Skeletal Tuberculosis Mimicking Seronegative Spondyloarthropathy

Sir,

There has been a resurgence of tuberculosis worldwide. Approximately 10-11% of extra-pulmonary tuberculosis involves joints and bones, which is approximately 1-3% of all TB cases. A high degree of sensitivity to this diagnosis would permit prompt institution of anti-TB therapy and prevent irreversible joint damage.

A 30 years female, presented with complaints of low backache of 2 month duration, with pain in the buttocks radiating to legs, aggravated on walking along with morning stiffness of 15 minutes duration. There was no other history of pain in any other joints, or any other neurological symptoms. She was evaluated and treated in a different hospital in 2004. X-ray lumbo-sacral (LS) and sacroiliac joint (SI joint) showed haziness of SI joint space. MRI of LS spine and SI joint (done in July 2004) showed irregular margin on right side with bone edema on left side along with altered signal intensity (Fig. 1). Patient was diagnosed as seronegative spondyloarthropathy and was started on anti-inflammatory drugs. She was admitted with us after 5 months with persistent low backache and pain in the legs and heel along with fever of 4 months duration along with significant weight loss. On examination, she was pale and febrile; there was tenderness in SI joints on both sides on applying pressure. Spine extension and flexion were painful. Investigations revealed anaemia with raised CRP, Mantoux test was positive, rest of the investigations including chest X-ray were normal. CT scan of the sacroiliac joints showed marked destruction of articular surfaces of SI joint on left side and reduced joint space on right side (Fig. 2). CT guided aspiration (Fig. 3) revealed acid fast bacilli. Patient was started on anti-tubercular treatment. After 6 months of follow up patient is better clinically and radiologically.

Skeletal tuberculosis (TB) is still a common problem in developing countries. Infections of the sacroiliac joint are uncommon and the diagnosis is usually delayed. The sacroiliac joint is involved in 3-9.7%. Lack of awareness of this now uncommon form of infection often leads to diagnostic delay and increased morbidity.

TB of the sacroiliac joint is usually unilateral and clinically presents with pain in the buttock and low back that may be of short duration—or as long as >1 year. There may be difficulty in clinically distinguishing it from inflammatory back pain. Other infective cause which may be sought as a differential diagnosis is Brucellosis. Features differentiating tuberculosis with brucellosis are shown in Table 1. MRI is reported to be the best modality for early detection of spondylitis. Radiographically, the sacroiliac joint may be normal or haziness or loss of the joint line may be seen in early disease. Irregularity of the articular surface and the sub-chondral erosions may follow. MR imaging is the most sensitive and specific imaging modality for diagnosing sacroiliitis at its early stage. However, because of the overlapping clinical

Fig. 1 : MRI of LS spine and SI joint (done in July 2004) showing irregular margin on right side with bone edema on left side along with altered signal intensity.

Fig. 2 : CT scan of the sacroiliac joints showing marked destruction of articular surfaces of SI joint on left side and reduced joint space on right side.

Fig. 3 : Showing CT guided aspiration which revealed acid fast bacilli.
Prevalence of Epilepsy in Rural Rajasthan — A Door-to-Door Survey

Sir,

Epilepsy is world wide health problem. Figures ranging from 1.28 to 8.87 per 1000 have been given in various studies from India.1 Very few neuroepidemiological studies have been possible in rural areas. This door-to-door survey was conducted in part of rural Rajasthan, with the aim to study the prevalence rate of active epilepsy and clinical profile including attitude and beliefs of people about epilepsy in Churu Tehsil (Rajasthan).

The study was conducted during the period of January, 2005 to October, 2005. Patients of active epilepsy were included in the study. Febrile seizures and pseudo-seizures were excluded. The study was conducted in 3 steps. In the first step, health workers and others posted at Primary Health Centres (PHCs) and subcentres did a door-to-door survey for finding epileptic patients using standard validated 9 questions screening questionnaires, having 92% specificity and 98% sensitivity.2 Positive cases were referred to the rural epilepsy center at Ratan Nagar where this study was conducted on every first Saturday of month for confirmation of epilepsy by the neurologist team. A team of 70 health workers and 16 doctors conducted the survey.

As a second step, to improve the case finding, pamphlets and public address system, mobile vans with posters were used to detect any cases of epilepsy which may have been missed during the step one of the study. As a third step a team of neurologist confirmed the diagnosis of epilepsy in patients referred from step-1 and step-2. They recorded the patient details and epilepsy was classified according to classification of ILAE (1981).

The total population under this study was 1,72,442 which was distributed in 11 PHC areas. 596 cases were referred as positive cases of epilepsy by peripheral field workers. They were screened by a team of neurologist, and 517 patients were confirmed as patients of epilepsy. Thus prevalence rate of active epilepsy in this area of rural Rajasthan was found to be 3/1000. This is the only such survey for epilepsy in Rajasthan. Other studies from India show a prevalence rate of 4.7/1000 in Parsi Community, Bombay; 4.74/1000 in Kerala.3 In our survey, sex prevalence is slightly higher in men than women, male:female 1.1:1. This could be due to the tendency of head of the family interviewed in the survey to conceal epilepsy in females due to social stigmas. The mean age of onset of epilepsy in our study was 16.2 years. Considering only the clinical data; generalized seizure were the most common type present in 78% of our patients.3

In our study treatment gap is nearly 40%. A variety of pre-disposing risk factors are thought to be significant in developing countries. In our study mental retardation was seen in 12.8% cases and family history was present in 4.2% cases. Patients beliefs regarding cause of epilepsy revealed that 23.5% of patients thought it to be due to disease of brain, 26.4% as evil spirits and 4.7% as a familial cause. These results were similar to study done by Birback GL et al.3

Such studies may be of help in properly mobilizing the services of both government and non-government organization in controlling the seizures in maximum number of cases.

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