

Case Report

Tuberculosis Cutis Orificialis (TBCO): A Rare Manifestation of Tuberculosis

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Abstract

Tuberculosis of the oral cavity is a very rare disease and accounts for less than one percent of all cases of tuberculosis. Primary lesions are extremely rare. Presentation is as a single ulcer, may be painful, however multiple painless ulcers have been described. Tongue is the most common oral site involved. The palate, buccal mucosa, floor of the mouth, gingiva, and lips are other possible sites. We hereby report a case of TBCO, a very rare manifestation of tuberculosis.

Introduction

The occurrence of tuberculosis of the oral cavity has become uncommon and is often not considered in the differential diagnosis of oral lesions. The differential diagnoses of oral cavity tuberculosis are primary syphilis, deep fungal diseases, chronic traumatic ulcer, and squamous cell carcinoma.¹ Tuberculosis of mouth and oral cavity is very difficult to diagnose on the history and clinical presentation alone. We here report a case of TBCO proved on histological examination, active pulmonary lesions in bilateral apices, and sputum positive for AFB. The lesion improved after antitubercular therapy.

Case Report

A 62-year-old male patient presented with history of swelling on the inner side of the right lip in oral cavity with difficulty in chewing for 3 months. The swelling was painless initially and increased in size gradually involving both upper and lower lips on right half. There was history of malaise and weight loss for the same duration. There was no history of cough, hemoptysis, fever, or sweating. Urinary and bowel habits were normal. Patient was a nonsmoker and there was no history of alcohol intake or tobacco chewing.

On examination, the oral cavity was hyperemic and the

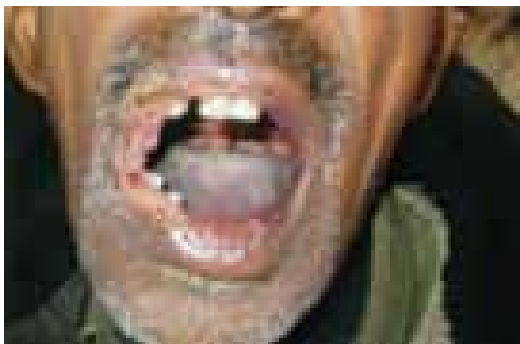


Fig. 1 : Picture showing lesions on both upper and lower lips on right side.

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Received: 18.11.2009; Revised: 04.02.2011; Accepted: 07.03.2011

buccal mucosa on the right side was irregular. The mucosa over it was pale (Figure 1). Examination of rest of the oral cavity including uvula, tonsils, gums, and upper respiratory tract was apparently normal on gross appearance. There was no cervical lymphadenopathy, patient had poor orodental hygiene and had dental caries. Examination of the chest was within normal limits. For these complaints patient was first investigated for possible squamous cell carcinoma. His biopsy was done which showed necrotizing suppurative granulomatous inflammation, and no evidence of malignancy (Figure 2). Patient was then investigated for pulmonary tuberculosis. His chest radiograph showed lesions in bilateral apices (Figure 3). The erythrocyte sedimentation rate was 90 mm in 1st hour. Sputum was positive for acid fast bacilli. Antituberculosis treatment with isoniazid, rifampicin, ethambutol, and pyrazinamide was started. Patient responded well to the treatment and at follow up the swelling reduced on gross appearance.

Discussion

The oral cavity is an uncommon site of involvement by tuberculosis. Infection in the oral cavity is usually acquired through infected sputum coughed out by a patient with open pulmonary tuberculosis. Infection may also be acquired by hematogenous spread. In general, the intact mucosa of the oral cavity is relatively resistant to invasion and saliva has inhibitory effect on the growth of mycobacteria. A breach in the mucosa due to any reason is one of the important predisposing factors for the development of tuberculosis of the oral cavity. Tongue is the most common site of involvement and accounts for nearly half the cases. The lesions are usually found over the tip,



Fig. 2 : Histopathology picture showing necrotizing, suppurative granulomatous inflammation.



Fig. 3 : Chest X-ray PA view showing lesions in bilateral Apices.

borders, dorsum, and base of the tongue. They may be single, or multiple, painful, or painless. The lesions may begin as nodules, fissures, or plaques. Initial picture resembles a malignant process and histopathology confirms the diagnosis. Other sites of involvement include: floor of mouth, soft palate, anterior pillars, and uvula. Secondary involvement of the draining lymph nodes may occur. Majority of these patients also have pulmonary tuberculosis².

Clinically, lesions of lupus vulgaris are usually on the exposed parts, especially face. They are asymptomatic and characterized by groups of firm papules and nodules, which when blanched by diascopic pressure have the characteristic 'apple jelly' color.³ TBCO remains undiagnosed because of its rare occurrence and lack of physician awareness.

In our case irregular growth involving mucocutaneous junction of both upper and lower lip on right half was seen. It was the characteristic histopathology of lesion, which led us to the diagnosis of tuberculosis. Cases have been reported which involved oral mucosa secondary to pulmonary tuberculosis⁴. Our patient also had pulmonary tuberculosis. This presentation of tuberculosis is very rare in present era and that is why eluded diagnosis or suspicion for three months and a simple chest x-ray could have given the lead to the diagnosis.

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