Extrapulmonary Tuberculosis Mimics Diffuse Metastatic Disease: A Case Report

Gulgun Engin¹ Kızıldag Yirgin¹ Hulya Kandemir²

¹ Department of Radiology, Oncology Institute, Istanbul University, Istanbul, Turkey
² Department of Obstetrics and Gynecology, Istanbul University, Istanbul Faculty of Medicine, Istanbul, Capa, Turkey

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Introduction

Tuberculosis (TB) is the leading cause of death from infectious disease worldwide. TB can often be controlled with early and accurate detection and diagnosis.¹ However, in cases without pulmonary TB, extrapulmonary TB is associated with major diagnostic difficulties because of its metastatic disease-like imaging findings and elevated levels of serum cancer antigen (CA) 125.²,³ Recognition and understanding of the spectrum of extrapulmonary TB imaging features can improve its early diagnosis and management.

Herein, we present a case of multisystemic extrapulmonary TB without pulmonary TB mimicking diffuse metastatic disease, and we discuss the diagnostic and differential criteria of this case.

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Case Report

We present the case of a 50-year-old woman with a 2-month history of pelvic pain. A vaginal examination revealed a left adnexal mass with tenderness on palpation. Transvaginal ultrasound revealed a complex cystic mass (5 × 4 cm in diameter) and a small amount of ascites in the pouch of Douglas. She had a high erythrocyte sedimentation rate (113 mm/h; reference range 0–30 mm/h), but normal peripheral blood laboratory tests (including a complete blood cell count, routine serum chemistry, and C-reactive protein level). She did not have leukocytosis or monocytosis. She had high levels of the tumor markers carcinoembryonic antigen (6.4 ng/mL) and CA 15-3 (22.9 U/mL) and CA 19-9 (24.65 U/mL) were normal. Human immunodeficiency virus serology and spumt culture were negative, and no pathologic finding was evident on plain radiography of the chest and abdomen.

A decision was made to follow up with the patient, as she had been diagnosed with Leriche syndrome and had a history of multiple abdominal surgical interventions because of aortobifemoral bypass and graft complications. Six months later, thoracoabdominal computed tomography (CT) revealed multiple supraclavicular, axillary, mediastinal, and abdominal pathologic lymph nodes (1–4 cm in length) along the short axis with central hypoattenuation. We also observed bone destruction accompanied by a hypoattenuating soft tissue mass in the sternum and dorsal vertebrae, as well as multiple hypodense and minimally rim-enhancing liver lesions (1–2 cm in diameter). The lesion in the liver’s left lobe had extended through the peritoneum and into the anterior abdominal wall (►Fig. 1). Pelvic CT demonstrated a left adnexal complex cystic mass (2 × 4 cm in size) with thick septa and solid portions. 18F-fludeoxyglucose positron emission tomography (18F-FDG PET/CT) revealed pathologic uptake in the cystic lesions, as well as in the ovarian cystic lesions.

The patient had no pleural or peritoneal ascites. However, histopathologic analyses of ultrasound-guided core biopsies of the supraclavicular lymph node revealed granulomatous inflammatory reaction with necrosis, whereas liver biopsy revealed diffuse granulomatous inflammation and fibrosis. Histopathology of the sternal bone biopsy also revealed a granulomatous focus.

On the basis of the aforementioned findings, multisystemic extrapulmonary TB with a tubo-ovarian abscess was considered. The patient was started on anti-TB treatment consisting of isoniazid, rifampicin, ethambutol, and pyrazinamide for 2 months, which should have been followed by isoniazid and rifampicin for 9 months. However, her treatment was terminated after 2 months because of elevated liver enzymes.

At the 6-month follow-up, the patient’s clinical recovery was marked by significant decreases in general body pain and palpable suprarenal cystic lymph nodes. The erythrocyte sedimentation rate remained high (31 mm/h; reference value 0–20 mm/h), but was significantly decreased compared with the pretreatment value. Peripheral blood laboratory tests as performed pretreatment were within normal limits.

Follow-up thoracoabdominal CT revealed decreases in the size of the Pott’s abscesses as well as in the number and size of the lymph nodes and liver abscesses. These findings were compatible with a partial response to the anti-TB therapy.

Discussion

In this report, abdominal CT and 18F-FDG PET/CT findings initially led to the suspicion of ovarian malignancy and diffuse metastatic disease, but careful analysis of CT imaging findings and pathologic results eventually revealed multisystemic extrapulmonary TB.

After the lymphatic system, the genitourinary system is the second-most frequent location of extrapulmonary TB. The fallopian tubes are involved in 90 to 100% cases of genital TB. Tubo-ovarian abscess is revealed as a multilocular cystic pelvic mass with pseudotumor papillary areas that mimic solid portions of ovarian malignancy. CA 125 is a tumor marker of...
nonmucinous ovarian cancer that may also be increased in peritoneal TB.\(^3\) \(^{18}\)F-FDG PET/CT findings are not helpful in distinguishing this type of TB from ovarian malignancy.

