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A Case of Bifocal Scrofuloderma in an Immunocompetent Patient at the Dermatology Hospital of Bamako

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ABSTRACT

Scrofuloderma is a Recognizer cutaneous manifestation of tuberculosis, typically arising from the direct extension of an underlying tuberculous focus, such as tuberculous lymphadenitis, to the overlying skin. Tuberculosis (TB) remains endemic in many developing countries and continues to pose a significant global health threat, particularly due to increased international migration. The clinical spectrum of cutaneous tuberculosis is broad and includes plaques (lupus vulgaris, cutaneous verrucous tuberculosis), macules and papules (acute miliary tuberculosis, papulonecrotic tuberculosis, scrofulous lichen), nodules and abscesses (Bazin's erythema induratum, tuberculous gumma), as well as érosions and ulcers (tuberculous chancre, orificial tuberculosis, scrofuloderma).We report the case of a 32-year-old Malian male who presented with a three-months history of a continuously evolving ulceration of the neck. The lesion initially manifested as a painless nodule, which subsequently underwent suppuration and progressed to a painful erosion unresponsive to empirical antibiotic therapy. Clinical examination revealed an 8 × 3 cm oval-shaped ulcer with an erythematous base, well-demarcated borders, and slightly undermined, tender edges. The surrounding skin was erythematous. The lesion was located in the right supraclavicular fossa. One week later, a painful nodule developed in the ipsilateral axillary region, which subsequently ulcerated with purulent discharge. The remainder of the clinical examination was unremarkable. The Mantoux test was strongly positive (30 mm induration), and chest radiography was within normal limits. Bacterial culture confirmed the presence of Mycobacterium tuberculosis. Histopathological examination was not performed. A diagnosis of scrofuloderma was established based on clinical presentation and microbiological confirmation. The clinical presentation of a painless subcutaneous nodule evolving into abscess formation and subsequent fistulization should raise strong suspicion of scrofuloderma. In tropical settings, the identification of Mycobacterium tuberculosis should be prioritized before considering alternative etiologies.

Keywords

Case, Scrofuloderma, Bifocal, Bamako.

Introduction

Scrofuloderma is one of the cutaneous manifestations of tuberculosis, generally occurring when an underlying tuberculous focus, such as lymphadenitis, directly involves the skin [1]. Tuberculosis (TB) remains widespread in many developing countries and may represent a renewed global health threat due to international migration. Cutaneous tuberculosis can be divided into two major categories: true cutaneous tuberculosis and tuberculid forms. The clinical manifestations of tuberculosis are numerous and may include plaques (lupus vulgaris, cutaneous verrucous tuberculosis), macules and papules (acute miliary tuberculosis, papulonecrotic tuberculosis, scrofulous lichen), nodules and abscesses (Bazin's erythema induratum, tuberculous gumma), as well as erosions and ulcers (tuberculous chancre, orificial tuberculosis, scrofuloderma) [2,3]. This clinical polymorphism can mimic various skin diseases. The treatment of cutaneous tuberculosis follows the same therapeutic regimens recommended

by the World Health Organization (WHO) for the treatment of new cases of pulmonary tuberculosis [4]. We report a case of bifocal scrofuloderma in Bamako.

Observation

The patient was a 32-year-old Malian man with no notable medical history, who presented with a three-month history of a persistently evolving ulceration on the neck. The lesion initially appeared as a painless nodule, which progressed to suppuration and then to a painful erosion. An antibiotic treatment was initiated, but without improvement. The persistence and progressive enlargement of the ulceration prompted the patient to seek medical consultation.

On examination, there was an oval-shaped ulcer measuring 8 × 3 cm, with an erythematous base, well-defined margins, and slightly undermined, tender edges. The surrounding skin was erythematous. The lesion was located in the right supraclavicular region.

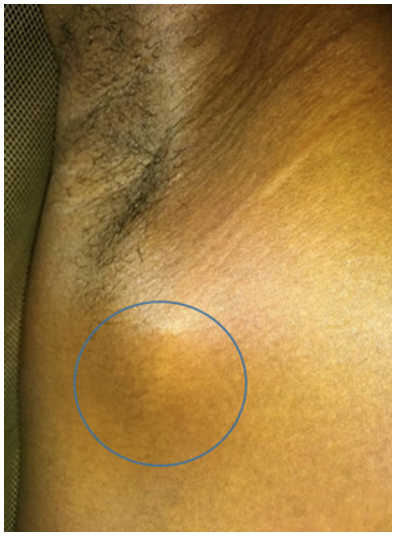

Figure 1: Nodule in the right axillary region.

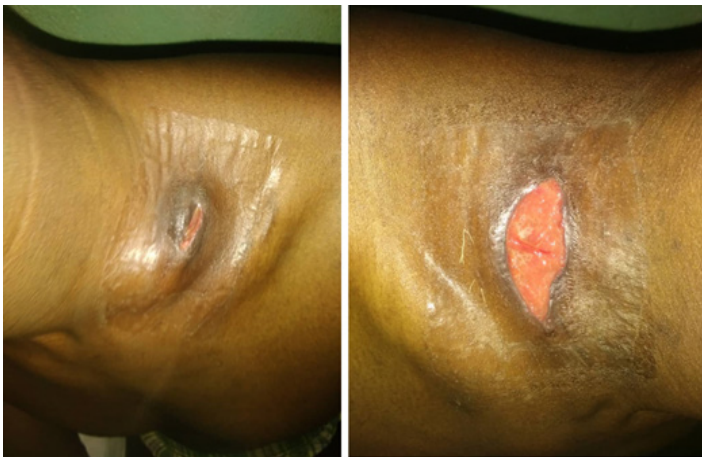

Figure 2: Ulcerated scrofuloderma on the right lateral side of the neck with ulceration

One week later, a painful nodule appeared in the ipsilateral axillary hollow, which subsequently ulcerated with purulent discharge. The remainder of the clinical examination was unremarkable. The Mantoux test was positive with 30 mm of induration. Chest X-ray and serological tests for HIV and hepatitis were normal. Bacterial culture of the pus revealed the presence of *Mycobacterium tuberculosis*. Histopathological examination was not performed. A diagnosis of scrofuloderma was considered. The patient was started on anti-tuberculosis treatment, and after four weeks, the clinical outcome was favorable, with complete resolution of the lesions. Upon follow-up, the patient presented no cutaneous or pulmonary lesions.

Argument

Scrofuloderma is a clinical form of secondary cutaneous tuberculosis. It is typically characterized by bluish-red nodules overlying lymph nodes, bones, or joints, which destroy the affected tissue and replace it with granulation tissue [2,5].

In our patient, the lesion was initially supraclavicular. The presence of the secondary lesion in the axillary hollow can be explained by the anatomy of the area, particularly the abundance of lymphatic terminations.

The diagnosis of this clinical form of tuberculosis is both clinical and paraclinical. Histopathological examination is a key tool for establishing the diagnosis [5,6], but it was not performed in our case due to local constraints. Tuberculosis can present in various forms in endemic areas. It is crucial to maintain a high index of suspicion and to initiate treatment early to prevent complications, which are mostly reversible.

In our patient, we found no specific factor that could explain this particular clinical presentation [7]. However, it responded well to treatment, as is often the case when diagnosis is made early, as it was for our patient.

Conclusion

The presence of a painless subcutaneous nodule evolving into abscess formation and subsequent fistulization should clinically raise suspicion of scrofuloderma, and the search for *Mycobacterium tuberculosis* should be prioritized before considering alternative etiologies in our tropical context.

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