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CUTANEOUS TUBERCULOSIS

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INTRODUCTION
Extrapulmonary tuberculosis, especially cutaneous form, occurs extremely rarely, despite the rising prevalence worldwide..Cutaneous form of tuberculosis can be obtained by exogenous or endogenous way. Endogenous way is far more frequent, but sometimes M.Tbc can be transmitted through direct skin inoculation. This way of transmission typically occurs in HIV positive patients, patients on immunosuppressive therapy, diabetes, terminal kidney failure, malignancies, intravenous drug use. Also, there is an increased risk of developing extrapulmonary and pulmonary tuberculosis in various rheumatic diseases. Extrapulmonary forms occurred more common in Sjogren's syndrome, systemic sclerosis, polymyositis and dermatomyositis. Cutaneous form of TB is difficult to diagnose because it mimics different skin conditions.

CASE PRESENTATION
A 53-year-old woman was diagnosed with mixed connective tissue disorder (CREST+polymiositis) with pulmonary fibrosis in 2008. and since then she was treated with low dose corticosteroids and methotrexate and showed no signs of active disease. In the beginning of 2016. she started to complain of increased fatigue, dry cough, increased sweating, dyspnea in exertion and occasionally painful swelling of arms and legs. After further workup (chest x-ray, pulmonary function tests, EMNG of upper and lower extremities, muscle biopsy) symptoms were interpreted as progression of immunological disease and corticosteroid dose was increased. After 2 months she was admitted to hospital due to high fever, myalgia, soft tissue edema (right hand, armpit, posterior part of left lower leg, perianal region) and increased inflammatory markers in blood. Chest x-ray showed no infiltrates and CT verified hilar and mediastinal lymphadenopathy with pulmonary fibrosis. She was treated with multiple-drug therapy (ciprofloxacin, vancomycin, piperacillin-tazobactam,linezolid, fluconazole, cefepime) with no

improvement. In the meantime the analysis of skin edema puncture revealed granulomatous inflammation with central necrosis. In the further course of disease she developed multiple fistula in the mentioned skin changes. After the skin swab came positive for M.tuberculosis the 4-ATL therapy was initiated with lowering the corticosteroid dose. After 3 months of therapy there was significant clinical improvement with regression of symptoms and skin lesions improvement. The therapy is still in course.

CONCLUSION

Diagnosis of cutaneous tuberculosis is challenging since it can mimic various skin lesions. Especially in the imunocompromised, it is very important to start early treatment to prevent possible complications. The increased awarness among clinicians of this rare form of tuberculosis will allow the proper diagnosis and management.