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Tuberculous Sinus: Gluteal Region Following Drainage of Pyogenic Abscess: A Case Report

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Abstract: Extra-pulmonary tuberculosis (TB) is a rare form of cutaneous TB and constitutes only about 0.11% to 2.5% of all patients with skin diseases. We had a case of 20yr old girl who presented with swelling in the gluteal region and pain. FNAC did not show the evidence of epithelioid cells/ granulomas.Incision and drainage of the abscess was done. The sinus tract was excised. The HPE of the sinus tract showed the presence of tuberculosis.
Keywords: Gluteal abscess, TB gluteal abscess.

INTRODUCTION

Mycobacterium tuberculosis is a worldwide, problematic, communicable pathogen that has increasingly been regarded as a notable and serious infection.Most often TB is an airborne transmissible disease with skin manifestations presenting as a result of haematogenous spread or direct extension from a latent or active foci of infection. However, primary inoculation may occur as a direct introduction of the mycobacterium into the skin or mucosa of a susceptible individual by trauma or injury.

CASE REPORT

A 20 Yr. old girl presented with swelling in the Rt. gluteal region of one month duration. The swelling was noticed insidiously and associated with pain. Patient gave h/o trauma to the region. There was no h/o any I.M. drug administration in the recent past. Patient had no difficulty in walking, no h/o evening rise of temperature or otherwise. O/E-a diffuse tender swelling was noticed occupying the upper half of the gluteal region in both medial and lateral quadrants. It was tender, borders could not be made out. A clinical diagnosis of abscess/ haematoma was made.

She was subjected to X-ray of the LS spine & Ultrasound. X-ray LS spine was reported as normal vertebral bodies, with no bony lesion. Ultrasound showed ill defined irregular cystic mass with multiple septations in Rt. gluteal area suggestive of abscess. Haematological investigations were within normal limits. Fine needle aspiration of the mass showed cytological features of suppurative lesion and there was no evidence of granulomas/epithelioid cells on smear. Based on the above findings, a final diagnosis of abscess was made and posted for Incision and drainage.

A cruciate incision was made and abscess drained which contained thick pus. Patient got discharged on the second day and visited the hospital for regular dressings. The swelling subsided in size but the discharge persisted & over a period of time, became thin watery and showed no signs of healing even after 4 weeks. An E.S.R. done was 60mm/hr. A c/s done showed MRSA (Methicillin Resistant Staphylococcus Aureus) which was treated accordingly. In spite of it the watery discharge persisted. A Sinogram was done which showed two sinuses of 5cm depth communicating with each other. Patient was posted for excision of the sinus tract & after delineating the tract with methylene blue ,was excised in toto and laid open. The HPE of the sinus tract was reported as the sinus tract lined by granulation tissue along with multiple epithelioid granulomas, & Langhan's type of giant cell consistent with tuberculous sinus tract (Fig. 1 & 2).

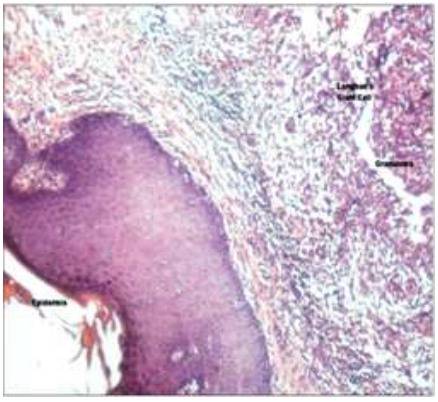

Fig. 1: (10x) Epidermis with sub epidermal tissue showing the sinus tract lined by granulation tissue consisting of Langhan's giant cell and epithelioid cells

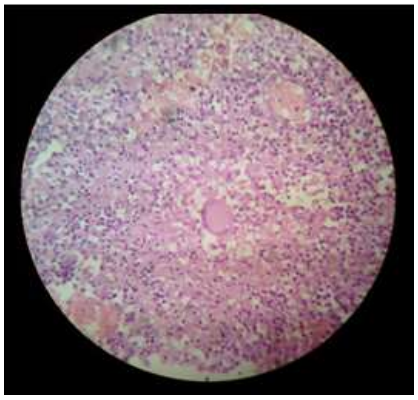

Fig. 2: (40x) showing the granulomas consisting of epithelioid cells and Langhan's giant cells

Patient was started on four drug regimen for tuberculosis for a period of three months and was told to continue for further period of five months. The laid open track healed in two months time and there was no further discharge.

DISCUSSION

The prevalence of tuberculosis (TB) is around 30 million globally and approximately one third of the cases are found in India. Cutaneous tuberculosis is rare and constitutes only about 0.15 percent of all dermatologic patients in our country [1]. Cutaneous tubercular abscess can occur from direct skin inoculation eg. from a contaminated needle or dressings or from extension of an underlying lymphadenitis, synovitis, or osteomyelitis(as in scrofuloderma) [2]. Vertebral tuberculosis is the most common form of skeletal tuberculosis; gluteal abscess may result from Pott's spine [3], the infection then tracking down along the aorta and its branches to present in the groin. TB has also been described following subcutaneous or intramuscular injection. Either the syringe, needle or fluid to be injected has been contaminated or the medical attendant has exhaled tubercle bacilli into the patient's skin, which are then introduced by the injection [4]. Our patient presented with gluteal abscess-pyogenic & might have developed tuberculosis later by contamination of the wound by tubercle bacilli. The diagnosis was made based on the raised ESR after the abscess drainage, histological features of the sinus tract and a favourable response to ATT. The absolute diagnostic criteria with conventional methods of smear or culture to demonstrate tubercle bacilli in cases of cutaneous tuberculosis have limitations [5]. Newer techniques such as polymerase chain reaction may be useful in view of high specificity and sensitivity [6]. Skin TB should be managed with drug regimens for pulmonary TB, as recommended by the American Thoracic Society and Centre for Disease Control. Tuberculous subcutaneous abscesses may develop during chemotherapy for pulmonary TB [7] but this does not necessarily indicate treatment failure.

CONCLUSION

Cutaneous tuberculosis (CTB) is frequently elusive as it mimics a wide differential diagnosis and also evades microbiological confirmation despite recent advances in sophisticated techniques [5]. Wound contamination by tubercle bacilli with a different post operative scenario should be always kept in mind. Although rare, given its worldwide prevalence, it is important for clinicians to recognize the many clinical variants of CTB to prevent missed or delayed diagnoses.

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