Correspondence

Abdominal tuberculosis

SIR,—We have read with interest the experience of Palmer *et al* with abdominal tuberculosis in Britain (*Gut* 1985; **26**: 1275–8). Based on our experience of managing more than 80 cases of abdominal tuberculosis over the last eight years we would like to differ with them on certain points.

In 19 of 42 cases of intestinal tuberculosis reported by the authors, diagnosis was based on radiological findings alone and antituberculous treatment was started. Radiographic appearances of abdominal tuberculosis are, however, non-specific and false-positive findings are seen.¹ Also, radiology may not differentiate tuberculosis from Crohn's disease and carcinoma.² Ileocaecal and colonic tuberculosis may radiologically mimic carcinoma in up to 10% of cases.³ We carried out barium studies in 37 patients – four were false-positive (evidence of tuberculosis on radiology but no abnormality found at laparotomy). In one case in which radiological diagnosis was tuberculosis, carcinoma was discovered at laparotomy. Treatment based on radiological findings alone, therefore, may result in unnecessary and prolonged administration of potentially toxic antituberculous drugs to normal subjects, missing and delaying the treatment of malignant lesions and maltreatment of Crohn's disease.

Palmer *et al* advocate emergency surgery for intestinal obstruction. Intestinal obstruction in abdominal tuberculosis may be acute but is more commonly subacute.⁴ It is not always caused by intestinal lesions and may be because of involvement of the peritoneum and/or lymph nodes. Emergency surgery in abdominal tuberculosis is associated with a high mortality – 18%¹ to 24%.⁴ Bhansali⁴ based on his experience of 300 cases of abdominal tuberculosis, advocates initial conservative treatment for acute intestinal obstruction due to tuberculosis. Many cases improve and are operated electively two to four weeks later; those who do not respond undergo emergency surgery. We tend to agree with Bhansali⁴ and manage our patients with intestinal obstruction due to abdominal tuberculosis with initial conservative treatment. In only three cases emergency surgery was undertaken as obstruction did not respond to conservative treatment. All of them died.

Morphologically the lesions of intestinal tuberculosis are ulceroconstrictive (small intestine) and hypertrophic (ileocaecal); in both the intestinal lumen is compromised. Medical treatment results in

healing by fibrosis further narrowing the lumen and increasing obstruction.⁵ An increased incidence of perforation with antituberculous treatment has also been reported.⁶ In our experience too, two of six cases with tuberculous perforations of the small intestine were receiving medical treatment for radiologically demonstrated intestinal tuberculosis, both were found to have perforations proximal to a stricture.⁷ The histopathological picture is altered by medical treatment⁸ so that differentiation between tuberculosis and Crohn's disease becomes difficult if doubts arise later. We therefore advocate surgery as the treatment of choice for intestinal tuberculosis. Mortality after elective surgery for abdominal tuberculosis is low, 2%⁴ to 3%.¹ None of our patients undergoing elective surgery died.

Clinical diagnosis of abdominal tuberculosis is strengthened by radiological studies. It can, however, only be confirmed at laparotomy, which also provides an opportunity to correct the mechanical effects of the disease. All patients must receive antituberculous treatment, steroids may be added in patients with tuberculous peritonitis to prevent formation of adhesions.⁹

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