Scholars Journal of Medical Case Reports
Sch J Med Case Rep 2016; 4(8):600-601
©Scholars Academic and Scientific Publishers (SAS Publishers)
(An International Publisher for Academic and Scientific Resources)
ISSN 2347-6559 (Online)
ISSN 2347-9507 (Print)
DOI: 10.36347/sjmcr.2016.v04i08.010

A Case Report of Tuberculosis of Rectum Mimicking Malignancy

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Abstract: Gastrointestinal tract tuberculosis is uncommon. Anorectal tuberculosis is rare and can mimic malignancy. We present a case of 55-year-old female patient who came to the hospital with complaints of severe epigastric pain for one week with a history of vomiting, loss of weight and loss of appetite. Colonoscopy revealed a growth in rectum and the specimen was sent for histopathological examination to rule out rectal malignancy, which turned out to be rectal tuberculosis. The patient was treated successfully by anti-tuberculosis medications. Rectal tuberculosis should be included in the differential diagnosis of rectal masses. As these lesions occur so sparsely, they are often not suspected.
Keywords: Tuberculosis, rectal tuberculosis, rectal malignancy, anti-tuberculosis treatment.

INTRODUCTION

Extra pulmonary Tuberculosis remains an important part of the total tuberculosis cases all over the world[1]. Tuberculosis of the gastrointestinal tract occurs as a primary lesion or secondary to a focus of tuberculosis somewhere else in the body, most commonly in the lungs[2].

CASE REPORT

A 55 year old female was admitted in the casualty of our institute with complaints of severe epigastric pain for one week and history of vomiting, loss of weight and loss of appetite. There was no significant past medical history Physical examination revealed mild pallor. She had no lymphadenopathy or hepatomegaly. Except this, the general and systemic examination was non-contributory.

Investigations revealed haemoglobin 9.0g/dL, total leucocyte count 6900/ cu mm (neutrophil 68%, lymphocyte 21% , eosinophil 4%, monocytes 7%), ESR 62 mm / hr. The patient had fasting blood sugar 107 mg/dL, urea17 mg/dL, and creatinine 0.8 mg/dL. Liver function tests showed normal bilirubin and enzymes. Urine examination revealed 3-4 epithelial cells and 2-3pus cells. Ultrasonography of the whole abdomen did not reveal any abnormality. Chest radiograph was within normal limits. Endoscopy was performed which revealed antral erosion. Patient developed loose stools and vomiting. Faeces for occult blood was found out to be positive. Colonoscopy was performed which showed a growth in the rectum. Biopsy was taken and the specimen was sent for histopathological examination to rule out malignancy but as the specimen was not adequate so a repeat biopsy was asked. Repeat rectal biopsy suggested tuberculosis rectum. AFB stain was done to confirm the diagnosis which also came out positive.(Fig 1-4) .The patient was started on anti - tuberculosis therapy to which she responded very well.

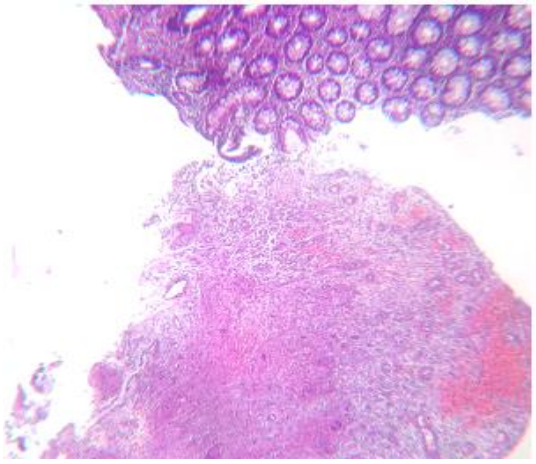

Fig-1: scanner view showing a fragment of colonic mucosa with ulceration and fragment of necrosis

