Non-Healing of Operation Wounds Due to Tubercular Aetiology A Series of Case reports

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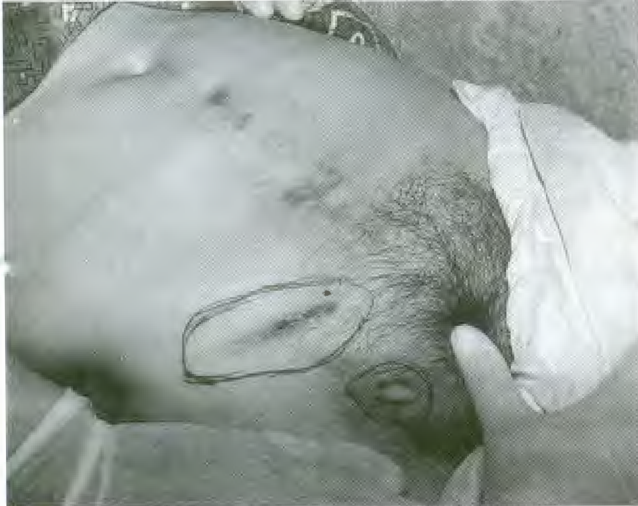
A unique observation of non healing of post operative scars and chronic sinuses at the wound site may be attributed to tubercular infection as observed in the following 6 cases out of 658 major surgeries done in the unit from Jan 97 to April 98. None of the other cases developed this kind of complictations. The usual routine of wound swab for culture and sensitivity appropriate antibiotics and antiseptic dressing were undertaken in all cases before non-healing was declared.

Case Reports:

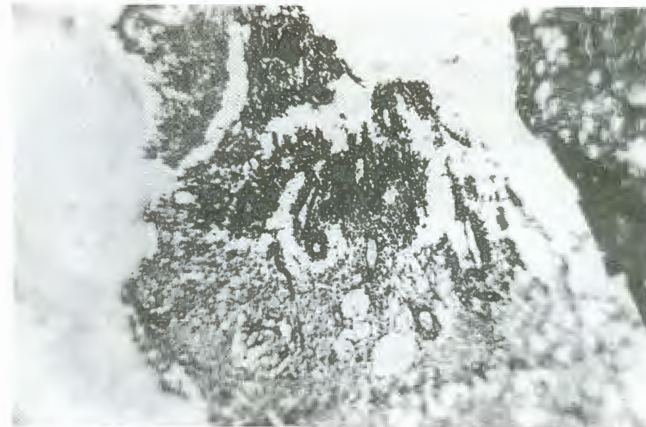
Patient MK 45 F, an operated case of hysterectomy came back two months later with multiple non-healing sinuses



Photograph I

Photograph II

Photograph III



Photograph IV

Photograph V

of wound and an indurated mass of 3x2 inch in the right inguinal region confluent with lower edge of scar (photograph 1). Needle aspiration of indurated mass revealed

tubercular granulation tissue. Patient was put on antitubercular therapy (four drugs regimen) in the intensive phase after investigation. The sinuses with undermined edges healed along with the indurated mass which had suppurated earlier. Last of the sinus track was seen in the right inguinal fold at the end of 2 months therapy. The treatment was continued for 7 months in consolidation phase with two drugs i.e. Rifampicin and Isonex.

A post operative patient of ectopic pregnancy reported one year after surgery with discharge P/A from non healing sinuses of scarline (Photograph II). They were three in number and formed 3 months after surgery. They failed to heal inspite of the treatment taken from ouside. On investigating ESR was 95mm in 1st hour and Mantoux was positive. Scrapping granulation tissue and biopsy from the ulcer edge confirmed the diagnosis of tuberculosis. She also responded to therapy (Photograph III).

Pt S.K. 40F presented with profuse discharge P/A from sinus of infraumbilical scar of hysterectomy one week after discharge. A swab culture showed gram negative organism sensitive to Cefotaxime. The sinus persisted despite vigorous antibiotics but with previous experience, patient was put on anti-tubercular therapy, to which she responded within 3 weeks and subsequently there was complete healing.

PK32 F underwent laparotomy for right sided ovarian cyst. Ovariotomy and tubal ligation procedure was carried out with uneventful postoperative period. Patient presented with non-healing injection site ulcer on the gluteal region on her first post operative visit after 1 month, with undermined edges and granulation tissue at base (Photograph IV). Histology from the scraping of granulation tissue and biopsy from ulcer edges confirmed the diagnosis of tuberculosis. Retrospective evaluation of the pre-operative investigations revealed negative Montoux with ESR 20mm at one hour. The patient responded to Anti tubercular therapy.

Pt. K39F who underwent hysterectomy in May 1997 through infraumblical midline incision was discharged with apparently healed incision line. She reported with multiple stitch abscesses 2wks later which failed to heal with antibiotic and antiseptic dressings. Although her Mantoux and ELISA tests were negative yet she responded to therapeutic test of anti-tubercular therapy. The wound sinuses healed within three weeks but complete therapy was continued.

Another female patient 28 yrs old with previous two Caesarean sections through transverse incision reported with cracks on the scarline with seepage and itching on it for the last two years (photograph V). This was not responsive to steroids and antifungal treatment. There was h/o lassitude, generalised weakness and loss of weight for the past 6 months. On investigations, Montoux test was 15mm and IgG antibodies against TB bacilli were 229 Elisa units. Patient was started on antitubercular therapy and showed rapid recovery within two weeks.

Tubercular infection of the operated scar is very rare. But it should still be thought of in isolation even in the absence of positive evidence of tubercular infection elsewhere in the body when patient has non-healing chronic post operative wound infection. It is suggested that the vigorous antitubercular four drug regimen initially for two months should be given to such patients in the intensive phase and with two drugs in the consolidation phase for another 7 months. It is further emphasized that in non healing postoperative wounds, clinician must have a high index of suspicion to reach the diagnosis. It should be treated as a separate disease actively. This variation of tubercular disease presentation is worth noticing and thus has been reported.