

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 ileocaecal 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

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course was uneventful. 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.^{1,2} The ileocaecal predominance is attributed to the prominence of lymphoid tissue in this region.³⁻⁵ Segmental tuberculosis of the colon comprises <10% of all abdominal tuberculosis cases.^{4,6} 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.⁷

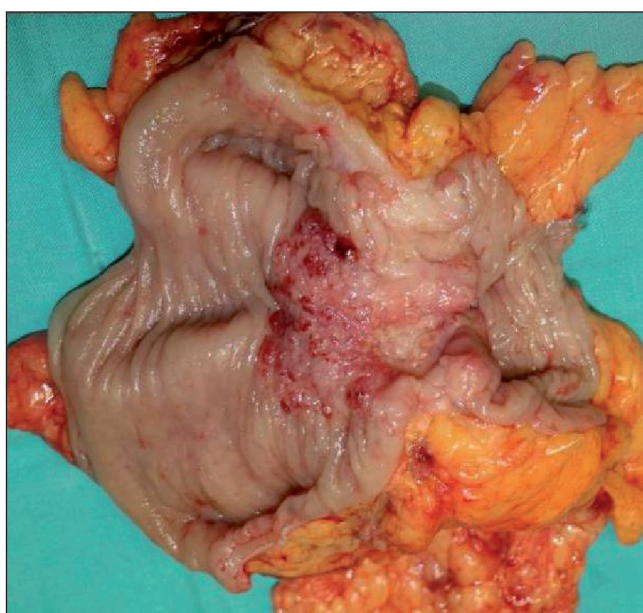


Fig. 1. The opened resected specimen of the transverse colonic stricture with dilatation of the proximal colon.

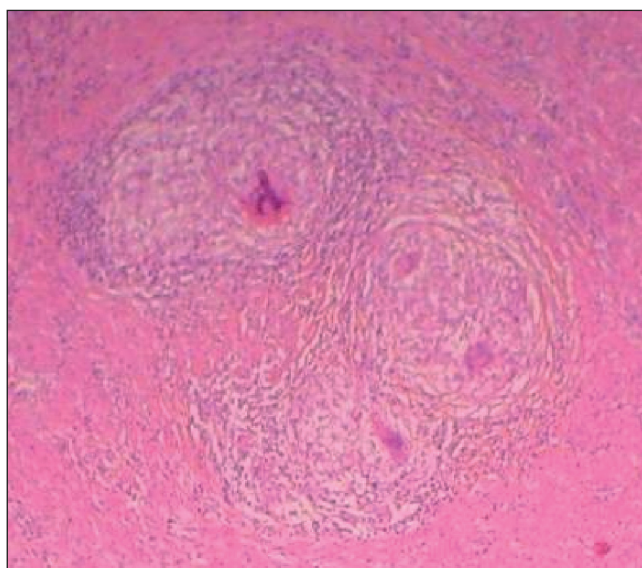


Fig. 2. Typical discrete granulomas with multinucleated giant cells (H&E section 100x magnification).

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.¹¹ 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,⁸ 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.⁹ 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.¹⁰

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.

D. Steer

A. Essa

D. L. Clarke

S. R. Thomson

*Department of General Surgery and Anatomical Pathology
Nelson R. Mandela School of Medicine
University of KwaZulu-Natal
Durban*

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