To the Editor: A 21-year-old woman presented with a history of abdominal pain, occasional vomiting, and fever of 2 weeks’ duration. She had no respiratory symptoms, and her past history was unremarkable. On examination she had a low-grade fever and mild tenderness in the abdomen. No masses were felt in the pelvis. Her white cell count was 3.7×10^9/l, and blood culture was negative. The chest radiograph was unremarkable. Computed tomography (CT) of the abdomen showed a remarkable omental thickening, with nodularity with ascites (Fig. 1). The level of the tumour marker CA-125 was 7 988 kU/l (normal 0 - 35), and the level of carcino-embryonic antigen was normal. At diagnostic laparoscopy, multiple seedlings were seen on the peritoneum. Peritoneal biopsy was negative for malignancy, acid-fast bacilli and Mycobacterium tuberculosis (MTB) complex DNA. The ascitic fluid also was negative for MTB complex DNA and for malignant cells. Histopathological examination of the peritoneal biopsy showed a chronic inflammatory infiltrate resembling tuberculosis. The patient was put on antituberculosis treatment, improved and was discharged.

Peritoneal tuberculosis may be misdiagnosed as peritoneal carcinomatosis, as the two conditions share many radiological and clinical features, especially when serum CA-125 levels also are elevated. CA-125 is a useful marker of ovarian epithelial malignancy. It is secreted by mesothelial cells of the pleura, peritoneum and pericardium. Its levels can rise in conditions with serosal involvement by tuberculosis, leukaemia and lymphoma. Acid-fast bacilli were not seen in the ascitic fluid and tissue specimen in our patient. The diagnosis was made by histopathology. This case reminds us that in any case of ascites with elevated serum CA-125 level tuberculosis should be considered in the differential diagnosis. It has been reported that CA-125 can be used to monitor the response to antituberculosis treatment.

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### Transverse colon tuberculosis presenting as colonic obstruction

To the Editor: A 35-year-old woman presented with long-standing constipation, vomiting, intermittent pain, loss of weight and abdominal distension. She was known to have HIV infection, was on antiretroviral therapy, and had completed a course of tuberculosis chemotherapy for pulmonary tuberculosis. On examination, she had a mildly distended abdomen with a palpable mobile epigastric mass. Her chest radiograph was normal, and the abdominal film showed a distended proximal colon. A diagnosis of colonic obstruction was made; on laparotomy, an obstructing lesion of the mid-transverse colon was found. The ileocecval region was not involved, nor were there any clinically pathological lymph nodes. The lesion was resected (Fig. 1) and continuity restored with a colo-colic anastomosis. Her postoperative...
Histology of the lesion showed ulceration with typical tuberculous granulomas (Fig. 2). Small foci of caseation and fibrosis were noted; acid-fast bacilli were present. She was started on a second course of antituberculosis chemotherapy. A follow-up colonoscopy and biopsy 8 months later showed no evidence of further colonic tuberculosis.

Most frequently, tuberculosis affects the ileocaecal region. We present an atypical presentation of a cicatrising mid-transverse lesion which mimicked an obstructing carcinoma. The ileocaecal predominance is attributed to the prominence of lymphoid tissue in this region. Segmental tuberculosis of the colon comprises <10% of all abdominal tuberculosis cases. A study on the aetiology of colonic strictures of black and Indian patients in Durban, conducted by Pillay et al., identified 24 patients with tuberculous strictures, of whom only 3 had a stricture in the transverse colon.

Diagnosis of colonic tuberculosis is possible both radiologically and endoscopically. The latter facilitates histological confirmation and culture, and allows drug therapy to be commenced with a firm diagnosis; in addition, it permits balloon dilatation of the stricture. Surgery is aimed primarily at treating the complications such as obstruction, fistula, perforation and bleeding, and for when diagnostic doubt exists. Medical therapy should be instituted immediately postoperatively, if it has not already commenced. There are reports in the literature of stenotic and subacutely obstructed colonic lesions being managed with antituberculosis chemotherapy alone, that have resolved, but we do not advocate this approach in clinically obstructed cases. However, our patient might have been spared surgery if colonoscopy had been performed earlier in her illness and the diagnosis established on biopsy. With the resurgence of tuberculosis as a result of HIV, it is important to keep this diagnosis foremost and manage it medically, if possible. Regarding the question of duration of therapy, Balasubramaniam et al. demonstrated that a 6-month regimen is as effective as a 12-month regimen in all forms of abdominal tuberculosis.

Our case raises the question of the optimal treatment period in the SA population as this patient had already completed 6 months of therapy with clinical resolution of her pulmonary disease. In view of the HIV-TB pandemic, endoscopy should be used liberally to establish the aetiology of digestive tract disease and institute appropriate therapy, thereby avoiding the complications of surgery.

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