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General Surgery

A RARE CASE REPORT : TB LYMPHADENITIS CAUSING OBSTRUTIVE JAUNDICE

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KEYWORDS :

INTRODUCTION

Tuberculosis is an infectious disease that is prevalent worldwide, but obstructive jaundice secondary to TB lymphadenitis in peri ampullary region remains rare. Abdominal tuberculosis (TB) commonly affects the intestinal tract, lymph nodes, peritoneum and solid organs in varying combinations. There are few citations of intrahepatic tuberculosis, but isolated bile duct tuberculosis is extremely rare. We report a case of obstructive jaundice due to tuberculosis of distal common bile duct (CBD) and periampullary region with clinical features mimicking cholangiocarcinoma

CASE REPORT

A 27 year old female came to the surgical opd of DHIRAJ hospital with complaints of pain in the right hypochondriac and epigastric region since 1 month associated with nausea and vomiting. Patient has given history of weight loss and loss of appetite.

On General examination of patient, she had pallor and Icteric with yellowish discoloration of the sclera.

On examination of abdomen it was found to be soft ,with tenderness present at the right hypochondrium with slightly palpable gall bladder.

We had undergone routine blood investigations in which the liver function tests were found to be deranged with SGPT-149, SGOT-107, Total Bilirubin-3.8 , Direct bilirubin-2.7 and Indirect bilirubin-1.1, hence was suggestive of more likely Obstructive Jaundice.

On USG abdomen there was a mass seen in the right hypochondrium region near CBD, which was query malignancy.

Hence, a CECT abdomen and pelvis was done which was suggestive of a conglomerated necrotic lymph nodal mass in right hypochondriac region encasing the lower end CBD and necrotic lymph node seen superior to body of pancreas.

To confirm the nature of the growth near CBD, ERCP guided stenting and biopsy of the mass was done. Patient underwent EUS with FNAC with ERCP with sphincterotomy with stenting, which was suggestive of large conglomerated mass lesion in peri ampullary region with centred necrosis.

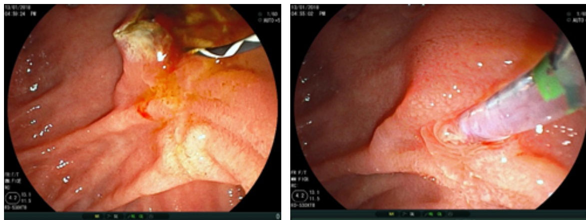

Figure : ERCP pictures showing sphincterotomy with stenting

FNAC suggestive of clustered epitheloid granulomas with necrosis and multinucleated giant cells suggestive of TUBERCULOSIS.

Histopathology report of the biopsy was suggestive of confluent granulomatous inflammation with focal necrosis, consistant with Tuberculosis

Patient was managed conservatively by starting AKT

DISCUSSION

Abdominal tuberculosis is common in the Indian subcontinent and tropical countries. It usually affects intestine, mesentery, lymph nodes, and peritoneum, but involvement of hepatobiliary system is rare. Isolated tubercular involvement of common bile duct and ampulla is extremely rare and only a few cases have been reported in published literature.[1]2]3]4]5]

Tuberculosis of lower end of common bile duct and periampullary region often forms pseudotumor [6] and strictures mimicking cholangiocarcinoma. Clinically the patients present with features of obstructive jaundice. Preoperative diagnosis of tuberculosis as the cause of obstructive jaundice is extremely difficult.

There are several proposed investigations for accurate preoperative diagnosis, e.g., ERCP with brush cytology and PCR for tuberculosis of the bile sample, FNAC, and frozen section. However, in most of the cases, diagnosis is reached in the postoperative period by the histological finding of caseation necrosis and epitheloid granuloma formation.

The disease responds well to antitubercular medications. Diagnostic difficulties often compel major resectional surgery such as pancreatoduodenectomy and final diagnosis is established with histopathology. However, if preoperative diagnosis is established, major surgery can be avoided and the disease cured with antitubercular medications. [7] Prognosis is excellent.

CONCLUSION

Although most common cause is CBD stone for obstructive jaundice, always rule out TB lyphadenitis in a developing and endemic country like INDIA.

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