Duodenal Tuberculosis

Pages with reference to book, From 53 To 54

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Abstract

Two cases of distal duodenal strictures are reported. One case had histopathologically confirmed tuberculosis and one suspected tuberculosis which responded dramatically to antituberculous therapy. Tuberculosis should be considered as a cause of distal duodenal obstruction in Pakistan (JPMA 35:53, 1985).

Introduction

Diseases of distal duodenum are rare. Although the distal duodenum is the locus of midgut rotation, developmental anomalies leading to obstruction are uncommon and present early in life. Superior mesentric artery compression has been suggested as a cause of obstruction to the third part of duodenum. Others regard obstruction at this point as being the results of neuromotor incoordination of functional origin associated with anorexia nervosa and SLE. Strictures are very rare and could be due to tuberculosis, cicatricial stenosing enteritis, peptic ulcer disease or benign and malignant tumors of the region[1].

Case Reports

1. A 22 years old Baluch male was admitted with symptoms and signs of upper small bowel obstruction of two months standing. He had low grade fever of four months duration for which he had taken irregular antitubercular therapy. At admission he was grossly malnourished and weighed 37 Kgs. Routine laboratory workup was inconclusive. X-Ray chest did not show active or healed tuberculosis. Barium was retained for nine hours in the stomach and showed an almost complete stricture of third part of duodenum (Fig. 1).

