Tuberculosis of the intestine

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Tuberculosis, like CD, can a ff ect any part of the gastrointestinal tract. The sites a ff ected most often are the ileum, proximal colon and peritoneum. There are two principal disease presentations. Ulcerative tuberculosis Ulcerative tuberculosis develops secondary to pulmonary tuberculosis and arises as a result of swallowing tubercle bacilli. Multiple ulcers, lying transversely , develop in the terminal ileum and the overlying serosa is thickened, reddened and covered in tubercles. Patients typically present with diarrhoea and weight loss, although subacute obstruc tion and even local perforation and fistula formation can occur. A barium follow-through or computed tomography (CT) examination fails to show filling of the distal ileum, caecum and the ascending colon as a result of narrowing of the ulcerated segment (Figur e 74.2). A course of antituberculous chemotherapy usually leads to cure, provided the pulmonary tuberculosis is adequately treated. Surgery is usually undertaken only in the rare event of a perforation or complete intestinal obstruction. Esche - - - - - Hyperplastic tuberculosis This is caused by the ingestion of Mycobacterium tuberculosis by patients with a high resistance to the organism. The infection usually occurs in the ileocaecal region, although solitary and multiple lesions in the distal ileum are also sometimes seen. The infection establishes itself in lymphoid follicles, and the resulting chronic inflammation causes thickening of the intestinal wall and narrowing of the lumen. There is early involvement of the regional lymph nodes, which may caseate. Unlike in CD, abscess and fistula formation are uncommon. Patients usually present with attacks of abdominal pain and intermittent diarrhoea. There is incomplete ileal obstruction, leading to stasis and bacterial overgrowth. This in turn causes steatorrhoea, anaemia and loss of weight. P atients may present with a mass in the right iliac fossa and vague ill health. The di ff erential diagnosis is that of an appendix mass, lymphoma, carcinoma of the caecum, CD, tuberculosis or actinomycosis. A barium follow-through or small bowel enema will show a - long narrow filling defect in the terminal ileum (which may result in a di ff erential diagnosis of CD). CT will also demon - strate the narrowed segment with proximal distension and the associated lymphadenopathy . When the diagnosis is clear and the patient has not yet developed obstructive symptoms, treatment with antituberculous medication is advised and may be curative . Where obstruction is present, or the possibility of CD or lymphoma requires clarification, ileocaecal resection is often required (see Chapters 6 and 65).

Figure 74.2 Ileocaecal tuberculosis showing dilatation of the distal ileum and stricturing of the terminal ileum and caecum (courtesy of Dr. VK Kapoor, Delhi, India).

Abdominal actinomycosis is rare. It is caused by infection with Actinomyces israelii and usually develops several weeks after an apparently straightforward perforated appendicitis. An abscess develops and spreads to the retroperitoneal tissues and the adjacent abdominal wall, eventually becoming the seat of multiple indurated discharging sinuses. At first, the discharge from the sinuses is thin, watery and ino ff ensive, but it may later become thicker and malodorous. Secondary fistulation may occur and the tissues may become extensively indurated and woody . In contrast to tuberculosis, however, mesenteric lymph nodes are not involved and the lumen of the

intestine is not narrowed. Haematogenous spread via the portal vein may lead to multiple liver abscesses. Pus should be sent for bacteriological examination, which will reveal the characteristic sulphur granules. Penicillin or co-trimoxazole treatment is required and should be prolonged and in high dosage.

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