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Intestinal tuberculosis as a diagnostic challenge in a high prevalence center

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Dear Editor,

A 21-year-old man from Morocco, with no relevant medical history, presents with intermittent abdominal pain and diarrhea, without pathological contents, associated with low-grade fever and weight loss over a three-month period. Physical examination reveals a distended abdomen, painful in the hypogastric region, without signs of peritoneal irritation. Blood tests show leukocytosis with neutrophilia and increased acute-phase reactants, as well as anemia and malnutrition parameters. No microbiological agent is isolated from stool cultures.

An abdominal CT scan shows a 15 cm segment of terminal ileum with thickened walls up to 10 mm and trabeculation of the surrounding fat, leading to stenosis and retrograde dilation. Colonoscopy reveals no alterations in the colonic mucosa, and 10 centimeters of terminal ileum are explored, showing edematous, friable mucosa with superficial ulcerations and a fistulous opening (Figure 1).

Empirical treatment with antibiotics and corticosteroids is initiated. After a slow response, an urgent right hemicolectomy and resection of the terminal ileum with a colo-intestinal anastomosis is performed. Finally, histological analysis of the surgical specimen shows abundant abscess-forming epithelioid granulomas with focal necrosis (Figure 2). Antituberculosis treatment is started, with good patient recovery in the following months.

DISCUSSION

Intestinal tuberculosis (ITB) is a rare extrapulmonary manifestation of tuberculosis, more common in endemic areas and in immunocompromised patients. Most cases do not present active pulmonary symptoms at the time of diagnosis (1).

Imaging and endoscopic studies may be indistinguishable between ITB and Crohn's disease (2,3). The histological characteristics of tuberculosis show granulomas which, unlike those seen in Crohn's disease, are characterized by caseating necrosis (2).

Molecular studies, such as reverse transcription polymerase chain reaction (RT-PCR), and microbiological tests for mycobacteria are essential when histology is not diagnostic (4).

Systemic corticosteroids are indicated in patients with Crohn's disease, and there are a few cases of ileal disease refractory to corticosteroids. Furthermore, emergence of fast-acting biological therapies such as anti-TNF agents is typically recommended in corticosteroid-refractory cases with severe progression, which could have led to a devastating outcome for our patient (5).

This case highlights the importance of proper screening for latent infections in patients suspected of having inflammatory bowel disease (IBD) before starting immunosuppressive treatment as it could result in a fatal outcome (4).

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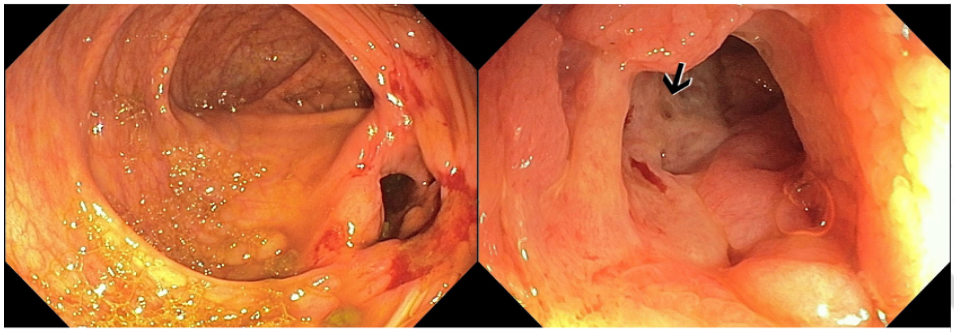

Figure 1: Colonoscopy image. On the left, normal mucosa in the cecum with a deformed and incompetent ileocecal valve. On the right, edematous mucosa of the ileum, with ulcers and a fistulous opening indicated by an arrow.

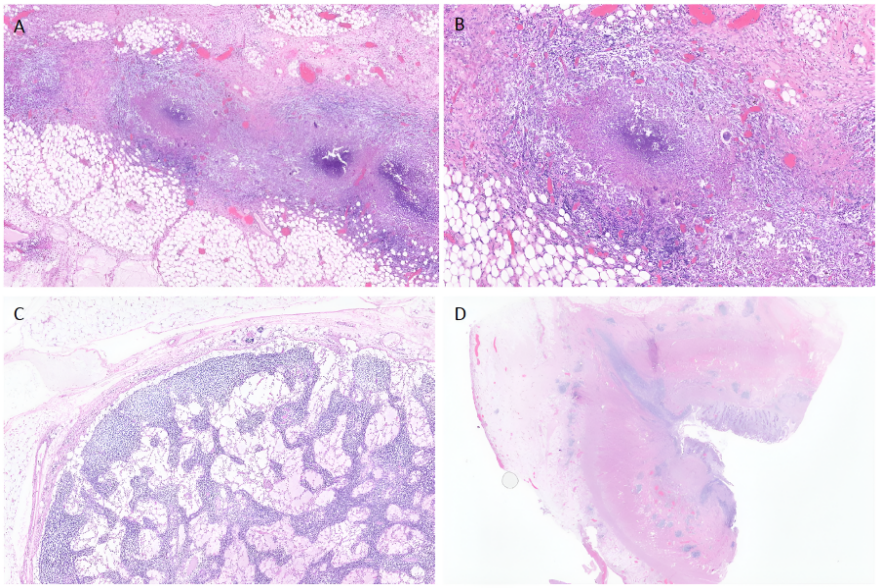

Figure 2: Optical microscope image

A) Abscess-forming and focally necrotizing granulomas in the omentum.

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B) Abscess-forming granulomas in the omentum.

C) Locoregional lymph node with marked reactive changes.

Section of the ileum with chronic ulcerative inflammation and fistulization.