Different Faces of Cutaneous tuberculosis

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Tuberculosis (TB), one of the oldest diseases known to mankind continues to be a significant health problem even as we have entered the 21st century. Worldwide it remains the leading cause of death by an infectious disease. According to the World Health Organization, over one-third of the world population is currently at risk of developing tuberculosis. Infections of the skin due to *Mycobacterium tuberculosis* form a large part of the historic backdrop of dermatology. Scrofuloderma, the King's evil and lupus vulgaris once ravaged faces around Europe and the world. Improved living standards, effective screening, and treatment procedures have greatly reduced the prevalence of TB in industrialized countries but resurgence of infection is being witnessed in some areas with the emergence of the acquired immunodeficiency syndrome (AIDS) epidemic. Extrapulmonary tuberculosis constitutes approximately 10% of all cases of tuberculosis and cutaneous tuberculosis makes up only 1.5% of all such cases. Though cutaneous TB comprises only a small proportion, bearing in mind the high prevalence of TB, these numbers become significant. Serious Underreporting due to diagnostic difficulties and categorization can not be overlooked.

Numerous attempts have been made to classify cutaneous tuberculosis based on clinical morphology, route of entry of organisms, the immune status of the host, and so forth but none of them is completely satisfactory. Lupus vulgaris is the most common form of cutaneous TB reported in studies from Africa and India. Diagnosing cutaneous tuberculosis is not always easy. The suggestive clinical picture, careful history of contact with a tuberculosis patient or previous tuberculous disease, tuberculin test, and histology contribute to a diagnosis of tuberculosis. However, the definitive diagnosis can only be made by identification of *M. tuberculosis* on the smear and the recovery of organisms on culture, guinea pig inoculation, and their demonstration in the tissue section. Clinical diagnosis and so definite treatment is often delayed resulting in mutilating and disfiguring lesions and occasional malignant transformation. Deep fungal infections, syphilis, leprosy, sarcoidosis etc. among other diseases can produce an identical clinical picture, difficult to distinguish from the characteristic tuberculous histology. Some of the fascinating cases of cutaneous tuberculosis will be discussed to understand its wider clinical presentations.

Cutaneous infection with tuberculosis cannot be viewed independently of this overall pattern of disease, but changes in epidemiology, diagnosis and practice will be reflected across the clinical spectrum of this infection and can be applied to the skin as elsewhere. The treatment of cutaneous tuberculosis in most cases is the same as for pulmonary tuberculosis, as lesions in the skin often represent hematogenously or lymphatically dispersed disease from the internal foci of infection. Along with the increase in the number of patients who have both HIV/AIDS and tuberculosis, developing countries are more likely to face growing epidemiological problem of diagnosis and therapy of cutaneous tuberculosis, and even drug resistance.