Tuberculosis of the terminal ileum

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EDITORIAL COMMENT This is an interesting case report reminding us that tuberculosis of the terminal ileum is still a differential diagnosis for Crohn's disease in western countries.

The incidence of intestinal tuberculosis has dramatically decreased over the past 25 years, and is reflected by the scarcity of case reports in the recent literature. The annotation, therefore, of a further proven case appears to be justified and may also serve as a reminder that the condition should always be borne in mind in the differential diagnosis of ileo-caecal lesions, particularly since there has been a suggestion (Amerson and Martin, 1964) that the incidence of gastrointestinal tuberculosis is on the increase due to the development of resistant strains of the bacillus. Howell and Knapton (1964), presenting a personal series of cases over the 12-year period 1951-62, found seven proven cases of ileo-caecal tuberculosis and six presumed cases. All authors agree that the condition is rare now in the western hemisphere. Ukil (1942) records 1,000 cases in India. The condition is usually secondary to pulmonary tuberculosis. In the series of Howell and Knapton, seven patients had evidence of pulmonary disease, although in only two were bacilli recovered; in six patients the lung fields were normal radiologically and there was no evidence of tuberculosis elsewhere. Ukil found that 95% of his cases were secondary to pulmonary tuberculosis.

A pre-operative diagnosis is unlikely: usually a regional ileitis is suggested. Even at operation the diagnosis may be difficult.

CASE HISTORY

A man, aged 39 years, complained of severe hypogastric pain, lasting for two days, which was eased by medicine given by his doctor. During the following week the patient felt feverish and nauseated and then developed diarrhoea. He was admitted to hospital at this time, some 14 days after the original onset.

On admission the patient was ill, and the abdomen was slightly distended. There was no leucocytosis. The stool cultures were repeatedly negative for bacterial growth. A tentative diagnosis of acute ulcerative colitis was made. Plain radiographs of the abdomen showed slight dilatation of both small and large bowels. A chest radiograph was clear at this time, but a repeat examina-

tion a week later showed a small left pleural effusion. During the next few days the condition improved and at this time a mass became palpable in the right iliac fossa.

Barium enema examination was undertaken, but this was normal. A month after admission a barium follow-through series was carried out and showed irregularity and narrowing of the terminal few inches of the ileum, the appearances being compatible with a regional ileitis (Fig. 1). The patient's condition had now generally improved and he was afebrile. The diarrhoea had ceased and the only symptom was anorexia. A further chest radiograph showed the pleural effusion to have absorbed.

Laparotomy was carried out a few days later and the surgeons reported multiple adhesions between the loops

FIG. 1. Radiograph showing irregularity and narrowing of the last few inches of the ileum.

FIGS. 2a and 2b. Photomicrographs showing caseating tuberculosis.

of bowel, a hard mass involving the terminal ileum, and numerous peritoneal deposits. The condition was thought to be malignant. A biopsy of one of the omental deposits was taken, but no further operative procedure was carried out. The histological report showed the presence of caseating tuberculosis and there was no evidence of malignancy (Fig. 2). The patient was placed on anti-tuberculous therapy.

A repeat follow-through examination five months later showed that there was still narrowing of the terminal

FIG. 3. Radiograph showing narrowing of the terminal ileum but no irregularity (cf. Fig. 1).

ileum, but that this was no longer irregular, and the appearances indicated improvement (Fig. 3). There was now no delay in the rate of passage, no mass was palpable, and the patient was symptom-free.

COMMENT

This patient is of interest because even at laparotomy the diagnosis was still not clear. Indeed the mass was thought to be malignant. The ultimate diagnosis rested entirely on the histological evidence. Further interesting features are that only the terminal ileum, and not the caecum, was involved, and that, although most cases of alimentary tuberculosis are secondary to definite pulmonary lesions, this appears to have

been a primary intestinal lesion. Nevertheless, one can speculate on the nature of the small, and rapidly clearing, pleural effusion which developed soon after admission.

Finally, it is gratifying to record the patient's improvement on anti-tuberculous therapy.

REFERENCES

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