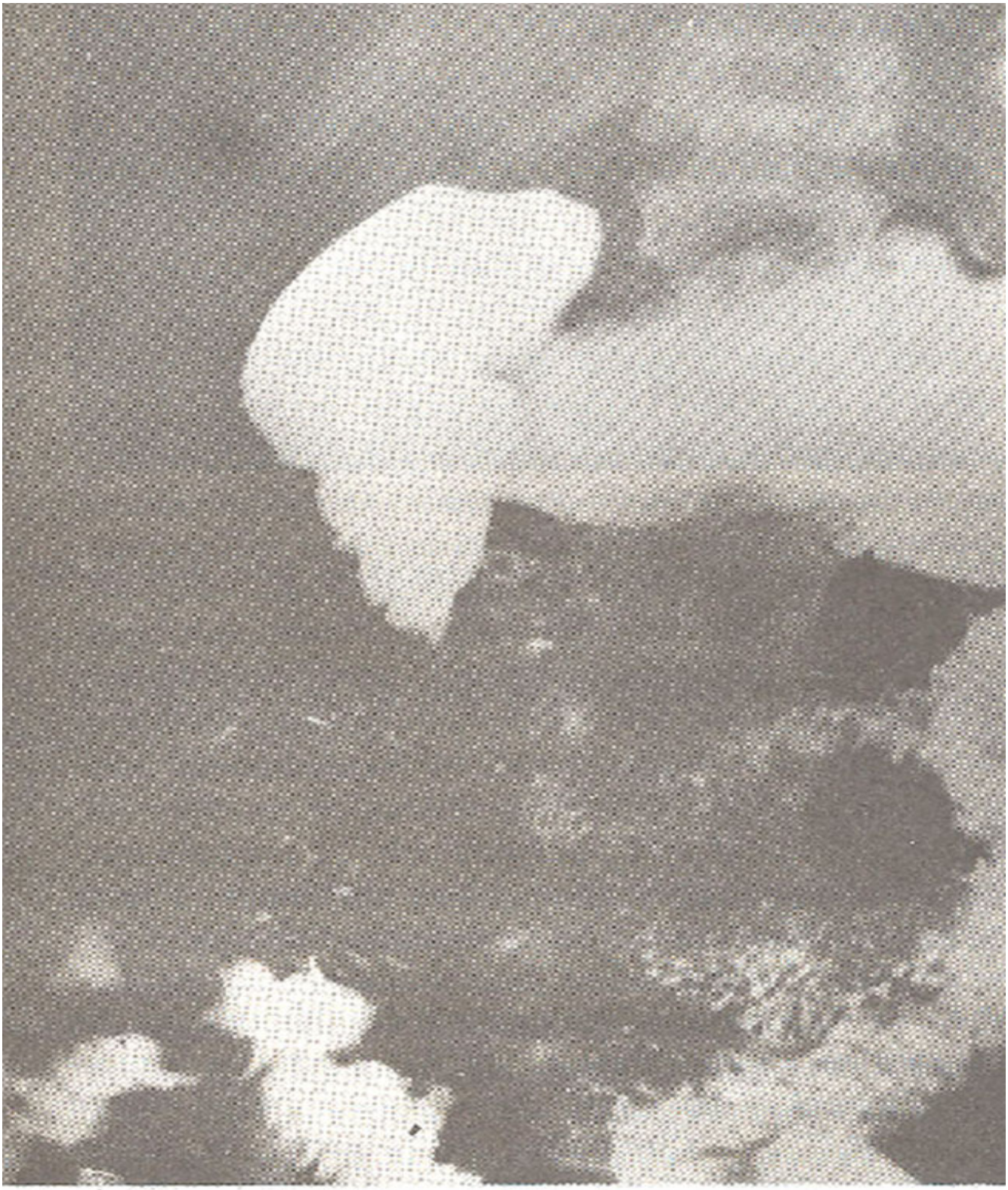

Fig. 1. Stricture in third part of Duodenum.

Upper GIT endoscopy showed normal oesophagus, stomach and first part of duodenum. At operation almost complete stricture of the descending duodenum was found, with matted and a few discrete lymph nodes of 4-5 cm size around the stricture and in the mesentery. Two other areas of slight narrowing with serosal tubercies were found in the terminal ileum. A retrocopic duodenojejunostomy

with 4 cm transverse stoma was performed. Histopathology of the lymph gland showed caseating tuberculous granuloma. Postoperatively combined antitubercular therapy was started.

Case II- An 8 years boy from lasbella district was admitted with the history of copious bilious vomiting and generalized abdominal pain of 5 days duration. Recurrent similar episodes ofcomparatively milder degree at irregular intervals had been occurring for past few months. Abdominal distension was absent. Except for bilateral cervical lymphadenopathy, no clue to the cause of upper bowel obstruction was found. Upper barium series performed after successful conservative management showed a persistent irregular area of narrowing in the IIIrd part of duodenum (Fig. 2).

