

# A case of disseminated cutaneous tuberculosis

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## Contents

Introduction .....	1
Case History .....	1
Clinical Examination .....	1
Laboratory investigations .....	2
Diagnosis.....	2
Treatment.....	2
Evaluation of case .....	2
Repertorization.....	3
Bibliography.....	5

## Introduction

An uncommon case of disseminated cutaneous tuberculosis in a young immunocompetent woman is presented here. Noticeable report of the natural history, clinical inference, morphological features, and the relevant laboratory details are described. Disseminated cutaneous tuberculosis (DCT) is an atypical presentation of lupus vulgaris.

## Case History

A Bacillus Calmette-Guerin (BCG) vaccinated 36-year old well-nourished woman reported with many, progressive, elevated lesions for the past 9 months. A few of them broke up to form raw, exuding, painful infected ulcers, and unresponsive to systemic as well as topical antibiotics. The lesions were progressive and had advancing borders leaving behind scars. There was no history of evening rises of temperature, night sweats, cough, or weight loss.

## Clinical Examination

The skin surface examination exposed the presence of multiple, round, soft ulcers, distributed over the lower back, hips and inner aspect of thighs with undermined margins. Ulcer's floor was erythematous, raw, and exuding. BCG vaccination scar on the right deltoid was visible.

On close examination, chronic inflammatory infiltrate formed by lymphocytes and increased vascularity was another feature confined mostly to the upper dermis.

## Laboratory investigations

Laboratory investigations revealed-

- Standard tuberculin purified protein derivative (Mantoux test)- highly positive, 20-mm (normal: 6–10 mm)
- Erythrocyte sedimentation rate (Westergren)- 44 mm/1 hr
- Total and differential leukocyte count- normal
- Haemogram- normal
- Blood sugar- normal
- HbA1C- normal
- X-ray of the chest- normal
- Ultrasound of abdomen were normal
- Ziehl–Neelsen stained smears for acid fast bacilli were negative from the ulcer

## Diagnosis

The diagnosis of DCT was made on the basis of distinct morphology comprising multiple nodules and nodulo-ulcerative lesions, conforming lupus vulgaris an atypical presentation of reinfection tuberculosis. The latter is well recognized entity and is characterized by history of primary infection/BCG vaccination scar evolution and cardinal morphological features. BCG vaccination over the right deltoid was a prominent finding in support of reinfection, in this case.

## Treatment

An antitubercular therapy comprising 800 mg of ethambutol hydrochloride, 300 mg of isoniazid, 1500 mg of pyrazinamide, and 450 mg of rifampicin was continued for last nine months, and the patient was not relieved, rather developed tremendous weakness, dyspnea, shortness of breath, pyrexia, chills, rigors, profuse perspirations and nausea with severe cachexia.

