EDITORIAL

Abdominal Tuberculosis - The Missing Diagnosis

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Tuberculosis is a major health problem in the world and continues to be a serious problem to SAARC member states which accounts for 30% of the global incidence[1, 5].

Pakistan ranks 6th among the 22 high TB burden countries. All member states of SAARC have adopted DOTS for effective control of tuberculosis[2].

Abdominal Tuberculosis is a fairly common problem encountered by physicians and surgeons of all interest. Abdominal tuberculosis is defined as tuberculous infection of the abdomen including gastrointestinal tract, peritonium, omentum, mesentry and its lymph nodes and other solid intra abdominal organs like liver, spleen and pancreas[3].
Tuberculosis can affect any part of the bowel and the patient may present with a wide range of symptoms and signs. Upper gastrointestinal tract involvement is rare and is usually an unexpected histological finding in an endoscopic or laparotomy specimen.

Early diagnosis is important as the infection can be treated with standard anti tuberculosis therapy. If surgery is necessary for complications such as obstruction and perforation it carries a mortality increasing from 2% for elective procedures to 20% for emergency operations[4].
In addition to non-specific symptoms such as malaise and anorexia, the major presenting features are abdominal pain (100%), altered bowel habit (67%) and a palpable mass (60%).[4]
Radiological evidence of pulmonary disease is less than 10% of all patients who have intestinal tuberculosis, so a normal chest radiograph does not exclude the diagnosis and often abdominal tuberculosis exists in the absence of respiratory tuberculosis.
For investigations, barium enemas and abdominal CT scans can be abnormal but are not diagnostic. If ascites is present fluid examination and culture can yield positive results, although cultures are often negative in the presence of disease and the result is delayed for six weeks as abdominal tuberculosis is Pauci bacillary, the yield for organisms is low. The yield may be increased by culturing a liter of fluid concentrated by centrifugation.
Tissue for rapid histological diagnosis can be obtained by colonoscopy or laparoscopy; the latter procedure is both safe and effective permitting full inspection of peritoneal cavity and accurate biopsy of any lesion.
Despite the availability of these investigations, the primary intestinal tuberculosis is still not detected until laparotomy is done, therefore a high index of clinical suspicion is often needed.[6]
There is a dire need to develop national guidelines for the diagnosis and treatment of abdominal tuberculosis by Pakistan Chest Society in collaboration with Pakistan Society of Gastroenterology and Pakistan Society of Surgeons. This is particularly important in

view of the need to diagnose and treat abdominal tuberculosis as early as possible to prevent its complications.
These guidelines should be based on available evidence from scientific research and experiences, and should take into consideration local circumstances and cultural issues.

References

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