

Miliary Tuberculosis with Cutaneous Affectations and SARS-CoV-2 Coinfection in Infant: Case Report in Mexico

ABSTRACT

Aims: To describe an infant presenting with miliary tuberculosis with cutaneous affectations and SARS-CoV-2 coinfection.

Presentation of case: 10 month old boy, with incomplete vaccination. Low Socio-economic status. The parents indicated, that lesion began with a single small, erythematous, non-pruritic, papule-type skin lesion on the left side of the infralabial region, with no other constitutional. During the following three months, the lesions became generalized. On June 23, 2020, he was admitted to the "Hospital para el Niño Poblano" in emergency area with mild malnutrition, lethargic state, fluid and electrolyte imbalance, metabolic acidosis, oral candidiasis, and septic shock, requiring endotracheal intubation. Besides, innumerable acid fast bacilli in skin biopsy and bronchial aspirate with diagnosis cutaneous TB was, identified. Immunodeficiency based on immunoglobulin profile and T and B cell markers. RT-PCR was performed for SARS-CoV-2 in bronchial aspirate, with a positive result. On June 25, 2020 died of cardiorespiratory arrest, secondary to septic shock and cutaneous tuberculosis.

Discussion: Miliary TB in infants is difficult to diagnose in addition the cutaneous manifestation has added onto the long list of differentials, and downplay others, generating inappropriate and delayed treatment. Additionally, SARS-CoV-2 can intensify the clinical manifestations of miliary tuberculosis and directly influencing the mortality of this type of patients.

Conclusion: The case described is rare, which reveals the importance to perform a differentiated diagnosis, considering Socio-economic and epidemiological context mainly in the first level of care. It is recommended to continue with research in order to generate information on the possible clinical pictures.

Keywords: COVID-19, immunodeficiency, Miliary tuberculosis, Mycobacterium tuberculosis.

1. INTRODUCTION

Tuberculosis (TB) is the infectious disease with the highest global mortality, causing 1.5 million deaths during 2020 [1]. Mycobacterium tuberculosis complex has the ability to grow within host cells and to be transmitted directly from one host to another [2]. The usual classification of TB is infiltrative, focal, tuberculoma, miliary, and fibrocavitary [3]. Miliary tuberculosis is a lethal form of TB with massive lymphohaematogenous spread from a Mycobacterium tuberculosis laden focus [4] with cutaneous manifestation being rare [5]. Low Socio-economic status has been associated with a greater risk of exposure to TB due to unfavorable conditions food, access to health services, education and housing. Once the

infection has occurred, there is greater susceptibility in people with comorbidities such as, human immunodeficiency virus (HIV), extremes of age, diabetes, silicosis or rheumatoid arthritis and other chronic or immunosuppressive diseases [6]. SARS-CoV-2 appears to induce cytokine storm, and therefore, generate immunomodulatory effects. Different studies have shown, TB status could influence the development, but not the mortality of severe acute respiratory syndrome in coinfection by SARS-CoV-2, finding a risk of 2.1 times greater for critical illness owing to COVID-19; contributing to worsen the prognosis and increase the mortality of TB patients [7]. The objective of this paper is to describe a case of miliary tuberculosis with cutaneous affectations and SARS-CoV-2 coinfection in an infant in Mexico.

2. PRESENTATION OF CASE

10 month old boy patient, native and resident from Central Region of the state of Puebla, Mexico. Weight at birth of 2.5 kg and 50 cm in length. Breastfed for six months, incomplete national vaccination schedule for age (administered BCG), without significant family and personal antecedents and Low Socio-economic status with overcrowding. The parents indicated that during the last week of February 2020, he began with a single, small, erythematous, non-pruritic, papule-type skin lesion on the left side of the infralabial region, no other symptoms. For the next three months, the lesions became generalized (face, neck, anterior and posterior thorax, abdomen and upper extremities), increasing in size, being confluent, pustular, non-suppurative, with an erythematous base, as well as, color changes to violaceous from the center to periphery and painful. He received, exclusively topical treatment with betamethasone for four weeks with no improvement and progression of lesions.

