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Coming HKSPR Clinical Meetings

Date	Venue	Title(s) of Presentation	Speakers	Chairperson
30 January 2013	KWH	To be confirmed	UCH	Dr. Eric Yat-Tung Chan
27 February 2013	KWH	To be confirmed	AHNH & NDH	Dr. Chiu Wah Keung
27 March 2013	KWH	To be confirmed	CMC & OLMH	Dr. Chow Siu Ngan

Answers to X-ray Quiz on page 18

Figure A showed a soft tissue mass over the left lower chest between the sternum and anterior end of left 6th rib.

Figure B showed an enlarged and calcified sub-carinal lymph node.

Mantoux test was strongly positive with induration of 2 cm. Aspiration of the mass was done and culture was positive for Mycobacterium Tuberculosis. Gastric aspirate also grew Mycobacterium Tuberculosis. The diagnosis was pulmonary tuberculosis and tuberculosis (TB) of chest wall.

On further questioning it was found out that WS's mother had chronic cough for more than 1 year while pregnant with WS. She consulted medical doctor in China when WS was 10 months old and was diagnosed to have open and disseminated TB involving lung, spine and urinary system. She completed 2 years of anti-TB treatment in China. According to her mother, WS did not have chronic cough; she had occasional low grade fever in the daytime and no other systemic symptoms.

Tuberculosis of the chest wall is uncommon and constitutes 1% to 5% of all cases of musculoskeletal TB. Tuberculous abscesses of the chest wall are most frequently found at the margins of the sternum and along the rib shafts. Destruction of the adjacent bone is more commonly seen when the lesion occurred along the rib shaft but less common when lesions occurred at or near the sternum. CT is ideal for evaluating tuberculous chest wall lesions as it demonstrates the nature and extent of soft tissue mass and accompanying intra-thoracic adenopathy and bone erosion. Unsuspected lesions of the lung parenchyma and the upper abdomen are also detected.