A 2-year-old girl presented with fever, anorexia and progressive spinal deformity for the past two months, and cough and breathlessness for the past two weeks. There was no apparent contact with a case of tuberculosis (TB). BCG scar was absent. Gibbus deformities were seen at the thoracic and lumbar regions (Figure 1). The child was tachypneic with reduced air entry on the right side of the chest. The central nervous system examination was normal. Mantoux test was positive (15 mm). Chest radiograph revealed right paratracheal lymphadenopathy, right lower zone collapse / consolidation with compensatory hyperinflation of the right upper and middle zones. CT scan of the chest confirmed these findings, and also revealed a calcified lymph node in the right paratracheal and subcarinal regions. X-ray spine showed loss of disc spaces between dorsal 6-7 and lumbar 3-4 vertebrae. MRI spine revealed multifocal spondylitis involving the dorsal 6-7 and lumbar 3-4 vertebrae (Figure 2), with abnormal prevertebral and paravertebral soft tissue shadows with smooth margins suggesting the presence of cold abscesses at these levels. Bronchoscopy revealed caseous material in the right middle bronchus suggestive of endobronchial TB. HIV-ELISA test was negative. A nine-month course of anti-TB therapy (for the first two months isoniazid, rifampicin, pyrazinamide and ethambutol, followed by isoniazid and rifampicin for the next seven months) along with oral prednisolone (for the first six weeks) was started. Orthopaedic surgeons advised conservative management and weekly follow-up to detect any neurological abnormality. The patient was lost to further follow-up.

Discussion
The clinical symptoms of spinal TB in a child are often insidious and include back pain, fever, paraparesis, sensory disturbance and bowel and bladder dysfunction.\(^1\) Histological proof of TB spine by isolation or culture of *Mycobacterium tuberculosis* is obtained only in a few patients who undergo surgery.\(^2\) In the majority of the cases of TB spine, the diagnosis is confirmed on characteristic MRI findings along with other positive findings (namely, insidious clinical history of fever and anorexia; positive Mantoux test; suggestive chest radiography/CT scan chest findings; and/or a positive response to anti-TB drug therapy).\(^2\)

MRI is an ideal modality for detecting TB spine disease early, assessing the extent of disease, identifying complications such as kyphosis and cord compression, and for assessing response to treatment.\(^2\) MRI features pointing to TB are soft-tissue masses/abscesses, involvement of multiple vertebral segments of the spine and absence of reactive sclerosis.\(^2\) When there is a para- or pre-vertebral abscess or disc involvement, the MRI
features are specific for TB infection. The use of gadolinium is promising in detecting the disease earlier, as it invariably results in bone enhancement and may assist in making the diagnosis when the rim-enhancing pattern of the soft-tissue mass is demonstrated. Follow-up MRI spine can demonstrate alleviation of cord compression (if present earlier), and decrease in the size of the soft tissue mass, which are the best indicators of improvement.

Causes of multiple destructive bone lesions in children, other than TB spondylitis, include malignancies, particularly metastases from neuroblastoma, lymphoma and Ewing’s sarcoma, benign bone tumours such as aneurysmal bone cysts, and infections such as pyogenic osteomyelitis, brucellosis, fungal disease and echinococcosis. By far the most common differential diagnosis in children is vertebral osteomyelitis. TB spondylitis can be differentiated from pyogenic spondylitis by its insidious onset, by the smooth margins of the paraspinal mass on MRI and by the rim enhancement of this mass on MRI enhanced with gadolinium-DTPA.

Almost 3% of spinal TB in children develop severe kyphosis. Factors that increase the risk of severe kyphotic deformity were present in our case, namely, age below 10 years, involvement of three or more vertebral bodies and lesions between cervical 7 to lumbar 1 vertebrae. Severe kyphosis often results in spinal cord compression, cardiopulmonary dysfunction and disfigurement. Chemotherapy and conservative orthopaedic treatment remain the cornerstone of the management of spinal TB. However, children presenting with or developing neurological deficit on follow-up must undergo spinal decompression surgery to prevent worsening deformity.

To our knowledge, such a young child presenting with double gibbus due to spinal TB has not been reported earlier.

References