

A Case Report of Colonic Tuberculosis

¹. A.K.Badrinath, ². K.Suresh, ³. B. Karthikeyan, ⁴. Suresh babu .S

¹. Professor , Department of General Medicine, Sri Manakula Vinayagar Medical college and hospital ,
Puducherry.

². Associate Professor, Department of General Medicine, Sri Manakula Vinayagar Medical college and hospital
, Puducherry.

³. Assistant Professor, Department of General Medicine, Sri Manakula Vinayagar Medical college and hospital ,
Puducherry.

⁴. Resident (M.D General Medicine), Department of General Medicine, Sri Manakula Vinayagar Medical
college and hospital , Puducherry

*Corresponding Author: Dr. A.K.Badrinath

Abstract: Tuberculosis a disease caused by *Mycobacterium tuberculosis* is a major cause of morbidity and mortality in our country. Tuberculosis can affect any part of the body but most commonly involves the lungs. Colonic tuberculosis can occur through hematogeneous spread or through oral route and involve the caecum most commonly. Here we present an elderly male patient with colonic tuberculosis extending from the caecum involving the ascending and transverse colon.

Date of Submission: 26-04-2018

Date of acceptance: 14-05-2018

I. Case Report:

A 63 year old male patient presented with complaints of abdominal pain for 5 months, diffuse pain associated with loss of appetite and weight loss over the past 5 months. Patient had history of difficulty in passing stools and constipation for the past 3 months. Patient also had complaints of non productive cough and breathlessness. Patient had a chronic history of smoking and occasionally consumes alcohol. On examination patient was conscious and oriented thin built with a low BMI – 16. Vitals were stable, systemic examination revealed harsh vesicular breath sounds and per abdomen mild rigidity with no organomegaly. Patient was admitted with provisional diagnosis of cachexia with ? GI malignancy and evaluated.

His complete haemogram and renal functions tests were normal with elevated ESR. Liver function tests were normal except for hypoalbuminemia and chest X ray revealed bilateral diffuse infiltrates involving all the zones. Ultrasonogram of the abdomen revealed Irregular circumferential bowel wall thickening including ileocaecal junction, ascending colon and hepatic flexure infiltrating into adjacent mesentery with thickened mesentery with multiple small lymph nodes. He was further investigated with a CECT Abdomen which showed Diffuse circumferential bowel wall thickening with submucosal edema involving caecum, ascending colon, hepatic flexure and right half of transverse colon. Screening of the chest (HRCT) revealed features of endobronchial tuberculosis. The possible diagnosis in this situation was a colonic malignancy or colonic tuberculosis. Colonoscopy of the patient showed circumferential nodular lesions causing luminal narrowing extending from the hepatic flexure to ascending colon. The scope was not able to pass beyond the ascending colon and biopsy samples were taken. Histopathology revealed chronic granulomatous lesions and tissue PCR for tuberculosis was positive. Patient was started on category 1 Anti-tuberculosis treatment and discharged.

II. Discussion:

Tuberculosis is a major health problem worldwide and with increasing age, diabetes and HIV infection it is re-emerging. Tuberculosis can affect any organ of the human body though the lungs are commonly involved, abdominal tuberculosis is often diagnosed lately and contributes significantly to morbidity and mortality. Concomitant pulmonary involvement is seen in around 20% of patients with abdominal TB and in this case he had pulmonary involvement. The mode of infection may be hematogenous or oral route. The usual site of involvement is the terminal ileum because of its rich lymphoid tissue and longer transit time. A high degree of suspicion is needed for diagnosing colonic TB and in many scenarios inflammatory bowel disease was suspected. Most of the patients with intestinal TB present with abdominal pain, cachexia, diarrhea, alternating bowel habits and abdominal mass. Imaging – ultrasonography may show ascitis, lymphadenopathy with thickening of the bowel and mesentery is seen. Computed tomography may be more specific than ultrasonography and reveals high density ascitis, thickened bowel loops and irregular soft tissue densities in omental area. Nodal enhancement (omental & upper para-aortic) with contrast similar to tuberculosis is seen in

metastasis, whipple's disease and lymphoma. Intestinal involvement in colonic TB may mimic crohn's disease. Tissue biopsy is necessary for a more definitive diagnosis with colonoscopy. Colonoscopy may reveal ulcers, nodules, luminal narrowing, polypoid mass and ileocecal valve deformity. Our patient had luminal narrowing due to nodules. Histopathology in case of intestinal TB shows granulomas which are noncaseating in most of the case reports as also in this case. In some cases caseation and acid fast bacilli has been reported in the intestinal biopsy. For definitive diagnosis requires tissue PCR of TB bacilli for diagnosis. Treatment of colonic tuberculosis is same regime of ATT with 2 months of HRZE and 4-5 months of HR. From various studies it has been shown that patients with colonic TB respond well with ATT as most of the pathology in these cases are inflammatory. Complications include intestinal obstruction (luminal narrowing) and stricture formation. The most common misleading diagnosis in patients with colonic TB is crohn's disease and malignancy. To conclude a proper history taking giving importance to subtle clues may be useful in early diagnosis of disease condition and importance of tissue level investigation for a definitive diagnosis.

References:

- [1]. Donoghue HD, Holton J. Intestinal tuberculosis. *Current opinion in investigational drugs.* 2009;22: 490-96.
- [2]. Horvath KD, Whelan RL. Intestinal tuberculosis : return of an old disease. *Am J Gastroenterol.* 1998; 93: 692-96.
- [3]. Das HS, Rathi P, Sawant P, et al. Colonic tuberculosis : colonoscopic appearance and clinico pathological analysis. *J Assoc Physicians India.* 2000; 48: 708-710.
- [4]. Nagi B, Kochhar R, Bhasin DK et al. colorectal tuberculosis. *Eur radiol.* 2003; 13 : 1907-12.
- [5]. Das S, Puri S, Puri AS. Gastrointestinal : multiple colonic strictures caused by tuberculosis. *J Gastreenterol hepatol.* 2006; 22: 476.

Dr. A.K.Badrinath. "A Case Report of Colonic Tuberculosis."IOSR Journal of Dental and Medical Sciences (IOSR-JDMS), vol. 17, no. 5, 2018, pp 35-36.