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ABDOMINAL TUBERCULOSIS – THE GREAT MIMICKER ABDOMEN – THE MAGIC BOX OF SURPRISES

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ABSTRACT

Tuberculosis is endemic in india. Abdomen is the sixth commonest form of extra pulmonary tuberculosis. It has varied clinical presentation mimicking a variety of diseases of the gastrointestinal tract including inflammatory bowel disease, peptic ulcer and malignancy. Tuberculosis can involve any part of the gastrointestinal tract from mouth to anus or solid organs or peritoneum. Tuberculosis causing gastric outlet obstruction is quite rare. We present a case of gastric outlet obstruction due to tuberculous intraabdominal lymphadenopathy associated with disseminated tuberculosis of the peritoneum. He had tuberculous involvement of the parietal and visceral peritoneum of the entire gastrointestinal tract but without involvement of gastrointestinal tract or solid organs and without ascitis.

Keywords: Abdominal Tuberculosis

1.INTRODUCTION

Tuberculosis is endemic in india. It can involve any part of the body. Primary pulmonary tuberculosis is the commonest form though extrapulmonary tuberculosis is not rare. Abdomen is the sixth commonest form of extrapulmonary tuberculosis. Mode of spread is by ingestion, haematogenous or direct spread from fallopian tubes. Commonest sites of involvement are ileocaecal region, peritoneum and lymph nodes. Abdominal lymph nodal and peritoneal tuberculosis may occur without gastrointestinal involvement in about one third of the cases. We present a case of tuberculosis of the abdomen with multiple lymph nodal enlargement causing gastric outlet obstruction and miliary tubercles all over the parietal and visceral peritoneum without significant ascitis.

A 45 year old male presented with complaints of abdominal pain and vomiting after food for 5 years duration. He had history of loss of weight but his appetite was normal. There was no history of haematemesis or malaena. His bowel and bladder habits were normal. There was no history of fever, cough, haemoptysis or other constitutional symptoms. He was under anti secretory medications without relief and was repeatedly hosplitalised for similar complaints. On examination he had visible gastric peristalsis without evidence of any palpable mass or organomegaly or ascitis. His blood counts were normal, ESR was elevated, renal and liver function tests were within normal limits. His chest X-ray was normal. Ultrasound of the abdomen didnot show any mass lesion or ascitis. Upper GI endoscopy showed pyloric antral ulcers and the scope could not be passed beyond gastric outlet. Biopsy from the ulcer showed only chronic gastritis. A provisional diagnosis of gastric outlet obstruction due to cicatrised duodenal ulcer was made. An exploratory laprotomy was performed and to our surprise there were extensive miliary tubercles all over the parietal and visceral peritoneum of the GIT from stomach to rectum. Multiple enlarged nodes were found in the greater and lesser omentum and the mesentry of small and large intestines. Stomach was dilated due to extraneous obstruction by multiple enlarged perigastric nodes largest of which measured 3cm in diameter. Omentum was thickened and found plastered to the transverse mesocolon. There was no significant ascitis and no adhesion between the bowel loops. The small and large intestinal loops did not show any evidence of wall thickening or narrowing. It was decided to avoid vagotomy and gastrojejunostomy as planned preoperatively because of the high possibility of anastamotic breakdown in peritoneal tuberculosis. The gastric outlet obstruction was temporarily managed by placing the ryles tube beyond the gastroduodenal junction. Biopsy from omentum, mesetric nodes and peritoneal tubercles showed caseating granulomas with positive staining for acid fast bacilli. Postoperatively patient was started on ATT with enteral feeding through the ryles tube. Slowly patient tolerated oral fluid diet and the ryles tube was removed. On follow up the patient was symptom free at 3 months.

