Abstract

Abdominal TB comprises around 5 % of all cases of TB worldwide and it includes involvement of the gastrointestinal tract, peritoneum, lymphnodes or solid organs. Pathogenesis of abdominal TB can be due to reactivation of latent TB, haematogenous spread in the setting of active pulmonary TB or milliary TB. Less commonly, tuberculous mycobacteria enter the peritoneal cavity transmurally from an infected small intestine or via contiguous spread from tuberculous salphingitis. As the disease progresses, the visceral and parietal peritoneum is studded with tubercles. Ascites is developed secondary to exudative proteinaceous fluid from the tubercles.

Peritoneal TB can mimic malignant ascites and CA 125 can mislead the diagnosis. CA 125 can be positive in various disease conditions, but mostly positive in bowel malignancies. In abdominal TB CA 125 can be significantly positive. Therefore the diagnosis of TB peritonitis is not simple and conventional diagnostic tests can be falsely negative.

21 year old previously healthy woman presented with progressive abdominal distension over 2 weeks duration and low grade intermittent fever and Examination revealed gross ascites without peri-orbital edema, ankle edema or peripheral stigmata of CLCD.

Her ESR was 56, peritoneal fluid aspiration revealed a lymphocytic predominant exudate and the ADA was positive with a value of 49 (<36u/l). Mantoux test was negative. Following that sputum AFB and ascitic fluid aspiration for TB PCR was negative with CA 125 was 125u/mL (<46u/mL). Eventually she had undergone lower and upper GI endoscopy and CECT chest, abdomen and pelvis, they didn't reveal any diagnostic clues. Finally, diagnostic laparoscopy was done by a GI surgical team and revealed milliary mottling of whole peritoneum.

Her illeal biopsy was negative without caseaous necrosis or langerhan giant cells but peritoneal biopsy shows granulomatous inflammation suggestive of tuberculosis. She responded to anti TB drugs and became symptoms free within first one month.