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RESEARCH ARTICLE

A UNUSUAL PRESENTATION OF KOCHS ABDOMEN WITH MULTIPLE ILEAL PERFORATIONS- A RARE CASE

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Abstract

Hypothesis- whether kochs abdomen causes multiple ileac perforation or not . Methodology- A case report with A 38-year old male presented with- Ø abdominal pain since 1 month Ø Constipation since 4 days Ø Anorexia since 4 days On examination – abdomen was distended, diffuse, tenderness with guarding and rigidity with absent of bowel sounds. Conclusion – TB should always considered in differential diagnosis in patients presenting with abdominal pain/distension, fever and ascites or with abdominopelvic mass. Recurrent bowel obstruction or anastomotic disruptions also give clues of its diagnosis.

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Introduction:-

Incidence of tuberculosis worldwide in 2020, an estimated 10 million people fell ill with tuberculosis (TB) worldwide with distribution of 5.6 million men, 3.3 million women and 1.1 million children. Extra pulmonary tb which includes Gastrointestinal TB, TB meningitis, TB peritonitis, cutaneous TB, potts spine, TB lymphadenitis, of which GI tuberculosis is rarest. Such an extensive perforation of the small bowel has not been previously reported in the literature.

We present an uncommon case of perforated intestinal TB. Multiple perforations necessitated emergency operation with intestinal resection. Intestinal TB should be considered in such patients presenting with pain in abdomen, vomiting, distention, constipation and anorexia.

Discussion:-

Gastrointestinal (GI) tuberculosis (TB) accounts for 1% to 3 % of all TB cases worldwide. It can occur in the context of active pulmonary disease or as a primary infection without pulmonary involvement. The ileocecal region is the most commonly affected site; however, it can involve any part of the gastrointestinal tract (GIT). Diagnosis is challenging and is often delayed due to its non-specific presentation. GI TB responds well to standard anti-tuberculous drugs. Surgery is only required in cases that develop complications such as strictures or obstruction, not responding to medical therapy. High clinical suspicion, early initiation of anti-tuberculous therapy, and involvement of an interprofessional team are necessary for reducing morbidity and mortality. This activity outlines the evaluation and management of gastrointestinal tuberculosis and highlights the role of the interprofessional team in managing patients with this condition.

Extra-pulmonary TB accounts for about 12% of all tuberculosis cases, of which gastrointestinal tuberculosis accounts for 11% to 16% of the cases.[2] It thus makes up 1% to 3% of all TB cases.[3][4] 6% to 38% of patients with intra-abdominal TB may have concomitant pulmonary TB as well.[5][6] However, the diagnosis of the

concurrent active pulmonary disease depends on the criteria used in different studies.[7] Some studies reported that 31% to 50% of patients with AFB-smear positive cavitory TB have concomitant tuberculous enteritis.[8]

Incidence of ileal perforation in TB–

Free perforation is a complication of severe untreated disease, occurring in 1–15% of patients with intestinal TB [9, 10]. The most common site of intestinal perforation is the terminal ileum because of its high absorptive rate, close contact of the bacilli with mucosa, the presence of abundant lymphoid tissue, and being a region of physiologic stasis [11, 12]. In majority of cases (approximately 90%), only a single perforation is present [13], but multiple perforations at a single site such as the jejunum or the ileum have also been reported as well [14].

Dasgupta et al. studied tissue samples from patients of abdominal TB that had surgical intervention and perforation was seen in 80% of the cases, mostly of the terminal ileum and being solitary in nature, with epithelioid cell granuloma visible in lymph nodes and the intestinal tract. However, in our case, there were multiple perforations 10–15 cm from DJ flexure up to the terminal ileum, with each site having a confluence of pinpoint perforations.

Case report –

A 38-year old male presented with abdominal pain since 1 month, Constipation and Anorexia since 4 days. On examination his abdomen was distended, diffuse, tenderness with guarding and rigidity with absent of bowel sounds. Patient was having loss of appetite, irregular bowel habit and history of alcohol consumption since 10 yrs .

On aspiration from Ryles’s tube, approx. 50 cc greenish fluid aspirated. Considering this, intestinal perforation was suspected .

After which we had done minimal investigation including XRAY abdomen erect with 100 cc air push S/O air under right dome of diaphragm.(fig 1)

USG abdomen and pelvis S/O hollow viscous perforation.

ESR done which was raised. CT scan was not done as diagnosis was clear on xray.



Fig 1:- X ray abdomen erect.

After all above clinical examination and investigation, patient was taken for emergency exploratory laparotomy under ASA grade IV.

Emergency laparotomy revealed Peritoneal fluid mixed with pus and fecal matter, multiple perforations noted along ileum segment(fig 3) with Ileal loops adhesion at multiple places .Segment was involved 10 cm of IC junction. Approx 2.5mm of ileal segment had multiple button hole approx 18-20 Perforations. Distal ileal stump closed and ileostomy done .

PRAJARA RURAL HOSPITAL LONI-413736
DEPARTMENT OF PATHOLOGY
BIOPSY REPORT

Name:	Rohitkhan Dheeshw Digha	Unit Incharge:	Dr. Madhe V V
Age:	36	Department:	Surgey
Sex:	Male	Receiving Date:	14-06-2021
STO/GPO:	1563821		
Biopsy No.:	B/2462/21		

There are numerous well formed epithelioid granulomas noted in the submucosa, mucosa propria and serosa with destruction of mucosal crypts. Granulomas also show suppuration and necrosis. Few multinucleate giant cells are seen. Submucosa shows edema with dense lymphoplasmacytic infiltrate. Serosal aspect shows neutrophilic exudate. Single lymphonodes noted with multiple caseating necrotizing granulomas. Sections from one of the lymph nodes show similar granulomas. Sections from separately sent perforation biopsy (P) also show necrotizing suppurative granulomas. Sections from mesenteric lymphonodes (C,D) reveal 3 lymphonodes showing complete effacement of the architecture by multiple caseating necrotizing well formed epithelioid granulomas with focal areas showing viable lymphoid cells. Areas of hyaline caseation are noted.

24 Slides. Numerous Acid Fast Bacilli Seen.
Intestinal Tuberculosis with Perforation.
Mesenteric Lymphonodes - Tuberculous Lymphadenitis.

Signature

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Fig 2:- Histopathology report.



Fig 3:- Multiple perforations noted along ileum segment.

Histopathological report of submitted specimen suggestive of intestinal perforation with tuberculosis and mesenteric lymphnode: TB lymphadenitis. (fig 2)

Conclusion:-

Although multiple perforation in tuberculosis is rare entity , it should be consider for diagnosis in acute abdomen. Therefore a differential diagnosis of ileal perforation in tuberculosis should always be consider.

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