abnormalities detectable by chest examination, whereas others have detectable rales in the involved areas during inspiration, especially after coughing. Occasionally, rhonchi due to partial bronchial obstruction and classic amphoric breath sounds in areas with large cavities may be heard. Systemic features include fever (often low-grade and intermittent) in up to 80% of cases and wasting. Absence of fever, however, does not exclude TB. In some recurrent cases and among people with low Karnofsky score, finger clubbing has been reported. The most common hematologic findings are mild anemia, leukocytosis, and thrombocytosis with a slightly elevated erythrocyte sedimentation rate and/or C-reactive protein level. None of these findings is consistent or sufficiently accurate for diagnostic purposes. Hyponatremia due to the syndrome of inappropriate secretion of antidiuretic hormone has also been reported.

■ EXTRAPULMONARY TB

In descending order of frequency, the extrapulmonary sites most commonly involved in TB are the lymph nodes, pleura, genitourinary tract, bones and joints, meninges, peritoneum, and pericardium. However, virtually any organ system may be affected. As a result of hematogenous dissemination in HIV-infected individuals, extrapulmonary TB is seen more commonly today than in the past in settings of high HIV prevalence.

Lymph Node TB (Tuberculous Lymphadenitis) The most common presentation of extrapulmonary TB in both HIV-seronegative individuals and HIV-infected patients (35% of cases worldwide and >40% of cases in the United States in recent series), lymph node disease is particularly frequent among HIV-infected patients and among children **(Fig. 178-8)**. In the United States, besides children, women (particularly non-Caucasians) seem to be especially susceptible. Once caused mainly by *M. bovis*, tuberculous lymphadenitis today is due largely to *M. tuberculosis*. Lymph node TB presents as painless swelling of the lymph nodes, most commonly at posterior cervical and supraclavicular sites (a condition historically referred to as *scrofula*). Lymph nodes are usually discrete in early disease but develop into a matted nontender mass over