INTRODUCTION
Tuberculosis (TB) is an infectious disease, caused by mycobacterium tuberculosis. Dissemination can arise from progressive pulmonary infection or via reactivation of a latent focus with subsequent spread.\(^1\) Diagnosis of TB is often challenging due to paucibacillary nature of disease and a low culture yield. In general, diagnosis of TB is made, based on epidemiological risk factors, clinical features, imaging studies; in addition to a positive skin testing or Interferon Gamma Release Assay (IGRA).\(^1,2\)

Tuberculous dactylitis is a rare form of extrapulmonary TB, usually affecting children < 5 years in endemic areas. Only 1.5% of children with tuberculosis have skeletal involvement.\(^3,4\) Short bones of hands and feet are most common site of involvement in infancy and early childhood.\(^5\)

Thyroid tuberculosis is a rare entity even in the countries where tuberculosis is endemic. The estimation of prevalence is difficult; however, it is reported to range from 0.1 to 1%.\(^5\) Tuberculosis may affect the thyroid gland via the haematogenous/lymphogenous route or by direct invasion from the larynx or cervical lymph nodes.\(^6\) Tuberculosis of the thyroid gland should be considered as a possible diagnosis whenever a localised swelling, cold abscess or thyroid nodule is found.\(^7,8\)

CASE REPORT
A 14-year boy presented at the outpatient department of Children's Hospital, Lahore, with complaints of fever on and off and weight loss for one year. He was an unvaccinated child, previously healthy, developmentally normal, belonging to a poor socioeconomic background with no history of contact with tuberculosis or BCG scar. He reported fusiform and painful swelling of left index and ring finger with discharging sinus for the past 6 months, associated with restriction of movement (Figure 1a) along with toes of left foot (Figure 1b). He was having a painless nodular swelling of thyroid measuring 3 x 2 cm (Figure 1c). He was also having squint (Figure 1d), leading to diplopia on account of right abducents nerve paralysis along with decreased visual acuity, although there was no associated headache, vomiting, fits papilledema or choroid tubercle.

Laboratory data showed erythrocyte sedimentation rate of 15 mm of fall after one hour. Mantoux test and HIV screening were negative. Cerebrospinal fluid routine examination, X-ray chest, thyroid profile and serum immunoglobulin levels were within normal limits. X-rays of left hand showed osteolytic and sclerotic lesion involving proximal phalanges of index and ring finger with discharging sinus for the past 6 months, associated with restriction of movement (Figure 1a) along with toes of left foot (Figure 1b). He was having a painless nodular swelling of thyroid measuring 3 x 2 cm (Figure 1c). He was also having squint (Figure 1d), leading to diplopia on account of right abducents nerve paralysis along with decreased visual acuity, although there was no associated headache, vomiting, fits papilledema or choroid tubercle.

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Department of Paediatric Medicine, The Children's Hospital and The Institute of Child Health, Lahore.

Correspondence: Dr. Sobia Qamar, Senior Registrar, Department of Paediatric Medicine, The Children's Hospital and The Institute of Child Health, Lahore.
E-mail: drsobiaqamar@gmail.com

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bacillus was identified on Zel Nelson stain. Keeping in view granulomatous lesion of thyroid, caseating granulomas of bone and tuberculomas of brain, the patient was finally labelled as a case of disseminated TB with involvement of skeleton, thyroid and brain. He was started on antituberculous therapy with four drugs in intensive phase (isoniazid 10 mg/kg, rifampicin 15 mg/kg, pyrazinamide 35 mg/kg, ethambutol 20 mg/kg) then after a period of two months, he was continued on isoniazid and rifampicin for next 16 months. Patient was regularly followed. His dactylitis was healed, thyroid nodule regressed and squint was corrected, after 8 weeks of therapy.

DISCUSSION

Extrapulmonary tuberculosis generally has an insidious onset, with slow evolution and paucibacillary nature, and can involve any site.9 This case had a combination of unusual presentation of extrapulmonary TB including tuberculous dactylitis, tuberculous thyroiditis and CNS tuberculomas.

Skeletal TB accounts for 1 - 2% cases of childhood tuberculosis. It usually follows an indolent course. Spectrum of skeletal involvement include vertebrae, knee, hip, elbow, smaller joints,3,4 Short bones of the hands or foot are the most frequent location in infancy and early childhood. Bones of hands are more frequently affected than those of feet with involvement of proximal phalanx of index and middle finger as in present patient. These short tubular bones have a lavish blood supply through a large nutrient artery entering almost middle of the bone. Disease following a natural course heals with shortening of the involving bones and deformity of the neighbouring joint.3,5

Thyroid tuberculosis is a very rare entity even in the TB endemic areas, first reported in a patient with disseminated TB.6 It may present as focal thyroid nodule like present case or multiple tubercule formation within gland. Rarity of tuberculosis of thyroid gland has been attributed to bactericidal properties of colloid, high vascularity, excess of iodine and possibly anti-tuberculous properties of thyroid hormones.10 Thyroid function tests are normal with occasional association of hypothyroidism or hyperthyroidism. Diagnosis is confirmed by FNAC or biopsy, showing characteristic histology.6,10

Tuberculosis of CNS is the most serious complication in children and is fatal without prompt management of tuberculous meningitis or tuberculoma. Around 20 - 40% cases of miliary TB have tuberculous meningitis. Keeping in view the paucibacillary and endemic nature of disease in our country and erroneous sites of involvement, patient was started on anti-tuberculous therapy and he responded well confirming the diagnosis. Extrapulmonary TB may present in the most unusual forms involving totally unexpected sites; and can only be catered for, if clinicians have high index of suspicion to make an early diagnosis of the rare forms of this ancient disease.

REFERENCES