Tuberculous Bursitis of the Greater Trochanter
- case report -

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INTRODUCTION

Primary tuberculous bursitis was a relatively frequent manifestation of the disease before the antituberculosis drug era. Nowadays, it is considered a rare condition; it accounts for 1-2% of all musculoskeletal tuberculosis. The diagnosis and treatment of tuberculous bursitis may be delayed because the paucity of symptoms, its indolent clinical course and consequently a low clinical suspicion. A 50-year-old patient with tuberculous trochanteric bursitis is reported.

CASE REPORT

A 50-year-old woman was referred to our department to investigate a persistent pain in her left hip with 6 months duration; especially when climbing stairs and lying in the left lateral position. The examination revealed a diffuse swelling from the buttock to the thigh, notable over the trochanter, but no sign of acute inflammation such as heat and redness. She was not limping and was afebrile. Her past medical and family histories revealed no previous tuberculosis.

Plain films of the left hip showed a partial destruction of the margin of the greater trochanter, lytic *foci* in the underlying bone and a small foci of calcification in the adjacent soft tissues [Fig.1].

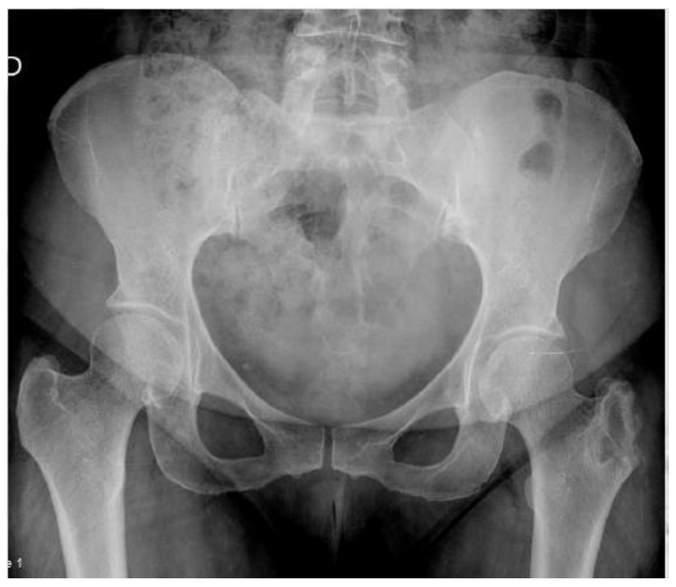

Fig. 1. Plain radiograph of the pelvis
[osteopenic changes in the left greater trochanter with cortical irregularities and small *foci* of calcification]

A computed tomogram showed a soft tissue mass and demonstrated the relationship with the trochanter [Fig.2]. We performed a needle biopsy which revealed granulomatous tissue. The patient underwent complete excision of the bursa and curettage of the surface of the trochanter. The postoperative course was uneventful. *Mycobacterium tuberculosis* was isolated and definitive diagnosis of tuberculous bursitis was made. There was no evidence of concomitant tuberculosis at other musculoskeletal sites.

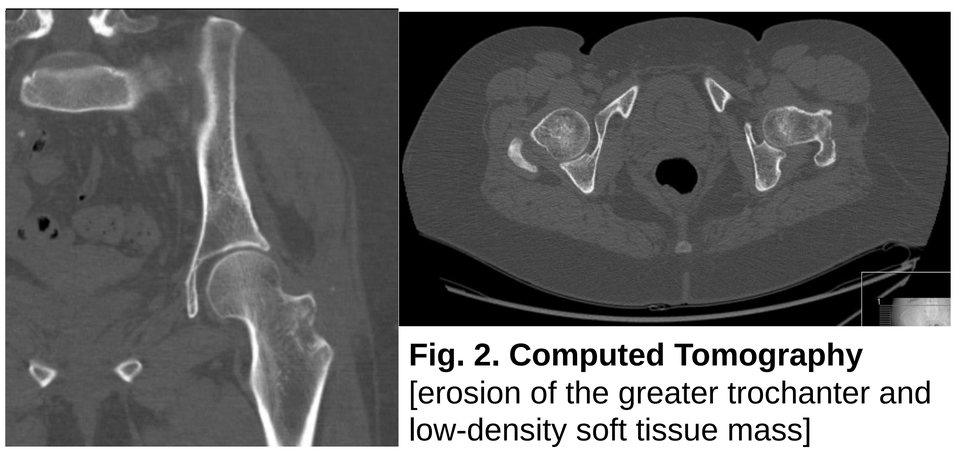

Fig. 2. Computed Tomography
[erosion of the greater trochanter and low-density soft tissue mass]

The patient completed a treatment with rifampicin and etambutol for 6 months. There has been a complete resolution of the symptoms after 3 months and no recurrence after 4 years of follow-up. On plain radiograph the remodeling of the bone structure is clearly visible [Fig.3].

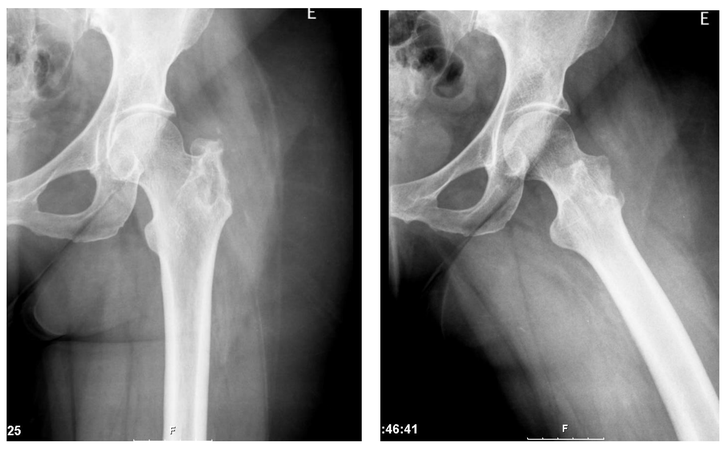

Fig. 3. Plain radiograph – 2y follow up
[remodeling of the bone structure]

DISCUSSION/CONCLUSION

Tuberculous trochanteric bursitis with osteitis is a rare cause of hip pain. This potential diagnosis is often not considered, resulting in a delay in treatment. The pathogenesis of tuberculosis of the greater trochanteric area has not been well defined. The incidence of concomitant tuberculosis at other musculoskeletal sites, as well as the lung, is approximately 50%. Both hematogenous infection and propagation from other locations are reasonable explanations. Surgical intervention is mandatory for cure and the use of several antituberculosis agents is the standard approach.

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