

Pleural Pseudo-Tumour Tuberculosis

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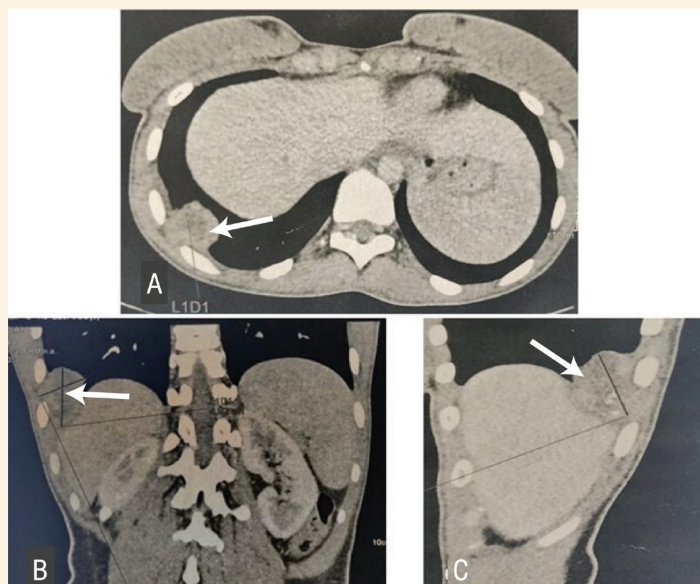


Figure 1: Computed tomography scan of the thorax in the axial (A), coronal (B) and sagittal (C) views showing pleural right based mass lesion with calcification and irregular margins (arrows).

THE PSEUDOTUMORAL FORM OF BRONCHO-pulmonary tuberculosis is rare. It can manifest as a bronchial, pulmonary, or pleural lesion, suggesting neoplasia, which makes the diagnosis difficult. A 23-year-old female patient was referred to our department for management of a right thoracic mass incidentally found on a chest computed tomography (CT) scan. She reported intermittent right-sided chest pain and fever. Clinical examination was normal. Chest CT showed a well-defined, homogenous right low pleuro-parietal mass measuring 50 × 50 × 24 mm with a peripheral enhancement of contrast without bone invasion, pleural effusion, parenchymal lesion or mediastinal lymph nodes [Figure 1]. Routine blood tests were normal except for a high erythrocyte sedimentation rate (ESR) at 32 mm/hr. Bacteriological testing for acid-fast bacilli and GeneXpert were negative in sputum. Bronchoscopy and percutaneous CT-guided needle-aspiration did not yield a pathological diagnosis. The patient underwent an elective right posterolateral thoracotomy. Intra-operative findings noted capsulated fluids mass with the presence of caseous necrosis after the accidental opening of the lesion, the

mass was resected completely [Figure 2]. Bacteriology revealed *Bacillus of Koch* in caseous liquid culture and pathological exams revealed the presence of areas of caseous necrosis with epithelioid granulomas, which were consistent with a tuberculosis infection. The patient received anti-tuberculous chemotherapy rifampicin + isoniazid + pyrazinamide for two months

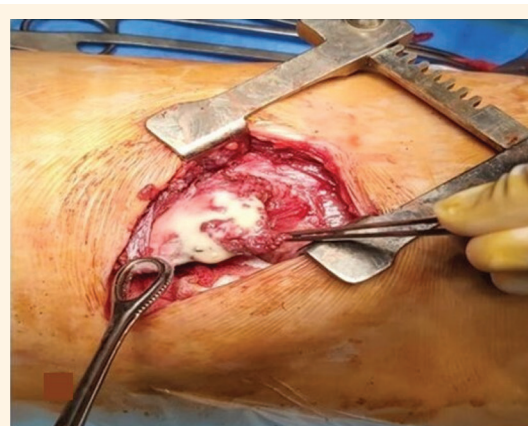


Figure 2: Operative view showing caseous necrosis after opening of the basal mass.

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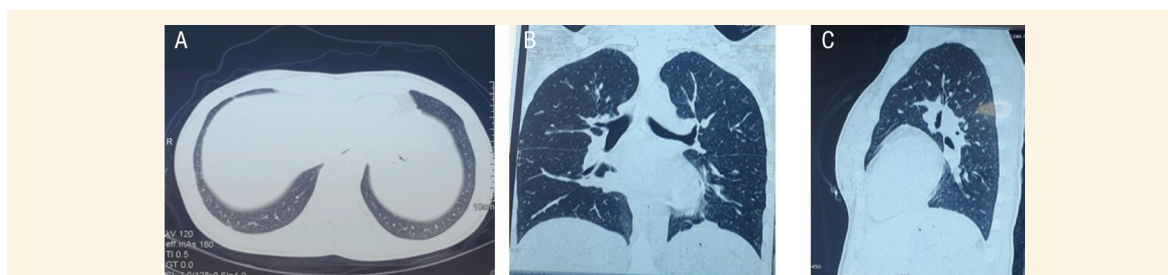


Figure 3: Computed tomography scan in the axial (A), coronal (B) and sagittal (C) views of the thorax at the two-year-follow-up showing no signs of recurrence or remaining infection.

and rifampicin + isoniazid for four months with a good clinical and radiological resolution [Figure 3]. Patient consent was obtained for publication purposes.

Comment

The incidence of pulmonary pseudotumor tuberculosis varies from 2–4%.^{1–3} Clinical and radiological manifestations are not specific and may suggest malignancy, bronchoscopic explorations can be negative. The differential diagnoses are lung cancer, metastasis, localised mesothelioma or a benign disease, such as inflammatory myofibroblastic tumours. Surgical removal of the mass through thoracoscopic or conventional approach is the best approach when a definite diagnosis could not be established and for management of complications such as haemoptysis.^{4–5}

AUTHORS' CONTRIBUTION

MA conceptualised and drafted the manuscript. ME interpreted the data in the manuscript. MO interpreted the pathological data. EHK contributed to drafting and revising the manuscript. All authors approved the final version of the manuscript.

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