On June 11, 2020, he developed a persistent and continuous fever of 38.5°C with increased temperature at nights, temporarily improved. Accompanied by a non-productive cough and inaccesses, presenting mainly in the mornings, being taken to private medical services. Started treatment with ambroxol and ceftriaxone (dose unknown). On June 21, 2020, he presented a productive cough in short accesses, with hyaline expectoration in moderate quantity. Adding respiratory difficulty with nasal flaring, expiratory whimper and intercostal drawing. The skin lesions disseminated with some punched out ulcers, some as suppurative papules / blebs. He admitted to private medical services without knowing the treatment granted. Lack of improvement made the parents to voluntarily discharge from that center and brought to our facility.

On June 23, 2020, he was admitted to the "Hospital para el Niño Poblano" in the Emergency Area with mild malnutrition, lethargic state, oral candidiasis, and septic shock, requiring endotracheal intubation (Fig. 1). He was treated with antibiotics intravenously based on meropenem (40 mg / kg / 24 h) and vancomycin (15 mg / 24 h), in addition to fluconazole (6 mg / kg / 24 h) and erythrocyte transfusion. He was transferred to the Pediatric Intensive Care Area. He was assessed by pediatric infectious disease specialist, with a probable diagnosis of ecthyma gangrenosum vs staphylococcal toxic shock, adjusting the doses of antibiotics (meropenem 120 mg / kg / 24 h; vancomycin 60 mg / kg / 24 h) already started, adding clindamycin (40 mg / kg / 24 h) to increase the inhibitory effect (synergism), and coverage with liposomal amphotericin B (1 mg / kg / 24 h), due to suspected superinfection by fungal agents according to the time of evolution.

On June 25, 2020, the pediatric dermatologist performed a skin biopsy fullstop histopathological results, tiny fragments of corneal material, without giant cells or granuloma formation (Fig. 2.1). In the Ziehl-Neelsen stain, innumerable acid-fast bacilli (AFB) seen and a diagnosis of cutaneous TB (Fig. 2.2). Periodic Acid-Schiff and Gram stains were negative.

On the same date, a real-time Reverse Transcriptase Polymerase Chain Reaction assay detected Mycobacterium tuberculosis Complex, (RT-PCR-RT, Xpert MTB / RIF system) in skin biopsy samples and bronchial aspirate, without detection of mutation in the rpoB gene associated by resistance to rifampicin. The Ziehl-Neelsen staining technique showed positive AFB smear microscopy (+++), skin culture (+++) (Fig. 3), and bronchial aspirate (+). This corroborated that the disease was extensive.

In addition, Löwenstein-Jensen culture medium, both material from skin aspirate and bronchial aspirate showed growth in 34 days. In the first, abundant, rough, pale yellow colonies were identified. In the second, smooth yellow confluent colonies were observed, contrasted by the color of the culture medium (Fig. 4). Identification and confirmation of Mycobacterium tuberculosis was carried out through molecular methods.

Table 1 shows the evolution of the blood count parameters and acute phase reactants and coagulation factors, during the length of stay. Progressive secondary cytopenias to infectious process and elevated levels of acute phase reactants and procalcitonin were observed. Diagnosis of immunodeficiency. Severe combined immunodeficiency was arrived on the basis of hypogammaglobulinemia (IgA < 2 mg / dL; IgG = 127 mg / dL; IgM < 10 mg/dL; and IgE < 4.56 UI / mL), and total depletion of T lymphocytes ($CD3^+ = 0.12$ cell / μ L; $CD3^+ / CD4^+ = 0.0$ cell / μ L; $CD3^+ / CD8^+ = 0.22$ cell / μ L) with normal production of B ($CD20^+ = 170.45$ cell / μ L) and NK ($CD3^- / CD16^+ / CD56^+ = 0.79$ cell / μ L). HIV status was negative.

Additionally, the Culture of mycobacteria was performed on a solid Löwestein-Jensen medium, with a positive result (+++) of abundant and uncountable AFB colonies by skin biopsy sample; and a positive result (+) of confluent colonies of AFB in number <100, at bronchial aspirate sample. Anti tuberculous treatment was started through isoniazid, rifampin, pyrazinamide, and ethambutol. On June 25, 2020 considering these results and due to COVID-19 pandemic, RT-PCR was performed to SARS-CoV-2 in bronchial aspirate, with a positive result. The patient presented an inappropriate clinical evolution, by septic shock refractory to inotropics, requiring an increase in the mechanical ventilation parameters. Chest radiographs showed a consolidation in the entire left lung (Fig. 5). This day, he died of cardiorespiratory arrest, secondary to septic shock. The epidemiological follow-up was carried out by the health authorities, so the hospital does not have the information in this regard.



