Tuberculosis of ascending colon mimicking carcinoma-A Case Report

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Introduction

Abdominal tuberculosis is quite common in developing countries but isolated ascending colon tuberculosis is extremely rare [1]. Though ileocaecal tuberculosis is the most common site of gastrointestinal tuberculosis, isolated colonic Tuberculous lesion of the colon without involvement of small bowel are very rare[2, 3]. Both the forms, ulcerative and hyper plastic, may be seen in colon [3]. Most common colonic involvement is transverse colon [3]. We hereby report a rare case of isolated ascending colon tuberculosis which mimicked like a colonic tumour.

Case report

A 65-year-old female patient presented with abdominal distension since 5 days. She had occasional bilious vomiting and 3-4 episodes of loose stools daily since 3 days. There was no haematemesis or passage of blood or mucus in stools.

She also gave history of anorexia and weight loss during previous 3 months. There was no history of fever, jaundice, abdominal pain, cough, chest pain or dyspnoea. Patient did not have any tuberculosis history in past.

Physical examination revealed tachycardia (100/min) and blood pressure of 110/70mmHg. She was a febrile. She was tachypneoa with respiratory rate of 24/min. She was pale. There were no signs of jaundice and lymphadenopathy.

The abdomen was soft, non-tender with generalized distension and ascitis was noted. There was no palpable mass. Bowel sounds were normal. Rectal examination did not reveal any abnormality.

Chest examination revealed bilateral basal crepitation with decreased breath

sounds on right side. She was confined to bed since 3 days due to sickness.

Her investigations were**:** Hb - 10 gm%, Total WBC – 10,600/cumm, DC – P-90, L9, M1, ESR – 40, Platelets – 4.36 lakhs/cumm, RBS – 79 mg%, Blood Urea – 29 mg%, Serum Creatine – 0.8 mg%, HIV was negative, S.Sodium - 129 mEq/L, S.Potassium- 4.2 mEq/L and S.Chloride - 98 mEq/L. Urine examination – Trace albumin, 2-4 pus cells/HPF, bacteria was present.

Ascitic fluid analysis: Glucose – 87, Protein – 3.7, Amylase – 14, LDH – 106, Cells - 90/cumm, Lymphocytes – 90%, Polymorph – 10%, No malignant cells.

Chest x ray showed bilateral minimal pleural effusion. X-ray abdomen showed no intestinal obstruction/air under diaphragm.

Ultrasound abdomen showed gross ascitis, hepatomegaly with fatty changes, Spleen and other viscera being normal.

CT scan revealed growth in ascending colon near hepatic flexure, probably carcinoma of colon.

Colonoscopy showed multiple transverse ulcers with nodularity extending up to 4 cm area at the region of ascending colon near hepatic flexure. Rest of the colon was normal. Scope could be passed up to terminal ileum.

Biopsies of the lesion revealed necrotizing granulomatous inflammation with many acid-fast bacilli suggestive of tuberculosis [Figure 1-3].

Figure 1 showing a fragment of colonic mucosa and separate fragments composed only of inflammatory cells [arrow]

