

PERFORATION OF THE HARD PALATE DUE TO TUBERCULOSIS

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Summary

A case of tuberculosis affecting the skin and nasal septum and 10 years later involving the hard palate causing perforation is reported.

Perforation of the hard palate is not a rarity in Dermato-Venereology clinics. The many causes of perforation of palate described are developmental defects, syphilis, nonvenereal treponemal infection, tuberculosis and other granulomas, neoplasms, scleroma, trauma, operative defect and chronic osteomyelitis. Among these syphilis is the most common cause of perforation¹. Perforation due to tuberculosis is extremely rare and hence we thought it worth reporting this case.

Case Report

A 22 years old female patient was admitted in the dermatology ward of Medical College Hospital, Trivandrum on 5-2-1977 with an ulcer on the hard palate and nasal regurgitation of 3 months duration. She also complained of slight defective hearing in both ears for 3 months. At the age of 10 years she developed swelling and ulceration just below the medial canthus of the left eye which then spread to the nose and upper lip. At the

same time she had an ulcer on the right elbow and left buttock. She had received some injections and tablets from a local hospital which produced healing of the lesion in 6 months time but left behind atrophic scars and depressed nasal septum.

Family History

Father died. Mother, 2 elder brothers and 4 younger brothers were alive and healthy. Mother had tuberculosis of the lung and tuberculous lymphadenitis which were treated. Her obstetrical history was satisfactory.

On examination, face showed depression of the nasal septum, thin atrophic scars below the nose in the upper lip and a linear scar below the left eye. (Fig. 1) There was an erythematous, soft, granular ulcerative lesion about 3 cms in diameter in the centre of the hard palate with a central perforation of $\frac{1}{2}$ cm. diameter. (Fig. 2). Thin, atrophic scar of about 12 cms. in diameter was present on the right elbow (Fig. 3) and a similar bigger scar involving the whole of left buttock.

E. N. T. examinations showed conductive deafness of both ears; Tympanic membranes were white and there

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Fig. 1 Face showing the nasal septum depression, thin atrophic scar below the nose in the upper lip and a linear scar below the left eye

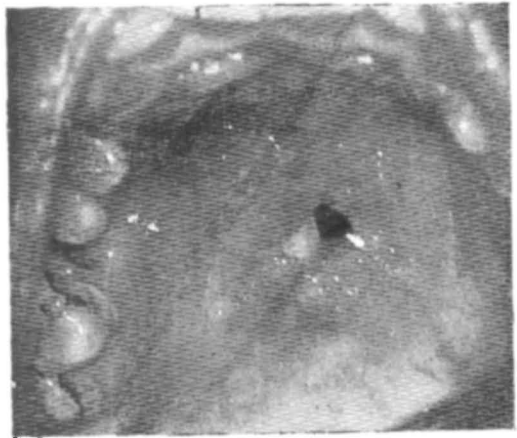


Fig. 2 Hard palate showing perforation



Fig. 3 Thin atrophic scar on the right elbow

were antero-inferior perforation in both ears. Cartilagenous part of nasal septum was completely absent and the bony part was absent in the inferior part. Inferior turbinate was destroyed. Posterior rhinoscopy showed scarring of posterior pharynx. Epiglottis was almost completely destroyed. Vocal cords were normal. C. V. S. revealed frequent, unifocal ventricular extrasystoles. No other abnormality was seen.

Investigations

Hb. Urine, ESR, VDRL, FTA-ABS, CSF and X-Ray chest revealed no abnormalities. WBC T was 8000 cm with P 50 L. 31 and E 19. Mx test was +ve with 20 m.m. induration and ulceration. X-ray face shows soft tissue shadow in the maxillary antrum and destruction of nasal septum. E. C. G. showed extrasystoles.

Biopsy of the ulcer from the palate showed pseudoepitheliomatous hyperplasia of the epidermis. Dermis showed collection of lymphocytes, epithelioid cells, few plasma cells and Langhans type of giant cells. Levadatti stain did not show any spirochetes. A. F. B. stain did not show any tubercle bacilli and PAS stain did not reveal any fungal elements.

Tissue was sent for AFB culture but only contaminants were grown.

Blood VDRL of mother and younger brothers was non-reactive.

Patient was put on streptomycin, I. N. H. and P. A. S. after the investigations and is still under follow up. After 40 days of treatment patient was seen. The ulcer showed signs of healing and the perforation was cleaner and without slough. Patient continues on antituberculous therapy.

Discussion

This patient was admitted with a provisional diagnosis of perforation

palate due to congenital syphilis. The features suggestive of congenital syphilis in this case were the age of onset of the disease, the depressed nasal septum, thin atrophic scars and perforation of the hard palate, and defective hearing. But repeated non-reactive VDRL, nonreactive FTA ABS test and the nonreactive VDRL of mother and younger brothers ruled out the possibility of syphilis or other treponemal infections. The possibility of malignancy and scleroma was ruled out by the histopathological features. The diagnosis of tuberculosis was made because of the family history of tuberculosis, strongly positive Mantoux reaction, consistent histopathology and the response to antituberculous treatment. The soft tissue shadow seen in the maxillary antrum may be due to extension of the tuberculous granuloma. The defective hearing is due to the conductive deafness produced by the suppurative middle ear disease which may be nonspecific or tuberculous in etiology. But the single perforation and the absence of granulomas are not suggestive of tuberculosis. The extrasystoles are not related to her disease and is a coincidence.

Tuberculosis first affecting the skin and then resulting in bone involvement and perforation is rare and because of the rarity this case is reported

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