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Extra pulmonary tuberculosis: An unusual presentation

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Abstract
Extra Pulmonary Tuberculosis (EPTB) has existed as a disease entity for centuries. It is a milder form of disease in terms of infectivity as compared to pulmonary tuberculosis, it can present in a various ways, here we are presenting an unusual presentation, A 28 years male patient, who presented to us with an ulcer over the iliac crest which turned out to be of tubercular aetiology which responded to ATT drugs.

Keywords: extra pulmonary tuberculosis, ATT

Introduction

Case presentation; A 28 years male pt presented to us with chief complaint as non-healing wound over the iliac crest, since one month, measuring around 3x4 cm, with induration around it. It started as a small swelling over the rt iliac crest which was diagnosed as abscess and aspirated which was negative for acid fast bacili and a course of antibiotic was given by the local doctor. Subsequently it burst open to form an ulcer. There was no h/o of cough or fever. There was no h/o tuberculosis.

O/e gen. exam revealed no abnormality; there was an ulcer of 1*2cm over the rt. iliac crest with undermined edges and indurated base. There was minimal serous discharge. Chest was clear. Spines normal. There was no history of cough/fever.

Investigation showed TC 8000 cells, DC lymphocytosis, ESR 16mm1st hour, chest x-ray was normal.

Ultra sound abdomen showed abscess in right posterolateral abdominal wall involving external oblique and qudratus lumborum muscles,

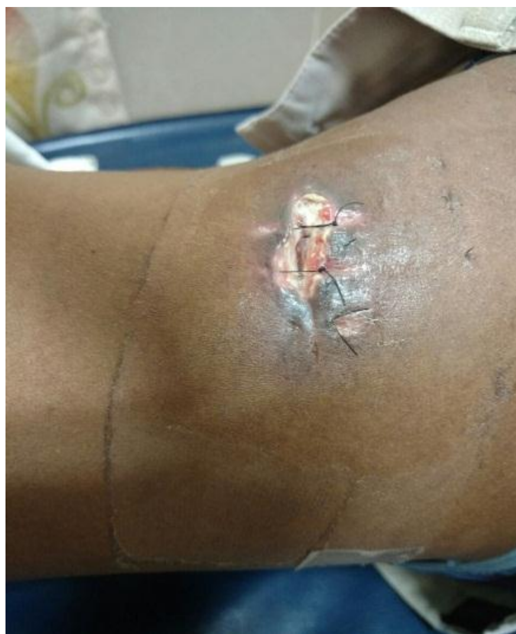
CECT abdomen done, it showed ill-defined peripherally enhancing hypo dense collection with air locules within the subcutaneous and intramuscular planes of the superior and lateral quadrant of the gluteal region over the right iliac bone likely to be infective collection, multiple enlarged Para aortic, iliac lymph nodes were enlarged.

Changes of infective spondylodiscitis involving L3, L4, L5 and S1 vertebrae with likely epidural collection. Visualized part of thorax revealed hypo dense nodules in left lower lobe of lung likely tubercular.

Local exploration was done and the tissue was sent for hpe, it showed fso caseating granulomatous lesion, possibly of tubercular aetiology.

ATT started as per modified RNTCP guide lines. Ortho opinion was taken, they advised to continue.

Pt responded well, and the wound started healing.



Discussion

TUBERCULOSIS (TB) is an airborne infectious disease whose main clinical form involves one or both lungs. Some clinical cases present with both pulmonary and extra-pulmonary (i.e., tuberculosis of organs than other lungs) forms as in this case.

India ranks top in being the highest TB burden country in the world [1].

It has been proven that cases with extra-pulmonary TB (EPTB) only are rarely contagious and therefore do not represent a public health risk. However, EPTB could represent a serious clinical problem due to the difficulties associated with its diagnosis as well as its clinical complications and sequelae. Every organ or system can be infected by mycobacterial strains, and the ensuing disease can show a dangerous mix of symptoms and clinical signs that rarely gives an indication of the true aetiology. To prove its association with Mycobacterium tuberculosis strains it is frequently necessary to perform a tissue biopsy for histological and microbiological testing.

Depending on the target organ it is often technically complicated to perform a biopsy, and the diagnosis is consequently either presumptive or, in the worst case,
inappropriate. Some patients are repeatedly exposed to inadequate medical and/or surgical treatment, as well as to frequent diagnostic evaluations [2].

EPTB constitutes about 15–20% of all cases of tuberculosis in immunocompetent patients and accounts for more than 50% of cases in HIV positive individuals [3, 4].

Antituberculosis treatment is the mainstay in the management of EPTB. However, the ideal regimen and duration of treatment have not yet been resolved. While the RNTCP and other National Tuberculosis Programmes world over which follow the World Health Organization's guidelines, directly observed treatment, short-course (DOTS) approach, advocates the use of short-course intermittent chemotherapy for patients with EPTB also. According to the recent DOTS guidelines, newly detected EPTB is categorized as category 1. And ATT is given for 7 months.

While the seven months treatment may be sufficient for many patients, each patient has to be individually assessed and, where relevant, treatment duration may have to be extended for a given patient [5].

Patients receiving antituberculosis treatment should be carefully monitored for adverse drug reactions, especially drug induced hepatotoxicity [6, 7].

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8. EPTB- extra pulmonary tuberculosis
9. Afb- acid fast bacilli
10. ATT- Anti tubercular treatment Hpe- Histopathological examination
11. Fso- Features suggestive of
12. CECT- Contrast Enhanced Computer Tomography
13. RNTCP- Revised National Tuberculosis control programme
14. DOTS- Directly Observed Treatment Shortcourse