

Neelsen staining of the discharges taken separately from all discharging sinuses, demonstrated acid fast bacilli. After one month of antitubercular treatment, all discharging sinuses completely healed.

Tuberculosis (TB) of metatarsals, metacarpals and phalanges is usually associated with active pulmonary involvement, as observed in present case. TB of phalanges results in characteristic spindle shaped swelling of fingers, a condition known as spina ventosa. Spina is a latin word for “short bone” and ventosa is a latin word for “inflated with air”. The differential diagnosis of such a swelling includes syphilis and sickle cell dactylitis. Disseminated tubercular dactylitis, as seen in this case has been reported very rarely. Differentials for multiple discharging sinuses in children include staphylococcal infection and mucormycosis, both are rapidly progressive in nature, and

later is associated with necrosis of skin and subcutaneous tissue leading to eschar formation. Other gradually progressive diseases presenting as discharging sinuses in children are actinomycosis, botryomycosis, nocardiosis, and sporotrichosis. Sinus tracts of actinomycosis and nocardiosis usually discharge granules; botryomycosis is associated with subcutaneous nodules and large verrucous (wart-like) lesions; and in sporotrichosis an ascending chain of nodules develops along skin lymphatic channels (nodular angitis).

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Erythema Nodosum as the Presenting Feature of Rheumatic Heart Disease

A nine-year-old boy presented with multiple painful nodular lesions on the extensor aspect of bilateral elbow and knee joints since 15 days (**Fig. 1**). There was no sore throat, pyoderma, arthralgia, abdominal pain, drug intake or Koch's contact. On enquiry, fever and exertional dyspnea were present since 5 days. Grade III/VI pansystolic murmur was present in the mitral area. Chest x-ray and ultrasonography of abdomen were normal.



FIG. 1 Nodular lesions on the extensor aspect of bilateral elbow and knee joints.

Mantoux test was negative. Antistreptolysin titre, erythrocyte sedimentation rate and C-reactive protein were elevated. Echocardiography showed moderate mitral regurgitation. Histopathology of the nodular lesions was consistent with erythema nodosum (EN). With a diagnosis of rheumatic heart disease and active carditis, benzathine penicillin prophylaxis and aspirin were started. On follow up after 3 weeks, the nodules had disappeared.

EN is a symmetric inflammatory process involving the subcutaneous fat that causes tender, erythematous nodules. Sites involved are pretibial (most common), extensor surfaces of forearm, legs, thighs, and trunk. The lesions do not ulcerate and resolve without atrophy or scarring in one to two months. EN is a cutaneous immune-mediated (type IV delayed hypersensitivity) reaction to a variety of antigens. Commonly associated conditions include streptococcal infection, tuberculosis, sarcoidosis, sulphonamides, amoxicillin, inflammatory bowel disease, lymphoma, amoebiasis, giardiasis and viral infections (hepatitis B & C, herpes simplex, HIV and EBV). Common differential diagnoses include infectious panniculitis, lupus panniculitis, cold panniculitis, leukemic infiltrates, necrobiosis lipoidica, lipodystrophies and scleroderma. Management includes treatment of underlying disorders and supportive care i.e. bed rest, avoiding contact irritation of affected areas, non-steroidal anti-inflammatory drugs for pain and systemic steroids.

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