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CLINICAL IMAGE

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Isolated Subcutaneous Tuberculous Paravertebral Abscess in an Immunocompetent Adult

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Clinical Image

A 31-year-old man with a history of neurofibromatosis type 2 was hospitalized 1 month after the appearance of progressively growing, painless, soft, fluctuating lumbar mass that were evident on physical examination. He reported no fever or respiratory complaints. No lymph nodes were detected and no other symptoms were found during complete physical examination. Laboratory tests were normal except for C-reactive protein (21 mg/L). Human immunodeficiency virus serology was negative. A computed tomography (CT) scan and magnetic resonance (MR) images, showed subcutaneous lumbar cystic lesion (Figure 1). The patient underwent successful complete surgical excision of the paravertebral cystic lesion (Figure 1). The mass underwent histologic examination and aerobic, anaerobic, fungal, mycobacterial cultures. A tuberculous granuloma was detected on histology. Ziehl-Neelsen stain confirmed the diagnosis.

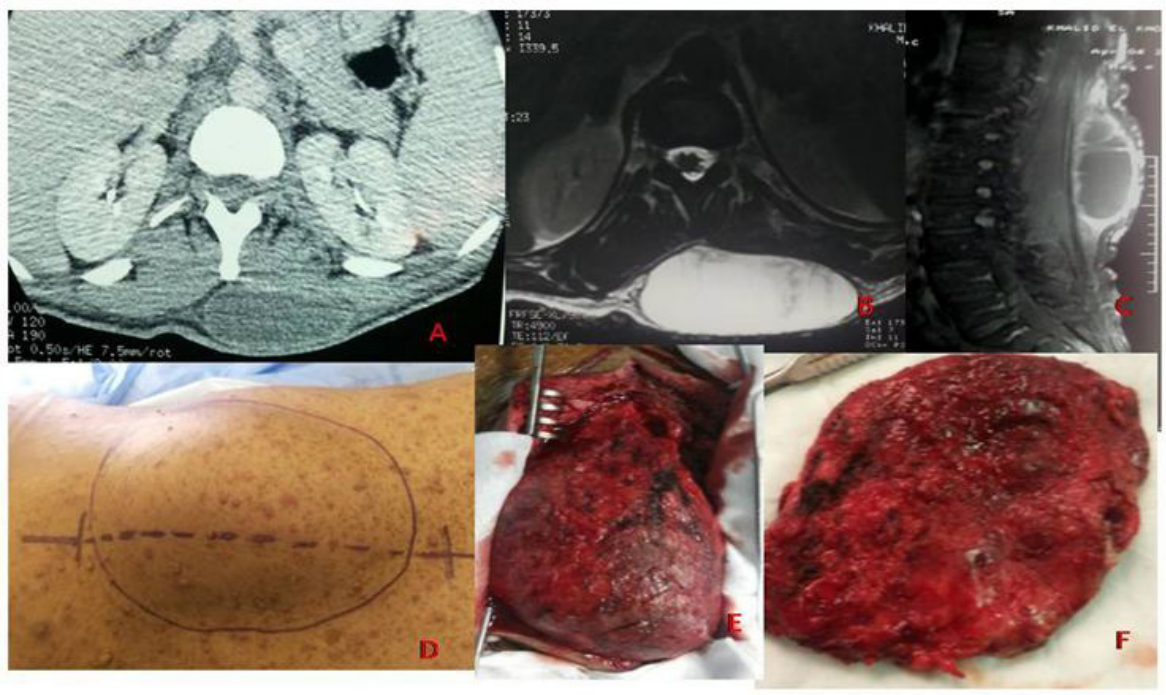

Figure 1: Axial computed tomography (CT) scan (A), axial (B) and sagittal (C) view (MRI) of the lumbar spine showing a voluminous paravertebral mass. (D, E,F) pre and periopertative views showing a large Subcutaneous Paravertebral cyst

The patient was started on four antituberculosis drugs, at doses adjusted for body weightisoniazid (300 mg/day); rifampin (600 mg/day); pyrazinamide (1,500 mg/day); and ethambutol (1,000 mg/day). After two months of treatment, the tuberculosis treatment regimen was reduced to two drugs isoniazid (300 mg/day) and rifampin (600 mg/day). At this writing, the patient has completed six months of treatment without major side effects and the subcutaneous lesion has completely disappeared.

Extrapulmonary tuberculosis comprises 10-12% of all cases, whereas Subcutaneous tuberculosis is seen in only 1-2%. Subcutaneous paravertebral localization is exceptional and is almost exclusively secondary to local extension of tuberculosis Pott's disease, psoas abscess, and lymphadenitis) or to hematogenous dissemination [1-4]. Our patient had neither concurrent active tuberculosis (local or distant) nor a history of tuberculosis. The possibility of tuberculosis must always be kept in mind in subcutaneous abscesses. Awareness of the unusual presentations of tuberculosis is essential for early diagnosis and proper therapy. Therefore physicians must have a high index of suspicion with regard to tuberculosis.

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