ORIGINAL RESEARCH PAPER
Volume - 11 | Issue - 09 | September - 2022 | PRINT ISSN No. 2277 - 8179 | DOI : 10.36106/ijsr
INTERNATIONAL JOURNAL OF SCIENTIFIC RESEARCH

A RARE CASE OF PERIANAL TUBERCULOSIS OF SKIN PRESENTING AS VERUCCOUS LESION— A CLINICAL DILEMMA

General Surgery

Dr Geetika* PG Resident General Surgery MGM Hospital, Kamothe *Corresponding Author

Dr Lisha Suraj Professor in General Surgery MGM Hospital, Kamothe

ABSTRACT

Perianal tuberculosis is a rare extra pulmonary form of tuberculosis. Perianal cutaneous ulcerations in tropical countries can be due to bacterial, viral, and parasitic.Tuberculosis is a major public health problem both in the underdeveloped and in developing countries. The appearance of multi drug resistant bacilli, non compliance with medications, social stigma and poverty play an important part in the increase in incidence of the disease. Ano-perianal tuberculosis can be present with or without the lungs being affected and can be diffused. Management is with conventional anti tubercular therapy for at least 6 months. The recommended surgical procedures today are conservative and a period of preoperative drug therapy is controversial. A verrucous growth in the perianal region since 3 years and diagnosed as tuberculosis after biopsy is a very rare entity and not much reported in literature.

KEYWORDS

Perianal tuberculosis, verrucous , ulceration

INTRODUCTION

Perianal tuberculosis is a rare extra pulmonary form of tuberculosis[1]. Abdominal tuberculosis is more frequent than perianal cases.[2] It's incidence being 0.7%. Various presentations include abscess, fistulae, ulcer, anal strictures, recurrent perianal growth, anal fissure.[3]A verrucous growth in the perianal region since 3 years and diagnosed as tuberculosis after biopsy is a very rare entity and not much reported in literature. Here we are reporting a rare case of perianal tuberculosis presenting as a verrucous growth.The postulated mechanisms by which tubercle bacilli reach the perianal region are:

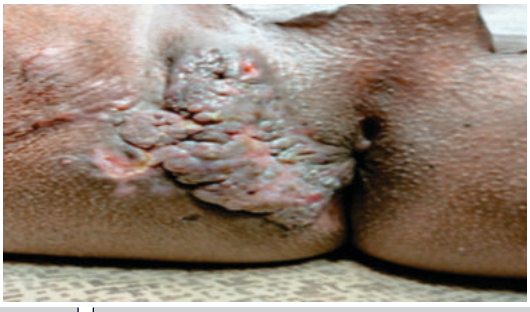
1) Hematogenous spread from the primary lung focus in childhood with later reactivation;
2) ingestion of bacilli in sputum from active pulmonary focus.
3) direct spread from the adjacent organs and
4) through lymph channels from infected nodes.[4]

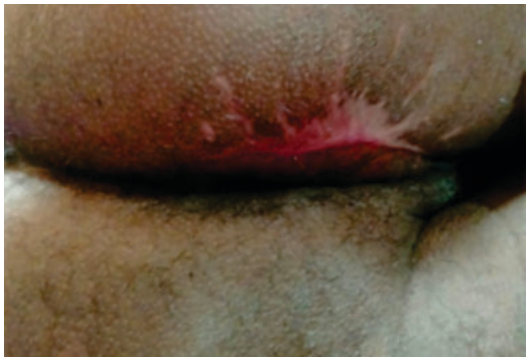
The overall sensitivity of tests for sero-diagnosis of extra pulmonary tuberculosis is as low as 16.7%.[5]

The simplest and rapid method for diagnosis of the disease is the detection of acid-fast bacilli by microscopy. But around 75% of patients with extra pulmonary tubercular disease are smear negative, and the culture methods take 2-6 weeks to become positive. Therefore, histological examination of the excised lesions is needed for the diagnosis of anal tuberculosis.[6]Perianal cutaneous ulcerations in tropical countries can be due to bacterial, viral, and parasitic. Infections like amoebiasis, foreign body reaction, sarcoidosis, syphilis, venereal lymphogranuloma and actinomycosis.[7] Crohn's disease and tuberculosis and malignancy are the other commonest conditions presenting as ulcer.[8]

Case Study

29 year male patient presented in the outpatient department with history of a swelling in the perianal region since 3 years and progressively increasing in size. He complained of on and off discharge from the swelling. Patient denied any sexual exposure or previous surgeries. His blood reports were within normal limits. Mantoux test was positive. An incisional biopsy was done to confirm the diagnosis which showed tuberculosis. Patient underwent a wide excision of the lesion & started on anti- tubercular drugs. He responded well to the treatment and the wound healed in a period of 2 months with a scar and patient is still on anti-tubercular treatment.





