Metastasic Tuberculous Abscess Of The Thorax

Silvia Jaramillo [1] Diana Medina [1] Jose Angel Pérez [2] Roberto Arenas [3]
General Doctor[1] Dermatologist[2] Infectologist HGR 220 IMSS[3] Head of Mycology at the Dr. Manuel
Gea González General Hospital, Mexico City[4]

INTRODUCTION

Descibe the case of a patient immuno-competent with metastasic tuberculous abscess

OBJETIVES

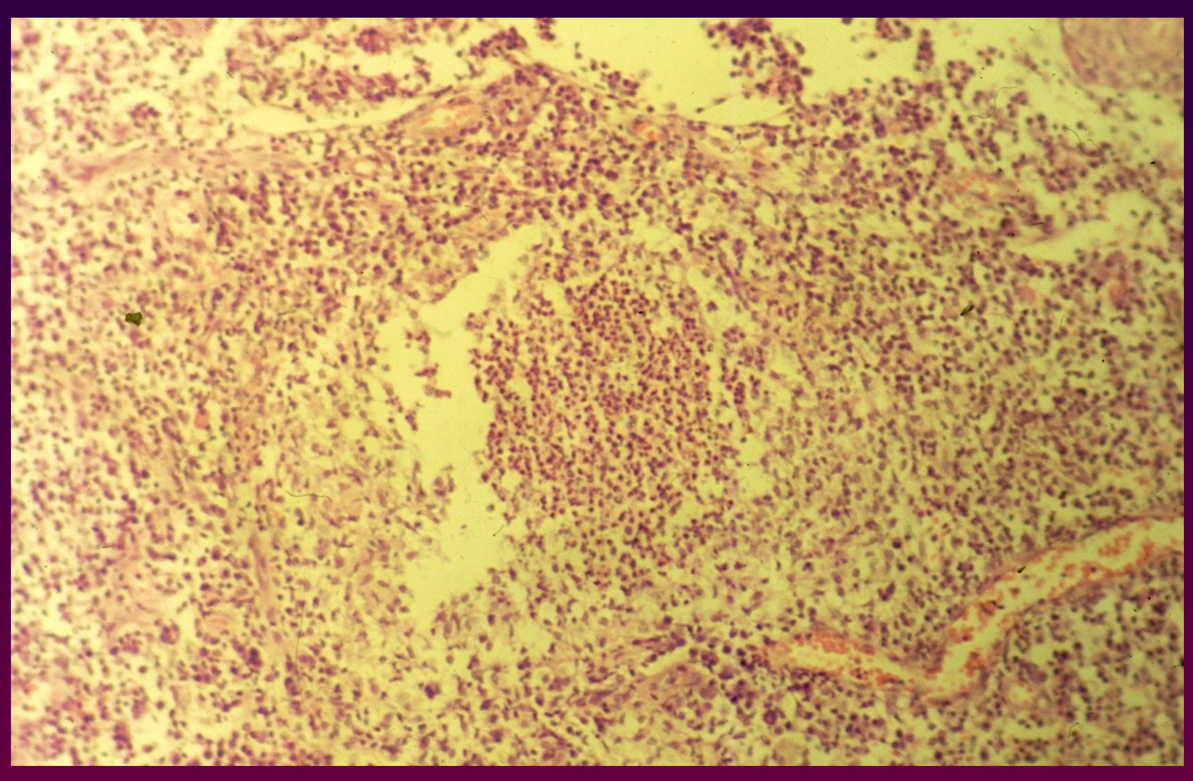
- Remember clinical presentation of cutaneous tuberculosis
- Identify laboratory test results for a proper diagnosis route
- Avoid late diagnosis
- Emphasize treatment



