SJIF Impact Factor: 6.260| ISI I.F.Value:1.241 Volume: 4 | Issue: 9 | September | 2019 ISSN: 2455-7838(Online)
EPRA International Journal of Research and Development (IJRD)
Peer Reviewed Journal

A RARE CASE REPORT ON TUBERCULOSIS OF SACROILIAC JOINT USUALLY TREATED BY CONSERVATIVE TREATMENT

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ABSTRACT

Introduction: *Tuberculosis remains a major public problem for the developing countries. Osteoarticular tuberculosis represents 2% to 5% of all cases of tuberculosis, in that the sacroiliac joint is involved in 3– 9.7%. Isolated tuberculosis of the sacrum is rarely reported; with Sacroiliac joint infections represent a diagnostic dilemma for their vague and non-specific clinical presentation.*

Case report: *A 26 yrs. Female presented with Pain, swelling over left Buttock since 2 month with Low Backache, Limping was present with Constitutional symptom Loss of Appetite, Low grade Fever, Weight Loss. Patient was investigated then planned for surgery incision and drainage curettage was done and sends for biopsy. After laboratory tests diagnosed Tuberculosis Osteomyelitis and after proper duration of ATT drugs patient was cured. Conclusion: So, it is rare case of Sacrum with Sacroiliac joint Tuberculosis. Clinical diagnosis of sacroiliac joint infection includes a thorough history and a meticulous examination of the lower back and the sacroiliac joint. Tuberculous sacroiliitis should be differentiated with various disorders. After confirmation of diagnosis with support of clinical features blood report biopsy ATT drugs given with proper duration and doses in Follow up serial x rays and bloods test was done. The prognosis of sacral tuberculosis is good, if a rapid and correct diagnosis is made and adequate treatment is provided with proper duration and drugs doses.*

KEYWORDS: *Tuberculosis SI joint , Introduction Tuberculosis can affect any bone and joint structure.*

INTRODUCTION

In many parts of the world, Tuberculosis is still a growing health problem particularly in developing countries and also increasing in developed countries. The incidence of spinal TB with neurological involvement is between 12.5-100% and it commonly leads to neurological sequelae if not treated sufficiently. Spinal TB in especially responsible for 1-3% of all TB cases and accounts for 40% of spine inflections.[1]

Tuberculosis can affect any bone and joint structures of the body. Osteoarticular tuberculosis represents 2% to 5% of all cases of tuberculosis and 11% to 15% of extra pulmonary tuberculosis [2]. The sacroiliac joint is involved in 3–9.7%. Isolated tuberculosis of the sacrum is rarely reported, which leads to a delay in diagnosis and subsequently persistence of a normally curable disease.[3]

Sacro-illiac joint is mostly involved in conjunction with spine or hip. Sacroiliac joint is a true synovial joint and is subject to infection as any other joint. The disease may start from lateral mass of sacrum, ilium or synovial membrane. Children are less commonly affected and in patients with poor nutritional status, bilateral involvement is not uncommon [4] Isolated sacroiliac involvement is further rare. It usually presents as vague back pain. Plain radiographs are often inconclusive.

Due to rarity of lesion, vague symptoms and non-conclusive X-rays, the diagnosis is often delayed and it is not unusual to see that patients are being treated with physiotherapy and anti-inflammatory drugs for long time. The natural history of sacroiliac tuberculosis is bony ankylosis [5] Tuberculosis remains a major public problem for the developing countries. Sacroiliac joint infections represent a diagnostic dilemma for their vague and nonspecific clinical presentation [3] We here present a s patient of *isolated* sacro-illiac tuberculosis

CASE REPORT

A 29 years Female presented with Pain Swelling over left Buttock since 1 year with Low Backache Limping present Constitutional symptom, Loss of Appetite, Low grade Fever, Weight Loss Pallor was present in Past history had no other medical illness. On examination patient is conscious and coherent, afebrile, vital signs included BP 120/80 mmHg, HR 86/min, back pain aggregation during nights, pain in right lower limb, dry cough.

