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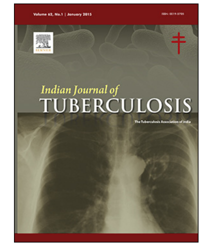

Case Report

A rare presentation of disseminated tuberculosis: Prostatic abscess

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ABSTRACT

Involvement of the prostate by tuberculosis (TB) occurs rarely and tuberculosis prostate abscess is an even rarer occurrence. It has been reported in immunocompromised patients, mainly human immunodeficiency virus seropositive individuals. We are reporting a case of tuberculosis prostatic abscess in an immunocompetent patient with relapse of TB.
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1. Introduction

Genito-urinary tuberculosis (GUTB) is one of the common forms of extra-pulmonary tuberculosis (EPTB) in the world. The organs, which are frequently involved in urinary TB, are kidneys, ureters and bladder while organs frequently involved by genital TB are fallopian tubes, uterus and ovaries in females and epididymis and testis among males. Involvement of prostate and seminal vesicles is rare and more so in immune-competent individuals. We are reporting such a case of TB prostatic abscess in an immunocompetent patient with relapse of TB. This case highlights the fact that unexplained urinary symptoms or persistent pyuria in patients with any history of TB or radiographs suggestive of active or inactive disease should lead to an evaluation for GUTB.

2. Case

A 35-year-old, non-diabetic, non hypertensive, non smoker male was referred to neurosurgery department from a private practitioner with left sided upper and lower limb weakness for one month and altered sensorium for 15 days. At admission, patient's Glasgow Coma Scale (GCS) was E_4 V_T M_5. Magnetic resonance imaging (MRI) brain revealed contrast-enhancing ring shaped lesions in right pons suggestive of tuberculoma. Patient was given supportive treatment and opinion was sought from our side.

Mantoux revealed 25 mm induration and chest X ray (CXR) showed right-sided pleural effusion (Fig. 1). Patient was unable to raise sputum. Under ultrasonography (USG) guidance, ~250 ml straw-coloured pleural fluid was aspirated. It was exudative, lymphocyte predominant with adenosine

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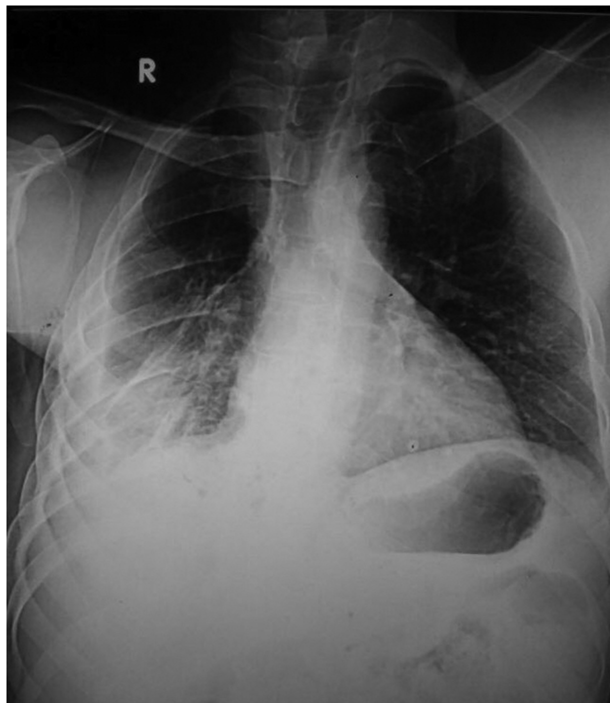

Fig. 1 – Chest radiograph posterio-anterior (PA) view showing right side plural effusion and infiltrates in lower zone.

