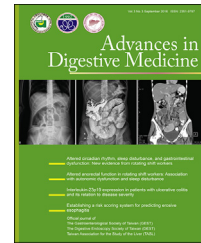




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CASE REPORT

Intestinal ileus and pneumatosis intestinalis as the major manifestations of tuberculous peritonitis: A diagnostic challenge



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KEYWORDS

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Summary Tuberculous peritonitis (TBP) is a continuing problem in populations with high prevalence of tuberculosis and is difficult to diagnose early. Here, we report a case of confirmed TBP that presented as intestinal ileus and pneumatosis intestinalis. The 79-year-old woman had a history of atrial fibrillation, chronic ischemic heart disease, and chronic renal failure (chronic kidney disease, stage V). She complained of abdominal fullness and pain for 1 week prior to hospitalization. A computed tomography (CT) scan revealed pneumatosis intestinalis. Laparoscopic surgery was performed, and multiple whitish nodules covering the peritoneum were discovered. Biopsy results were consistent with caseating granulomatous inflammation. A modified anti-tuberculosis regimen (isoniazid, 300 mg daily; rifampicin 600 mg daily; ethambutol 800 mg three times per week; and pyrazinamide 1200 mg three times per week) was initiated, stabilizing the condition of the patient. The total duration of anti-tuberculosis therapy was 12 months, with patient condition gradually improving to normal. The elderly, uremic patients recovered fully after the modified anti-tuberculosis regimen for 12 months. For clinical practice, we developed a decision-making algorithm for patients suspecting TBP.

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Introduction

Tuberculous peritonitis (TBP) is a continuing problem in populations with a high prevalence of tuberculosis (TB). According to reports by the World Health Organization, one-third of the world population is at risk for TB. In the 1990s, more than 30 million people died of TB, particularly in Asia and Africa [1]. Abdominal TB is one of the most common forms of extrapulmonary TB [2], with TBP usually diagnosed late due to lack of specific symptoms and laboratory findings. Intestinal obstruction and pneumatosis intestinalis are seldom reported as the major manifestations of TBP.

In 75% of patients, acute intestinal obstructions result from many conditions that must be differentiated, included adhesive bands secondary to previous abdominal surgery, adynamic intestinal obstruction, and primary intestinal pseudo-obstruction [3]. Some cases of mechanical intestinal obstruction require surgical intervention. Clinical presentation, laboratory reports, and radiographic studies are sometimes used to decide between surgery and non-surgical treatment [3].

Here, we report a case of confirmed TBP presenting as intestinal obstruction and pneumatosis intestinalis.

Case Report

A 79-year-old woman with a history of atrial fibrillation, chronic ischemic heart disease, and chronic renal failure

(chronic kidney disease, stage V) complained of abdominal fullness and pain for 1 week prior to hospitalization. The characteristics of her abdominal pain were as follows: located at the umbilical area, 1–2 hours in duration, an onset-to-maximal intensity interval of seconds, a frequency of 2–3 times/day, aggravated by feeding, and relieved by rest. The abdominal pain became more severe and frequent with additional nausea and vomiting, and fever developed 1 day before hospitalization. Subsequently, she was brought to the emergency department (ED) of our institute for help. At the ED, vital-sign measurements were: blood pressure, 100/90 mmHg; temperature, 37°C; pulse rate, 110 beats/min; and respiratory rate, 20 breaths/min. The patient appeared acutely ill, and the abdomen was distended and ovoid. There was radiation pain and tenderness to her back, and abdominal fullness over the right quadrant area (negative Murphy's sign), but no rebounding pain. Initial laboratory data at the ED showed a white blood cell count of 2900/ μ L, with 68.1% neutrophils, 8.7 g/dL hemoglobin level, 97,000/ μ L platelet count, 19.8 s prothrombin time with an international normalized ratio of 1.84, 140 mm/h erythrocyte sedimentation rate (ESR), 7.1 mg/dL C-reactive protein level, 73 U/L serum amylase level, 2.56 mg/dL total bilirubin level, 156 U/L glutamic-pyruvic transaminase level, 94 μ g/dL ammonia level, 55 mg/dL urea nitrogen level, and 6.13 mg/dL serum creatinine level. A kidney, ureter, and bladder (KUB) X-ray showed excessive bowel

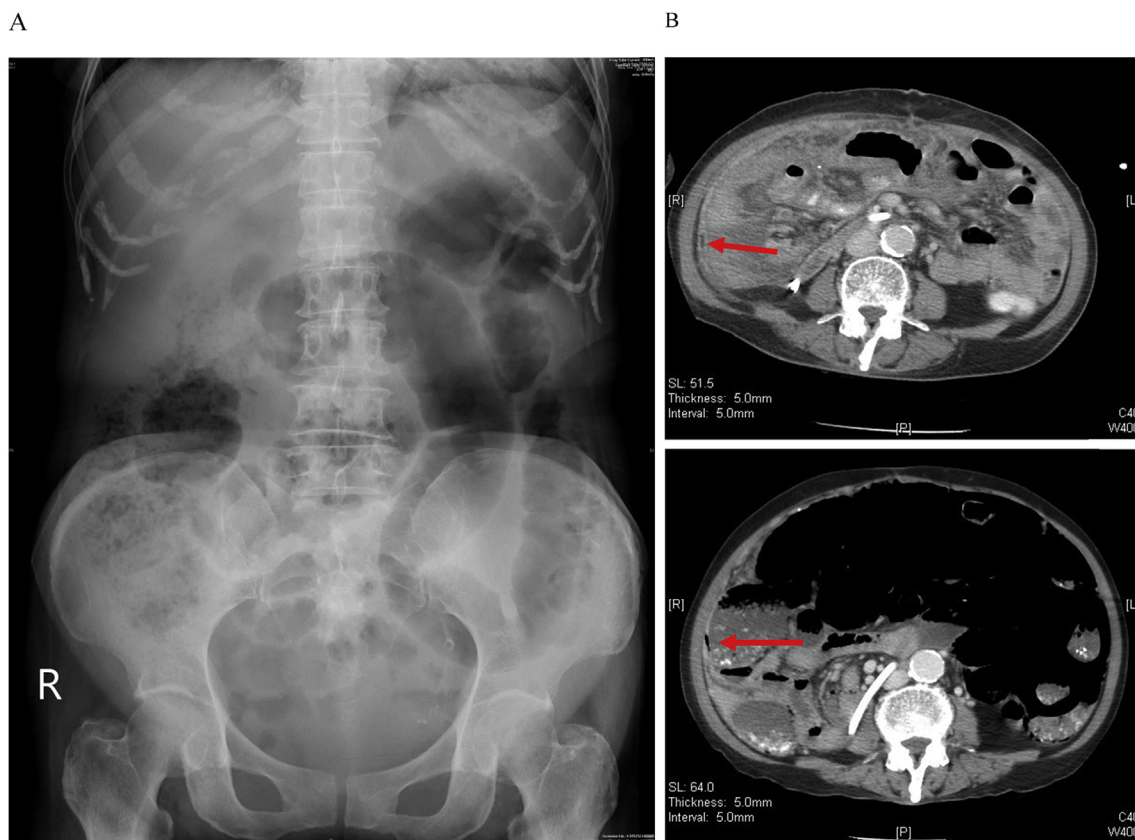


Figure 1 Images of the patient consistent with tuberculous peritonitis. (A) Kidney, ureter, and bladder X-ray showing increased bowel gas. (B) Computed tomography indicating thickened peritoneum with mild ascites and air collection (arrow) in the bowel wall from the jejunum to the ascending colon and suspected pneumatosis intestinalis.

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