

Duodenal mass in a patient with rheumatoid arthritis

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Case

A 41-year-old woman who had been followed for rheumatoid arthritis (RA) was admitted to the gastroenterology clinic with a complaint of dyspepsia and bloating for a month. Her past-medical history was insignificant other than RA and she was using infliximab for last two years. The physical examination was unremarkable. Laboratory tests such as complete blood count, creatinine, liver enzymes were within normal range and the C-reactive protein level was 9.1 mg/L (N: 0–6). Endoscopy of upper gastrointestinal tract showed erosive gastritis and a mass partially obstructing the lumen at the distal site of the second part of the duodenum (Figure 1A-1B). There were ileal ulcerations at colonoscopy. Multiple biopsies were taken from the duodenum, stomach and ileum. Thoracoabdominal computed tomography (CT) scan revealed a mass lesion at 3rd part of duodenum and uncinata process level of pancreas (Figure 1C), multiple enlarged lymph nodes in the intraperitoneal and retroperitoneal area, and multiple nodular lesions, less than 5 mm in diameter, in both lungs. What could the patient's diagnosis be?

Answer

The histopathological examination of the stomach, duodenum and ileum biopsies revealed chronic gastritis, granulomatous duodenitis (Figure 2A) and granulomatous ileitis (Figure 2B) respectively. The tuberculin skin test was positive (21 mm). The patient was diagnosed with disseminated tuberculosis and antituberculous therapy for 9 months (combination of isoniazid/rifampicin/pyrazinamide/ethambutol for 2 months in the initial phase, and combination of isoniazid/ rifampicin for 7 months in the continuation phase) was initiated. There was no clinical or laboratory adverse event during the treatment period. A month after the antituberculous treatment completed, endoscopy and abdominal CT were repeated. Duodenal mass was completely disappeared at both endoscopy (Figure 2C) and CT.

Gastrointestinal tuberculosis often involves ileocecal region but rarely affects duodenum (1). Primary or secondary duodenal tuberculosis may present with non-healing or bleeding ulcer or an obstructing or fistulising mass suggesting other diseases including Crohn's disease and malignancies (2). Hence, diagnosis may be a dilemma and is often put after surgical resection



Fig. 1.

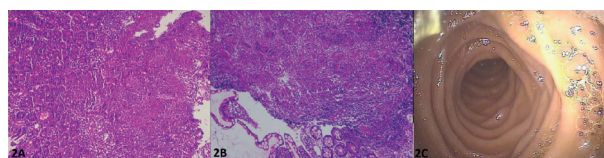


Fig. 2.

(3). Our patient developed disseminated tuberculosis after receiving infliximab treatment. It was previously demonstrated in many studies that anti-tumor necrosis factor (anti-TNF) agents including infliximab increase the tuberculosis infection risk. Careful retrospective analysis revealed that our patient was not evaluated for prophylactic antituberculosis treatment before infliximab with an unknown reason. It would be prudent to keep rare forms of tuberculosis in mind such as duodenal tuberculosis while following patients who are using anti-TNF agents.

References

1. GİOULEME O, PASCHOS P, KATSAROS M, PAPALEXİ F, KARABATSOU S, MASMANIDOU M, *et al.* Intestinal tuberculosis: a diagnostic challenge case report and review of the literature. *Eur J Gastroenterol Hepatol.*, 2011, **23** : 1074-7.
2. NAGI B, LALA, GUPTA P, KOCHHAR R, SİNHA SK. Radiological findings in duodenal tuberculosis : a 15-year experience. *Abdom Imaging*, 2015, **40** : 1104-9.
3. KENTLEY J, OOI JL, POTTER J, TİBERİ S, O'SHAUGHNESSY T, LANGMEAD L, *et al.* Intestinal tuberculosis: a diagnostic challenge. *Trop Med Int Health*, 2017, **22** : 994-9.

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