



Research Paper

## Tuberculosis Abscesses in An Immunocompetent Patient

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A 30-year-old man was admitted to the hospital with a 6 month history of coughing, weight loss and night sweats.

The clinical examination of the patient finds a collection of the right breast and an other one on the flank, which appeared 2 months previously (Panel A, blue and red arrow).

A computed tomographic (CT) scan of the chest revealed an extensive parenchymal abnormality in the left and right upper lobe (Panel B).

The CT also showed two confluent fluid collections well limited, oval, with regular contours, wall enhanced after injection of contrast product, the first one located at the right anterior chest wall, measuring 88\*40\*135mm fusing in subdiaphragmatic and coming into contact with the liver, in intimate contact with the pleura and the second one at the right lateral abdominal wall opposite the right oblique muscle, encompasses the middle arches from k9 to k12 without bone lysis and fusing in retroperitoneal and measuring 90\*58\*80mm (Panel C, D and E).

A soft tissue ultrasound showed a very limited collection, with regular contours, heterogeneous, hypoechoic, measuring 92\*33 mm, related to an abscess of the right anterior chest wall

A sputum sample was smear negative for acid-fast bacilli, the test for human immunodeficiency virus was negative.

A puncture of the abscess brought a purulent fluid, the direct examination of which was positive for acid-resistant bacillus and the test Xpert MTB/RIF detected a rifampin-susceptible *Mycobacterium tuberculosis*.

The patient began receiving combination therapy with rifampin, isoniazid, pyrazinamide, and ethambutol.

Given that the pharmacologic treatment of a tuberculosis abscess is seldom sufficient and opendrainage or surgical excision is often required, the patient was treated and transferred to thoracic surgery for surgical intervention.