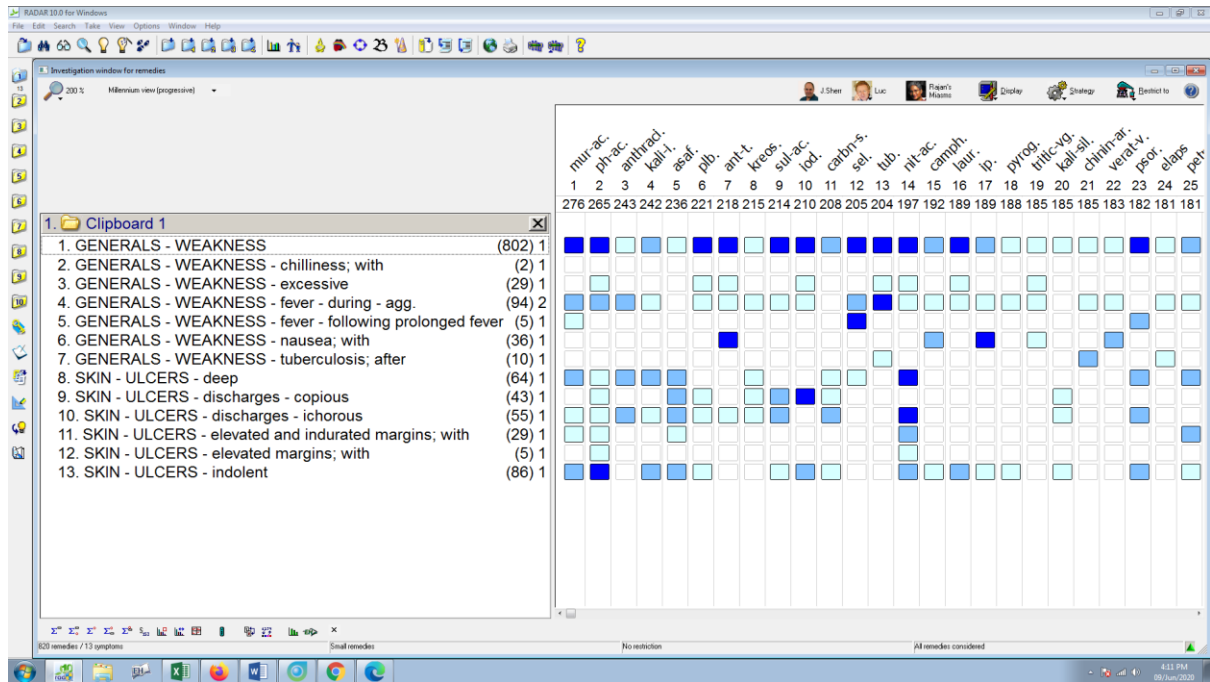
## Evaluation of case

On evaluation of condition, the following rubrics were selected for repertorization-

- GENERALS - WEAKNESS
- GENERALS - WEAKNESS - chilliness; with
- GENERALS - WEAKNESS - excessive
- GENERALS - WEAKNESS - fever - during - agg.
- GENERALS - WEAKNESS - fever - following prolonged fever
- GENERALS - WEAKNESS - nausea; with
- GENERALS - WEAKNESS - tuberculosis; after
- SKIN - ULCERS - deep
- SKIN - ULCERS - discharges - copious
- SKIN - ULCERS - discharges - ichorous
- SKIN - ULCERS - elevated and indurated margins; with
- SKIN - ULCERS - elevated margins; with
- SKIN - ULCERS - indolent

Mental and other constitutional symptoms were not considered in this case. This approach was only to prove the efficacy of particulars and pathological generals in finding the similimum remedy.

## Repertorization



The remedy was selected on basis of pathological generals and prescribed in 200 C potency, on every alternate day. All other treatments were stopped immediately. Patient was catheterized, i.v. fluids were started to maintain her vitals and nutrients supplementation was done. After a week, the perceptible regression of all the lesions during the period prompted to continue the treatment to complete the cure. A complete resolution of lesions was recorded after completion of the month.

The miracle remedy in this case was Acidum muriaticum.

Let us see the progress of the case through an atlas-



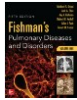
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Approach to the Patient with Respiratory Symptoms > Tuberculosis Book: Fishman's Pulmonary Diseases and Disorders, 5e..., develop associated regional lymphadenitis, followed by systemic dissemination of the organism. A person who was previously infected with Mycobacterium tuberculosis is apt to develop tuberculosis verrucosa cutis after receiving a cutaneous inoculation. The characteristic lesion in a sensitized person...



Human Immunodeficiency Virus Infection > 2. Infections related to immunodeficiency Book: Current Diagnosis & Treatment: Pediatrics, 25e... Bacteremia, especially due to Streptococcus pneumoniae, occurs at rates of 3 per 100 child-years without ART and decreases to 0.36 per 100 child-years with ART, but this remains approximately ten times higher than in HIV-uninfected children. Infections with M tuberculosis are a major cause...



South Asia > Cutaneous Tuberculosis Book: Taylor and Kelly's Dermatology for Skin of Color, 2e... FIGURE 91-4. Lupus vulgaris showing well-defined plaque with bluish-violet borders and area of scarring as well as area of activity. Epidemiology The overall prevalence of cutaneous tuberculosis (TB) in the study by Varshneya and Goyal 34 (0.7%) was a little higher than...



Tuberculosis > MILIARY TUBERCULOSIS Book: Tintinalli's Emergency Medicine: A Comprehensive Study Guide, 9e... Miliary tuberculosis is a historic term noting the gross appearance of the lung during disseminated tuberculosis. In such cases, the lung has many small lesions resembling millet seeds. Classic miliary tuberculosis shows diffuse nodules on radiographs (1 to 3 mm) in a patient with positive...



Encyclopedia Homoeopathica



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