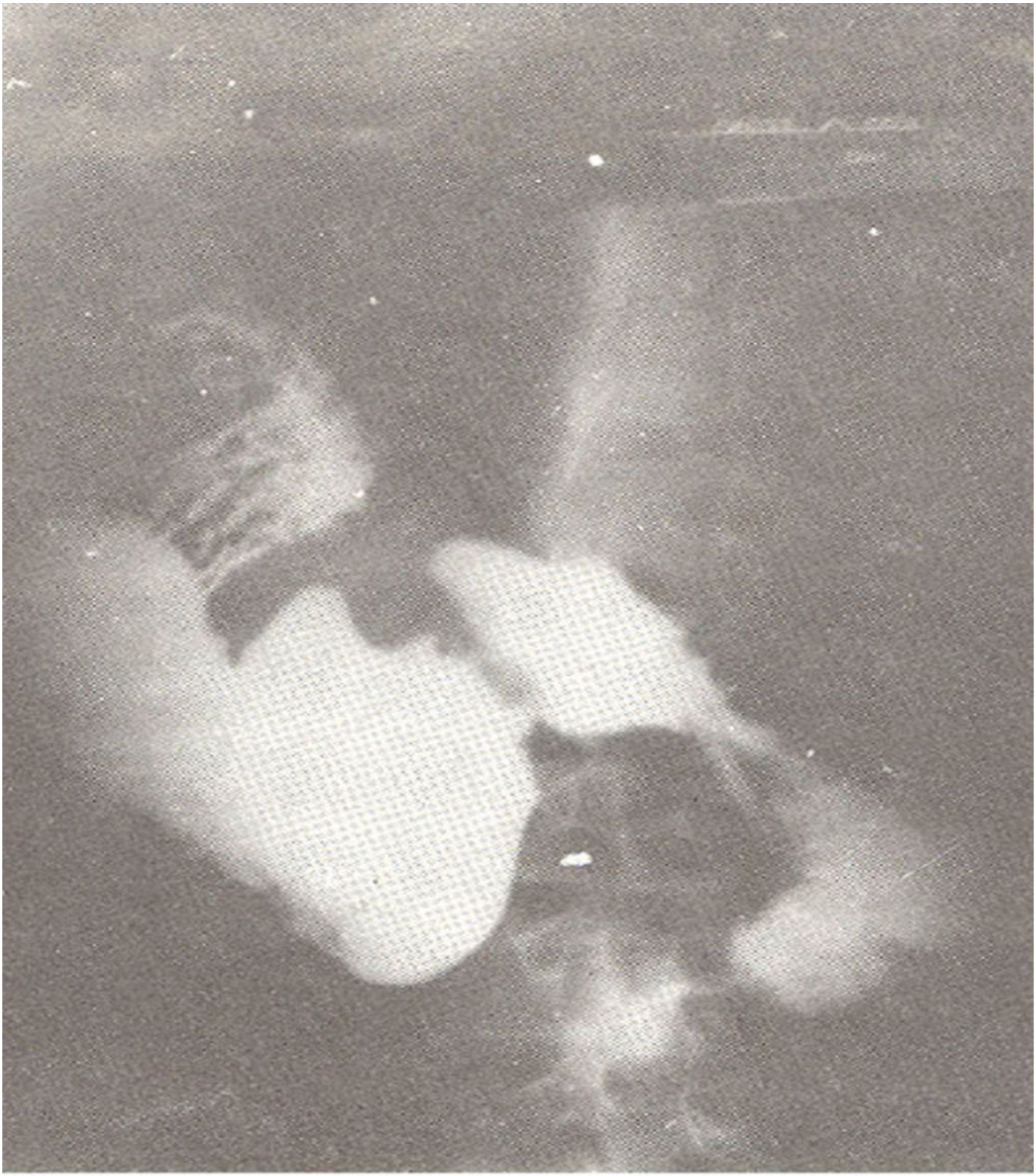

Fig. 2. Persistent irregular narrowing of the third part of the duodenum.

Chest radiograph was normal. Anti-tubercular drugs started empirically improved his condition dramatically and he gained 10 Lbs in a month.

Discussion

Duodenal tuberculosis, although a rare entity has been reported from India.[2,3]
Tuberculgus lesions of duodenum can be ulcerative, hyperplastic, mfilterative or enteroperitoneal, the first two types being more common.[4-7] Clinically, all present as upper bowel obstruction with upper abdominal' pain and bilious vomiting without abdominal distension. Lesions in pyloroduodenal area mimic peptic ulcer disease. Occasionally the patient may present with a palpable mass but many more may be symptomless or with vague abdominal complaints. Bleeding is rare complication[8]. Perforation and fistulae are even rare[9]
Diagnosis of isolated duodenal tuberculosis is difficult ESR is both our sifgnifc. Mantoux test was negative in both our cases but even a positive test has on significance in adults as exposure is almost inevitable in our country. In the present study routine barium meal demonstrated the lesion clearly but hypotonic duodenography may define the lesion when routine barium series are unhelpful[3]. There is no Pathognomic lesion of tuberculosis on endoscopic examination. Endoscopic biopsy usually fails to show classical caseating granuloma probably because the tuberculous granuloma is found in the submucosa whereas an endoscopic biopsy is limited to mucosa.[3] Laparotomy is therefore suggested for making a histological diagnosis[9] but even a surgical specimen has to be subjected to serial sectioning in search of tubercules and acid fast bacilli. Endoscopy may have a role in the followup of tuberculous lesions of duodenum[3].
Antitubercular therapy produces dramatic response. Operative treatment is required usually for complications usually strictures but occasionally haemorrhage. In obstruction bypass is the procedure of choice. It is certainly less hazardous than resection. Peroperative frozen section may be of help to avoid extensive resections.

References

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