References


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Abdominal tuberculosis: importance of knowing the differences between the different site involvements

Sir,

I read with interest the article by Ramesh et al., published in a recent issue of the journal on abdominal tuberculosis (ATB). Not unexpectedly, they showed that ATB was more common among the immigrant populations, particularly from the South Asia, where TB infections remain endemic. Their findings are comparable with what have been reported in the literature. Despite the large sample size, they only presented their data as a whole and provided very little details of the clinical presentations and findings of specific sites involvements. As such, they failed to highlight the important differences between different organ involvements.

ATB collectively refers to the involvements of gastrointestinal tract (mouth to anus), biliary tree, liver, pancreas, spleen, peritoneum and abdominal lymph nodes. Despite sharing some similarities in their clinical manifestations, there are differences. We previously showed that the clinical presentations and findings are different between different organ involvements. In addition to the non-specific symptoms of fever, weight loss and sweating, most patients with peritoneal TB present with abdominal pain and distension secondary to ascites whereas patients with hepatobiliary TB present with either biliary obstructions or hepatic mass lesions mimicking neoplasms. Hepatic calcifications are also commonly encountered and usually indicate previous...
hepatic involvement. In our setting, this has always been a useful clue to the underlying aetiology, present in 64.3% of patients with hepatobiliary involvements. Presentations of gastrointestinal TB typically include abdominal pain, mass lesion in the right iliac fossa or bowel obstructions. Pancreatic involvements commonly present with mass lesions often mimicking neoplasm. I am also surprised that despite 27% having multiple site involvements; none of their patients actually had involvements of other organs grouped under ATB. Simultaneous involvements of intra-abdominal organs are not uncommon, hence the presence of overlapping symptoms and findings are commonly encountered. These differences can provide guidance to the line of investigations; endoscopy for suspected gastrointestinal or biliary involvements, imaging guided biopsy for hepatic involvement or evaluations of ascetic fluid and even visualization of the peritoneum with biopsy using either laparoscopy or laparotomy for suspected peritoneal TB. The main aim of investigations is to isolate the mycobacterium. However, this is not always possible and concerns for missing underlying malignancies remain a problem. In such cases, diagnosis can be made based on consistent clinical, histological findings and even response to empiric TB treatment. It is also very important to be aware that outcomes may be different between different site involvements. In our experience, patients with peritoneal TB tended to be sicker with lower haemoglobin, serum albumin and higher erythrocyte sedimentation rate. They also have higher mortality rate compared to patients with either hepatobiliary or gastrointestinal TB. Therefore, knowing the differences in the manifestations of ATB with different site involvements is very important in the management of patients with ATB.

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