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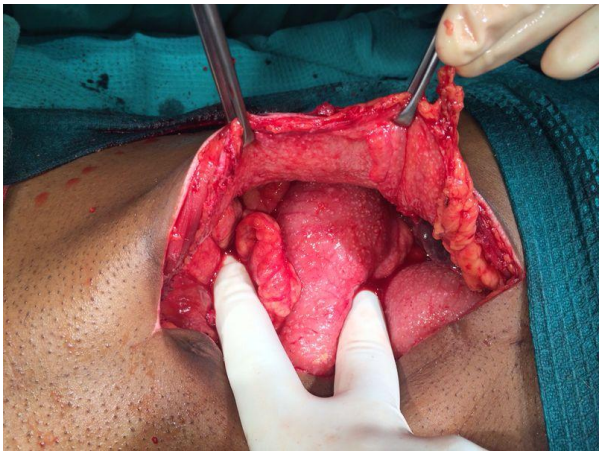
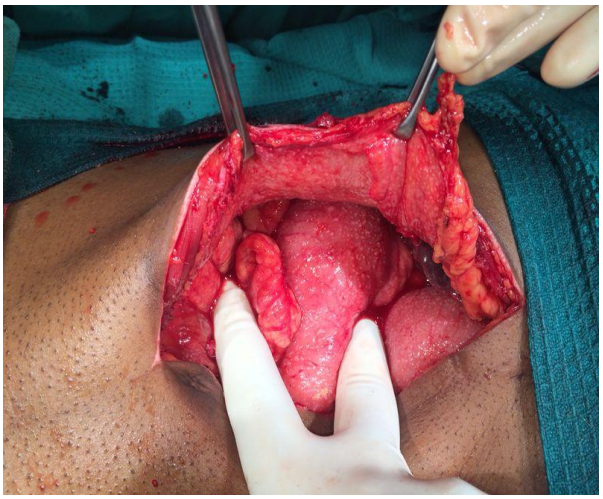
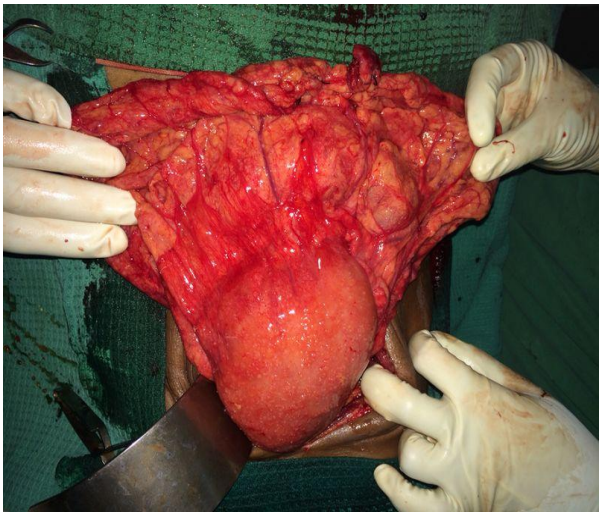
Case record







2.DISCUSSION:

Tuberculosis of the abdomen may involve gastrointestinal tract, lymphatic system, peritoneum and solid viscera to varying degrees alone or in combination. It may or maynot be associated with pulmonary tuberculosis. The possible route of spread is by ingestion , haematogenous or direct spread from fallopian tube. In the gastrointestinal tract ileocaecal region is the commonest site of involvement due to stasis and high density of lymphoid tissue in the submucosa. However involvement of the peritoneum and lymphnodes of the abdomen without associated hollow viscus involvement can occur in one third of cases. Involvement of lymph nodes is the commonest CT finding in abdominal tuberculosis followed by involvement of peritoneum.

Tuberculosis of the lymph nodes commonly involves omental, mesenteric, periportal and peripancreatic nodes whereas involvement of retroperitoneal nodes is less common. Tuberculous Lymph nodes causing bowel or biliary obstruction is rare and only a few cases have been reported in the literature. In our patient there were multiple enlarged nodes in the greater and lesser omentum, mesentery of the entire small intestine and transverse mesocolon. The largest of the lymph nodes measured 3cm in diameter and was found along the origin of right gastroepiploic artery.

Tuberculosis of the peritoneum has three forms of presentation: ascitic type, plastic type and fibrous type. Though ascitic (wet) form is the commonest, some degree of overlapping is present in majority of cases. Disseminated peritoneal tuberculosis is almost always associated with ascitis but in our patient ascitis was characteristically absent and loops of small and large intestine were free of adhesions and none of them had wall thickening or narrowing.

Several investigators who studied the CT findings have concluded that CT findings are highly non specific and a high degree of suspicion is needed to diagnose abdominal tuberculosis. In our patient CT scan [was not performed] didnot show significant ascitis or mass or thickening of bowel wall.

3.CONCLUSION

This case is presented because of the rarity of gastric outlet obstruction due to intraabdominal tuberculous lymphadenopathy. Moreover disseminated peritoneal tuberculosis was present without ascitis. So, in an endemic area like India tuberculosis should always be borne in mind as a possible differential diagnosis of gastric outlet obstruction though characteristic clinical features may be absent.

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