Tuberculous peritonitis

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Intra-abdominal tuberculosis (TB) is common in resource- poor countries; however, the incidence is rising in resource-rich countries as a consequence of migration and immunosuppres sion. Mycobacterium avium intracellulare is becoming increasingly prevalent with the widespread increase in human immuno deficiency virus (HIV) co-infection. The abdomen is involved in approximately 11% of patients with extrapulmonary TB and includes intraperitoneal, gastrointestinal tract and solid organ disease for ms. TB peritonitis requires specific mention because it is often diagnosed late, resulting in undue patient morbidity and mortality . TB can spread to the peritoneum through the gastrointesti nal tract (typically the ileocaecal region) via mesenteric lymph nodes or directly from the blood, usually from the ‘miliary’ (Figure 65.8a) but occasionally from the ‘cavitating’ form of pulmonary TB, lymph and the F allopian tubes; 50–80% of patients with abdominal TB can be expected to have perito neal involvement. The most common form of TB peritonitis is the wet, ascitic type disease (90%), which is characterised by generalised or loculated ascites. Multiple tubercle deposits are present on both layers of the peritoneum. In the less common form fibrotic fixed loops of bowel and omentum are matted together and may present with subacute intestinal obstruction. Ascites is not with abdominal pain, weight loss and abdominal distension. Distinction from di ff use peritoneal metastases is di ffi cult and may require biopsy . Diagnosis is via abdominal ultrasonography or CT to detect ascites and lymphadenopathy with/without di ff use thickening of the peritoneum, mesentery and/or omentum (Figure 65.8b,c). Ascitic fluid is typically a straw-coloured exudate (protein >25–30 /uni00A0 g/L) with white cells >500/mL - and lymphocytes >40%. Unfortunately , diagnostic smears for acid-fast bacilli are often not diagnostic and culture may take up to 4–8 weeks. Laparoscopy and peritoneal biopsy may thus be helpful to couple typical appearances with his - - tology . The value of new laboratory investigations such as ® MTB/RIF assay and the interferon-gamma the Xpert release assay in diagnosing extrapulmonary TB remains to be determined; however, measurement of adenosine deaminase activity in ascitic fluid has a high sensitivity and specificity in diagnosing peritoneal TB. TB management is principally supportive (nutrition and hydration) and medical (systemic anti-TB therapy , noting that multidrug resistance may be higher for abdominal than for - pulmonary TB), although surgery may be required f or specific complications such as intestinal obstruction. Summary box 65.6 Tuberculous peritonitis /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF - -

Acute (may be clinically indistinguishable from acute bacterial peritonitis) and chronic forms Abdominal pain, sweats, malaise and weight loss are frequent Ascites common, may be loculated Caseating peritoneal nodules are common – distinguish from metastatic carcinoma and fat necrosis of pancreatitis Intestinal obstruction may respond to anti-TB treatment without /uni00A0 surgery

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Revision #1
Created 2025-12-31 15:24:14 UTC by Omar Ayman
Updated 2025-12-31 15:24:14 UTC by Omar Ayman