A Case of Cutaneous Tuberculosis Is Simulating Paraneoplastic Vasculitis

Joana Atxotegi Sáenz de Buruaga, Mariví Montejo Olivares, Alberto Alonso Ruiz, Jesús Gardeazabal García, Elena Urra Zalbidegoitia, and Pilar Manrique Martínez

1Sección de Reumatología, Hospital de Cruces, Barakaldo, Vizcaya, Spain
2Medicina de Familia, Hospital de Cruces, Barakaldo, Vizcaya, Spain
3Servicio de Dermatología, Hospital de Cruces, Barakaldo, Vizcaya, Spain
4Servicio de Reumatología, Hospital de Cruces, Barakaldo, Vizcaya, Spain
5Sección de Dermatología, Hospital de Galdakao, Galdakao, Vizcaya, Spain

We present the case of a patient with type T non-Hodgkin lymphoma, in clinical remission after treatment with chemo and radiotherapy, who was hospitalized due to hemorrhagic and necrotic skin lesions on his right hand and a clinical suspicion of paraneoplastic vasculitis. Nonetheless, study of the patient and complementary testing led to the diagnosis of disseminated tuberculosis with skin and lung involvement (cutaneous milliary tuberculosis). Anti-tuberculosis treatment was initiated with a satisfactory resolution of symptoms and signs.


Un caso de tuberculosis cutánea semejante a una vasculitis paraneoplásica

Presentamos el caso de un paciente con linfoma no hodgkiniano tipo T, en remisión clínica después de tratamiento con quimioterapia y radioterapia, que ingresa por lesiones cutáneas necroticohemorrágicas en mano derecha, sospechosas de vasculitis paraneoplásica. Sin embargo, el estudio del paciente y las pruebas complementarias condujeron al diagnóstico de tuberculosis diseminada con afectación cutánea (tuberculosis miliar cutánea) y pulmonar. Se instauró tratamiento tuberculostático con resolución del cuadro clínico.

Palabras clave: Tuberculosis extrapulmonar. Linfoma no hodgkiniano. Seudovasculitis. Tuberculosis diseminada.
mm/hour, hemoglobin 9 g/dl, platelets 50,000/µL, and leucocytes 3500/µL. The rest of the measurements (blood chemistry, blood proteins, coagulation tests, urine, and its sediment, autoantibodies, anticardiolipin antibodies, and cryoglobulins) were normal or negative.

An x-ray showed a small pleural effusion that had previously been described in the clinical history and the radiograph of the right hand showed a sclerotic-lytic unspecific, mixed pattern lesion on the pyramidal and pinciform bones. A thoraco-abdominal computed tomography was normal and the magnetic resonance imaging showed a marked subcutaneous tissue edema and in all muscle planes of the right hand without synovitis or bone affection.

With the possible diagnosis of paraneoplastic vasculitis, dermatology, vascular surgery, and oncology evaluated him. An arteriogram showed a significant focal hyperemia of the 1st and 2nd fingers, the carpal region, and the tip of the 3rd finger, eliminating an ischemic cause for the process.

The skin lesions evolved during a period of 3 days to ulcers with a necrotic background (Figure 1B; 5th day after internment), with the appearance of a new lesion on the tip of the 3rd finger, coinciding with the start of fever of up to 39.5°C, mainly nocturnal and well tolerated. We started treatment with amoxicillin/clavulanate 1 g every 8 hours i.v. for 3 days, with the posterior addition of ciprofloxacin 400 mg every 12 hours i.v. during 6 more days, persisting with fever.

Samples from the skin lesions were taken for aerobic and anaerobic germs as well as mycobacteria. Acid-alcohol resistant (auramin-positive) bacilli were observed. We suspended the administration of ciprofloxacin (9 days after the image in Figure 1B was taken) and we started antituberculosis treatment with rifampin 600 mg, isoniazide 300 mg, and pirazinamide 1500 mg daily, with a progressive disappearance of fever and disappearing progressively after a week.

The lesion cultures were positive for Mycobacterium tuberculosis (Figure 2). Both urine and blood cultures were negative and the sputum culture was positive for M. tuberculosis. The booster was negative. Ulcers progressively healed and the lesion of the third fingertip did not progress into an ulcer (Figure 1C; 16th day after hospitalization).

Discussion

Summarizing, this case illustrates a non-Hodgkin lymphoma patient that is admitted into a rheumatology department under suspicion for a paraneoplastic vasculitis syndrome. Lymphoproliferative illnesses are associated to paraneoplastic vasculitis with digit necrosis. Our patient did not present Raynauds phenomenon but, taking into account the fast progression to skin necrosis, an arteriogram was done allowed us to eliminate ischemia as a mechanism of necrosis. In spite of the fact that the diagnosis was not initially suspected by any of the specialist that evaluated the patient (rheumatologists, dermatologists, oncologists, and vascular surgeons), cultures taken from the skin lesions showed objective evidence of acid-alcohol resistant bacilli.

Cases of disseminated tuberculosis in association to tumor processes, after chemotherapy or prolonged corticosteroid therapy have been described. Skin affection
is a rare form of tuberculosis. Our patient initially had vesicles, hemorrhage, and necrotic ulcers compatible with milliary skin tuberculosis, a very rare form of presentation of skin tuberculosis. Isolated cases of patients with HIV induced immunosuppression, renal transplant, or neoplasia have been described. Progression is rapid and prognosis is poor. Tuberculin testing is commonly negative.

With the start of antituberculosis therapy, the patient had a favorable evolution with the disappearance of fever and a progressive improvement of the skin lesions. The necrotic lesion on the third finger did not progress into an ulcer probably due to antituberculosis treatment. This case reflects the fact that rare diseases with an atypical presentation (such as milliary tuberculosis on the skin) can simulate rheumatic processes and constitute a difficult diagnostic problem.

References