Abdominal Tuberculosis-Predicament to Physicians

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Abdominal tuberculosis is always remains a dilemma for gastroenterologist. It is the most common cause of chronic diarrhea in developing countries and have high mortality rate due to disseminated tuberculosis. Abdominal tuberculosis present in number of different ways. Most common presentation is with chronic diarrhea and ascites. It can present with chronic Abdominal pain and weight loss as well. It always remained a challenging situation to diagnose and treat in an appropriate way because crohns disease and lymphoma have most of the time similar presentations. Second most common issue that few patients cannot tolerate anti-tuberculous medications and present with fulminant hepatic failure which also have high mortality rate.

Abdominal tuberculosis has three different types i.e. ulcerative, hypertrophic and mixed subtype. Ulcerative type present with diarrhea and malabsorption while hypertrophic type present with intestinal obstruction, chronic abdominal pain, weigh loss and ascites. Situation becomes more challenging when female patient present with Ascites and weight loss.

Number of investigations needed to diagnose abdominal TB in a patient with Ascites and chronic diarrhea. After basic investigations, ascitic fluid examination needed including ascitic fluid examination i.e. cells, proteins, glucose, LDH, amylase, Bilirubin, ascitic fluid culture, SAAG ratio calculation, fluid ADA Levels, PCR in ascitic fluid for Mycobacterium tuberculli, and Gene xpert for multidrug resistance tuberculosis. ADA levels have high sensitivity in tuberculosis patients but have low sensitivity in patients with mixed Ascites like portal hypertension. While raised CA 125 levels have no sensitivity in patients with ascites.

Ileocolonoscopy remains an investigation of choice with ileocecal biopsies. Biopsies is gold standard for its diagnosis including Histopathological findings, AFB, PCR for mycobacterium tuberculli, culture for organism. If this remains inconclusive than laparoscopic peritoneal biopsy is indicated. Number of other investigations can be used like capsule endoscopy and enteroscopy.

Once diagnosed antituberculous (ATT) medication can be started as soon as possible. First line drugs are isoniazid, rifampin, pyrazinamide and ethambutol. Mostly patients respond in 2 - 4 weeks that is evidenced by improvement in diarrhea, weight gain and decreased in ascitic fluid volume. Diuretics have no role in low SAAG ascites patients while can be used for pedal swelling. ATT should be used for 12 months in abdominal tuberculosis in order to prevent recurrence. In case of multidrug resistant TB or ATT induced hepatitis then second line ATT medications can be used.

So early diagnosis and treatment can prevent mortality and morbidity in number of patients but for its diagnosis always needed a high index of suspicion in patients mostly from developing world.