

DIAGNOSIS DIFFICULTIES IN A RARE LOCATION OF PRIMARY PERITONEAL TUBERCULOSIS

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Abstract

Peritoneal tuberculosis (TB) is a rare location of primary tuberculosis. It usually occurs associated to pulmonary tuberculosis. We report a patient case of a 78 – years-old admitted for complaints suggesting an acute pancreatitis. Biologic changes and paraclinic investigations lead to suggest ascites due to pancreatic or neoplastic origin. CT scan suspected an abdominal wall sarcoma. Even surgical aspect of the lesions pleaded for a muscular abdominal wall sarcoma, imposing resection. Diagnosis was established after detection of giant multinucleate Lash cells in a caseous granuloma. The present case exemplifies a rare location of primary tuberculosis.

keywords: *Primary peritoneal tuberculosis, Tuberculous ascites*

Introduction

Peritoneal tuberculosis (TB) has nowadays a significant rising in incidence in Europe and North American countries, caused primarily by the high incidence of immunodepressed patients (AIDS, immunosuppressive drugs). Some cases are the consequence of reactivation of latent peritoneal tuberculosis disseminated from a pulmonary origin with hematogenic dissemination. TB bacillus is penetrating transmural in the peritoneal cavity from the contaminated bowel, from a TB salpingitis, from a TB nephritis or other sources. The majority of patients have a positive intra-

dermic reaction. Peritoneal tuberculosis has a slow clinical onset, with fever, anorexia, asthenia and weight loss, and more than half patients have diffuse abdominal pain. Moderate ascites can be present. About 30 % of patients have general clinical signs of TB infection: anorexia, weight loss and night sweating. Two clinical types of TB peritonitis were described: the dry and the wet form. The wet form is the subacute phase with fever, progressive ascites, sometimes massive, with abdominal pain and asthenia. The dry form is the expression of a late stage without ascites, with presence of peritoneal adhesions. Diagnosis is usually set by the histopathologic

examination. The treatment consists of isoniazidum, rymfampicinum and pirazinamidum twice a week for 2-3 months, followed by isoniazidum and ryfampicinum twice a week for 4-6 months. Some authors suggest that therapy should be continued for at least two years.

It is well known that TB ascites etiology is very rare and positive diagnosis is raising multiple problems.

Case report

We present the case of a 78 years old patient admitted for asthenia, anorexia, nausea, vomiting, pain in the upper abdomen, fever (38.4 Celsius) mainly in the afternoon, with slow onset for about two weeks. Antibiotic and antisecretory drugs treatment recommended by the family doctor was carried on at home without any improvement. The patient had no history of tuberculosis. He had a history of alcohol abuse. He was a smoker.

The physical examination at admittance revealed paleness, asthenia, fever (38.5 Celsius), blood pressure 130/80 mmHg, heart rate 90 bpm. Ronchus on pulmonary auscultation. No limphadenopatia was found, sensitivity in palpating the upper abdomen, nonpruriginous periumbilical erithema, no hepato-splenomegaly.

Laboratory findings : AST 56 U/l, ALT 79 U/l, γ -GT 258, Alkaline phosphatasis 181 U/l (cholestasis), amilazuria: 866 u/l, inflammatory signs : sedimentation rate 56/72, fibrinogen 837mg/dl. No leukocytosis or lymphocytosis were found.

Heart ultrasound revealed large aortic stenosis, left ventricular concentric hypertrophy, mitral 1-st degree regurgitation, aortic atheromatosis.

Abdominal ultrasound revealed hepatic steatosis, gallbladder sludge, minimal ascites. No abdominal limphadenopaty or masses were found.

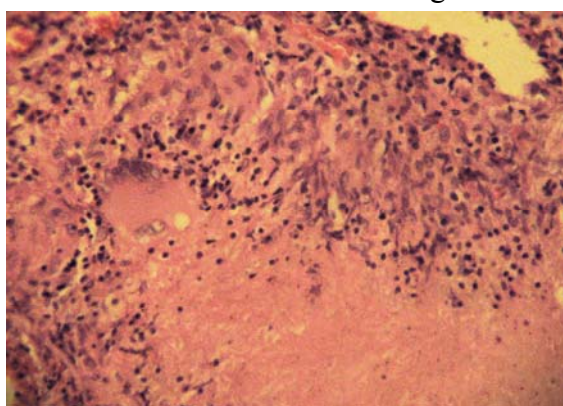


Abdominal CT revealed minimal ascites with peritoneal infiltration, without etiologic findings, pulmonary CT showed pulmonary emphysema, without specific lesions.

Pneumologic and radiologic examination did not reveal any pulmonary pathologic findings.

Eso-gastroscopy revealed a hypertrophic corporeal gastritis with intense hyperemia of the pylorus, a cardial polip and an axial hyatal hernia.

The tuberculin skin test was negative.



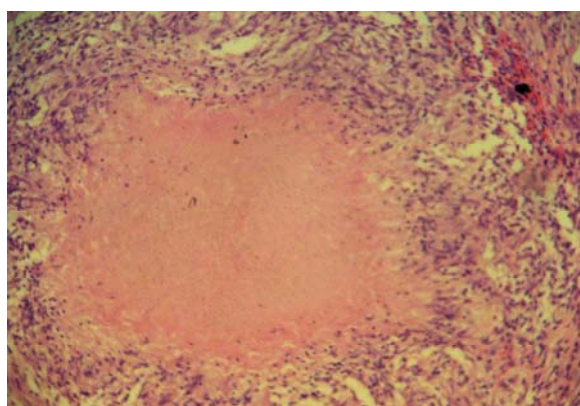
Discussion

Peritoneal tuberculosis is an infrequent disease, but new cases occur in certain conditions, in the present case alcoholism in particular.

Absence of skin reaction to tuberculin, absence of lymph nodes reaction and also of lymphocitosis in conjunction to the impossibility of performing paracentesis can mislead diagnosis in actual patient.

Colonoscopy revealed no pathologic findings.

Taking in consideration the unfavorable clinical evolution under broad spectrum antibiotic therapy, we decided to do exploratory laparotomy. Intraoperative abdominal muscle wall infiltration was found rising the suspicion of sarcoma. Biopsy and hystopathologic exam revealed the diagnosis of TB infiltration. After tuberculostatic treatment evolution was positive.



In conclusion, there are no typical clinical signs and symptoms of peritoneal tuberculosis, diagnostic and etiologic treatment is usually delayed.

Therefore, in the presence of not precise abdominal simptomatology, ascites of undetermined origin, one has to take into consideration also tuberculosis.

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