Biliary fistula in AIDS-related abdominal tuberculosis

To the Editor: Tuberculosis (TB) is often the first manifestation of AIDS. Extrapulmonary disease can occur in up to 40% of these patients, particularly when immunosuppression is advanced. Abdominal TB can mimic common non-infectious abdominal syndromes. Several cases of digestive fistulas attributed to AIDS-associated TB have been described, most of them being oesophageal fistulas from mediastinal lymph nodes. More distal intestinal fistulas are extremely rare.1 2 3 We report what is probably the first case in which a biliary fistula was the first presentation of abdominal TB and AIDS.

A 34-year-old man from Nigeria was admitted to the Department of Surgical and Gastroenterological Sciences at the University of Padova in June 2008 with abdominal pain and fever. He had complained of vague abdominal pain for 4 months and had no history of liver disease or surgery. Three weeks previously, an upper gastro-intestinal (GI) endoscopy had showed a bulbar ulcer (Helicobacter pylori-negative) that had been treated with standard proton pump inhibitor therapy.

On physical examination, he appeared dehydrated with a diffusely painful abdomen. Blood tests showed moderately increased gamma-glutamyltransferase, glutamic pyruvic transaminase and glutamic oxalacetic transaminase levels. A plain abdominal radiograph revealed pneumobilia, confirmed by a computed tomography scan that also showed abdominal lymph node enlargement. A second upper GI endoscopy demonstrated an orifice with bile effusion in the upper duodenal knee. Findings at laparotomy included a distended and oedematous gallbladder, a small amount of free fluid in the sub-hepatic region, and many enlarged, ‘cheesy’ lymph nodes with multiple abscesses in the hepatic pedicle, around the coeliac axis and in the mesentery of the terminal ileum. Intra-operative cholangiography revealed severe stenosis of the choledocus caused by compression resulting from the nodal enlargement. Cautious dissection across the inflammatory mass revealed a fistula between the posterior side of the duodenum and the choledocus. Frozen sections from the choledocus and duodenal ‘ulcer’ were negative for neoplastic disease and showed the presence of granulomatous disease. The duodenal ‘ulcer’ was excised along its margins and simply sutured after limited mobilisation of the duodenum. The choledocus was transected and distally ligated, and a hepatico-jejunal anastomosis on a Roux-en-Y loop was performed. Histological examination confirmed the tubercular origin of the lymph node enlargement, with no gallbladder stones or other disease that could give an alternative explanation for the fistula.

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