



Case Report

Multifocal Tubercular Dactylitis of Feet with Tubercular Ulcers 足部多發性結核指炎與結核性潰瘍 - 病例報告



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ABSTRACT

Tuberculosis is a common disease in developing countries like India, affecting all age groups. Pulmonary tuberculosis is the most common manifestation of the disease but the disease may affect almost any part of the body. Among cases presenting with skeletal tuberculosis, tuberculosis of the spine, commonly known as Pott's spine, is the most common. Tuberculosis of the short and tubular bones of hands and feet is called tubercular dactylitis. It is a very rare presentation of the disease, usually affecting the small bones of the hand in children younger than 6 years. Tubercular dactylitis, particularly involving the small tubular bones of the foot, is extremely rare.

中文摘要

結核病是一種常見的疾病，影響在發展中國家如印度所有年齡組。肺結核是疾病的最常見的表現，但該疾病可能會影響幾乎任何身體部位的。在骨結核病中，脊椎結核病呈現是最常見的。發生在手和腳的短管狀骨結核病被稱為結核指炎。結核指炎非常罕見，通常影響以下六歲以下兒童手部的小骨頭。在足部，特別是涉及小管狀骨的結核指炎，極為罕見。

Introduction

Tuberculosis of the short tubular bones of hands and feet is called tubercular dactylitis. The disease is also called “spina ventosa” because of the classic radiological feature of cystic expansion of the short tubular bone affected by the disease. It constitutes about 2.5% of all cases of skeletal tuberculosis. The disease is uncommon after the age of 6 years. Here we present a case of tubercular dactylitis in a child aged 11 years because of the very unusual presentation.

Case report

An 11-year-old male child presented with pain, swelling, and an ulcer on the dorso-medial aspect of the right midfoot and another nonhealing ulcer at the dorsal aspect of the base of the second toe on the left foot with pain and swelling. The patient noticed swelling

over these sites for the past 3 months. These had been gradually increasing in size with mild pain which was dull, continuous, and limited to the sites of the lesions. The patient noticed two small ulcers: one over the antero-medial aspect of the right foot and the second over the bases of the second toe on the left foot, about 1.5 months previously. These ulcers had gradually increased in size over the period. There was no significant history of injury and the patient attributed these ulcers to the use of shoes. There was no history of any associated constitutional symptoms like chronic cough, fever, or weight loss. The patient had a past history of cervical tubercular lymphadenitis in early childhood at the age of 6 years, for which he had received antitubercular drugs under the Revised National Tuberculosis Control Programme, which was run by the World Health Organisation. The records available with the patient showed that he was Category III under the programme and was put on an intermittent regime. That included isoniazid, rifampicin, and pyrazinamide three times weekly for 2 months. Subsequently, he was given isoniazid and rifampicin three times weekly for another 4 months. Thus, the total duration of treatment was 6 months. The records showed that all the lymph nodes resolved and he was declared fit. For the current problem, the

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patient had already received a course of antibiotics for 2 weeks along with supportive treatment but there was no improvement. There was a positive family history of tuberculosis. His older 15-year-old sister was suffering from Pott's spine and was under antitubercular drug treatment.

The patient had an average build. Systemic examination did not show any obvious signs suggestive of pulmonary disease or any evidence of peripheral lymph-adenopathy. Local examination of the right foot revealed a small ulcer (2 cm × 2 cm.) over the superio-medial aspect of the midfoot with dirty granulation tissue. Examination of the left foot revealed an ulcer (1.5 cm × 1.5 cm) over the dorsal aspect of base of second toe at the level of proximal phalanx. The signs of inflammation in the form of erythema and induration were present and ulcer margins looked undermined in both of the lesions (Figures 1A and 1B). Both the ulcers had

evidence of fresh blood which was attributed to the recurrent friction with footwear. There was evidence of peeling of the epidermis around the lesion in the right foot, whereas the area around the ulcer of the left foot showed hyper-pigmentation. In the left foot, the base of the phalanx appeared broadened. There was deep tenderness in the affected area around both the lesions, and the underlying bones appeared to be widened compared with the corresponding healthy sides. The movements at the interphalangeal joint of the second toe of the left foot were painful.

All routine haematological investigations were within normal limits except the erythrocyte sedimentation rate which was high (54 mm/1st hour, Westergren's method). The child was negative for human immunodeficiency virus serology. C-reactive protein was negative (< 0.6 mg/dL). Blood culture was sterile. The gram stain and Ziehl–Neelsen stain of the imprint smears from the base of the



Figure 1. (A, B) Clinical and (C, D) radiological picture at the time of presentation.

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