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**Answer: Tubercular cold abscess**

The patient's chest radiography is shown in panel showing right upper zone consolidation. Sputum examination were all negative. Bronchoscopy showed a mass partially obstructing the anterior segment of right upper lobe bronchus. Biopsy revealed multiple multinucleated granulomas and Langhans giant cells with areas of caseation and Acid Fast Bacilli (AFB) on Zeil-Neelsen staining. The patient responded to anti-tubercular treatment (ATT).



Ten percent of extra-pulmonary tuberculosis (TB) and one to two percent of total the cases of TB are musculoskeletal in origin. Out of all the tubercular cold abscesses, tuberculous spondylitis (cold abscess of spine) is the most common.<sup>1</sup>

Tuberculous abscess of the chest wall can involve the sternum, costochondral junctions, rib shafts, costovertebral joints and the vertebrae. Most commonly found at the margins of the sternum and along the rib shafts. The varied manifestations seen in TB depend upon the number and virulence of bacilli, routes of infection and the immune status of the patient.<sup>2</sup>

Cold abscesses may occur by means

of two mechanisms, a) haematogenous dissemination in association with activation of a dormant TB focus, and or b) direct extension from lymphadenitis of chest wall.<sup>3</sup>

Controversies remain regarding the treatment of cold abscesses. Some reported good results with only ATT. Others reported that medical treatment alone is not sufficient and recommended surgical resection of the abscess, including resection of affected bones followed by a 12 months course of ATT.<sup>4</sup> The World Health Organisation recommendation is a standard 6-month regimen of ATT, but suggested the treatment can be extended up to 9 to 12 months according to clinical presentation, bacillary load and response to ATT.

**REFERENCES**

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- 4: Kim YT, Han KN, Kang CH, Sung SW, Kim JH. Complete resection is mandatory for tubercular cold abscess of the chest wall. *Ann Thorac Surg.* 2008; 85:273-7.