Tuberculous abdomen presenting as gluteal abscess

K. Karunakaran

Received: 28 July 2008 / Accepted: 20 November 2008

Abstract Tuberculosis (TB) abdomen presenting as gluteal abscess is very rare and difficult to diagnose in the absence of high index of suspicion; ruling out the possibilities of other diagnosis by means of suitable investigations is the only way to arrive at this diagnosis in an immuno-competent patient. We report an interesting case of TB abdomen presenting as gluteal abscess in a 27-year-old young female patient, who is otherwise hale and healthy.

Keywords TB abdomen · Gluteal abscess · TB gluteal abscess.

Introduction

Abdominal tuberculosis (TB) is the sixth most common form of extra pulmonary tuberculosis change TB. A cold abscess as a result of Pott's spine can spread along the aorta and it branches and beyond A) into ischio rectal fossa. B) in the buttocks under the gluteus maximums and manifest as gluteal abscess. C) along the psoas sheath or D) in the lumbo-dorsal region (Petit's triangle). This latter event is not very rare. It can also track down along the femoral or obturator artery and present on the medial side of the thigh, femoral triangle or popliteal fossa or on the medial side of the Achilles tendon. Abdominal tuberculosis presenting as gluteal abscess is very rare in an immuno-competent person. We are reporting this case for its rarity.

Case report

A 27-year-old female patient presented to the department of Surgical Gastroenterology as an out-patient with history of pain over the right gluteal region for 9 months, swelling over the Rt. Gluteal region for 6 months; loss of appetite and loss of weight present for 6 months. There was no history of cough with expectoration or other history suggestive of pulmonary Tuberculosis. The patient was admitted and evaluated.

Erythrocyte sedimentation rate (ESR), white blood cell count were markedly elevated. Test for HIV was negative, her chest X-ray was normal. Her barium meal follow through pictures were normal; ultrasound abdomen suggested mass in the right iliac fossa and abscess in the gluteal region. CT scan abdomen revealed that the gluteal abscess cavity communicated with the mass in the ileo-caecal region. Colonscopic biopsy was inconclusive. The abscess was aspirated and drained and sent for Zeihl-Neelsen stain for acid-fast bacilli and culture. Even though both the results were negative, a provisional diagnosis of

K. Karunakaran (✉)
Assistant Professor of Surgery,
Madurai Medical College & Govt. Rajaji Hospital,
Madurai - 625 020, Tamil Nadu,
India

E mail: fleshy22man@yahoo.co.in

ileo-caecal tuberculosis was made and the patient was put on anti-tuberculous treatment (ATT). After 3 weeks of ATT, the patient was subjected to laparotomy. At laparotomy, the mass in the ileo-caecal region was seen to fistulate into the gluteal region, the patient underwent right hemicolectomy and ileo-transverse colon anastomosis. The specimen was sent for histopathological examination and was reported as TB abdomen.

Discussion

Extra pulmonary manifestations of the tuberculosis, such as enteric TB, are common. Symptoms of enteric TB are non-specific and a high index of suspicion is required in order to make a timely diagnosis and initiation of appropriate treatment [1].

Clinical features of abdominal tuberculosis include weight loss, general malaise, anorexia, fever, diarrhoea, abdominal pain, abdominal masses, ascites and peritonitis. Presentation can be acute, acute on chronic or chronic and insidious. Since the symptoms are vague and the disease closely mimics other diseases, the diagnosis of enteric TB is often delayed [1, 2].

Laboratory investigations can be non-specific or normal. The most common abnormality noted is an elevated ESR which is found in 90% of patients [1]. Radiographic studies may be helpful, but these too, are non-specific. Evidence of active or healed TB on chest X-ray lends support to a diagnosis of TB; however, a normal chest X-ray does not exclude the disease [1]. Bhargava et al reported a series of 29 patients with colonic TB, only 35% of whom demonstrated evidence of old or active pulmonary mycobacterial infection [3]. Abdominal X-rays are equally inconclusive. Peritoneal biopsy is of considerable help, being positive in 88% of ascitic cases and in 42% of non ascitic cases [4]. Barium studies are more useful, supporting a diagnosis of enteric TB in 66% of cases [5]. A CT scan may also aid in

diagnosis, with a sensitivity of about 67% [1]. Many believe laparoscopy to be the investigation of choice for an accurate and timely diagnosis [1]. Colonoscopy is considered a valuable diagnostic tool [3].

Once a diagnosis of TB has been made, most patients will improve with ATT, so that elective surgery, when necessary can be performed 2–4 weeks later with significantly less morbidity [6]. Limited ileo-caecal resection and ileoplasty are of immense value in chronically ill and emaciated patients [7].

TB enteritis remains a challenge to the diagnostic acumen and therapeutic skills of both physician and the surgeon. An increased awareness of enteric TB, coupled with an appreciation of the pathophysiology, diagnostic methods and treatment of the disease should increase the number of cases identified preoperatively, thus improving patient prognosis [8].

References

1. Niamh NC, Hallihan P, Fulton G (2006) Enteric tuberculosis presenting as a painful inguinal swelling. *Modern Medicine* 36:23–25
2. Howell JS, Knapton PJ (1964) Ileocaecal tuberculosis. *Gut* 5: 524–529
3. Bhargava DK, Kushwaha AKS, Dasarthy S et al (1992) Endoscopic diagnosis of segmental colonic tuberculosis. *Gastrointes Endosc* 38:571–574
4. Das P, Shukla HS (1976) Clinical diagnosis of abdominal tuberculosis. *Br J Surg* 63:941–946
5. Jerome SA, William DH (1964) Tuberculosis of the gastrointestinal tract. *Arch Surg* 160:282–293
6. Vaidya MG, Sodhi JS (1978) Gastrointestinal tract tuberculosis. A study of 102 cases including 55 hemicolectomies. *Clin Radiol* 29:189–195
7. Pujari BD (1979) Modified surgical procedures in intestinal tuberculosis. *Br J Surg* 66:180–181
8. Bhanasali SK (1972) Abdominal tuberculosis. Experiences with 300 cases. *Am J Gastroenterol* 67:324–337