Fig. 1. Clinical appearance of ulcerative, punched-out, suppurative and disseminated dermal lesions upon admission.

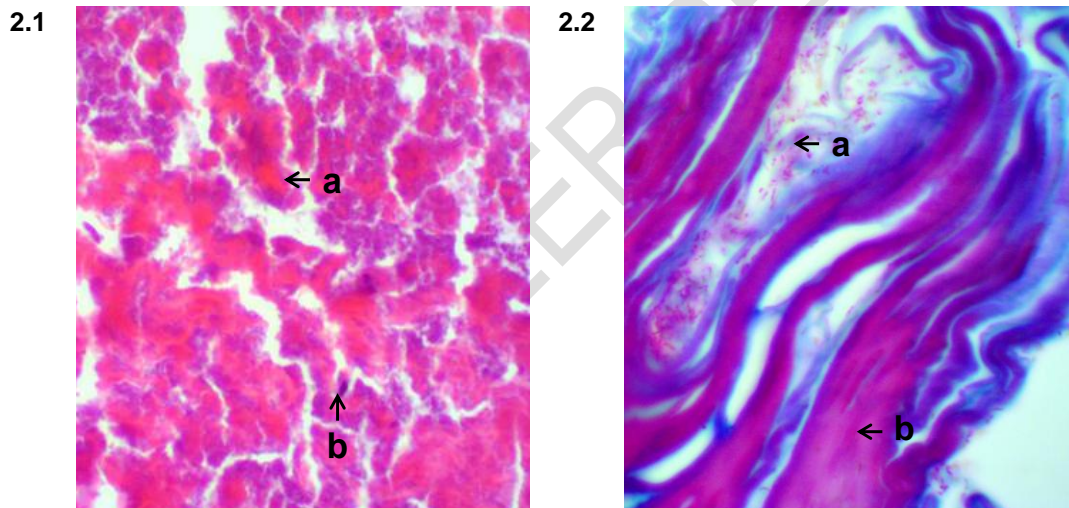


Fig. 2. Skin biopsy. Simple light microscopy. 2.1 Objective magnification 40x. Hematoxylin and eosin staining technique. Tissue showing total loss of skin histology, replaced by cellular debris with granular cytoplasm (a) and polymorphonuclear leukocytes (acute inflammation) (b). 2.2 Objective magnification 100x. Ziehl-Neelsen technique. Visualization of the bacilli of the Mycobacterium tuberculosis complex in red (a); contrasting with the cellular debris and laminated keratin of the stratum corneum of the skin (b).

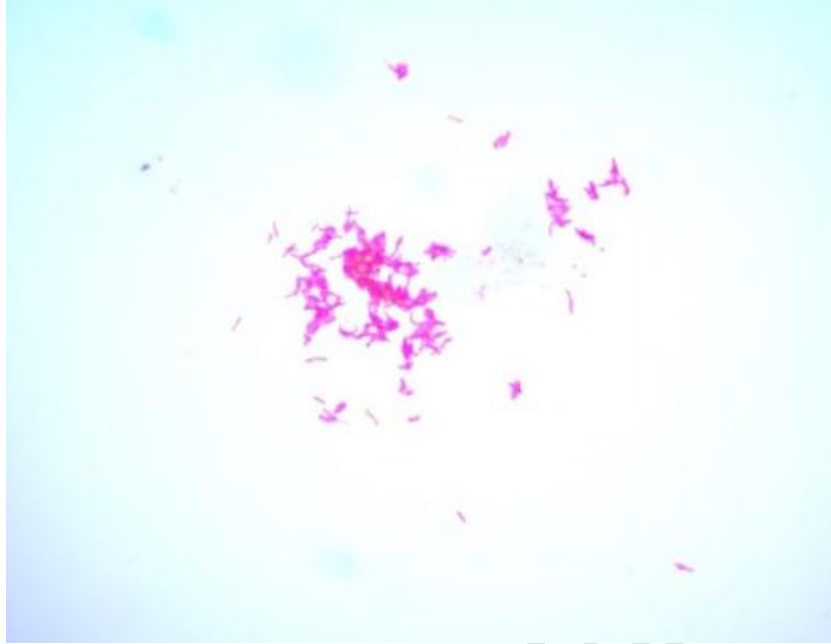


Fig. 3. Skin biopsy culture. Simple light microscopy in an immersion objective, magnification 100x. Ziehl-Neelsen staining technique. Large conglomerates of AFB are observed in a “bead effect” exhibiting a spotty appearance.

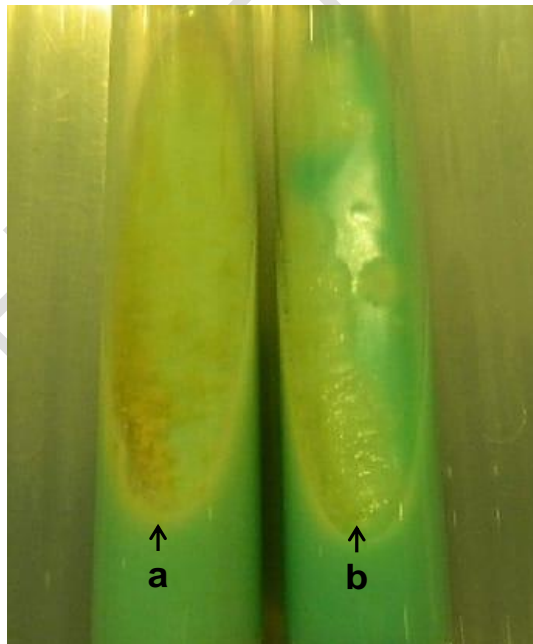


Figure 4. Skin cultures and bronchial aspirate. Löwestein – Jensen culture medium. Growth rate in 34 days. Incubation conditions: 37 ° C temperature in ambient atmosphere. Skin biopsy culture: abundant, confluent, rough, faint yellow colonies (a). Culture of bronchial aspirate: confluent, smooth, pale yellow colonies (b).

Table 1. Evolution of blood count parameters and acute phase reactants and coagulation factors.

Parameter	Date of sampling			
	23-06-2020	24-06-2020	25-06-2020	26-06-2020
Hemoglobin (g/dL)	5.40	6.60	-	7.80
Hematocrit (%)	18.60	21.50	-	25.30
Leukocytes (10 ³ /μL)	7.21	0.45	-	1.95
Neutrophils (10 ³ /μL)	6.49	0.36	-	1.35
Band (10 ³ /μL)	3.76	0.12	-	0.04
Lymphocytes (10 ³ /μL)	0.72	0.08	-	0.29
Eosinophils (10 ³ /μL)	-	0.0045	-	0.058
Platelets (mm ³)	84,000	4,000	-	9,000
ESR* (mm/h)	-	2	-	-
CRP** (mg/L)	-	>96	-	-
Procalcitonin (ng/mL)	-	-	242.7	-
Ferritin (ng/mL)	-	1207.27	-	-
D-dimer (ng/mL)	2578	3723	-	-
Fibrinogen(mg/dL)	553	300	-	-

*ESR: erythrocyte sedimentation rate; **CRP: C-reactive protein

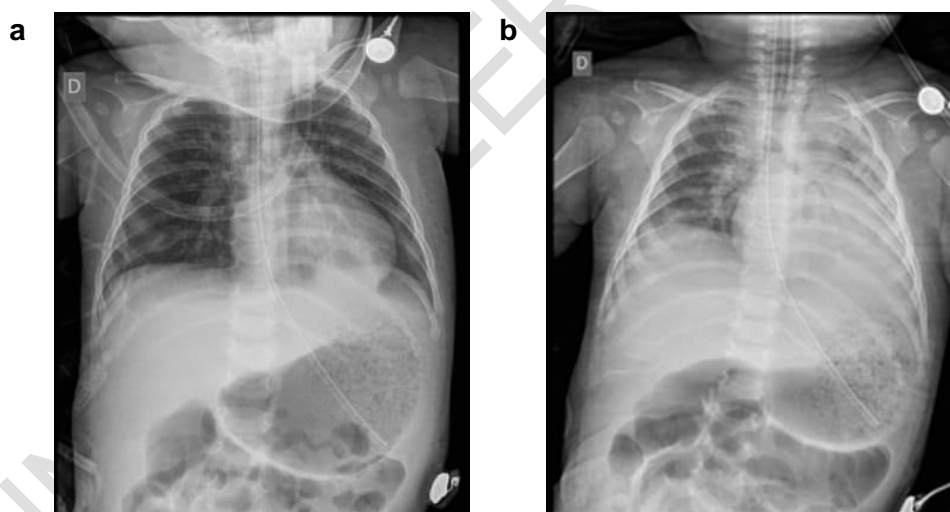


Fig. 5. Plain anteroposterior chest radiographs. X-ray on admission, observing right parahilar infiltrates with air bronchogram (a). Chest X-ray 48 hours after admission, with consolidation in the entire left hemithorax, loss of the contour of the cardiac silhouette and the ipsilateral costo-diaphragmatic angle (b).

