Original Research Paper

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General Surgery

A CASE OF SPINAL TUBERCULOSIS MISEVALUATED AS INTESTINAL OBSTRUCTION

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ABSTRACT Tuberculosis of spine (Pott's disease) is a frequently encountered extra pulmonary form of tuberculosis and is the most dangerous form[1]. We report a case of spinal tuberculosis which present with clinical features of intestinal obstruction. A 45 year old male patient came to general surgery out patient department with chief complaints of pain abdomen since two weeks, constipation since two weeks and distension of abdomen since 10 days. History of fever present since 2 months low grade on and off. Case was evaluated with X ray erect abdomen, colonoscopy, CT abdomen which showing features of tuberculosis of spine. Patients of tuberculosis of spine can be asymptomatic and sometimes diagnosis is made incidentally during the course of evaluation for other symptoms.

KEYWORDS : Tuberculosis of spine, Intestinal obstruction, pain abdomen.

INTRODUCTION:

Tuberculosis of spine (Pott's disease) is a frequently encountered extra pulmonary form of tuberculosis and is the most dangerous form[1]. Delay in diagnosis and management cause spinal cord compression and spinal deformity[2]. The thoracic region of vertebral column is most frequently affected[1]. Here we are reporting a case of spinal tuberculosis misevaluated as intestinal obstruction.

CASE STUDY:

A 45 year old male patient came to general surgery out patient department with chief complaints of pain abdomen since two weeks, constipation since two weeks and distension of abdomen since 10 days. History of fever present since 2 months low grade on and off. Per abdomen examination include soft abdomen, nontender, no free fluid and no lump felt, bowel sounds are sluggish. Patient was kept in nil per oral, nasogastric tube inserted and investigations done. Haematological and blood chemical investigations were done which are within normal limits. X ray erect abdomen (figure 1) showing gas filled large bowel loops. Ultrasonography of abdomen showing gross left pleural effusion, large bowel loops filled with gas. Case was evaluated with colonoscopy and it shows internal hemorrhoids and colon, rectum were normal. Pleural fluid aspiration was done and sent for analysis showing exudate with lymphocyte predominance. CECT scan of abdomen (figure 2 and 3) showing degeneration of D8 and D9 vertebra with destruction of intervertebral disc, circumferential pre and paravertebral soft tissue density with peripheral enhancement, left pleural effusion. No other pathology was detected in the abdomen.

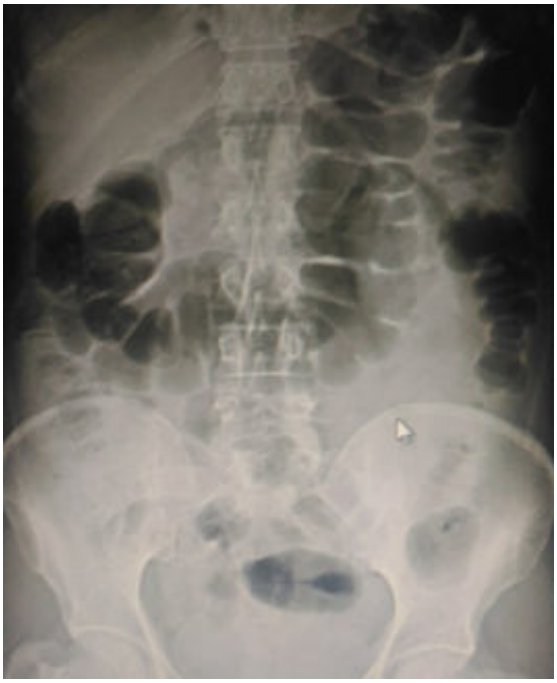

Figure 1: X ray erect abdomen

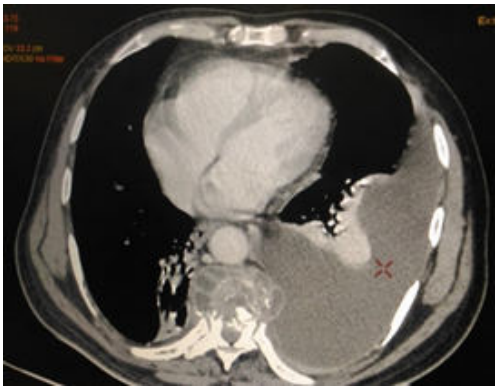

Figure 2: CT abdomen axial section

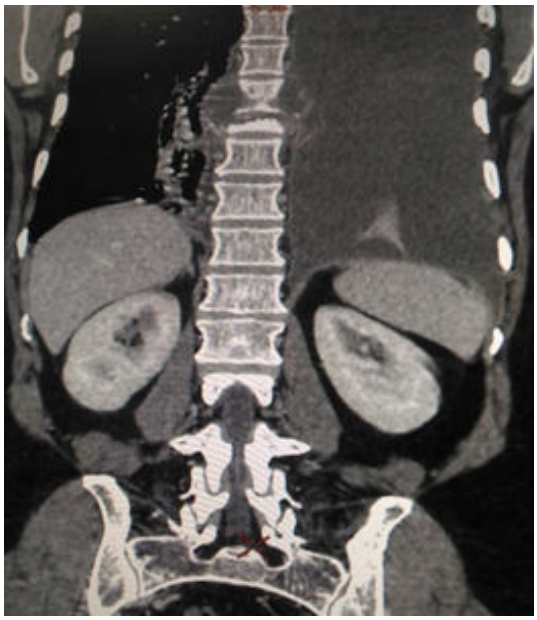

Figure 3: CT abdomen coronal section

DISCUSSION:

Our patient suffered from spinal tuberculosis and presented with symptoms of obstruction mostly due to paralytic ileus.

Instead of mechanical obstruction, pseudo-obstruction due to neuropathy was the likely mechanism in this case. Inflammation affecting the lateral horn of the spinal cord may cause overactivity of the sympathetics. The autonomic imbalance leads to impaired peristalsis. In addition the enteric nervous system may also be compromised, thus contributing to the pathophysiology[3].

Autonomic nervous system impairment due to the spondylosis

tuberculosis could cause a sympathetic and parasympathetic outflow disturbance to the gastrointestinal tract; this would disrupt the peristalsis and cause adynamic ileus[3].

Adynamic ileus has been reported previously in spinal cord injury due to causes other than tuberculosis i.e. thoracolumbar compression fractures of T8, T12 and L4; post-lumbar spinal surgery due to the severe lumbar spinal stenosis of L1–L2 to L4–L5, an unstable degenerative spondylolisthesis at L4–L5 and a ruptured L4–L5 disc; and herpes zoster infection at L4 level[3].

CONCLUSION:

Patients of tuberculosis of spine can be asymptomatic and sometimes diagnosis is made incidentally during the course of evaluation for other symptoms.

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