SOB in the last 15 days, Tenderness and swelling over left side of buttock SI Joint Posterior aspect of Hip Joint.

Patient was investigated Routine Blood test (RBC – Microcytic, Hypochromic, WBC-normal, Platelets -adequate) Haematology Blood for ESR (40mms for first hour, 70mms for second hour), CRP (12mg/dl) was raised. Quantiform tuberculosis gold test was positive. Mantoux skin test was positive -35mm induration seen after 48 hours. Hormones and special was found to be 150-100pg/ml. smear for AFB no AFB seen

X ray Chest x-ray shown that grade- 1 spondylitis's at the L5-S1 region. MRI of LS spine L5–S1, mild disc bulge,2+2 cm swelling in medial out put of right upper limb, no axillary lymph nodes (Impression: LIPOMA). A follow-up magnetic resonance imaging (MRI) of the lumbar spine reveal to have spondylolysis of L5 vertebrated desiccated to L5-S1 intervertebral disc sub articular sclerosis at bilateral sacroiliac joint. Follow up x-ray reveals pelvis with both hips the patient was treated with ATT drugs (Rifampicin, Isoniazid Ethambutol, Pyrazinamide) and on Calcium, B complex, Ranitidine.

DISCUSSION

Spinal location at the thoracolumbar spine in 80% of cases. Isolated tuberculosis of the sacrum is rarely reported in the literature [1, 2] with a frequency estimated at 5% by Pertuiset et al [6]. In a review of 63 cases of spinal tuberculosis by Lindahl et al [7], sacral involvement was found in just four cases, while none was involved in 107 patients in the series of Lifeso et al. [8].

Spinal tuberculosis is often due to hematogenous spread of mycobacteria from primary foci in the lung and/or genitourinary tract. It is widely believed that the paravertebral venous plexus of Batson provides the primary pathway for dissemination of the tuberculous bacilli into the vertebral column. It is also possible that lymphatic drainage of the pleura or kidney may involve the para-aortic lymph nodes, which may secondarily involve the vertebrae. [9, 10,11]

Clinical manifestations of sacral tuberculosis depend primarily on the age of the patient. Presenting symptoms and signs of sacroiliac tuberculosis [3] are often insidious and localized to that joint. Pain is the most common initial symptom [12]. Because of its location deep in the pelvis, most of the classical signs of a peripheral joint inflammations Swelling, redness and warmth-are not present so that infection may easily be over looked [13]

The most common presenting complaint of spinal TB is back pain. Other associated symptoms include tenderness, stiffness, muscle spasm, kyphosis from progressive bone destruction, and cold abscess. These symptoms tend to progress gradually, with average illness duration ranging from 4 to 11 months Buttock pain is invariably present in tuberculous sacroiliitis. The sacroiliac pain can be referred to the groin, posterior thigh, and occasionally below the knee, mimicking pain originating from the lumbar spine, the hip and the lower abdominal quadrant.

The disease first affects the anterior inferior vertebral body and then progresses to involve the paradiskal, anterior, and central areas, most commonly affecting the upper lumbar and lower thoracic spines.

Routine laboratory tests such as elevated ESR and CRP are not significant in the diagnosis of tuberculosis, but are considered useful in the assessment of the response to anti-tuberculous therapy. The ESR of the current patient was significantly higher than normal, suggesting pyogenic infection.

Currently, multiagent anti-tuberculous chemotherapy is used is the treatment of choice for tuberculosis. In the present patient, to treat the sacroiliac joint lesion conservatively and to operate directly on the tuberculous abscess to prevent spreading to the hip joint. The patient had an excellent outcome, according to the healing criteria of Kim et al. Analogous response to either conservative or surgical treatment has also been reported. Recurrences are generally not anticipated.

