Atypical presentations of rectosigmoid tuberculosis

Abstract

Isolated involvement of rectosigmoid region is very rare. Such cases are difficult to diagnose clinically due to their nonspecific and atypical presentations. This may lead to misdiagnosis and sometimes unplanned treatment. A 65-year-old female had operated for suspected traumatic intestinal obstruction with operative findings suggestive of carcinoma rectosigmoid region. Later on, investigations had proved the case to be tuberculosis of that region without any other signs. Thus, a thorough knowledge of the various presentations of rectosigmoid tuberculosis is important in order to improve patient management.

Key words: Atypical, rectosigmoid cancer, tuberculosis

INTRODUCTION

Abdominal tuberculosis usually affects terminal ileum, lymphatics, peritoneum, and greater omentum. Colonic tuberculosis is usually associated with ileal tuberculosis. Right colon involvement is more common than left colon. Isolated involvement of rectosigmoid region is very rare. Such cases are difficult to diagnose clinically due to their nonspecific and atypical presentations. This may lead to misdiagnosis and sometimes unplanned treatment. Thus, a thorough knowledge of the various presentations of rectosigmoid tuberculosis is important in order to improve patient management.

CASE REPORT

A 65-year-old female had presented to the emergency department with complain of pain abdomen since 5 days when she underwent a trivial trauma in the lower abdomen through the corner of her bed. On examination, vitals were stable and abdomen was soft, mild deep tenderness was present in the lower abdomen. Erect roentgenogram demonstrated the presence of free air under right dome diaphragm. Keeping in mind of traumatic intestinal perforation, emergency exploratory laparotomy was planned. Mild amount of purulent fluid was found in pelvis. Whole of small and large bowel was found dilated and a mass was present in pelvis. After dissection, it was found that there was a perforation in terminal part of sigmoid colon and the adjoining wall of the colon was thickened and adherent to the adjacent ovary and parietal peritoneum. Suspecting malignancy, en bloc resection and Hartmann’s procedure was done [Figure 1]. Patient had shown good recovery. Postoperative carcinoembryonic antigen level was normal. Cylogical examination of peritoneal fluid revealed lymphocytes and neutrophils only. Histopathological examination revealed granulomas with Langhan’s and foreign body type of giant cells with areas of fibrosis and congested blood vessels in the section through rectosigmoid region [Figure 2]. Inflammatory infiltrates were infiltrating the wall of the gut. Section through ovary had shown congestion and section through lymph nodes had shown reactive changes. Chest X-ray and sputum for culture were normal. Patient was started with category-III antituberculous therapy. She is maintaining well.

DISCUSSION

Rectosigmoid involvement of tuberculosis is known since a century. Despite this, tendency to include it in the differential diagnosis of rectosigmoid region disease is very less, which may lead to misdiagnosis and mismanagement. Both the forms, ulcerative and hyperplastic are known to occur. Ulcerative lesions give rise to fibrous strictures.
Although isolated tubercular involvement of rectosigmoid region is very much rare but it is very common to be confused with cancer in that region which is the common site of colon cancer.[1‑8] This can lead to significant delay in treatment and even overtreatment, increasing mortality and morbidity. Confusion increases when elderly patient presents with alteration of bowel habit, bleeding and mucus with faeces, mass abdomen along with weight loss and anaemia. These are common presentations of both the diseases. Rectal examination usually reveals irregular mass, stricture or ulceration and inflamed mucosa. Rectal examination and sigmoidoscopy may be inconclusive unless adequate biopsy is taken. Normal chest X‑ray findings are not uncommon. Other common presentations include lower abdominal pain, prolonged diarrhea and tenderness in the lower abdomen. To the best of our knowledge, the presentation with peritonitis after blunt trauma, we thought of rectosigmoid cancer, the specimen had been reported.[2,6‑12] These presentations may be misinterpreted as Crohn’s disease. Only biopsy findings, microscopy and serology may be confirmatory.

Rectosigmoid tuberculosis presentation with diverticulitis, abscess, obstruction, rectal stricture and rectovesical or rectourethral fistula has been reported.[2‑6] These presentations may be misinterpreted as Crohn’s disease. Only biopsy findings, microscopy and serology may be confirmatory.

If colonic tuberculosis is suspected, empiric treatment is warranted, despite negative histology, smear, and culture results. Patients will usually show a dramatic response in 1‑2 weeks. Treatment is solely medical, and all patients should receive a full course of antituberculous chemotherapy. However in the this case, as the patient had presented with signs of peritonitis after blunt trauma, we decided surgery. As we thought of rectosigmoid cancer, the specimen received was in usual formalin and sample for staining, microscopy, and culture was not received. Thus, a high index of suspiciousness is required to prevent initial misdiagnosis.

REFERENCES