CONCLUSIONS

Tuberculosis is a major public health problem both in the underdeveloped and in developing countries. The appearance of multi drug resistant bacilli, non compliance with medications, social stigma and poverty play an important part in the increase in incidence of the disease.

Anal fistula is the most frequent presentation of anorectal TB (80–91%). The ulcerated form of anal TB presents as a superficial ulceration with necrotic tissue and thick purulent secretions of mucous9. The tuberculin skin test remains a valuable guide because it is positive in 75 percent of cases. Positive diagnosis of anal TB depends on histopathology or bacteriologic analysis. The typical histologic finding is the epitheloid and giant cell tubercle around a zone of caseous necrosis10.Diagnosis can also be done by looking for Koch's bacillus in the anal lesions by Ziehl-Nielsen stain , TB culture and gene X pert. Anal TB necessitates specific antibiotic therapy under rigorous supervision. Although in certain cases the fistula may heal after antituberculosis treatment, surgical removal of tuberculous fistulas is necessarily recommended as standard procedure.

There is a high prevalence of anal lesions as a result of acquired immunodeficiency syndrome that is estimated as being between 16

and 34 percent. Although the incidence of TB is increasing in these patients, especially in extra pulmonary forms, the anoperineal region is only exceptionally affected. There appears to be a reciprocal Koch's bacillus/HIV potentiation; in fact, Koch's bacillus stimulates the propagation of HIV through released growth factors.

Tuberculosis of perianal skin might not resolve spontaneously and can lead to death due to miliary spread if adequate treatment with anti tuberculosis regimen is not taken.However, if the skin lesions do it respond to medications a surgical approach is frequently required.

In our case the patient did not show any signs and symptoms of tuberculosis or have a history of tuberculosis. In conclusion we present a case of perianal tuberculosis of skin presenting as a verrucous lesion confirmed on histology report.

REFERENCES:

[1] Harland RW, Varkey B. Anal tuberculosis: report of two cases and literature review. Am J Gastroenterol. 1992;87:1488–1491. [PubMed] [Google Scholar]
[2] Alvarez Conde JL, Gutierrez Alonso VM, Del Riego Tomas J, Garcia Martinez I, Arizcun Sanchez-Morate A, Vaquero Puerta C. Perianal ulcers of tubercular origin. A report of 3 new cases. Rev Esp Enferm Dig. 1992;81:46–48. [PubMed] [Google Scholar]
[3] Myers SR. Tuberculous fissure-in ano. J R Soc Med. 1994;87:46. [PMC free article] [PubMed] [Google Scholar]
[4] Le Bourgeois PC, Poynard T, Modai J, Marche C, Avril MF, Chaput JC. Peri-anal ulceration. Tuberculosis should not be overlooked. Presse Med. 1984;13:2507–2509. [PubMed] [Google Scholar]
[5] Conde MB, Suffys P, Lapa E, Silva JR, Kritski AL, Dorman SE. Immunoglobulin A (IgA) and IgG Immune Responses against P-90 Antigen for Diagnosis of Pulmonary Tuberculosis and Screening Mycobacterium tuberculosis Infection. Clin Diagn Immunol. 2004;11:94–97. [PMC free article] [PubMed] [Google Scholar]
[6] Ohse H, Ishii Y, Saito T, Watanabe S, Fukai S, Yanai N, Tamai N, Monma Y, Hasegawa S. A case of pulmonary tuberculosis associated with tuberculous fistulas of anus. Kekkaku. 1995;70:385–388. [/] [Google Scholar]
[7] Candela F, Serrano P, Arriero JM, Teruel A, Reyes D, Calpena R. Perianal disease of tuberculous origin: report of a case and review of the literature. Dis Colon Rectum. 1999;42:110–112. [PubMed] [Google Scholar]
[8] Jayanthi V, Robinson RJ, Malathi S, Rani B, Balambal R, Chari S, Taghuram K, Madanagopalan N, Mayberry JF. Does Crohn's disease need differentiation from tuberculosis? J Gastroenterol Hepatol. 1996;11:183–186. [PubMed] [Google Scholar]
[9) Chung CC, Choi CL, Kwok SP, Leung KL, Lau WY, Li AK. Anal and perianal tuberculosis: a report of three cases in 10 years. J R Coll Surg Edinb. 199 7;42:189–190. [PubMed] [Google Scholar]
[10] Le Bourgeois PC, Poynard T, Modai J, Marche C, Avril MF, Chaput JC. Peri-anal ulceration. Tuberculosis should not be overlooked. Presse Med. 1984;13:2507–2509. [PubMed] [Google Scholar]
[11] Musch E, Tunnerhoff-Mucke A. Tuberculous anal fistula in acquired immunologic deficiency syndrome. ZGastroenterol. 1995;33:440444. [PubMed] [Google Scholar]