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Case report

Tubercular osteomyelitis of the maxillae: A case report and review



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ABSTRACT

Increasing incidences of tubercular infections in developing countries has become a cause of concern. The extra-pulmonary tuberculosis is more commonly seen in malnourished and immuno-compromised susceptible individuals. We report a case of young female who worked as a commercial sex worker suffering from disseminated miliary TB with secondary involvement of mid facial skeleton. This case report highlights a lack of healthcare facilities and general apathy of society for these neglected sections of society.

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1. Introduction

Tuberculosis (TB) is a chronic granulomatous, highly infectious debilitating disease that can be traced back to the earliest of centuries and is still a leading cause of death worldwide. According to the World Health Organization (WHO) there are approximately 20 million active cases and 2 billion infected persons all over the world of which 80% are in the developing countries [1]. The high incidences of TB in these countries account for 2.4% of all mortalities and have been attributed to malnutrition, low socioeconomic conditions, association with acquired immunodeficiency syndrome and the emergence of multidrug resistant TB (MDR-TB) [2].

TB typically involves the pulmonary system but can affect any organ or tissues, including the oro-facial region [1]. TB of the oral cavity is a relatively rare manifestation, usually coexistent with pulmonary disease [3]. The incidence of the oral manifestation in TB is about 0.05–1.5% [4]. The tongue and gingiva are the most common sites of infection [5,6]. Other sites include tooth socket, the soft palate [7,8], the floor of mouth, lips [9], buccal mucosa, jaws [10], maxillary antrum and salivary glands. The clinical presentations of oro-facial TB may be ulcers, granulomas, tubercular osteomyelitis (TB-OML) of the jaws, tubercular salivary glands and tubercular lymphadenitis [11]. Skeletal TB accounts for 6.6% of extrapulmonary cases [12] and TB-OML of the jaws constitutes less

than 2% of the latter [13]. The jaw involvement is more commonly seen in immuno-compromised older males [14,15].

We present a rare case of 19-year-old female patient who reported to department of Dental Surgery, Armed Forces Medical College primarily for an oral lesion, which was diagnosed as a case of disseminated miliary TB with secondary involvement of mid facial skeleton. The patient later died of ignorance and self negligence.

2. Case report

A 19-year-old female patient was referred to the department of Oral and Maxillofacial surgery with a chief complaint of persistent pus discharge below her both the eyes since last five months. About eight months ago she had developed mobility of left upper posterior teeth and few of them got self exfoliated with resulting nasal escape of fluids. Subsequently she developed swelling of bilateral periorbital area with draining sinus. A course of antibiotic was taken for which no records were available. This patient had no family or social support and was working as a commercial sex worker.

The general appearance of patient was cachexic, malnourished and anemic. Her body weight was 31 kg and she had lost 11 kg of weight since last 1 year. She was afebrile and her vitals were stable. Foul smelling pus was draining from bilateral infraorbital region (Fig. 1). The patient was suffering angular cheilitis with enlarged, tender cervical lymph nodes bilaterally. Intra oral examination revealed severe halitosis and poor oral hygiene. The left maxillary posterior teeth were missing along with large oro-antral communication (Fig. 2). Remaining maxillary teeth were also mobile with blanched and unhealthy palatal mucosa. Clinically she was diagnosed as a case of the Osteomyelitis maxilla.

Haematological investigations revealed raised erythrocyte sedimentation rate for first hour (ESR; 35 mm/h), white blood cell count of 8900/mm³ (Neutrophils 63% and lymphocytes 35%), lowered

* AsianAOMS: Asian Association of Oral and Maxillofacial Surgeons; ASOMP: Asian Society of Oral and Maxillofacial Pathology; JSOP: Japanese Society of Oral Pathology; JSOMS: Japanese Society of Oral and Maxillofacial Surgeons; JSOM: Japanese Society of Oral Medicine; JAMI: Japanese Academy of Maxillofacial Implants.

