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Clinical Image

CLINICAL IMAGE

Isolated sacral and pelvic TB abscess—an enigmatic tale of a ubiquitous pathogen

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A 45-year-old male from a remote village in Nepal presented to our outpatient clinic with a history of intractable backache since last 1 year. He had history of weight loss but no positive history of trauma, fever, chills, rigor, altered bladder and bowel habits. He had no previous contacts to tuberculosis. General examination did not reveal any lymphadenopathy or neurological deficits. He was immunocompetent.

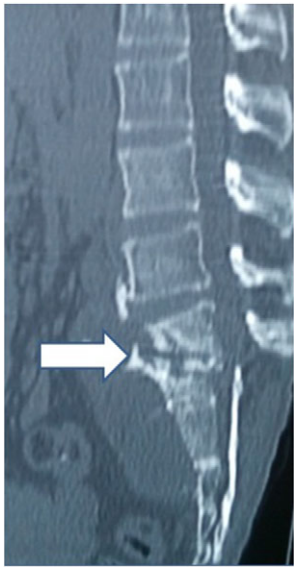

Figure 1: CT image revealing lytic lesion in the LS junction.

Computerized tomogram (CT) of the lumbo-sacral (LS) spine revealed the presence of lytic lesion in the LS junction (Fig. 1). Magnetic resonance imaging (MRI) revealed pre-sacral and left pelvic collection with destruction of the L5-S1 space with signal changes in the upper vertebral bodies as well (Fig. 2). His chests X-ray, ultrasound of the abdomen, serum calcium, alkaline phosphatase were normal. Monteux test was also negative. Erythrocyte sedimentation rate and C reactive protein were slightly elevated. Ultrasound-guided

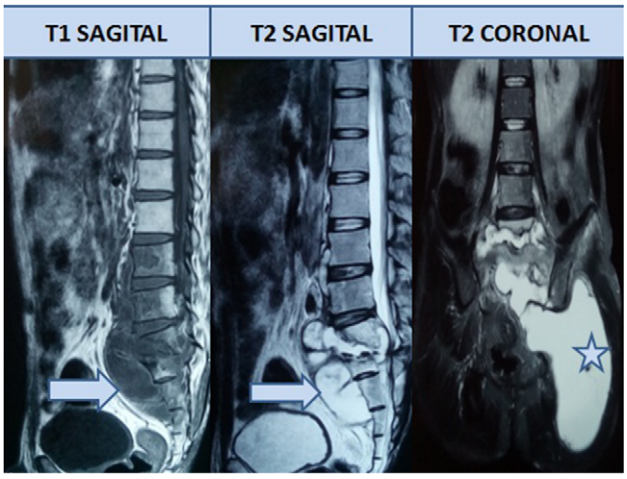

Figure 2: MRI images showing lesions on the LS region that was hypo-intense lesion on T1, hyper-intense lesion on T2 and also collection in the pre-sacral and left pelvic region.

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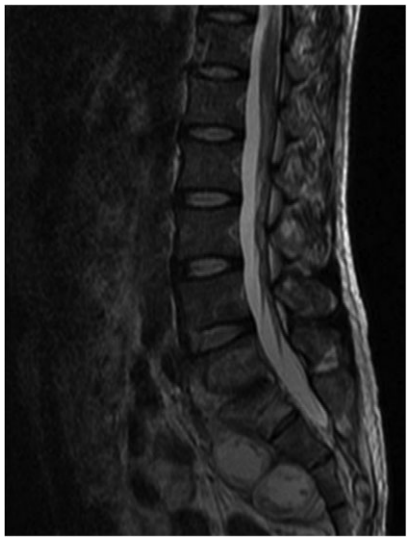

Figure 3: Repeat image at follow-up showing evidence of resolution of the previous lesions.

diagnostic aspiration revealed pus. Gram stain, AFB stain, KOH mount and culture and sensitivity of the pus were all negative. Tuberculosis (TB) polymerase chain reaction, however, came positive. Patient was started on anti-tubercular therapy (ATT) following which patient showed gradual improvement within few months (Fig. 3).

Isolated sacral TB is a rare entity compromising only 5% of all spinal TB. Monteux test will be negative in 53% and AFB stain will be negative in 38% of patients with non-pulmonary TB [1, 2]. High index of suspicion in patients presenting with refractory backache, showing lytic lesions in the spine and coming from TB endemic region are some key pearls for prompt diagnosis and early initiation of ATT [3]. In patients with neurological deficits or with significant collection, transpedicular aspiration is justified [4].

CONFLICT OF INTEREST STATEMENT

None declared.

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