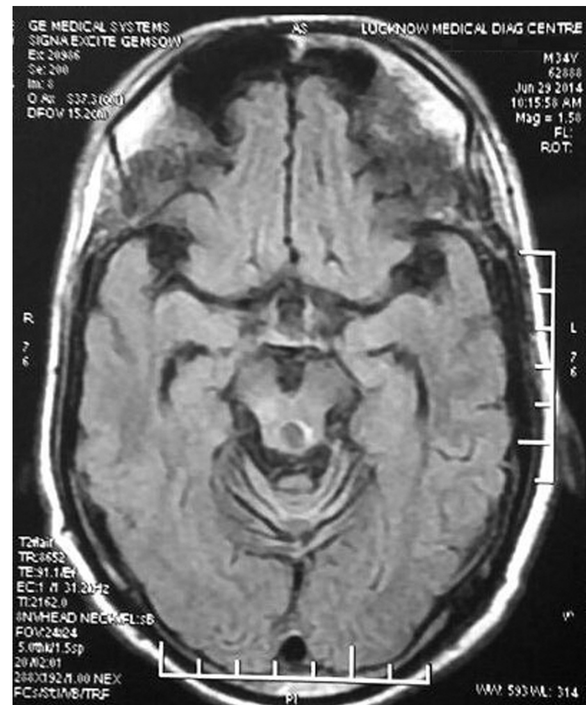

Fig. 2 – Magnetic Resonance Imaging (MRI) brain showing few focal rounded areas of signal intensity alteration suggestive of calcified nodules in pons.

deaminase (ADA) of 46 IU/ml. Patient was started on 4-drug anti-tuberculosis treatment (ATT) including rifampicin, isoniazid, ethambutol and pyrazinamide as per weight with the diagnosis of disseminated TB. GCS improved to E_4 V_T M_6. He was discharged on Ryle's Tube feeding, tracheostomy in situ and per-urethral catheter.

On two months follow-up visit, patient responded significantly to ATT. There was improvement in left hemiparesis, gaining a weight of ~10 kg; tracheostomy was closed and GCS was E_4 V_4 M_6. With adjuvant physiotherapy, limb power improved to 4/5. He started self-feeding and self voiding. He was shifted to continuation phase with 3 drugs after 6 months. Follow-up MRI after one year revealed reduction in size of lesions and after 18 months revealed few focal areas of calcification in pons without any significant enhancement around them and communicating hydrocephalus (Fig. 2). CXR showed clearing of pleural effusion. There was residual weakness on the right side of body, but otherwise, patient had improved. ATT was stopped in view of clinico-radiological improvement. He was lost to follow-up after that.

For the past two months, patient developed high grade fever with chills. There was no burning micturition. Complete blood count (CBC) revealed leukocytosis and peripheral blood smear for malarial parasite was negative. Urine routine and microscopic (R/M) examination showed no abnormality. Despite antibiotics, patient had persistent fever. Patient later developed whitish discolouration of urine.

A repeat urine R/M was done which showed 30 pus cells/high power field (hpf) and urine Gram (G) stain showed *E. coli*. Patient was advised USG whole abdomen which revealed hepatosplenomegaly and an anechoic structure with a size of 4.6 cm × 3.5 cm posterior to the urinary bladder (Fig. 3). For further demarcation, CT kidney ureter and bladder (KUB) was performed, showing enlarged left seminal vesicle with abscess and hypodense areas in prostatic parenchyma suggestive of abscess (Fig. 4). Trans-rectal USG (TRUS) was done, which showed 30 cc prostatic collection. TRUS-guided aspiration of pus from prostatic abscess was performed under local anaesthesia (LA) and sent for Gram stain, pyogenic culture and acid fast bacilli (AFB) stain. G stain revealed few pus cells, no micro-organisms and culture was sterile. AFB were

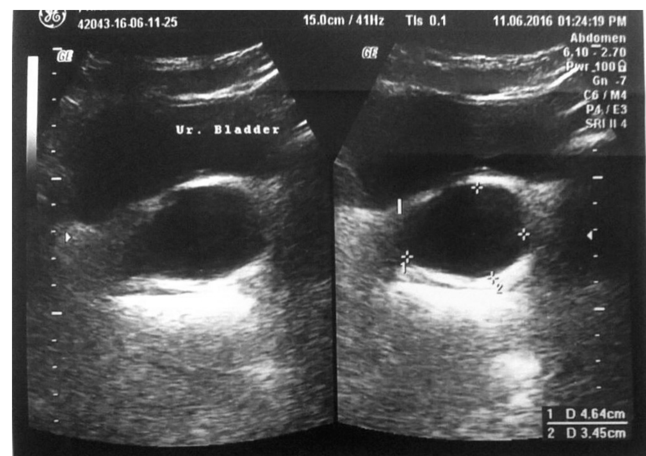

Fig. 3 – Ultra-sonographic image of lower abdomen showing an anechoic structure measuring 4.6 × 3.5 cm posterior to bladder suggestive of prostatic abscess.

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