

Skin Tuberculosis : An Unusual Presentation To A Surgeon

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Cutaneous tuberculosis presents very rarely to a general surgeon as a primary lesion. Most of these cases are seen and managed by dermatologists. Such lesions result from inoculation of tubercle bacilli into the skin of the exposed areas. Our case presented as an axillary abscess due to caseating lymph nodes. Examination of the area of

drainage revealed an indolent ulcer, which was later reported as cutaneous tuberculosis on histopathology. Early diagnosis after biopsy of the lesion and institution of antituberculous therapy results in rapid recovery.

Keyword : Skin tuberculosis.

An eighteen years old student from poor socioeconomic background presented with six weeks history of swelling in the right axilla, which increased to the size of a walnut. The swelling became painful with in a span of one week. There was history of evening rise of temperature with easy fatigueability. Past history was unremarkable. On examination, a thin built young boy has a 2cm x 3cm swelling in the right axilla. The skin overlying the swelling was red. It was slightly tender and local temperature was increased. The edges of the swelling were firm due to matted lymph nodes and there was a central area of fluctuation. The features were suggestive of a cold abscess. Further examination showed a nodular lesion with central ulceration present on the dorsal aspect of the right wrist, which was painless and present for seven months.

On investigation, patient has an ESR of 48mm after 1st hour, normal white cell count and x-ray chest. Mantoux test was positive. The abscess was drained and the abscess wall curetted. Excision biopsy of the caseating Lymph Nodes was also undertaken. The lesion on hand was excised with an elliptical incision.

The histopathology report of skin lesion was consistent with the diagnosis of cutaneous tuberculosis and biopsy of lymph nodes further confirmed tuberculous lymphadenitis.

Discussion

Tuberculous chancre develops as a result of inoculation into the skin or less frequently, into the mucosa of an individual, who does not have a natural or artificial immunity to tubercle bacillus¹. In recent years, cutaneous infections with *Mycobacterium tuberculosis* with an atypical clinical appearance have become more common because of the increasing number of immunocompromised patients².

The inoculation occurs on the exposed areas, especially the extremities and face from cuts, scratches, insect bites and sometimes as a result of ritual circumcision³.

After 2-3 weeks of inoculation, three types of lesions may be seen. First is Chancriform type, second is impetiginous and third is ecthymatous⁴. This patient had chancriform lesion. Such

lesions have classical regional adenopathy that occurs three to four weeks or longer after the development of the ulcer. The availability of bactericidal drugs has improved the prognosis and prospect of life. Tuberculous chancre usually heals with in 1 year after start of antituberculous therapy. Local excision and drainage of tuberculous nodes with the administration of anti-tuberculous drugs results in rapid healing and smooth recovery.



Fig 1. Skin Tuberculosis

Prior to the development of tissue reaction, a nonspecific inflammatory response showing numerous polymorphonuclear leukocytes, lymphocytes and numerous bacilli is seen under the microscope. A diffuse granulomatous reaction with areas of necrosis and scattered focal collection of epithelioid Langhans giant cells may appear later. After the appearance of tuberculoid infiltrate, acid fast bacilli are difficult to demonstrate⁴. In this case a course of antituberculous drugs for nine months resulted in complete recovery and uneventful healing of both the lesions. Similar cases from different parts of world have been reported in the literature in recent years emphasizing the unusual presentation of tuberculous chancre. In one case tuberculous skin lesion of the face developed in the

Operations on the urinary bladder for removal of stones are the commonest procedures for Urologist to perform. Litholipaxy, intravesical lithotripsy, ESWL and open vesicolithotomy are the various techniques used for vesical calculi.

Litholipaxy and lithotripsy have a significant failure rate^{1,2} in cases of hard stones. In children, when paediatric lithotrite is not available, litholipaxy or intravesical lithotripsy is possible. There is significant risk of damage to urethra in cases of pulling stone per urethra in children; therefore endoscopic vesicolithotomy is a very suitable option.

In children and elderly people with vesical calculus, urethrocytoscopy is considered mandatory to rule out bladder outlet obstruction^{3,4}, so this technique can also be combined with definitive treatment for bladder outlet, obstruction, e.g., fulguration of posterior urethral valves, BNI, TURP.

The author has used this technique in age group ranging from 4-70 years, with stone size varying from 1.0 cm x 0.5 cm, in children and 2.5 cm. x 2.00 cm. in elderly successfully.

The illustration shows authors technique of removal of these stones (Fig. 1-5). No claim is made of originality. In children kept urethral catheter for 48 hours post-operatively. In elderly who had TURP and vesicolithotomy for a stone of

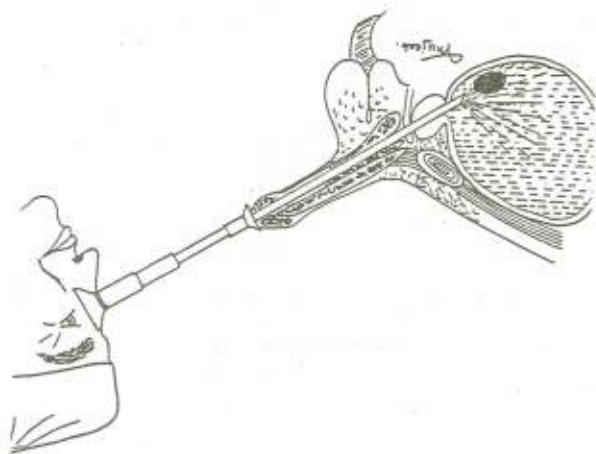


Fig. 1. Bladder filled with normal saline

Endoscopic Vesicolithotomy : An Option.

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Technical Note

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