

## Disseminated tuberculosis in a full term pregnant female presenting as possible malignancy with gross metatarsal bone destruction of left foot

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### Abstract

*Tuberculosis is known to be the 'Master Mimic' in disease presentations in most unusual settings. Unless a clinician is alert to its existence, such cases may be misdiagnosed. Here, such a case is presented, with rare involvement of small bones of left foot and disseminated bilateral lung lesions, in a full term pregnant female detected just after labour. As it is small, hand and foot bones are rarest of bone T.B involvements.*

**Keywords:** *Disseminated Koch's, Small Bone Tuberculosis*

### Case Report

A 26 year old female presented with 8½ months amenorrhea, pain in left foot (over 4 months duration), pain in abdomen, history of smooth cough without expectoration, breathlessness and increasing weakness and loss of appetite. She also had pervaginum leaking membranes of 3 hour duration. She had not got this investigated anywhere and thought it was due to pregnancy. Her last menstrual period was 17/7/05 and expected date of delivery was 24/4/06; she was Gravida 3, Para1, with one abortion. She was afebrile and on examination of respiratory system had bilateral crepitations in most areas with bronchial breathing over left infrascapular area. Tenderness and swelling were present over the left foot. On investigations, Hb was 7.2 gm/dl, leucocytosis: 19,000/cumm with polymorph - 74%, lymphocytes -12% and 14% metamyelocytes and band forms. X-Ray of left foot (fig 1) showed extensive lytic lesions in tarsal and metatarsal bones which was reported as suspicious of metastasis / infective pathology.

Ultrasonography of the abdomen showed hepatomegaly with bilateral minimal pleural effusion. A preterm baby was delivered and patient was further investigated the next day.

X-ray chest (fig 2) showed dense, near ground glass

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opacity in left mid zone and left lower zone with bilat-eral multiple nodular opacity. CT scan of the thorax (fig: 3) showed partial collapse and consolidation of left lung with a large cavity in the upper lobe, patchy nodular lesions in the right lung and enlarged mediastinal lymph nodes.

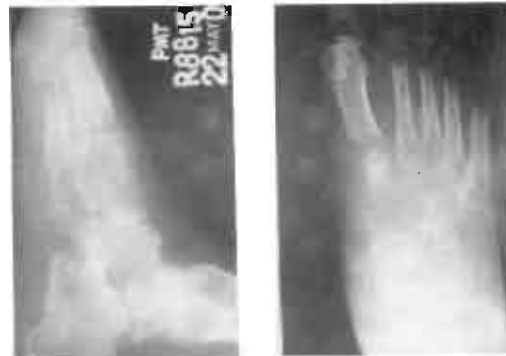


Fig 1: X Ray: Left foot

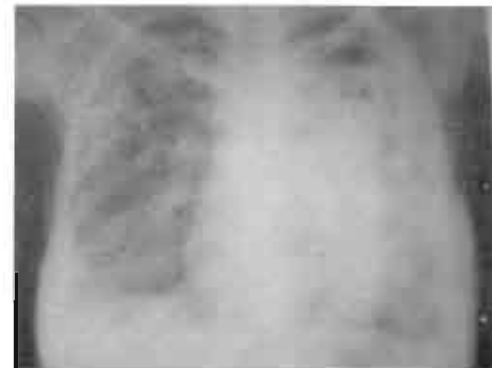


Fig 2: X Ray: Chest

Patient made a gradual but consistent recovery and at present time her lung lesions are regressing (fig5).



**Fig 3: CT Scan : Thorax**

A bone biopsy from the left foot was carried out which was reported as few inflammatory cells and no definite opinion was possible. Fiber-optic bronchoscopy was carried out next (fig 4).



**Fig 4: Bronchoscopic view**

It revealed acute inflammatory mucosa with whitish exudates. Bronchoalveolar lavage specimen and post bronchoscopy sputum were reported as positive for acid fast bacilli. A diagnosis of advanced pulmonary tuberculosis with dissemination to left foot bones was established and patient put on standard antitubercular regime.



**Fig 5: X Ray : Chest : Regressing lesions**

## Discussion

Tuberculosis is one of the most ancient scourges of mankind. Often it presents in such dubious ways that it becomes a great diagnostic dilemma. Unless the clinician is alert, there is every likelihood of mistaking it for some other disease. Dissemination of bone tuberculosis is primarily lympho-hematogenous, and rarely by direct inoculation like occasionally on fingers. The infection of non-weight bearing bones are extremely rare and insidious in onset, thus they are usually diagnosed very late[1]. Less than 50% individuals with osteo-articular tuberculosis have any detectable pulmonary lesion. Local pain, swelling and muscle wasting are the only signs [2]. Small joint tuberculosis is even rarer and delayed diagnosis is compounded by the fact that they present as widespread lytic lesions which are usually regarded as highly suggestive of a malignant lesion [3]. In tuberculous lesions of the foot, the commonest involvement in order of frequency is the calcaneum, followed by subtaloid and mid-tarsal joints. Metatarsals and other joints are the last to be involved[3].

Enderteritis of nutrient arteries in these bones causes a large amount of destruction. The tuberculous process spreads around rapidly due to intercommunicating synovial channels of these joints[4]. Isolated lesions of one tarsal and metatarsals are therefore exceptions[4].

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