

Isolated Caecal Perforation Secondary to Ileocaecal Tuberculosis

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Abstract

Although gastrointestinal tuberculosis is a common clinical entity an isolated case of caecal perforations has been reported once only in the last 35 years. We report a case who presented to us with clinical features mimicking acute appendicitis. At exploration we found multiple perforations in the caecum for which right colectomy was performed. He was started on anti-tubercular drugs after histopathological confirmation.

Introduction

Gastrointestinal tuberculosis has made a comeback with resurgence of pulmonary tuberculosis in the era of HIV infection.¹ Clinical presentations vary from adhesions, ascites, peritonitis, bowel strictures, perforations to cacooned abdomen. Perforations are commonly located in the distal ileum or in the appendix.²

Case Report

A 35 year old male patient presented with acute onset of pain in the right iliac fossa of one day duration associated with vomiting. He also had history of loose motions for two days. There was no history of fever. He had two similar episodes eight months and two years ago, which responded to conservative treatment and no further investigations were done. He had pneumonia two years ago. On examination, patient had tachycardia. Abdominal examination revealed tenderness in right iliac fossa with guarding and rebound tenderness. Our clinical diagnosis was acute exacerbation of chronic appendicitis. X-rays did not reveal any free gas under diaphragm or air fluid levels in the abdomen. Ultrasonography showed no evidence of free fluid in the abdomen. There was marked probe tenderness in right iliac fossa suggestive of acute appendicitis. The patient was explored through

McBurney's incision. During surgery, we found, three acute caecal perforations 5 mm in diameter each on anterior wall on taenea coli without any oedema of edges, induration or pouting mucosa. Severe faecal peritonitis was present in right iliac fossa and pelvis. Small and large intestines and ileocaecal junction were normal, there was no mesenteric lymphadenopathy and the appendix was normal. On table we thought of (1) amoebic typhlitis with perforation, (2) enterocolitis with perforation and (3) HIV typhlitis with perforation, as the probable pathology. Right quarter colectomy with ileostomy and ascending colostomy was performed, in view of local bowel and peritoneal conditions. Patient recovered post-operatively. HIV test done after surgery was non-reactive. Histopathological diagnosis was ileocaecal tuberculosis with caecal perforations (Fig. 1). Patient was started on suitable complete antituberculous

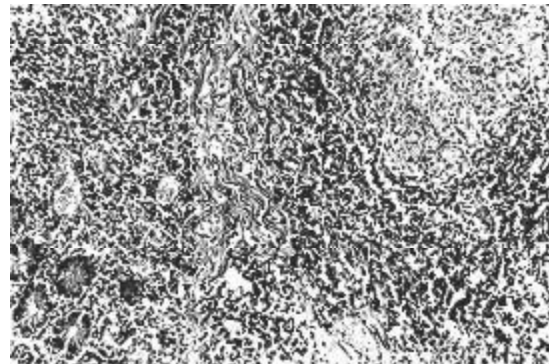


Fig. 1 : Microphotograph showing caecal tuberculosis with transmural inflammation (H and E X 160).

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treatment. Patient is better and was gaining weight at two months follow-up.

Discussion

With the worldwide resurgence of pulmonary tuberculosis in recent years, gastrointestinal tuberculosis has also made a comeback. The most common site for gastrointestinal involvement is the ileocaecal region.¹ Commonest pathologies seen include strictures, adhesions, small intestinal perforations or mesenteric lymphadenopathies. Perforations are commonly located in the distal 100 cms of ileum or in the appendix.² Isolated caecal perforation is reported in the literature on one occasion only.³ This patient had colonic perforation secondary to ileocaecal tuberculosis. He had a proliferative and ulcerated lesion in the caecum on colonoscopy. This patient was treated by right colectomy and antitubercular drugs and remained asymptomatic at two years follow-up.³

Caecal perforations in association with colonic pseudo-obstruction (Ogilvie's syndrome) are commonly reported. Three cases of diverticular perforations of caecum and ascending colon are also reported.⁴ Isolated caecal perforation is also reported in severe enterocolitis - particularly

pseudomembranous due to *Clostridium difficile*. Rarely, caecal perforation may occur due to fulminant amoebic colitis.⁵ Treatment of choice is right hemicolectomy. In our case, the clinical features mimicked acute perforative appendicitis leading to incorrect preoperative diagnosis. X-rays were inconclusive and ultrasonography was misleading. However, patient made a good recovery postoperatively and is now awaiting ostomy closure.

References

1. Abraham P, Mistry FP. Tuberculosis of the gastrointestinal tract. *Ind J Tub* 1992; 39 : 251-56.
2. Paustian FF, Marshall JB. Intestinal tuberculosis. In Berk JE, Haubrich WS, Kalsner MH, Roth JLA, Schaffner F, (Editors). *Bockus' Gastroenterology*. 4th edition, WB Saunders Company, 1985; 3 : 2018-36.
3. Bannura G, Valencia C, Fernandez W. Colonic perforation secondary to ileocaecal tuberculosis. Report of one case. *Rev Med Chil (Spanish)* 1999; 127 : 704-8.
4. Mauvais F, Benoist S, Panis Y, Chafai N, Velleur P. Three cases of diverticular perforation of the caecum and ascending colon. *Am Chir* 1999; 53 : 89-91.
5. Hsu YB, Chen FM, Lee PH, *et al.* Fulminant amebiasis : a clinical evaluation. *Hepatogastroenterol* 1995; 42 : 109-12.