Autoimmune hemolytic anemia responding to antituberculous treatment

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method for confirmation of diagnosis in doubtful cases. The technique is inexpensive and is quicker than excisional biopsy. Moreover, an immediate diagnosis can be made if the fresh aspirate is mounted in a drop of saline and examined microscopically immediately after aspiration when living motile microfilariae are easily identified.

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Autoimmune haemolytic anaemia responding to anti-tuberculous treatment

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INTRODUCTION

Autoimmune haemolytic anaemia (AHA) due to cold antibody is an entity characterized by the presence of auto antibodies which agglutinate human red blood cells (RBC) at temperatures below body temperature, maximally at 0–5° centigrade[1]. Depending on the titre, affinity for RBCs and ability to activate complements, these cryopathic immunoglobulin M antibodies produce haemolytic and vasoclusive syndromes of varying severity[1].

Causes of AHA due to cold antibody can be classified as primary and secondary. Common secondary causes are *Mycoplasma pneumoniae*, infectious mononucleosis and malignant lymphoproliferative disorders[1].

CASE HISTORY

A 37-year-old teetotaller presented to Colombo North General Hospital in May 1993 with central chest pain and shortness of breath with mild exertion (New York Heart Association, functional classification; class 3) of 1 month's duration. There was no obvious blood loss on direct questioning. There was no consanguinity or family history of haemolytic disease. On examination he was anaemic and icteric but there was no lymphadenopathy or purpura. The blood film showed normochromic cells with significant polychromasia, some spherocytes and auto agglutination. His blood group was 'O' positive. Osmotic fragility was within normal limits. No abnormal haemoglobin was detected on haemoglobin electrophoresis. Bone marrow aspiration showed active marrow with normoblastic hyperplasia. The direct and indirect antiglobulin tests were both positive. A diagnosis of AHA was made but the patient requested discharge due to personal reasons.

One month later he was admitted to Sri Jayawardanepura General Hospital with high remittent fever of 2 weeks' duration. His temperature was 40°C. He had palpable and tender submental lymph node which was 2 cm in size. There were no other palpable lymph nodes. The haemoglobin was 6.6 g/dl and the reticulocyte count remained at 10%. Computerized tomography of the abdomen did not show any enlargement mesenteric or paraortic lymph nodes. His investigations done at Sri Jayawardanepura General Hospital are in Table 1.

Serum protein electrophoresis showed polyclonal gammopathy. Serology for mycoplasma was negative. The Paul–Bunnell test for heterophile antibody was negative. Donath–Landsteiner tests, direct and indirect antiglobulin tests (against polyspecific antisera) were negative. Lung fields were clear and Mantoux test was negative. A diagnosis of AHA due to cold antibody was made.

The biopsy of submental lymph node revealed areas of caseation and microscopy showed foci of tubercle granuloma compatible with a diagnosis of tuberculous (TB) lymphadentitis. Anti-TB treatment was commenced in September 1993 with rifampicin, ethambutol, isoniazid, pyrazinamide. After 4 days of anti-TB therapy fever subsided. By December 1993 the haemoglobin had risen to 11 g/dl and the reticulocyte count had decreased to 2%. When he was last seen at the medical clinic in December, the haemoglobin had risen to 12 g/dl and he was on folic acid only. He was not given any treatment for AHA.

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Table 1. Results of autoimmune haemolytic anaemia investigation of a 37-year-old Sri Lankan man

Haemoglobin	98 g/L
Packed cell volume	0.317 (31.7%)
Mean corpuscular volume	8.04 fL
MCHC	248 g/L
Red blood cell count	3.98 × 10* 12
Erythrocyte sedimentation rate	120 mm; first hour
Reticulocyte count	10%
Total serum proteins	70 g/L
Albumin	34 g/L
Globulin	36 g/L
Albumin : globulin ratio	0.94
Immunoglobin G	29.91 g/L (normal 5–12)
Immunoglobin A	1.21 g/L (normal 0.5–3.5)
Immunoglobin M	4.18 g/L (normal 0.3–2.3)†
Cold agglutination titre	37 c Anti i (adult) 16
	Anti i (cord) 16
	25 c Anti i (adult) 64
	Anti i (cord) 32
	4 c Anti i (adult) 1024
	Anti i (cord) 128

†Normal values for Sri Lanka are not available
MCHC = Mean corpuscular haemoglobin concentration

DISCUSSION

The clinical illness of AHA due to cold antibody was associated with fever, increased erythrocyte sedimentation rate and submental lymphadenitis. Histology confirmed TB lymphadenitis. There was abatement of fever, resolution of anaemia and decrease of reticulocyte count after anti-TB therapy. It is reasonable to assume a causal relationship between TB lymphadenitis and AHA due to cold antibody.

Tuberculosis can cause anaemia by several ways. Marrow suppression, dyshaemopoeitic anaemia due to anorexia, ileocaecal TB causing malabsorption syndrome and nutritional deficiency anaemia are some of the examples[2,3].

As with most patients with TB lymphadenitis this patient too made a good recovery after chemotherapy. He was not given steroids which was the standard treatment for primary AHA. To our knowledge this is the first report of cold antibody mediated AHA responding to anti-TB chemotherapy.

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Conjoined twins in a septate uterus

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INTRODUCTION

Conjoined twins is a rare condition, the incidence reported being one in 50 000 to 100 000 births. However, the presence of conjoined twins in a septate uterus at term is rarer still.

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CASE HISTORY

A 30-year-old gravida 6 (Para 3, abortions 2) presented to the department of obstetrics and gynaecology as an emergency admission. She was referred by an untrained traditional birth attendant (TBA) from a remote village and had amenorrhoea of 9 months, mild labour pains and leaking *per vaginum* for at least 24 h. Overall, the duration of her labour was approximately 24 h, the onset of labour pains following soon after the rupturing of the membranes. There was a history suggestive of having taken an indigenous medication in the first trimester with the object of ensuring a male baby.

The patient was referred because of the inability of the TBA to deliver the baby beyond the delivery of the baby's head. On examination, the patient was found to be exhausted and dehydrated, her abdomen was over-distended and the presentation could not be made out on palpation. The congested, blue head of the baby was lying outside the introitus.

A sonographic examination and plain X-ray of the abdomen were carried out revealing conjoined twins (Figure 1). Cardiac activity of both fetuses was absent.

The mother was resuscitated and, under general anaesthetic, traction was applied on the head hanging