Mycobacterium Tuberculosis Osteomyelitis Of Right Tibia

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INTRODUCTION:
Skeletal tuberculosis (TB) accounts for 10-35% of cases of extra pulmonary tuberculosis. While the most common site of osseous involvement is the spine, any bone can potentially be affected. We present a case of a 38 year old man who presented with a 3 years history of non healing right leg ulcer which was eventually diagnosed as Mycobacterium tuberculosis osteomyelitis of the right tibia.

CASE REPORT:
A 38-year-old man presented with 3 years history of non healing right leg ulcer. He had on and off fever and pain at right leg when there was pus discharge from the ulcer. He denied any history of recent trauma. There was no history of cough, hemoptysis, night sweat or lost of weight. He had seek medical treatment from clinic several times prior to admission and was given oral antibiotics with dressing at the ulcer. Physical examination revealed an ulcer on the anteromedial aspect of distal part of right leg measuring 3cm x 2cm with necrotic base and pus discharge (Figure 1). Right ankle Xray (Figure 2) showed intracortical lytic bone lesion with sclerosis of the affected bone segment. He was diagnosed to have chronic osteomyelitis of right tibia. He underwent surgical debridement and treated with antibiotic. However, histopathological examination of sample taken intraoperatively showed acid fast bacilli on Ziehl Neelsen stain which suggestive of mycobacterium tuberculosis infection. He was then started with anti-TB medication, Akurit-4 (Ethambutol HCl 275 mg, rifampicin 150 mg, isoniazid 75 mg, pyrazinamide 400 mg). His wound had healing well since then.

DISCUSSIONS:
The diagnosis of tuberculous osteomyelitis requires a high degree of suspicion for accurate diagnosis. Clinical symptoms are very nonspecific and can include insidious onset of pain and swelling. Histopathological examination should be done to confirm diagnosis when there is clinical suspicion.

CONCLUSION:
Tuberculous osteomyelitis should be considered in the differential in patients with persistent or recurrent skin and soft tissue infections, especially in patients with risk factors such as immunosuppression.

REFERENCES: