Scrofuloderma: A clinicopathological and epidemiological study

Sir,

Scrofuloderma (SCF) is a type of secondary tuberculosis (TB) from an endogenous source; it occurs by contiguous spread from tuberculous lymph nodes, bones, or joints.

Tuberculous lymphadenitis of the neck is also known as *scrofa*, a word derived from the Latin word *scrofa* — a brood sow, due to likeness of the cluster of nodes to piglets feeding from the sow.[1]

Thirty-eight patients with SCF attending the dermatology department of Rajah Muthiah Medical College Hospital, from 1991 to 1998, were evaluated clinically and by skin biopsy, Mantoux test, x-ray chest, hemogram, and serum biochemical investigations. Where indicated, fine needle aspiration cytology (FNAC) and lymph node biopsy were undertaken. Personal and socioeconomic data like smoking, diet habits, alcohol consumption, housing conditions, etc., were recorded.

Majority of cases presented with discharging sinuses overlying caseating tuberculous lymph nodes [Figure 1]. The lesions healed in one area, while new lesions developed elsewhere. There was a female preponderance [F:M = 2:1], most cases occurring in the second decade. The youngest was a 2½-year-old boy; while the oldest, an 88-year-old man. The youngest female was 8 years old; while the oldest, 70 years, overall mean age being 31 years. Cervical nodes were most commonly involved (76.3%), followed by inguinal (28.9%), axillary (28.9%), and submandibular groups (10.5%) [Figure 2]. Among cervical nodes, bilateral involvement was seen in 30% of the cases, upper deep cervical group being the most common site. The time interval between onset of disease and seeking treatment varied from 1 month to 30 years, with an average of 1 year 9 months.

Four cases of coexistent pulmonary tuberculosis (PT) (4 patients, 10.5%), 1 of these with TB laryngitis, hilar
lymphadenitis, and bronchitis (7.9%); elephantiasis of external genitalia and lymphedema (2 women) [Figure 3]; and 1 case each with tuberculous synovitis of right thumb, lepromatous leprosy, protein energy malnutrition (PEM), tuberculous synovitis, and tuberculous abdomen were also seen.

In India, the commonest type of cutaneous tuberculosis is lupus vulgaris, followed by scrofuloderma, according to different workers,[2-4] though the highest incidence of scrofuloderma, followed by lupus vulgaris and tuberculosis verrucosa cutis (TBVC) has been reported by other authors.[5,6]

Biopsy revealed typical tuberculous pathology in 30 (88.2%) patients. In 8 cases biopsy showed non-specific features like granulation tissue with acute inflammatory infiltrate and scattered epithelioid cells with no evidence of well formed granulomas. Diagnostic importance was given to the clinical features and therapeutic response, as documented by other workers.[4]

Concerted attempts at improving the socioeconomic status, creating awareness about health and hygiene among the population, and provision of primary medical care facilities in developing countries will go a long way in the eradication of tuberculosis, 'the king of diseases'.

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REFERENCES