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Ileocaecal and transverse colonic tuberculosis mimicking colonic malignancy – A case report



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ABSTRACT

INTRODUCTION: Gastrointestinal tuberculosis is common in the developing world especially in the lower socioeconomic groups. In elderly, it may mimic malignancy.

CASE PRESENTATION: A 46-year-old female presented with a 6 month history of diffuse pain in abdomen with low grade fever and loss of weight and appetite. Clinically, differential of malignancy of the large bowel was considered. The computerized tomography(CT) scan of the abdomen revealed a diffuse concentric long segmental thickening of terminal ileum, ileo ceecal junction, ascending colon and narrowing of the transverse colonic end of the splenic flexure suggesting an infective etiology. Colonoscopy showed an ulcero-nodular lesion at the splenic flexure raising the possibility of colonic cancer and thickening of ascending colon and caecum. Colonoscopic biopsy from both sites, on histopathology, showed a moderate mixed inflammation and occasional lymphoid collection and crypt abscesses in the lamina propria giving a differential of tuberculosis or Crohn's disease. Biopsy smear showed occasional acid fast bacilli(AFBs) and the gene Xpert detected mycobacterium tuberculosis(MTB). The patient was started on anti Koch's therapy(AKT).

DISCUSSION: In this case the differential diagnosis was malignancy of the colon, inflammatory bowel disease and tuberculosis as all these conditions may have similar clinical profile and radiological findings. Tuberculosis of bowel was considered as the most probable diagnosis due to the CT findings. But the colonoscopy suggested malignant etiology.

CONCLUSION: Possibility of tuberculosis should be kept in mind while dealing with synchronous lesions in large intestine.

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1. Introduction

There were an estimated 2.5 million cases of tuberculosis in India in 2015 [WHO, Geneva, 2015]. Gastrointestinal tuberculosis is common in the developing world especially in the lower socioeconomic groups. The abdominal TB, which is not so commonly seen as pulmonary TB, can be a source of significant morbidity and mortality and is usually diagnosed late due to its nonspecific clinical presentation [1].

Approximately 15%-25% of cases with abdominal TB have concomitant pulmonary TB [2,3]. The diagnosis of gastrointestinal tuberculosis is difficult in the middle aged as the clinic-radio-

pathological spectrum mimics malignancy and Inflammatory bowel Disease (IBD). This case was managed at a tertiary care teaching hospital, academic setting.

2. Case presentation

A 46 year old female patient came walking to the outpatient department with a 6 month history of diffuse abdominal pain with low grade fever and loss of appetite and weight. No significant past medical or surgical history. There was no history of pulmonary tuberculosis.

On examination, general condition was fair, vitals were stable. Abdominal examination revealed a soft non tender abdomen with a normal digital per rectal examination.

Haematological investigations were normal except erythrocyte sedimentation rate(ESR) which was 80 mm (0–30 mm normal). Her serum levels of carcinoembryonic antigen(CEA), cancer antigen 19-9(CA 19-9) and serum adenosine deaminase(ADA) levels were within normal limits.

Contrast enhanced CT(CECT) abdomen revealed a diffuse concentric long segmental circumferential wall thickening of terminal

Abbreviations: ESR, Erythrocyte Sedimentation Rate; ADA, Adenosine Deaminase; CT, Computerized Tomography; CEA, Carcino Embryonic Antigen; CA 19-9, Cancer Antigen 19-9; AKT, Anti Koch's Treatment; MTB, Mycobacterium Tuberculosis; IBD, Inflammatory Bowel Disease; GITB, Gastrointestinal Tuberculosis.

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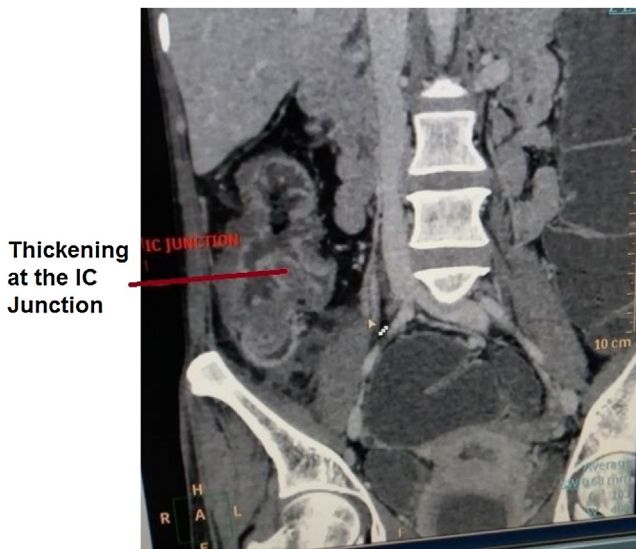


Fig. 1. Showing thickening at the IC junction.

ileum, ileocaecal(IC) junction and ascending colon with peripheral fat stranding and lymphadenopathy with narrowing at the splenic flexure (Figs. 1–3).

Colonoscopy showed an ulceronodular lesion with lumen compromise at the splenic flexure and thickening of the ileocaecal junction. Biopsy was taken from both the sites and sent for histopathological examination and also for culture and gene xpert for MTB.

Pathology showed moderate mixed inflammation and occasional lymphoid collection in the lamina propria with no evidence of malignancy. There were also occasional crypt abscesses which raised suspicion of inflammatory bowel disease. The final diagnosis of tuberculosis of the intestine was made as the biopsy smear showed AFBs and the Gene Xpert detected MTB. The patient was started on Anti tubercular therapy. At 6 month follow up, patient is asymptomatic. Repeat CT scan shows no narrowing (Fig. 4).



Fig. 2. Showing thickening at hepatic flexure.



Fig. 3. Showing narrowing at the splenic flexure.

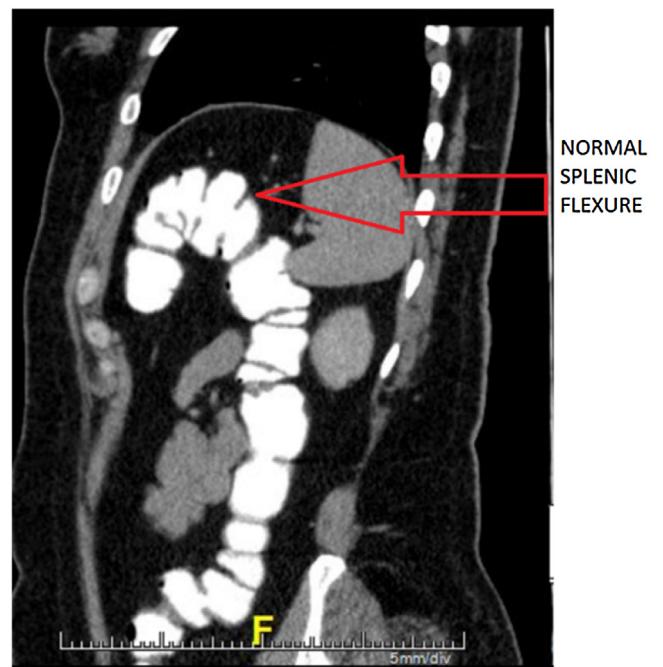


Fig. 4. Showing resolution of narrowing at splenic flexure.

3. Discussion

In India, TB is one of the commonest infections affecting poor socioeconomic groups.

Gastrointestinal Tuberculosis is a major health problem and is a rising threat due to transglobal migration [4]. It is not entirely known if the bacteria colonize the bowel by penetrating through the wall or enter that site through the arterial circulation. The most common site of gastrointestinal involvement is the ileocaecal region which is involved in 64% of cases of gastrointestinal TB

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