Commentary

Tuberculosis remains an important public health problem in developing countries and is the most common infectious cause of death, second only to HIV/AIDS. Central Nervous system tuberculosis accounts for 2-5% of all cases and often is associated with high mortality and a severe neurological sequelae.[1] All granulomatous lesions are generally grouped as tubercular in nature and are empirically treated with antitubercular treatment. A small percentage of such lesions are discovered to be fungal granuloma, which is low in virulence and histopathological examination reveals ill-formed granuloma with numerous foreign body giant cells. These cases must be appropriately treated with antifungal therapy.[2] Lakshmi *et al*. 2010 reported a rare concomitant tubercular with fungal (fonsacaea pedrosi) infection 1 in 352 cases, in middle year cleft extending and destroying cranio-vertebral junction at skull base.[3,4] Tubercular disease involving the cranio-vertebral junction requires special mention because of the difficulty in early diagnosis and possibility

of serious complications. Craniovertebral tuberculosis is rare, less than 1% of spinal tuberculosis. Common clinical signs and symptoms include pain in the neck, restriction of neck movements, low grade fever, difficulty in swallowing due to orpharyngeal bulge, lower cranial nerve palsy, and quadriparesis. Traction and antitubercular drugs are the principal mode of therapy and stability is usually achieved within 3-6 months. This is followed by immobilization of neck with cervical collar and the patient is allowed normal activities[5] Surgical decompression is indicated in patients who do not undergo spontaneous stabilization or there are progressive neurological signs. All diseased bone, synovium, and granulomatous tissue are removed and after removing any subluxation by traction anterior fusion is performed using homologous iliac or rib grafts. Following such fusion traction is used till radiological union (6-17 weeks) becomes apparent.

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