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Fig. 1. Draining pus from bilateral infraorbital sinuses.

hemoglobin at 6.8 g/dL and hypoproteinemia. Pus culture from infraorbital area produced colonies of *Mycobacterium tuberculosis* sensitive to rifampicin, isoniazid and pyrazinamide. Biopsy from the oral lesion showed Langhans giant cells, fragment of dead bone and granulomas (Fig. 3) and acid fast bacilli were demonstrated by Ziehl-Neelson staining of sputum smear. Chest radiograph revealed fibrotic opacities of right upper zone and calcific opacities in left upper and middle zone. There was volume loss of left lungs with ill defined haze and plural thickening (Fig. 4). Computerized tomography (CT) revealed moth eaten appearance of alveolar bone, labial and palatal cortical bone and oroantral communication (Fig. 5). Mantoux test showed induration of 10 mm × 10 mm but Enzyme-linked immunosorbent assay (ELISA) and Venereal Disease Research Laboratory test (VDRL) were non reactive. She was diagnosed as case of disseminated miliary TB with secondary involvement of mid facial skeleton. The patient was referred to

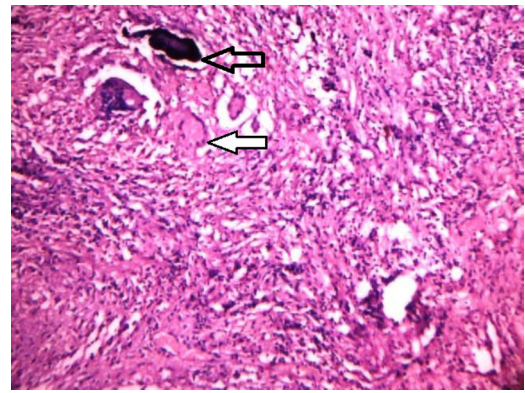


Fig. 3. Microphotograph (×100) showing necrotic bone (black arrow) and Langhans type of giant cell (white arrow).

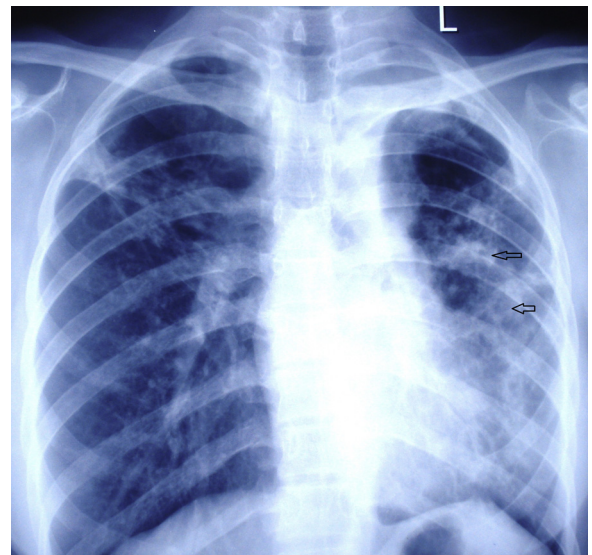


Fig. 4. PA view chest showing non homogenous opacity in left mid and lower zone partially obscuring cardiac border (black arrows). Reticular opacity is also seen in right upper and mid zone and hylum is pulled up.



Fig. 2. Missing maxillary teeth with large oro-antral communication.

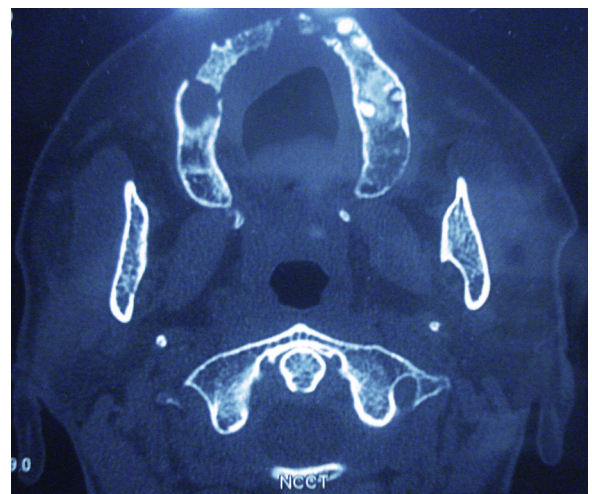


Fig. 5. CT scan showing extensive resorption of bone.

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