of Addison's disease and there was no azotemia. As would be noted that granulomatous disease was one of the first differential but as she initially improved, metabolic encephalopathy was being managed. Despite the peripheral blood picture, a bone marrow trephine did not help in diagnosis. The whole idea of publishing the case is to suspect tuberculosis (especially cryptic variety) even when evidence is not forthcoming. On the other hand, not to attempt to make a definite diagnosis when facilities are available would be unscientific and unethical besides the medicolegal aspects. Regarding case 2, although the patient had marked splenomegaly, the pre-operative ultrasound did not show any dilatation of portal or splenic vein, there was no ascites and liver enzymes were normal. In this setting one cannot presume that splenomegaly was due to portal hypertension. Even subsequent histopatbology of spleen showed tropical splenomegaly! I agree that one should consider liver biopsy but as patient was thrombocytopenic, liver biopsy was a risky procedure, we opted for bone marrow trcphine as the preferred invasive diagnostic investigation. One is surprised that histopathology of spleen did not show granuloma "while subsequent liver biopsy did."

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