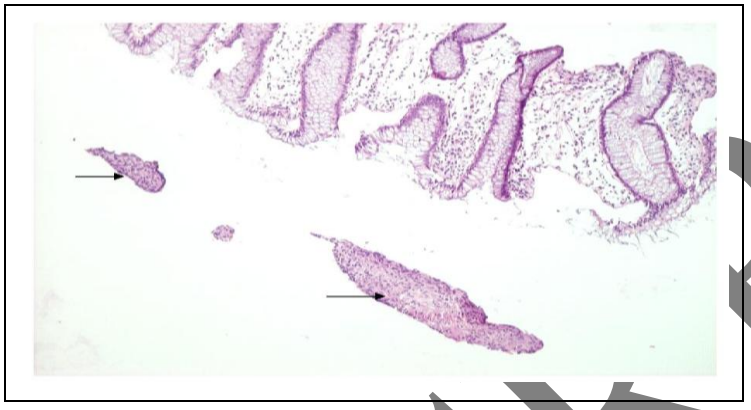
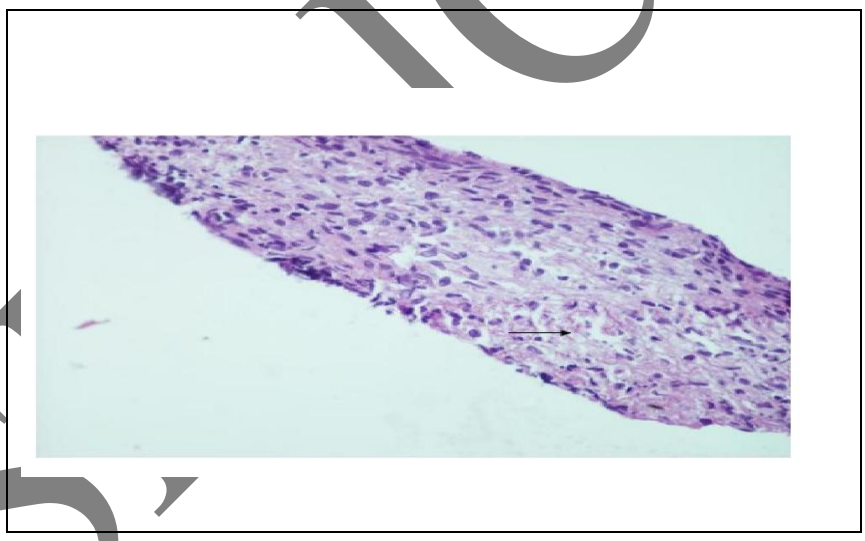


Figure 2 showing Epitheloid Granuloma with focal necrosis in one of the separate fragments [arrow]



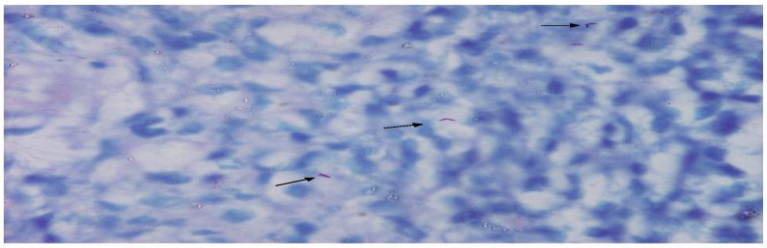


Figure 3: Ziel Neelsen (Z-N Stain) Stain demonstrate acid fast bacilli [arrow]

The patient was started on anti-tubercular drugs with supportive care and diet, following initial symptomatic improvement.

She developed pulmonary embolism and was managed in the intensive care unit, where she expired despite adequate anticoagulation and ventilator support.

Discussion: Tuberculosis of the gastrointestinal tract is a common clinical condition due to ingestion of contaminated food or is secondary to swallowed sputum containing tubercle bacilli. The ileocaecal region is the most commonly involved segment due to abundance of lymphoid tissue, prolonged stasis and increased absorption at that site.

Tuberculosis of the colon can present as strictures [4], polyps [5], and segmental ulcers or diffuse colitis.

Colonic tuberculosis is an uncommon condition, with about 2-3% of patients with abdominal tuberculosis have isolated [3]. Isolated colonic tuberculosis, especially at ascending colon, is reported infrequently in the literature.

In the absence of pulmonary or ileocaecal involvement, colonic tuberculosis may be difficult to differentiate from neoplasia or Crohn's disease by symptomatic or radiological means. Colonoscopy [6] and biopsy are necessary to diagnose this condition.

Patients are treated with anti-tubercular drugs and one might have to resort to surgery if complication like perforation or obstruction prevails. The treatment would include limited resection of colonic segment or right hemi-colectomy.

Conclusion: Isolated colonic tuberculosis is a rare condition that presents with non specific symptoms. Colonoscopy and biopsy guides one for a definitive diagnosis. Anti-tubercular therapy has got a role in treating colonic tuberculosis. Surgery is recommended in cases of complications.

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