Pattern of Tuberculosis in General Practice

Pages with reference to book, From 183 To 184

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Abstract

An audit of 690 cases of tuberculosis out f 46,276 patients seen during the last 25 years in a busy general practice is reportes. Of the 690 cases, 67% were pulmonary, 33% extre-pulmonary TB.Modes of both types of tuberculosis are described and the reason for extra-pulmonary tuberculosis are discussed (JPMA 48:183, 1998).

Introduction

Tuberculosis is a common disease in Pakistan and World Health Organization in 1987-88, reported a sputum postive prevalence of 0, 17 per 1000 million[1]. Tuberculosis is more prevalent in urban low socio-economic conditions, chiefly due to malnutrition, over crowding and unhy gienic conditions. with increased resistance to anti-tuberculosis drugs that is being reported from all parts of the world the problem has become acute with AIDS compounding its incidence in developing countries, specially in Africa and South East Asia. Treatment with three or four drugs is being advocated, which makes it much more expensive; this further reduces the compliance, as not many patients can afford expensive drugs over a period of six to nine months. An audit of all the cases of tuberculosis seen in a busy general practice, in a middle to lower middle class populace during the past 25 years was conducted by adopting simple organizational measures of health care to see the pattern of disease encountered and evaluate the final out come.

Patients and Methods

In the general practice, record of all patents seen over 20 years were maintained. Special sheets and reference registers with complete details of the patients were filled in. Reference cards had individul numbers for each patient which were used for all the future ailments, that helped in establishing a system for supervision and for operational management, treatmenta and follow- up[2]. In this retrospective analysis, case records of 813 suspected cases of tuberculosis seen during the study period were reviewed. In each case the patent had X-ray\'s, complete blood picture with ESR, Mantoux test and sputum for A.F.B. Other investigations i.e. FNAB, histopathology and specialized X-ray\'s i.e. small bowwl enema, lumbar puncture, ultra sound guided aspiration of psoas abscess and thotacocentesis were also obtained when requires. Based on the site of lesion, cases were divided into pulmonary and extra pulmonary cases.

ResuIts

Of 813 suspected cases of tuberculosis, 123 were non-tubercular and hence excluded. Of the 690 remaining cases, 335(48.5%) were maleand 355(51.4%) females[3]. Ages of the patients ranged from 2 to 60 years, 70% were between 10-39 years; of the total, 466 (68%) were pulmonary tuberculosis, 27 (4%) had both pulmonary and extra puhnonaiy tuberculosis and 224 (32.4%) were only extra pulmonary. The chief presenting symptoms among the puhnonaiy cases were cough with expectoration,

fever, weight loss, malaise. Haemoptysis waspresent in 127 (18%) cases and night sweat in 10 cases. Infiltration was observed in 218 (47%) cases, of which 110 (59%) were bi-lateral. Infiltration plus cavitation was seenin 91 (20%) and 27(6%) were pneumonic (Table I).

Table I. Pattern of Lung lesions (n=466).

	Total		Left		Right		Both	
	Nos.	%	Nos.	%	Nos.	%	Nos.	%
Infiltration	235	50	56	12	75	16	104	22
Infiltration with cavities	91	20	37	6	52	11	2	2
Pleuristy	29	6	14	3	15	3	0	0
Pneumothorax	28	6	9	2	15	3	4	1
Pneumonic	27	6	9	2	15	3	3	1
Fibrotic	56	12	18	4	24	5	14	3

Among extrapulmonary tuberculosis the chief presentation was swellings of glands. very few complained of constitutional symptoms, except these with pleural and pericazdial involvement and these suffering fmm abdominal, bone and joint disease. Tie pattern of extm-pulmomiy lesion is presented in Table II.

Table II. Pattern of extra pulmonary lesions (n=224).

Lesion	Nos.	%
Hilar lymph adenitis	80	36
Peripheral lymph adenitis	51	23
Pleural effusion	34	15
Primary abdominal tuberculosis	23	10
Spines	15	7
Bones and joints	8	4
Meningitis	4	2
Pericardial effusion	3	1
Paratrachial lymph adenitis	2	0.9
Others (Larynx, BCG vaccination etc)	4	2

In this sezies;except one case of axillazy and one of supicacavicularlymph adenopathy, none required surgical intervention.

Discussion

The frequency of extra pulmonary tuberculosis is consistent with UK experience[1], where 34% of the Asians compared to18% of whites were seen with this lesion. In USA there has been a gradual increase of extra pulmonary disease over the years. It has always been suggested that inareas where bovine tuberculosis is common, lympatic and abdominal tuberculosis is more frequent. In a study from Lahore no bovine bacilli were discovered in 100 cervical gland specimens[4]. some a typical mycobacteria, mainly Scotochromogenic were isolated. Similarly in Saudi Arabia, atypical Mycobacterium mainly Mycobactenum Fortuitum and Mycobacterium Chlome were isolated. Asian and African variants were isolated from both Saudi and non Saudi patients[5]. The incidence was highest among young adults, and in females. In Karachi there is a gradual increase in extra pulmonary tuberculosis. It seems that altered immune status may be responsible for this change. Tubercular meningitis, a disease of childhood is now being reported amongst adults. Recently fifty consecutive cases of meningeal tuberculosis amongst adults aged 15-70 years were reported from tertiary treatment centers[6]. Diagnosis of extra pulmonary tuberculosis presents a problem specially in abdominal tuberculosis, which comprised 10% in these series. Fourteen (6 1%) of these had ileocaecal tuberculosis and 6 (26%) had peritonitis. In majority of cases modem technique of imaging i.e. small bowel enema, ultra sound, fine needle aspiration biopsy are of great help for diagnosis, subject to proper clinical assessment.

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