After confirmation of diagnosis ATT drugs given for 12 Months with serial x rays bloods test. The prognosis of sacral tuberculosis is good, if a rapid and correct diagnosis is made and adequate treatment is provided.

CONCLUSION

So, it is rare case at rare site Sacrum with reactionary sacroiliac joint tuberculosis. It was mention spondylitis at L5-S1. A clinical diagnosis of sacroiliac joint includes a through history and medical examination of lower back pain and the sacroiliac joint. After confirmation of diagnosis with clinical feature, blood reports and ATT drugs given with proper duration of 12 months and follow up serial x rays and blood tests was done the progression of sacral tuberculosis is good because of rapid and correct diagnosis is made and adequate treatment is provided with proper duration and drug doses.

REFERENCE

1. *Davies PD, Humphries MJ, Byfield SP, Nunn AJ, Darbyshire JH, Citron KM, Fox W Bone and joint tuberculosis. A survey of notifications in England and Wales. J Bone Joint Surg Br 1984; 66(3):326-330[PubMed]*
2. *Gordan G, Kabins SA. Pyogenic sacroiliitis. Am J Med 1980; 69:50-56 [PubMed]*
3. *Shembekar A, Babhulkar S. Chemotherapy for osteoarticular tuberculosis. Clin Orthop. 2002; 398:20-26.[PubMed]*
4. *Tuli S.M. Jaypee Brothers Publication; New Delhi: 2010. Tuberculosis of the Skeletal System (Bones, Joints, Spine and Bursal Sheaths) pp. 3–15.*
5. *Soholt S.T. Tuberculosis of the sacroiliac joint. J Bone Joint Surg Am. 1951;33:119–129. [PubMed]*
6. *Pertuiset E. Peripheral bone and joint tuberculosis. EMCRheumatologie Orthopedie. 2004; 1:463-86.*
7. *Lindahl S, Nyman RS, Brismar J, Hugosson C, Lundstedt C. Imaging of tuberculosis. IV. Spinal manifestations in 63 patients. Acta Radiol 1996; 37:506-11.*
8. *Patankar T, Krishnan A, Patkar D, Kale H, Prasad S, Shah J et al. Imaging in isolated sacral tuberculosis:a review of 15 cases. Skeletal Radiol. 2000; 29:392-6.*
9. *Pertuiset E, Beaudreuil J, Liote F, Horusitzky A, Kemiche F, Richette P et al. Spinal tuberculosis in adults:A study of 103 cases in a developed country, 1980-1994. Medicine. 1999; 78:309-20.*
10. *Pouchot J, Vinceneux P, Barge J, Boussougant Y, Grossin M, Pierre J et al. Tuberculosis of the sacroiliac joint: clinical features, outcome, and evaluation of closed needle biopsy in 11 consecutive cases. Am J Med. 1988; 84(3 Pt 2):622-628. doi: 10.1016/0002-9343(88)90146 5. [PubMed][Cross Ref]*
11. *Richter R, Nubling W, Kobler G, Iljinski A. Tuberculosis of the iliosacral joints. Treatment, results, prognosis and differential diagnosis. Z Orthop Ihre Grenzgeb. 1983; 121(5):564-570. [PubMed]*
12. *Bernard TN, Jr, Kirkland-Willis WH. Recognizing specific characteristics of nonspecific low back pain. Clin Orthop. 1987; 217:266-280. [PubMed]*
13. *Chen WS. Chronic sciatica caused by tuberculous sacroiliitis-a case report. Spine 1995; 20(10):1194-1196[PubMed]*
14. *Davidson PT, Horowitz I. Skeletal tuberculosis. A review with patient presentations and discussion. Am J Med. 1970; 48(1):77-84. [PubMed]*
15. *Davies PD, Humphries MJ, Byfield SP, Nunn AJ, Darbyshire JH, Citron KM, Fox W Bone and joint tuberculosis. A survey of notifications in England and Wales. J Bone Joint Surg Br 1984; 66(3):326-330[PubMed]*