A complex tubo-ovarian abscess may mimic the PET/CT imaging characteristics of an ovarian or pelvic carcinoma.\(^5\) On PET/CT, abscesses often exhibit a hypometabolic center surrounded by an intensely FDG-avid rim.\(^6\)\(^7\) However, they can also exhibit solid and uniformly intense FDG uptake throughout.\(^5\)\(^8\) In their study, Sharma et al reported the results of 17 patients with proven tuberculous tubo-ovarian masses who underwent \(^{18}\)F-FDG-PET/CT imaging, and these findings were compared with those of ultrasound (for all patients), magnetic resonance imaging (MRI; for 9 patients), CT (for 4 patients), and laparotomy or laparoscopic findings (for 14 patients). The detection rates of tubo-ovarian masses with \(^{18}\)F-FDG-PET/CT were similar to those obtained with CT or MRI, but there was less characterization of adnexal masses. However, \(^{18}\)F-FDG-PET/CT was equally as accurate as laparoscopy or laparotomy in detecting the presence, laterality, and activity of tubo-ovarian masses. The authors of the study concluded that \(^{18}\)F-FDG-PET/CT is clinically useful for noninvasively detecting the presence and activity of tubo-ovarian masses, but not for their characterization.\(^9\) In our case, there was no pathologic uptake in the ovarian cystic lesion on \(^{18}\)F-FDG PET/CT, which may have been due to inactivity.

Differential diagnosis becomes more difficult when extrapulmonary TB is a multisystemic disease, as in the case presented herein. However, knowing the characteristics, but not specific, imaging findings may facilitate the diagnosis.

TB lymphadenopathy is a common form of extrapulmonary TB. The cervical (63%), mediastinal (27%), and axillary (8–10%) lymph nodes are the most commonly affected. Most cases are unilateral, including the patient described herein who had involvement of the supraclavicular, axillary, and mediastinal lymph nodes on the right. Peripheral enhanced and central necrotic lymph nodes are highly suggestive, but not pathognomonic, of TB.\(^10\) However, they should be differentiated from metastatic head and neck squamous cell carcinomas and inflammatory conditions.\(^11\) Nodal calcification often develops late in TB, which helps to differentiate TB nodes from malignancy.

Hepatic TB is an unusual form of extrapulmonary TB that constitutes less than 1% of all TB cases. The imaging findings of hepatic TB are nonspecific.\(^12\) Both micro- and macronodular forms can be observed, although macronodular forms are less common. The macronodular forms appear as hypoattenuating lesions 1 to 3 cm in diameter, or as a single mass with hepatosplenomegaly.\(^13\) MRI reveals hypointense and minimally enhanced honeycomb-like lesions on T1-weighted images.\(^10\) The differential diagnosis of the macronodular form includes metastasis, fungal infection, sarcoidosis, and lymphoma, whereas the differential diagnosis of the macronodular form includes metastasis, primary malignant tumor, or pyogenic abscess. Similar to metastatic disease, these lesions also show avid FDG uptake on PET/CT imaging.\(^13\) However, a liver abscess that extends through the peritoneum and into the extraperitoneal compartment suggests TB, as in the case presented herein.\(^10\)

Lymphadenopathy is the most common manifestation of abdominal TB, which most commonly affects the mesenteric and peripancreatic groups.\(^13\) In general, the nodes are typically multiple and large, averaging 2 to 3 cm in diameter with a hypoattenuating center with or without calcification. In \(^{18}\)F-FDG PET/CT imaging, TB can lead to a false-positive metastatic lymph node diagnosis, as in our current case.\(^14\)

Approximately, 1 to 3% of patients with TB have skeletal involvement. Skeletal TB most commonly involves the spine or weight-bearing joints, whereas the sternum is involved in ~1% of cases.\(^10\) More than one vertebral body is typically affected. Paraspinal infection may involve the psoas muscle, resulting in Pott’s disease. Calcification within the abscess is virtually pathognomonic of TB.\(^4\)

The imaging findings of multisystemic extrapulmonary TB mimic metastatic diseases. Therefore, an understanding of the spectrum of imaging findings of extrapulmonary TB plays a crucial role in its early and accurate identification. However, PET/CT imaging findings have potentially serious pitfalls in the evaluation of extrapulmonary TB. It is important for those reading PET/CT results to be aware of this benign differential diagnosis of extrapulmonary multisystemic TB, even in the context of CT or MRI findings suspicious for malignancy.

### Informed Consent

Written informed consent was obtained.

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### Conflicts of Interest

There are no conflicts of interest.

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