The Enemy within—Multifocal Tuberculous Abscesses Complicating Dermatomyositis

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Sir,

Tuberculosis can present with diverse manifestations, particularly in immunocompromised hosts. Although cold abscesses can complicate spinal tuberculosis, subcutaneous abscesses due to tuberculosis are considerably uncommon and, unlike cold abscesses, necessitate surgical drainage.1 We present an extremely rare case of disseminated tuberculosis in a patient with subcutaneous involvement mimicking cellulitis.

A 42-year-old male presented with progressive proximal lower and upper limb weakness, associated with a facial rash typical for dermatomyositis, developing over 2 months. Elevated creatine phosphokinase, electromyography findings, and muscle biopsy were consistent with dermatomyositis. He was initiated on oral prednisolone (1 mg/kg) and azathioprine. He showed improvement in muscle strength over the next 2 months. In the 3rd month, he presented with fever and painful swelling of the left thigh, associated with overlying erythematous induration of the skin, developing over 5 days. Similar swelling was also noted in the right neck and axilla (Fig. 1). He had enlarged axillary and left inguinal nodes.

He was initially managed for suspected pyogenic cellulitis with intravenous antibiotics for 7 days. Venous Doppler lower limbs showed extensive subcutaneous edema. However, he showed no clinical response. Reexamination on the 8th day revealed fluctuant swellings in the left thigh, right axilla, and right neck. Computed tomography (CT) chest demonstrated large abscesses in the right neck and axillary region, along with pulmonary nodules and consolidation (Fig. 1). Ultrasound (left thigh) showed a large collection. Surgical drainage of the left thigh and right axillary collections yielded frank pus. Ziehl–Neelsen stain showed abundant acid-fast bacilli (AFB). Aerobic and fungal cultures were sterile. Sputum for AFB was negative.

He was managed with extensive surgical drainage, along with antituberculosis therapy (ATT). Steroids and azathioprine were reduced as myositis was stable. Surgical drainage of the left thigh was required twice more over the next 2 weeks due to repeated abscess formation. The fever subsided after 2 weeks. ATT was continued for 12 months in total. The patient showed gradual but complete clinical recovery.

The common sites of development of tuberculous abscesses include the thoracic and abdominal wall and paravertebral region.1–3 Subcutaneous tuberculous abscesses are highly uncommon and have been previously reported only in six cases.1 Of these, concomitant pulmonary involvement was seen in five, four were immunocompromised, and one had dermatomyositis. The usual site of predilection was the thigh, and these collections were extensive in immunocompromised patients. All responded well to a combination of surgical and medical management. Unusually, our patient demonstrated simultaneous multifocal involvement, suggesting extensive hematogenous dissemination.

Due to overlying cutaneous changes, tuberculous abscesses may simulate pyogenic abscess or cellulitis, leading to the institution of antibiotics. Suspicion for an alternative etiology must be maintained in patients with compromised immunity and in the absence of clinical response. Combinational therapy is increasingly advocated. Surgical drainage seems crucial because ATT drugs have poor

Figs 1A to F: (A) Presence of a swelling on the right side of the neck; (B) Erythematous induration and swelling seen in the right axillary region; (C) CT demonstrating collection in the neck (arrow); (D) CT demonstrating collection in the axilla (arrow); (E) Organizing collection; (F) Multiple, variable-sized nodules in the lungs (arrows)
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penetrability across the abscess wall. Multiple drainage procedures may be required as new locules emerge.

Our case highlights that extrapulmonary tuberculosis may present with atypical features, particularly in immunosuppressed individuals. Early diagnosis and aggressive surgical management, in combination with appropriate ATT, ensure excellent recovery.

REFERENCES