INTRODUCTION
Osteoarticular tuberculosis, especially in the foot is uncommon.\textsuperscript{1} It makes up less than 3% of cases of extra-pulmonary tuberculosis. As such, it has remained a diagnostic enigma despite improvements in investigative technology.\textsuperscript{1,4} It is an aggressive disease. Any significant delay in diagnosis may lead to spread of the infection from bone into adjacent joints and surrounding soft tissue. This leads to significant functional disability.\textsuperscript{1,4}

CASE REPORT
A 36-year-old South Indian priest attended the orthopaedic department with a 1-year history of spontaneous onset right foot pain. There was no history of trauma or any systemic symptoms that may indicate infection. By the time of presentation he had been living in the UK for over 5 years. His symptoms were affecting his work as a priest as footwear was not permitted in his temple.

On examination there was mild smooth swelling over the dorsal aspect of the midfoot and also diffuse hindfoot swelling. Initial radiographs showed non-specific changes in the right second tarsometatarsal joint with mild cystic change and osteopaenia. (Figure 1).

Magnetic resonance imaging (MRI) demonstrated a soft tissue mass arising from the second and third tarsometatarsal joints with associated bone destruction and soft tissue expansion. (Figure 2).

The lack of significant inflammatory change suggested a locally aggressive lesion of possible neoplastic origin. Due to lack of diagnostic clarity, further tissue diagnosis was sought with appropriately planned biopsy for histology and culture to include atypical organisms.

Initial acid-fast bacilli (AFB) result was negative. Histology revealed multiple compact granulomata with necrotic centres consistent with a mycobacterium infection. This was discussed with the histologists and respiratory physicians and the decision was made to commence treatment for tuberculosis. Subsequent culture confirmed mycobacterium tuberculosis that was sensitive to routine antimicrobials.

On completion of a 6-month antimicrobial treatment regimen had become clinically asymptomatic with regards to his foot. He was able to continue his work as a priest with no reported functional limitation. Radiographically the architecture of the midfoot was preserved with only mild second and third tarsometatarsal degenerative change.

DISCUSSION
Tuberculosis is sometimes referred to from the second and third tarsometatarsal joints with associated bone destruction and soft tissue expansion. (Figure 2).

The lack of significant inflammatory change suggested a locally aggressive lesion of possible neoplastic origin. Due to lack of diagnostic clarity, further tissue diagnosis was sought with appropriately planned biopsy for histology and culture to include atypical organisms.

Initial acid-fast bacilli (AFB) result was negative. Histology revealed multiple compact granulomata with necrotic centres containing multinucleated giant cells consistent with a mycobacterium infection. This was discussed with the histologists and respiratory physicians and the decision was made to commence treatment for tuberculosis. Subsequent culture confirmed mycobacterium tuberculosis that was sensitive to routine antimicrobials.

On completion of a 6-month antimicrobial treatment regimen had become clinically asymptomatic with regards to his foot. He was able to continue his work as a priest with no reported functional limitation. Radiographically the architecture of the midfoot was preserved with only mild second and third tarsometatarsal degenerative change.

DISCUSSION
Tuberculosis is sometimes referred to as a diagnostic enigma despite improvements in investigative technology. It is an aggressive disease, and any significant delay in diagnosis may lead to spread of the infection from bone into adjacent joints and surrounding soft tissue, resulting in significant functional disability.

CASE REPORT
A 36-year-old South Indian priest presented with a 1-year history of spontaneous onset right foot pain. There was no history of trauma or any systemic symptoms. By the time of presentation, he had been living in the UK for over 5 years. His symptoms were affecting his work as a priest as footwear was not permitted in his temple.

On examination, mild smooth swelling was observed over the dorsal aspect of the midfoot and diffuse hindfoot swelling. Initial radiographs showed non-specific changes in the right second tarsometatarsal joint with mild cystic change and osteopaenia (Figure 1). Magnetic resonance imaging (MRI) demonstrated a soft tissue mass arising from the second and third tarsometatarsal joints with associated bone destruction and soft tissue expansion (Figure 2).

Due to the lack of significant inflammatory change, further tissue diagnosis was pursued with appropriately planned biopsy for histology and culture to include atypical organisms. Initial acid-fast bacilli (AFB) results were negative. Histology revealed multiple compact granulomata with necrotic centres consistent with a mycobacterium infection. This was discussed with the histologists and respiratory physicians, leading to the decision to commence treatment for tuberculosis. Subsequent culture confirmed Mycobacterium tuberculosis that was sensitive to routine antimicrobials.

Upon completion of a 6-month antimicrobial treatment regimen, the patient had become clinically asymptomatic with regards to his foot. He was able to continue his work as a priest without functional limitation. Radiographically, the architecture of the midfoot was preserved with only mild second and third tarsometatarsal degenerative changes.

Figure 1. Plain antero-posterior radiograph. Loss of definition of cortices in the tarsometatarsal joint of the right foot compared to the left. Mild osteopaenia and cystic changes.
colloquially as ‘the great mimicker’, and as a result many cases of foot tuberculosis do not present in a classical manner. To further complicate the issue, radiological findings are often atypical and serological markers of infection are often equivocal. In the case of this patient, his symptoms had been present for over a year, and yet there were no clear clinical or radiological signs of infection to help guide diagnosis. However the suspicious appearance of the lesion on MRI was enough to warrant biopsy, which led to the final diagnosis within 6 weeks of initial presentation.

The prevalence of tuberculosis is increasing in developed countries. In the UK the Health Protection Agency’s annual tuberculosis report demonstrates significantly greater incidence in 2012 than 2010. This is widely attributed to migrant population, increasing rates of immunosuppressive disease (especially the current HIV epidemic), multidrug resistant strains of the mycobacterium, and increasing healthcare worker exposure.

Pulmonary disease is the most contributory to this increase but relative increasing incidence of osteoarticular tuberculosis is also reported.

Patient consent
The patient has provided written consent for this article to be published.

Provenance
Freely submitted; externally peer reviewed.

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