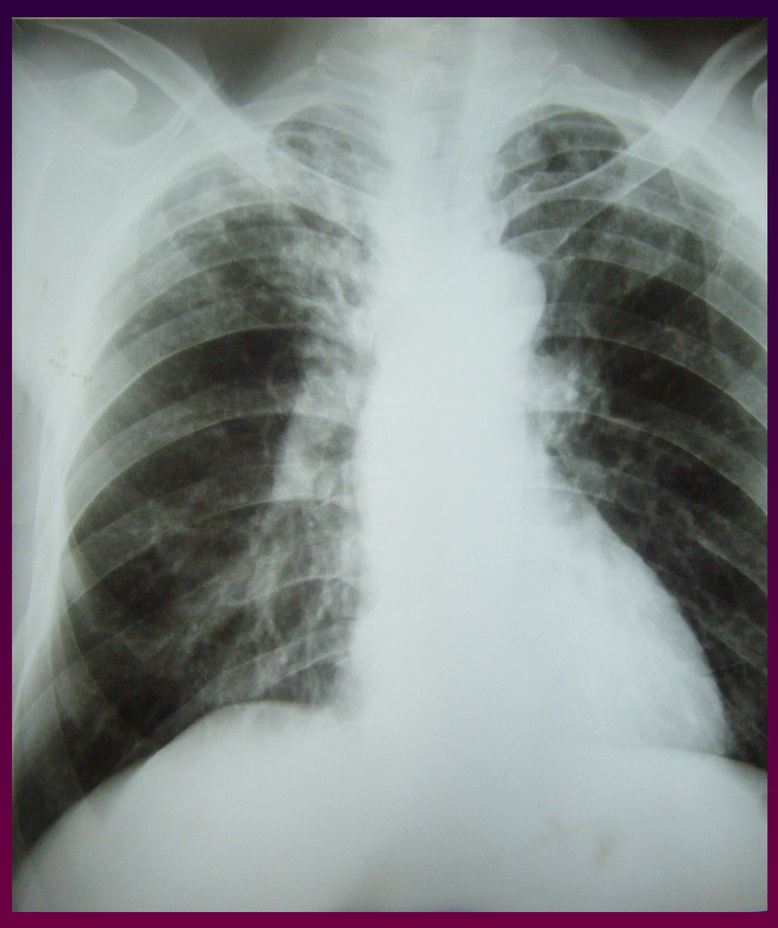
1) Erythematous purulent ulcer

MATERIAL AND METHODS

We present a 47 year-old male, with a six year history of a purulent ulcer at the parasternal region. Biopsy showed a granulomatous infiltrate with giant multinucleated cells, and a mycobacteria was cultured in Löwenstein-Jensen. PCR was positive for *Mycobacterium tuberculosis*. Mantoux test was 15 mm. Chest radiography showed right apical and basal reticular infiltrate . Culture was negative and no evidence of acid-fast bacilli (AFB) on sputum and urine samples. HIV was no reactive. Improvement was observed after antituberculous therapy. The patient lost his social security , we could not undertake any clinical or epidemiological monitoring.



2) Granulomatous infiltrate H/E 40x



3) Chest radiography right apical reticular infiltrates

RESULTS AND CONCLUSIONS

Cutaneous tuberculosis is a rare form of extrapulmonary tuberculosis (3.5% of cutaneous tuberculosis).[1] Its incidence has increased for the emergence of AIDS, use of immunosuppressive monoclonal antibodies, but also by the emergence of multi-resistant strains, lack of interest in social control programmes related to antituberculous, overcrowding, promiscuity and migration of people from endemic areas.[1,2]

Metastatic tuberculous abscess is the result of hematogenous dissemination, which can occur in immunocompromised or immunocompetent patients.

It usually affects trunk and extremities with a "cold" abscess with secondary liquefaction, sinus tracts and ulcers. Lesions can be multiple in miliary tuberculosis.[3] Currently, diagnosis of tuberculosis should include culture and identification of species / complexes and drug sensitivity, after probability criteria such as: tuberculoid granuloma with or whithout caseous necrosis; positive PPD, or tuberculosis confirmed in another organ and a therapeutic trial with success after one week.[4,5,6] Treatment includes a scheme of four drugs:

Rifampicin 150mg
Isoniazid 75mg
Pirazinamid 400mg
Ethambutol 300mg

Treatment should last for six months, as well as for treating patients co-infected with HIV, regardless of the stage of viral infection, and patients should have treatment restarted when cultures and diagnostic testing persist with positive results.[7]

REFERENCES

1.- Dekeyzer S, Moerman F, Callens S, Vandekerckhove L. Cutaneous metastasic tuberculous abcess in a patient with cervico-mediastinal lymphatic tuberculosis Acta Clinica Belgica, 2013; 68-1
2.- Marco A, Solé R, Raquer E, Aranda M Goma o absceso tuberculoso metastásico como diagnóstico inicial de tuberculosis en un paciente inmunocompetente: una presentación inusual. Rev Esp Sanid Penit 2014; 16: 59-62
3. Bravo FG, Gotuzzo E. Cutaneous tuberculosis. Clinics in Dermatology 2007; 25: 173-180.
4. Morris BS, Maheshwari M, Chalwa A. Chest wall tuberculosis: a review of CT appearances. Br J Radiol 2004;77: 449–457.
5. Grover SB, Jain M, Dumeer S, Sirari N, Bansal M, Badgujar D. Chest wall tuberculosis—a clinical and imaging experience. Indian J Radiol Imaging 2011; 21: 28–33.
6. Hernandez SA, Herrera GNE, Cazarez F, Mercadillo PP, Olivera DH, Escobar-Gutierrez A, Cortés OI *et al* Skin biopsy: a pillar in the identification of cutaneous Mycobacterium tuberculosis infection J Infect Dev Ctries 2012; 6 : 626-631.
7.- Pacheco C, Silva E, Miranda J, Duarte R Cutaneous tuberculosis as metastatic tuberculous abscess. J Bras Pneumol. 2015;41:200-202