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TUBERCULOSIS COXITIS: DIAGNOSTIC PROBLEMS

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Abstract. Tuberculosis (TB) is one of the most socially significant infectious diseases in the world. TB of bones and joints is secondary to foci in the lungs and mediastinal lymph nodes. The spread of infection occurs in the hematogenous route. The intensity of the inflammatory process in articular TB depends on the state, first of all, of the cellular link of immunity, the presence of comorbid diseases, and the virulence of the pathogen.

Key words: tuberculosis, tuberculosis coxitis, diagnostics, methods, disease prognosis

One of the problems in confirming the diagnosis of osteoarticular TB is the oligobacillary nature of the biopsy material. As a result of confirmation of the diagnosis occurs later, the cost of financial costs for other laboratory methods increases. With late diagnosis of specific damage to bones and joints, delayed treatment, destructive damage progresses and leads to permanent disability [1, p. 445].

TB of the hip joint includes a combination of tuberculous arthritis and osteomyelitis. Timely diagnosis of tuberculous coxitis is of particular relevance in view of the damage to people of working age.

Instrumental examination of patients with TV of the hip joint includes X-ray, magnetic nuclear tomography (MRI), multispiral computed tomography (MSCT). Some patients require fistulography.

Samples of biopsy material, especially with negative results of microscopy and culture, can be examined by the Gene Expert / Hain Test method with further

determination of the sensitivity to both series of anti-tuberculosis drugs in a liquid medium MGIT-960 [2, p. 3739].

Biopsies are examined using histological and genetic molecular methods. In most patients, it takes 1 to 2 years before the diagnosis of tuberculous coxitis is established. Pain syndrome and limitation of movements progress slowly, subfebrile condition is rare. Most of these patients are treated at the first stage in the centers of medical and social assistance.

Rapid progression of TB of the hip joint is less common, accompanied by febrile fever, total destruction and contracture of the joint. With this course, the diagnosis is established from 3 months to 2 years, on average after 6 months [3, p. 18].

In X-ray and MSCT studies with TV of the hip joint in adults, primary foci in the head of the femur are practically not determined. Very rarely, primary foci in the femoral neck are visualized.

In most patients, the tuberculous process spreads to the femur from the pelvic bones around the acetabulum, where primary destruction develops. The femur is affected secondarily. With the destruction of bone structures around the acetabulum, spongy sequesters are formed.

Spongy sequesters are pathognomonic for tuberculous coxitis. A specific lesion of the hip joint can occur with trochanteritis. The combination of TB from the hip joint with active infiltrative TB in the lungs is rarely observed [4, p. 23].

Thus. with tuberculous coxitis, in the absence of timely prescribed treatment, there is a progressive destruction of the joint with a complete loss of function. Diagnosis of tuberculous coxitis is carried out taking into account clinical and laboratory data, microscopy, inoculations on Gene Expert / Hain Test nutrient media. A number of patients require an active biopsy followed by biopsy examination. An open biopsy is especially important in elderly and senile patients with the simultaneous presence of pronounced degenerative-dystrophic changes in the hip joints [5, p. 22].

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