



TUBERCULOSIS VS ACUTE PANCREATITIS: A CASE REPORT

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ABSTRACT

Tuberculosis is a very important cause of morbidity and mortality in Indian subcontinent specially in India. Tuberculosis has very wide range of presentation. So, some time it creates a lot of confusion in the diagnosis. Patient may present as acute abdomen. Some time patient present with ascitis which can mimics as malignancy. In this study our aim is to keep tuberculosis as provisional diagnosis in case of acute abdomen. Here, patient of abdominal tuberculosis present with feature of acute pancreatitis.

KEYWORDS : acute pancreatitis, abdominal tuberculosis, peritoneal tuberculosis

INTRODUCTION

Tuberculosis is one of the most frustrating and problematic diseases which is known to affect human health. It is caused by the bacteria *Mycobacterium tuberculosis*. Abdominal tuberculosis is defined as infection of the peritoneum, hollow or solid abdominal organs with *Mycobacterium tuberculi*. This primary gastrointestinal focus is established as a result of haematogenous spread from a pulmonary focus acquired during primary infection in childhood or later stage of life. It may also be caused by swallowed bacilli which pass through the Peyer's patches of the intestinal mucosa and are transported by macrophages through the lymphatics to the mesenteric lymph nodes, where they remain dormant.¹ The peritoneum and the ileocaecal region are the most likely sites of infection and are involved in the majority of the cases by hematogenous spread or through swallowing of infected sputum from primary pulmonary tuberculosis. Other locations of involvement, in order of descending frequency, are the ascending colon, jejunum, appendix, duodenum, stomach, oesophagus, sigmoid colon, and rectum. Multiple areas of the bowel can be affected.² This old disease may be fatal within just 5 years in more than 50% of cases.³ Extrapulmonary tuberculosis (ETB) accounts for 18.7% of all tuberculosis patients in the USA, and peritoneal tuberculosis is not a common form of it. It is seen just in 4.7% of all patients.⁴ India is a country that has a moderate level of TB. With the implementation of the Health Transformation Programme, our health indicators reached the same level as those in upper-income countries. Tuberculosis prevalence decreased from 38 per 100,000 populations in 2002 to 24 per 100,000 population in 2011 in provinces and district centres.⁵ Ascites of tuberculosis is an exudative form just as in malignancy cases. Clinically, abdominal tuberculosis may present as an acute abdomen, either due to obstruction of bowel, perforation or mass in right lower abdomen mimic appendicular mass or acute appendicitis.⁶ Moreover, they share many similarities in symptoms and radiology and laboratory results. True diagnosis with and correct follow-up can decrease patient morbidity and deaths. Peritoneal tuberculosis is a rare entity in the literature and will be discussed in this case report.

THE CASE:

A patient named Mr. X 19 years/male, by occupation worker in cement factory, presented with chief complain of pain in epigastrium which was sudden in onset, throbbing in nature, which is decrease by opioids analgesic, and pain radiates to back. Pain is not associated with nausea and vomiting. On examination there is guarding and rigidity in epigastrium and right sub costal area. On further examination, there is multiple lymph node palpable in cervical, which is soft, non tender non matted (discrete). There is 1*1 cm lymph node in

axilla in central group and 1 supraclavicular lymph node was also present with same characteristic. Patient also complains of breathlessness. There is no history of alcohol intake. There is no history of right hypochondrium pain or no any history suggestive of cholelithiasis.

His pulse is 96 BPM BP 116/80 mm of Hg spo2 96% on the presentation. There is mild decrease in breath sound in right sound. X-ray chest PA view was in normal limit. His CBC was in normal limit but ESR was 50mm/hr (normal value 0-15mm/hr) lipase 654 his peripheral blood smear was in WNL. Renal function and liver function test was also WNL. There is no electrolyte imbalance.

His USG whole abdomen S/O mild bulky pancreas with hypoechoic echotexture. CECT abdomen and pelvis (dated 31/5/2019) – shows mild hepatomegaly. There was multiple conglomerated pre and para aortic aortocaval, mesenteric lymph node showing central necrosis. Moderate pleural effusion with basal collapse. Pancreas shows smooth contour with normal size, shape and position. Pancreatic duct not dilated. CECT NECT (31/5/2019): shows enlarged conglomerated nodes showing areas of central necrosis in left prevascular space.

Lymphnode biopsy from neck: show granulomatous changes with central necrosis suggestive of tubercular in origin.

Initially Patient was treated on line of acute pancreatitis but patient had only symptomatic relief. After 5 days of admission CECT chest show gross pleural effusion with basal collapse. Once we received report of LN biopsy, patient shifted on anti tubercular drug. Subsequent follow up revealed dramatic response, patient no longer have acute episode of pain abdomen, breathlessness also subsided and appetite and general well being of the patient also improved.

DISCUSSION:

Peritoneal tuberculosis is a very rare disease in developed countries but always should be considered in developing countries. It accounts for 0.1% to 0.7% of tuberculosis cases.⁷

It manifests the symptoms such as fever, loss of weight, infertility, abdominal and pelvic pain.

Abdominal TB needs to be treated with at least 3-4 anti TB drugs for the initial 2 months and subsequently 2 anti TB drugs for at least 7-10 months. The commonly used drugs during the initial 2 months therapy (intensification phase) are Isoniazid (INH), Rifampicin, Ethambutol and Pyrazinamide. During the next 7-10 months (continuation phase) the drugs commonly

used are INH and Rifampicin. Surgery is required whenever there is perforation, abscess or fistula formation. The postulated mechanisms by which the tubercule bacilli reach the gastrointestinal tract are:

- (i) hematogenous spread from the primary lung focus in childhood, with later reactivation;
- (ii) ingestion of bacilli in sputum from active pulmonary focus;
- (iii) direct spread from adjacent organs; and
- (iv) through lymph channels from infected nodes.

The most common site of involvement is the ileocaecal region, possibly because of the increased physiological stasis, increased rate of fluid and electrolyte absorption, minimal digestive activity and an abundance of lymphoid tissue at this site. It has been shown that the M cells associated with Peyer's patches can phagocytose BCG bacillus.

Conclusion:

A multidisciplinary approached should be taken in managing a case of pain abdomen and ours being a developing country with still high prevalence of tuberculosis, should always kept in mind as a provisional diagnosis. In our case Koch's abdomen mimicked as acute pancreatitis.

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