

Case Report
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A Case of Extrapulmonary Tuberculosis

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Case Report

A 21 years old man immigrant from Nigeria came to our observation for swelling of the chest wall and fever. The laboratory tests showed neutrophilic leukocytosis and absence of HIV / others viruses' infection. Chest X-ray was not conclusive. An abdomen echography showed diffuse lymphadenopathy. In the suspicion of a lymphoproliferative disease we performed a total body CT, that detected collimated lymph nodes in the later cervical, abdominal and pelvic stations; at the left pectoral region there was an abscess collection (58x54mm) crossing the intercostal spaces until to the anterior pleura (Figure 1). Echocardiography showed mild pericardial effusion. The thoracic abscess was drained and a sample of PCR for Mycobacterium tuberculosis was positive. We started therapy with rifampicin, isoniazid, pyrazinamide, ethambutol and methyl prednisone, waiting for cultural examination. The patient was discharged in good clinical status with diagnosis of disseminated lymph node tuberculosis (LNTB) fistulized to the chest wall abscess and he was referred to specialist follow-up.

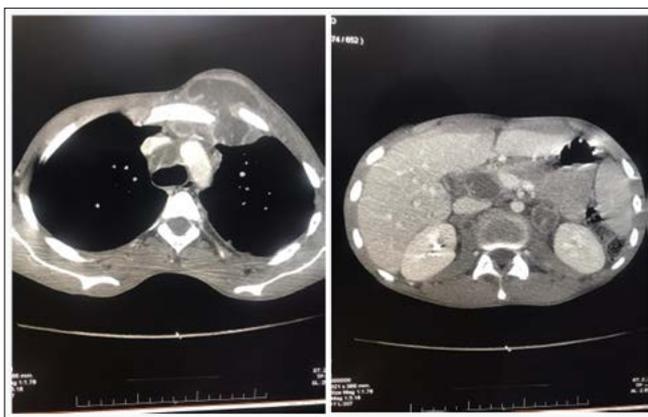


Figure 1: Total body CT images showed an abscess collection (58x54mm) crossing the intercostal spaces until to the anterior pleura at the left pectoral region and multiple collimated lymph nodes in the abdominal stations.

Discussion

Each year, there are more than eight million new cases of tuberculosis and 1.3 million deaths. There is a renewed interest in extrapulmonary forms of tuberculosis as its relative frequency increases. Up to 25% of tuberculosis cases present extrapulmonary

involvement [1-2]. This is produced by hematogenous and lymphatic spread of the *M. tuberculosis* bacillus to other organs. The most common locations are the lymph nodes, pleura and the osteoarticular system [3]. The problem with these types of tuberculosis is the difficulty in establishing a definitive diagnosis, since the clinical symptoms and results of imaging tests may be vague. It is often necessary to resort to invasive diagnostic testing such as ultrasound or CAT-guided FNAB, used to collect biological samples for diagnosis. Despite the growing use of and advances in recent years of molecular methods for early detection of mycobacteria DNA, cultures continue to be the gold standard that enable a firm microbiological diagnosis to be made [4-5]. Treatment for these types of tuberculosis do not differ from treatment regimens for pulmonary forms of the same disease [6]. The same antibiotic regimens for 6 months are recommended, and any extension of this period is advisable solely in tuberculosis affecting the central nervous system and in Pott's disease [7].

Conclusion

The objective of the present report is to emphasize that LNTB should be considered as a noteworthy differential diagnosis in patients with enlarged lymph nodes, particularly in tuberculosis-endemic countries. Awareness of these clinical manifestations and greater clinical competence could facilitate early diagnosis and initiate targeted treatment.

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