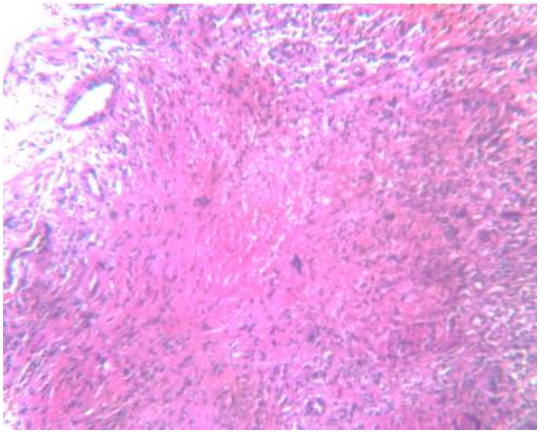

Fig-2: Low power view showing area of necrosis surrounded by a granulomatous reaction

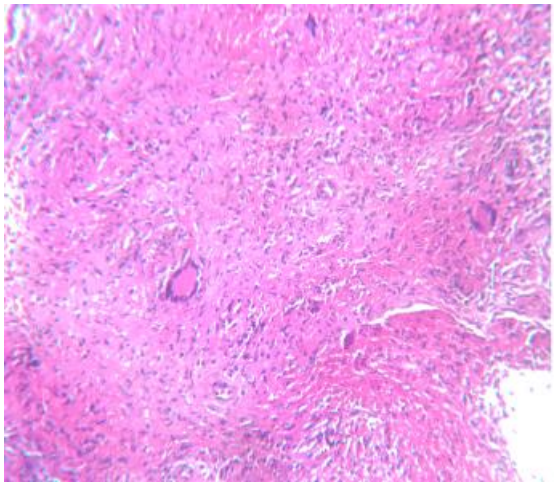

Fig-3: Low power showing a granulomatous reaction composed of langhan type of giant cells, lymphocytes and epitheloid cells.

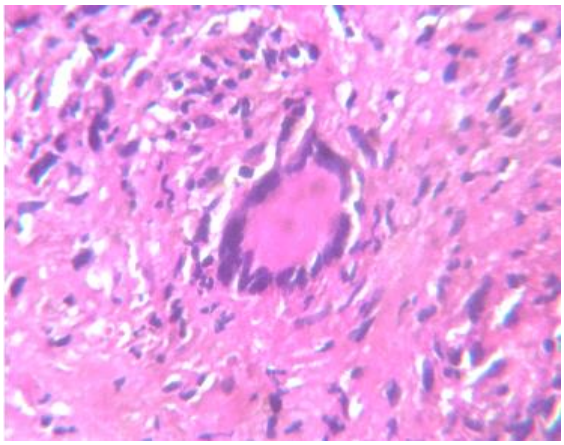

Fig-4: High power view showing a langhan type of giant cells.

DISCUSSION

Tuberculosis of gastrointestinal tract can involve any portion of bowel extending from oesophagus to anus, though, involvement of bowel distal to ileocaecal junction is rarely seen[3]. Tuberculosis around the anus is a rare extrapulmonary form of the disease[4].While the rate of extrapulmonary tuberculosis has increased in few years (around 5%), the anal presentation still is rare (0.7%) [5].

Anorectal tuberculosis may present in six morphological types of. 1. Fistula in ano 2. Ulcer with undermined edges 3. Stricture 4. Multiple small mucosal ulcers 5. Lupoid form with submucosal nodule and mucosal ulceration 6. Verrucous form with multiple warty excresences[6]. Due to the diverse presentation of anal TB, it should be considered in all lesions not responding to the standard treatment [7].

CONCLUSION

Rectal tuberculosis can mimic a malignant lesion clinically, radiologically and endoscopically. Histopathological study provides the definitive diagnosis of rectal tuberculosis. Repeated biopsies may be required in some cases as tuberculous lesions may be submucosal in nature [8]. In our case also a definite diagnosis was made after a repeat biopsy. An early diagnosis is necessary to prevent recurrences as well as surgeries of such an easily curable disease[7]. Precise diagnosis of extra-pulmonary tuberculosis is essential for better management and to avoid complications.

ACKNOWLEDGEMENT

We thank Dr. Vinod Kumar from Medicalgastroenterology department for his support.

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