CASE REPORT: TUBERCULOSIS VERRUCOSA CUTIS

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ABSTRACT: Tuberculosis verrucosa cutis, otherwise called as warty tuberculosis is a disease due to acquired infection from an exogenous source in a person who has moderate to high immunity for tuberculosis. Lesions are frequently reported on hands and lower limbs. It is an occupational hazard in people who handle tuberculous tissues during work, example: Veterinarians and mortuary at tenders, farmers, butchers, anatomy at tenders (anatomist's warts). Auto inoculation by sputum in a pulmonary tuberculosis patient can cause the disease. Clinical features are variable, but verrucosity always forms. Lesions are usually single indurated, verrucous plaque with serpigenous edge which may show some scar at centre with keloidal changes and are seen at trauma prone sites. Histopathology shows psedoepitheliomatous hyperplasia with infiltration of plasma cells and sometimes with caseating granuloma. Tissues rarely show positivity to bacilli on staining. Treatment of the disease is by anti TB therapy which will completely resolve the lesion.

KEYWORDS: Warty tuberculosis, occupational hazard, anatomist wart, psuedoepitheliomatous hyperplasia, caseating granuloma, anti TB therapy.

INTRODUCTION: Tuberculosis verrucosa cutis (TBVC) is a disease usually presents as an isolated verrucous plaque with scaling crusting and sometime with purulent discharge. The lesions are seen usually on the exposed parts of the body usually on the limbs. There are asymptomatic in many situations and may not respond to usual treatment. Anti TB treatment gives complete relief. In this case it has an unusual presentation.

CASE REPORT: A 49 year old female has presented to the OPD with hyper pigmented, scaly, verrucous annular plaques with inflammatory borders. She had reddish, brown, shiny indurated plaques on the right shoulder, on the right breast, on lower limbs and buttocks of 2 years duration. The lesions were asymptomatic with occasional pain in the right breast area. She has reported to the OPD with the complaint that, in spite of repeated antibiotic therapy both systemic and topical the lesions were not healing. The lesions are slowly enlarging in size. She was the wife of a butcher and she frequently assisted her husband in his work.

Routine examinations of blood done :Hb% -8 gms, Total WBC count: 10,600, DC: P-46%, L-47%, E-o2%,M-02%.ESR- 78 mm/Hr, Mantoux test – 22 mm positive, X-Ray chest PA view shows – Bilateral hilar lymphadenopathy, FNAC-Auxiliary lymph grands shows reactive hyperplasia and blood STS- Nonreactive. Sputum smears for AFB- Negative, Sputum for culture –negative. Tissue smear - negative for deep mycosis. Mammography shows irregular thickening and tissue scarring of skin of right breast with discrete calcification.

Histopathology examination shows pseudoepitheliomatous hyperplasia dense infiltration of plasma cells and giant cells and caseation necrosis. Methanamine silver and PAS stain for fungus are negative and tissue for fungal culture negative.

DISCUSSION: Tuberculosis verrucosa cutis is a slowly progressive infection and presents with clinical features of variable nature. Initially a dull red deep seated papule or nodule appear which gradually enlarges and become verrucous. Purulent discharge and crusting will occur. Lesions are usually single, extends slowly and irregularly and later regress over several months leaving a thin atrophic or keloidal scar. Sometimes regional lymph glands are enlarged but not tender. Calcification rarely occurs in chronic lesions. In western countries lesions are more in upper limbs, but in eastern situation are more on lower limbs. Lesions are more or less asymptomatic, but active areas of the lesions may be tender with signs of inflammation. Histological examination of the lesions shows pseudoepitheliomatous hyperplasia with caseating granuloma which is very characteristic. The disease should be differentiated from common warts, blastomycosis, hypertrophic lichen planus and oriental sore in an endemic area.

CONCLUTION: The case is reported because of its unique appearance and unusual sites of evolution of lesions and its association with keloidal changes.

REFERENCES:

1. Grange JM, Noble WC, Yates MD, Collins CH. Inoculation mycobacterioses. Clin Exp Dermatol. 1988;13:211–20. [PubMed]
2. Irgang S Ulcerative cutaneous lesions in sarcoidosis. Br J Dermatol. 1955;67:255–60. [PubMed]
3. Iizwa O, Aiba S, Tagami H. Tuberculosis verrucosa cutis in a tumour like form. Br J Dermatol. 1991;125:79–80. [PubMed]
4. Wong KO, Lee KP, Chin SF. Tuberculosis of the skin in Hong kong. Br J Dermatol. 1968;80:424–9. [PubMed]
5. Gopinathan R, Pandit D, Joshi J, Jerajani H, Mathur M. Clinical and morphological variants of cutaneous tuberculosis and its relation to mycobacterium species. Indian J Med Microbiol. 2001;19:193–6. [PubMed]
6. Chowdhury MM, Varma S, Howell S, Holt PJ, Statham BN. Facial cutaneous tuberculosis: an unusual presentation. Clin Exp Dermatol. 2000;25:48–50. [PubMed]
7. De Jong JW, van Altena R. Non-respiratory tuberculosis with Mycobacterium tuberculosis after penetrating lesions of the skin: five case histories. Int J Tuberc Lung Dis. 2000;4:1184–87. [PubMed]
8. Sehgal VN, Wagh SA. Cutaneous tuberculosis: Current concepts. Int J Dermatol. 1990;29:237–52. [PubMed]
9. Padmavathy L, Lakshmana Rao L, Pari T, Ethirajan N, Krishnaswamy B. Lupus vulgaris and tuberculosis verrucosa cutis: Clinicopathological study of 71 patients. Indian J Tub. 2008; 55:203–9. [PubMed]
10. Prasad P.V.S, Ambujam S, Paul Elizebeth K, Krishnasamy B, Veliath A J. Multifocal tuberculosis verrucosa cutis: An unusual presentation. Indian J Tub. 2002;49:229.
11. Montali RJ, Mikota SK, Cheng LI. Mycobacterium tuberculosis in zoo and wildlife species. Rev Sci Tech. 2001; 20:291–303. [PubMed]

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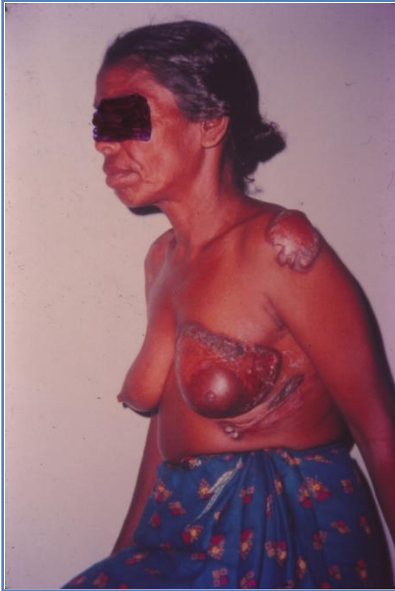
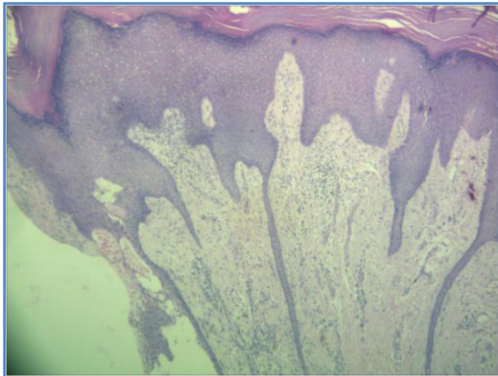


Lesions of TBVC on shoulder and breast.



Histopathology showing pseudoepitheliomatous hyperplasia in TBVC.

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