

A WOMAN WITH A LONG HISTORY  
OF ABDOMINAL PAIN

To the editor,

A 39 years old white woman was admitted to our GI Unit for abdominal discomfort and pain in right lower quadrant. She had a 6-year history of abdominal pain, sometimes nocturnal, progressively increasing for intensity and frequency of the episodes. She underwent appendicectomy 6 years before, when the surgeon macroscopically diagnosed a Crohn's disease (CD) but did not perform microscopic histological examination. Since CD was diagnosed, the patient has been treated for short term with mesalazine. At admission physical examination showed abdominal tenderness; a sensation of palpable mass in the right lower quadrant was present. Laboratory data were all within the normal range apart microcytic hypochromic anemia. Abdominal ultrasound showed a bowel wall thickening with limited mobility in the ileocecal region and dilatation of intestinal loops. Colonoscopy revealed multiple aphthous ulcerations involving the mucosa of the cecum, which was friable and easily bleeding; the ileocecal valve was deformed and stenotic. Small biopsy specimens showed chronic inflammation and infiltration of lymphocytes and plasma cells. The barium study demonstrated an irregu-

lar stricture of terminal ileum with pre-stenotic dilatation; the cecum was deformed and contracted (Figure 1). All findings were not specific but compatible with a diagnosis of CD previous formulated. Thus, the patient was treated with prednisone (initially 50 mg/die and successively with scalar dose) and 5-ASA (2.4 g/die), without any benefit. Four months later, the patient was admitted to the Emergency Room of our University Hospital with colicky mid-abdominal pain, nausea and vomiting. A bowel obstruction was diagnosed and the patient has been undergone to ileo-cecal resection and the surgical specimen was analyzed. Grossly, ulcers and erosions were present in the cecum; the cercal walls were thickened with mucosal nodules and ulcerations located between the nodules (cobblestone appearance). Microscopically, granulomatous inflammation with transmural extension and caseating granulomas were present both in the bowel and in the lymph nodes. The patient was diagnosed as suffering from intestinal tuberculosis. A clinical evaluation was performed: chest X-ray was normal; the Purified Protein Derivative (PPD) test was positive. ESR, total serum proteins and fractions were within normal range. HIV was negative. She started the antitubercular therapy with isoniazid, pyrazinamide and ethambutol over a 6-month period and finally recovered.

*Intestinal tuberculosis is an always-difficult clinical diagnosis: symptoms are vague*

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Figure 1.—Ileocecal tuberculosis: in the double contrast phase of enteroclysis, the terminal ileum (i) shows, near the narrowed, segment nodularity of cecal mucosa. The cecum cannot be identified. The terminal ileum and gaping ileocecal valve (arrows) are in direct continuation with the ascending colon.

and signs are non-specific.<sup>1</sup> The clinical presentation and the reason for starting a diagnostic work-up include anorexia, weight loss, fever, right lower abdominal pain and abdominal tenderness, palpable mass, ascites, diarrhea and anal lesions.<sup>1</sup> Ultrasound, radiological, endoscopic and histological examination facilitate the differential diagnosis between CD and TB, but frequently these findings are non-specific and the most of patients do not receive a definite diagnosis until surgery.<sup>1, 2</sup> A common radiological finding of the intestinal TB is an involvement of cecum and colon more severe than the ileum; further the cecum is deformed and retracted with a fixed, irregular and incompetent ileo-cecal valve, which in the first stages appear thick-

ened with submucosal nodules and when the process evolves it may become rigid and incontinent. In CD, cecum is not usually involved and ileocecal valve is competent.<sup>1, 3, 4</sup> The yield from endoscopy has been variable.<sup>1, 2</sup> As result, surgical specimens are sometimes required for a definitive diagnosis. Tuberculous colitis is an important diagnosis because of the potentially catastrophic consequences of giving steroids to these patients (developing of pulmonary miliar TB) due to a mistaken diagnosis of inflammatory bowel disease. In addition to radiology and endoscopy, laparotomy may be required to establish the diagnosis. In cases where the information available does not reveal a definite differentiation between intestinal tuberculosis and CD, cor-

*ticosteroids should be avoided for preventing disastrous results.*<sup>1, 2, 5</sup>

### References

1. Horvath KD, Whelan RL. Intestinal tuberculosis: return of an old disease. *Am J Gastroenterol* 1998;93:692-6.
2. Jayanthi V, Robinson RJ, Malathi S, Rami B, Balambal R, Chari S *et al.* Does Crohn's disease need differentiation from tuberculosis? *J Gastroenterol Hepatol* 1996;11:183-6.
3. Balthazar EJ, Gordon R, Hulnick D. Ileocecal tuberculosis: CT and radiologic evaluation. *Am J Roentgenol* 1990;154:499-503.
4. Thoeni RF, Margulis AR. Gastrointestinal tuberculosis. *Sem Roentgenol* 1979;4:283-93.
5. Arnold C, Moradpour D, Blum HE. Tuberculous colitis mimicking Crohn's disease. *Am J Gastroenterol* 1998;93:2294-6.

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