A rare case of abdominal tuberculosis with vomiting : letter to the editor

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To the Editor,

A 40-year-old female patient presented with vomiting, consisting of bile and food consumed the previous night, approximately 1 hour after each meal. She had experienced this symptom for 4 months, and the vomiting had increased in severity during the previous 2 months. The patient had not experienced abdominal pain, abdominal distension, jaundice or fever. An oesophago-gastro-duodenoscopy revealed two distal duodenal ulcers. Biopsies (Figs. 1 and 2) revealed non-specific inflammation. The patient was treated with proton pump inhibitors and aluminium phosphate gel for 2 months, but the vomiting did not improve. A barium meal (Fig. 3) was then administered, and a colonoscopy (Fig. 4) was performed despite the absence of lower gastrointestinal (GI) symptoms. The barium meal revealed one long stricture in the descending part of the duodenum, and a colonoscopy revealed persistent narrowing of the ascending colon and a circumferential ulcer. In addition, nodular ileitis was noted in the terminal ileum. A biopsy revealed non-specific inflammation, and acid-fast bacilli (AFB) staining was negative.

This presentation is most consistent with

A. Crohn's disease
B. Lymphoma
C. A malignant tumour
D. Abdominal tuberculosis (TB)
E. Sarcoidosis

Answer

This patient had abdominal TB (specifically, combined duodenal and intestinal TB). If she had received an early diagnosis, she might have only required anti-TB therapy. A right hemicolon resection combined with a gastrojejunostomy was performed to relieve the duodenal obstruction and to exclude Crohn's disease and lymphoma. The final pathological examination revealed chronic granulomatous inflammation of the lymph nodes below the common bile duct and right hemicolon. AFB staining identified AFB in the right hemicolon. After the operation, the patient received an anti-tubercular fixed-dose combination (isoniazid, rifampicin, pyrazinamide and ethambutol) for one year and regained a good general condition.

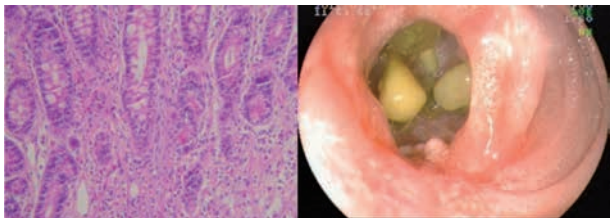

Fig. 1

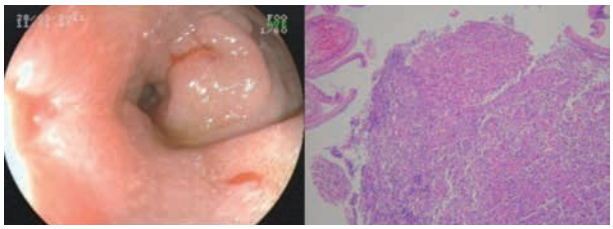

Fig. 2

Discussion

GITB is a rare disease, even in regions of the world where TB is endemic (1,2). However, only 2% of GITB patients are diagnosed with duodenal TB (3,4,5). The clinician's role is to differentiate duodenal TB from other causes of GI ulcers (which include inflammatory bowel disease, lymphoma, and malignant tumours) while avoiding unnecessary investigation and intervention. The patient described here was misdiagnosed for four months. The clinical manifestations of duodenal TB are non-specific and can mimic the symptoms of several other GI diseases and can thus lead to a prolonged misdiagnosis. A colonoscopy should be performed even in the absence of lower GI symptoms (as in our case) to provide more evidence for an early TB diagnosis. Thickening of the duodenal wall, which is associated with lymph node enlargement, is often visible via a CT scan and can facilitate TB diagnosis as well (2). Jumbo forceps biopsies with PCR and AFB staining are also vital for the

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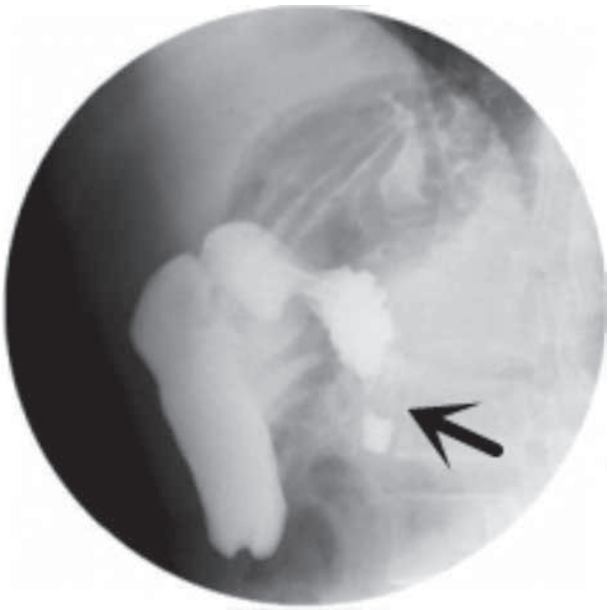

Fig. 3

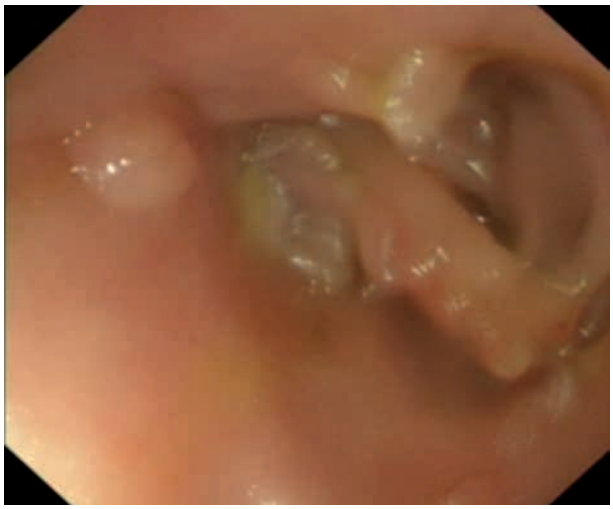

Fig. 4

diagnosis of TB. Moreover, a high index of suspicion for TB is required for any patient with GI symptoms who resides in an endemic area, such as China.

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