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Case Report / *Olgu Sunumu*

Abdominal Tuberculosis Mimicking Peritoneal Carcinomatosis

Peritonitis Karsinomatozayı Taklit Eden Abdominal Tüberküloz Olgusu

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Abdominal tuberculosis is a rare disease, with non-specific findings. Abdominal tuberculosis can mimic different pathologies. Abdominal tuberculosis could affect the entire gastrointestinal tract, peritoneum, mesentery as well as the solid organs like liver, spleen and pancreas. We present a 42-year-old woman with intra-abdominal mass of unknown origin which was interpreted as peritoneal carcinomatosis intraoperatively.

Key words: Tuberculosis; peritoneal carcinomatosis.

Abdominal tüberküloz nadir bir durumdur ve bulguları çoğu zaman nonspesifiktir. Birçok değişik patolojik durumu taklit edebilir. Abdominal tüberküloz tüm gastrointestinal sistemi, mezenteri ve peritonu tutmasının yanı sıra, solid organlar olan dalak, karaciğer ve pankreasıda tutabilmektedir. Karın içinde kitle nedeniyle ameliyat edilen ve ameliyat sırasında makroskopik olarak peritonitis karsinomatoza tanısı düşünülen 42 yaşındaki kadın hastaya ilişkin olgu literatür bilgileri eşliğinde sunuldu.

Anahtar sözcükler: Tüberküloz; peritonitis karsinomatoza.

The rate of tuberculosis continue to rise throughout the world.[1] Tuberculosis can clinically be presented in many different forms. Abdominal tuberculosis is a rare form of tuberculosis which usually causes non-specific findings.[1-3] Abdominal tuberculosis could affect the entire gastrointestinal tract, peritoneum, mesentery as well as the solid organs like liver, spleen and pancreas.[3,4]

We present a case with intra-abdominal mass of unknown origin which was thought to be as peritoneal carcinomatosis preoperatively.

CASE REPORT

A 42-year-old woman was admitted to the hospital with abdominal pain. She was suffering from abdominal pain for approximately 2 years. The radiologic evaluation through ultrasonography and computed tomography revealed intra-abdominal ascites with 3.5x1.5 cm sized mass in the mesentery of small bowel. Although the CA 125 level was found to be as high as 223 U/l, cytologic examination of ascites was not able to show any malignant transformation. Other tumor markers were negative. She was referred to the department of general surgery. After imaging with ultrasonography and computed tomography, absence of any peritoneal dissemination of the mass in the small bowel mesentery, encouraged us to plan a curative resection after open surgical exploration rather than a laparoscopic approach. However explorative laparotomy showed 2500 cc ascites and diffuse intra-abdominal implants which were interpreted as a peritoneal carcinomatosis, which were unfortunately not detected with any of preoperative imaging methods (Figs. 1, 2). Multiple biopsies were taken for histopathologic examination. The postoperative period was uneventful. The patient was discharged on 4th postoperative day. After detecting the diffuse

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Fig. 1. *Granulomatous deposits on peritoneal surfaces intra abdominally.*

Fig. 2. *Abdominal tuberculosis (operative view).*

granulomatous inflammation in the histopathologic evaluation the diagnosis of intra-abdominal tuberculosis was established. A combined multi drug regimen against tuberculosis was started immediately. Her complaints dramatically improved after the anti-tuberculosis medication which also confirmed the diagnosis of abdominal tuberculosis.

DISCUSSION

Abdominal tuberculosis can mimic different abdominal pathologies including gastrointestinal cancer.[4] Differential diagnosis between tuberculous peritonitis and peritoneal carcinomatosis is extremely difficult in patients with ascites, peritoneal implants and elevated levels of CA 125.[4,5] In most of the cases elevated levels of CA 125 tend to decrease dramatically after anti-tuberculosis treatment.[5] Abdominal tuberculosis should be kept in mind for differential diagnosis of abdominal mass with ascites in immunosuppressed patients, and especially in patients with known accompanying tuberculosis of other systems of the body.[1-5] The microbiologic culture of the ascitic fluid for mycobacterium tuberculosis should not be ignored in suspected patients.

Whereas elevated tumor markers and diffuse intra-abdominal tumor-like deposits may be usually observed in patients with intra-abdominal cancers of advanced stages, the eventual histopathologic examination is always more reliable than the initial macroscopic interpretation of the surgeon peroperatively, because as in our case abdominal tuberculosis can mimic gastrointestinal cancer.

As a conclusion, in patients with ascites and diffuse intra-abdominal implants without any obvious primary tumor intra-abdominally, abdominal tuberculosis should be thought in differential diagnosis. According to that, preoperative screening of the entire gastrointestinal tract endoscopically as well as radiologically and eventual diagnostic laparoscopy and biopsy may decrease the need for unnecessary laparotomies especially in endemic areas.

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