VERTEBRAL OSTEOMYELITIS DUE TO *MYCOBACTERIUM AVIUM* COMPLEX AFTER THORACIC FRACTURE: A CASE REPORT

[1]Chie YAMAMOTO, [2]Haruka KUNO, [2]Wataru FURUTANI, [2]Isao HASEGAWA, and [2]Yutaka KUBOTA

Abstract A 77-year-old woman presented to hospital in December 2016 with back pain. She was diagnosed with thoracic compression fracture of the Th6 and Th8 vertebral bodies. She received conservative treatment, and the pain had improved. However, in September 2017, the pain worsened again, and in October 2017, paralysis of both lower limbs appeared, at which point, she was admitted to hospital again. Computed tomography (CT) revealed a tumor-like shadow around the Th6−Th8 vertebral bodies. Subsequently, she was transferred to our hospital. On admission, she was presented to the Department of Respiratory Medicine for abnormal shadows on chest CT. Chest CT revealed bronchiectasis and small nodules in the right middle and lower lobes and left lingular segment. As the sputum was not out, the patient's gastric juice culture was analyzed; it was positive for *Mycobacterium intracellulare*. Needle biopsy samples from the areas of tumor-like shadows around the Th6−Th8 vertebral bodies were taken, and these were also positive for *M. intracellulare*. Based on these findings, we diagnosed the patient's condition as vertebral osteomyelitis due to *M. intracellulare*; subsequently, she received antimycobacterial therapy with rifampicin, ethambutol and clarithromycin, following which, she underwent radical debridement and decompression surgery with anterior spinal fusion. Postoperatively, we continued antimycobacterial therapy for 2 months, and no recurrence was detected. The rate of osteoarticular nontuberculous mycobacterial (NTM) infection has been reported to be 1−2%. Although vertebral osteomyelitis due to NTM is rare, clinicians should consider the combination of nontuberculous mycobacteriosis and vertebral osteomyelitis in cases such as the case presented herein.

Key words: Nontuberculous mycobacteria, *Mycobacterium avium* complex, Vertebral osteomyelitis, Paresis, Thoracic fracture

[1]Department of Pulmonary Medicine, Graduate School of Medical Science, Kyoto Prefectural University of Medicine; [2]Department of Respiratory Medicine, Japanese Red Cross Society Kyoto Daini Red Cross Hospital

Correspondence to: Chie Yamamoto, Department of Pulmonary Medicine, Graduate School of Medical Science, Kyoto Prefectural University of Medicine, 465 Kajiicho, Kawaramachi-Hirokoji, Kamigyo-ku, Kyoto-shi, Kyoto 602−8566 Japan. (E-mail: yamamoto.chie1111@gmail.com)

Case Report

A CASE OF HEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS CAUSED BY PULMONARY TUBERCULOSIS

Motoaki TANIGAWA, Yuhei ITO, Hidetoshi ITANI, Hajime SASANO, and Hirokazu TOYOSHIMA

Abstract A 61-year-old man had terrible cough. He lost consciousness and displayed hypoglycemic coma and shock. He regained consciousness after receiving glucose infusion. His sputum sample tested positive for tuberculosis (TB)-PCR. Based on these results, he was diagnosed with pulmonary TB. He was diagnosed with hemophagocytic lymphohistiocytosis (HLH) based on the symptoms of high fever, pancytopenia, hyperferritinemia, hypofibrinogenemia and hemophagocytosis in bone marrow, and with disseminated intravascular coagulation based on the symptoms of increased coagulation and fibrinolysis. He was successfully treated with antituberculous drugs, steroids and anticoagulants. This case emphasizes the importance of early diagnosis and treatment for the successful treatment of HLH associated pulmonary TB.

Key words: Pulmonary tuberculosis, Hemophagocytic lymphohistiocytosis, Disseminated intravascular coagulation, Hyperferritinemia, Steroid

Department of Respiratory Medicine, Ise Red Cross Hospital

Correspondence to: Motoaki Tanigawa, Department of Respiratory Medicine, Ise Red Cross Hospital, 1−471−2, Funae, Ise-shi, Mie 516−8512 Japan.
(E-mail: m.tanigawa@ise.jrc.or.jp)