3. DISCUSSION

The reported case shows how significant, is social protection (food, health, education and housing) to prevention, diagnosis and adequate management of TB in all its variants, and hence, its future incidence [8]. In this sense, exposure to TB is intensified in collective living environments, homes of people with active tuberculosis and crowded places not, poverty

adds on to these above factors [9]. The host's immune system stops the progression of TB, whereas immunodeficient conditions and malnutrition being important risk factors for developing its active form. Active TB is responsible nearly half of deaths in untreated people, so that early diagnosis and effective treatment is determinant [10].

TB is usually acquired through the lungs and intestines with, cutaneous TB being a manifestation of systemic involvement. The add common agents are generally Mycobacterium tuberculosis and rarely Mycobacterium bovis, and the Calmette-Guérin bacillus [11]. Cutaneous TB represents a very small proportion of all TB cases, classified by the type of dissemination (exogenous and endogenous), route of infection (autoinoculation, direct inoculation, hematogenous, lymphatic, BCG vaccine), as well as, by the bacterial load (multibacillary, paucibacillary). The clinical manifestations in exogenous infection can be Lupus vulgaris, Tuberculosis verrucosa cutis and Tuberculous chancre. In endogenous group common to rare presentation are Lupus vulgaris (most cases), Scrofuloderma, Miliary tuberculosis, orificial tuberculosis, tuberculosis abscess and papulonecrotic tuberculosis [12,13].

Any disease coinfection with TB can lead on to clinical dilemmas, and diagnostic and therapeutic challenges, as the case report presented [14]. Co-infections of any origin during COVID-19 pandemic need an effective strategy in the diagnostic and therapeutic approach, and even more in miliary TB with skin affectations, due to their clinical manifestations they may represent an obstacle in the prioritization of the medical care [15]. The co-infection of miliary TB with skin involvement and SARS-CoV-2, mainly in first-time patients, probably results in the lack of identification of either disease, due to nonspecific clinical characteristics of both, coupled with scarcity of clinical resources. [14,15].

The most prevalent primary immunodeficiency is common variable immunodeficiency, which is a heterogeneous disorder characterized by hypogammaglobulinemia and a wide variety of infectious (fungal and bacterial) and non-infectious complications. [16,17]. Various immunological and genetic defects are involved in the pathogenesis. In most cases of genetic origin, the disease remains unidentified [16,17] as was possibly this case report, in which socio-economic factors and first contact medical care were determining factors in the result.

Immunodeficiency or the use of immunomodulators can lead to the intensification and reactivation of TB, which in turn can be a predisposing factor to manifestations of SARS-CoV-2 [18,19]. Miliary tuberculosis with cutaneous affectations is difficult to diagnose because, its clinical manifestations can be confused with various diseases, and downplay others, generating inappropriate and delayed treatment. SARS-CoV-2 can intensify the clinical manifestations of miliary tuberculosis and if unnoticed can, directly influencing the mortality of this type of patients [20]. In the current epidemiological context, the suspicion of co-infections with TB in addition to COVID-19 in patients with respiratory tract infections, nonspecific clinical characteristics and an unexplained or prolonged clinical course must be contemplated [14].

4. CONCLUSION

The case study described is rare, which reveals the importance of differential diagnosis based on the Socio-economic status and epidemiological context, mainly in the first level of care, from human, material and technological resources which are usually insufficient, reflecting a lower quality and opportunity in medical services, and resulting in higher morbidity and mortality in this type of patients. More research is needed on the knowledge

gap as to why SARS-CoV-2 increases mortality and morbidity in those with pre existing disease including TB.

CONSENT

All authors declare that written informed consent was obtained, from the patient's parents for publication, of this case report and accompanying images.

ETHICAL APPROVAL

The research work was examined and approved by the hospital research and ethics committee.

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