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An unusual sore finger...

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DESCRIPTION

We describe the case of a 75-year-old man with a history of chronic lymphoid leukaemia stage B in Binet system treated by chemotherapy with chlorambucil and prednisolone. The patient was in complete remission with this treatment for 3 years. When he presented to our department, he complained of two painful and indurated swellings in the right fifth finger and in the right wrist that had appeared 7 months before (figures 1A and B). Blood tests showed increased erythrocyte sedimentation rate and C reactive protein level with a normal white cell count. Tests for rheumatoid arthritis factor, hepatitis B and C viruses, HIV, brucella and *Salmonella typhi* were negative. Mantoux tuberculin skin test showed an induration of 34 mm after 72 h. A tuberculous infection was suspected but bronchoalveolar lavage and mycobacterium culture was negative. A surgical synovectomy was performed and macroscopic findings revealed numerous white nodules that appeared like scattered grains of boiled rice (figure 2). Histopathological examination of the biopsy specimen revealed granulomatous inflammation with caseous necrosis (figure 3). The diagnosis of tuberculous dactylitis was established and treatment was initiated with four drugs (rifampicine, ethambutol, isoniazide and pyrazinamide) for 2 months followed by two drugs (rifampicine and isoniazide) for 6 months. The swelling disappeared

and dactylitis was cured 6 months after initiation of antitubercular treatment.

DISCUSSION

Metacarpals and phalanges are unusual sites for extrapulmonary tuberculosis. This rare aetiology of dactylitis must be kept in mind and should be considered in patients suffering from chronic lesions, especially in immunocompromised patients.

Tuberculous dactylitis (TD) is difficult to diagnose as it is difficult to distinguish from other lesions. To make the correct diagnosis of TD during an early stage it is crucial that physicians are aware of this disease. There are no typical clinical signs and symptoms. Specific investigations and radiographical findings must first rule out sarcoidosis dactylitis and gout. Then, the differential diagnosis may be required between TD and other joint diseases, such as inflammatory arthritis, especially rheumatoid arthritis, which may exhibit cystic changes, and between TD and malignant neoplasm (Kaposi's sarcoma) or benign tumour (haemangioma or enchondroma). Culture and early biopsy with appropriate microbiological testing can provide an earlier diagnosis. Diagnosis lag can have serious consequences. It is very important that patients recover a full range of motion as soon as possible to prevent joint contracture and subsequent ankylosis.

Figure 1 (A) Right fifth finger: marked swelling and induration of the finger. (B) Right wrist: marked swelling and induration of the wrist.

Figure 2 Perioperative view of the wrist's tenosynovitis: numerous rice grain like bodies.

Figure 3 Synovial biopsy (H&E400): granulomatous inflammation with caseous necrosis.

Competing interests None.

Patient consent Obtained.

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