Galicia Clínica | Sociedade Galega de Medicina Interna

PULSE PARA VOLVER AL ÍNDICE

Presentación inusual de la enfermedad de Pott: Reporte de un caso

Unusual presentation of Pott's disease - A case report

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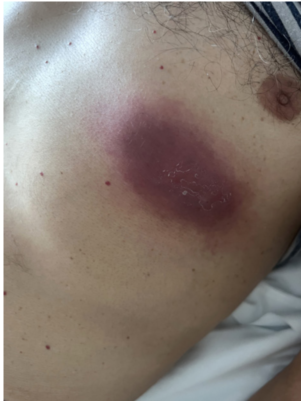

Figure 1. Chest wall abscess on hospital admission.

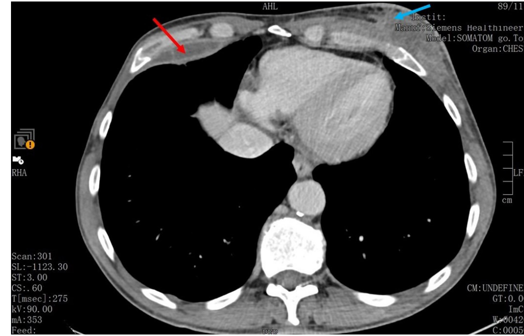

Figure 2. CT scan revealing an abscess on the right cardiophrenic recess of 50 x 13 mm (red arrow) and also showing a lateral left thoracic wall abscess of 49 x 20mm (blue arrow).

A 63-year-old Portuguese male was admitted with a 2-week-history of chest wall swelling and a 2-year chronic lumbago. He had been diagnosed with bladder urothelial carcinoma and underwent transurethral-resection and BCG-instillation the year before. He had no prior history of tuberculosis infection or contact. Physical examination and lab work was unremarkable except for an ovaloid-lump of approximately 9 cm on the anterior-left chest wall with no involvement of the ribs [Figure 1 and Figure 2]. He had elevated inflammatory markers and no lung lesions. CT-scan revealed other abscesses: one on the right cardiophrenic recess [Figure 2] and another prevertebral at L4-L5 level [Figure 3]. MRI confirmed the diagnosis of spondylodiscitis [Figure 4]. HIV-serology was non-reactive and blood-cultures were negative. A diagnostic puncture of the thoracic wall abscess was performed. Bacterial culture was sterile but Ziehl–Neelsen stain and *Mycobacterium* tuberculosis-complex detection by molecular testing were positive. A diagnosis of Pott's disease (PD) with multiple cold abscesses was established and treatment with isoniazid, rifampin, ethambutol and pyrazinamide was started. The latter was withdrawal after the isolation of Calmette-Guérin bacillus in the mycobacterial culture confirming the diagnosis of *M. bovis* - BCG infection.

PD is a severe form of extrapulmonary tuberculosis mainly affecting thoracolumbar column with potential to permanent neurological sequelae. The diagnosis tends to be delayed because of nonspecific manifestations (such as lumbago)[1]. Cold abscesses may be the first presentation and typically they are paravertebral or localized over the chest wall[3]. PD is rarely caused by BCG therapy (attenuated strain of *M. bovis*) and clinicians should be aware of the possibility of disseminated infection in the appropriate clinical setting, since early diagnosis and treatment are of utmost importance to ensure a good outcome.[2,3]

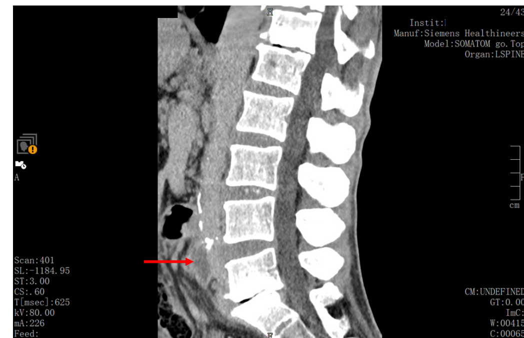

Figure 3. CT scan revealing a prevertebral abscess at L4-L5 level of 25x21x15 mm.

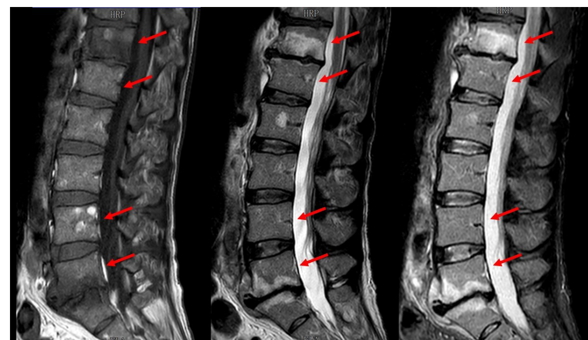

Figure 4. MRI showing spondylodiscitis signs on D12-L1 and L4-L5 like reduction of intervertebral space and irregularities and edema of the vertebral platforms.

CONFLICT OF INTEREST
The authors declare that they have no conflict of interests.

SOURCE OF FUNDING
This research had no funding sources.

ETHICAL ASPECTS
All participants submitted a consent form to be included in this study.

REFERENCES

1. Trecarichi EM, Di Meco E, Mazzotta V, Fantoni M. Tuberculous spondylodiscitis: epidemiology, clinical features, treatment, and outcome. Eur Rev Med Pharmacol Sci. 2012;16(Suppl 2):58–72.
2. Asín MAP-J, Fernández-Ruiz M, López-Medrano F, et al. Bacillus Calmette-Guérin (BCG) infection following intravesical BCG administration as adjunctive therapy for bladder cancer: incidence, risk factors, and outcome in a single-institution series and review of the literature. Medicine. 2014;93(17):236–254.
3. Rajasekaran S, Soundararajan DCR, Shetty AP, Kanna RM. Spinal Tuberculosis: Current Concepts. Global Spine J. 2018;8(4 Suppl):96S-108S.

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