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Transverse Colon Stricture due to Koch's - A Rare Case Report

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Abstract: ***Isolated colonic tuberculosis (TB) is rare, and the symptoms are nonspecific making early diagnosis and management difficult. Although colonoscopy and biopsy is an important diagnostic modality, the features are variable and the distinction from other conditions of the colon, especially Crohn's disease and malignancy, may be impossible without surgical resection. We report a case of transverse colon Tuberculosis which was diagnosed as benign stricture on colonoscopy, with non-specific results on biopsy. The diagnosis was finally made when the histopathology report was received. The rare presentation of transverse colonic tuberculosis is presented.***

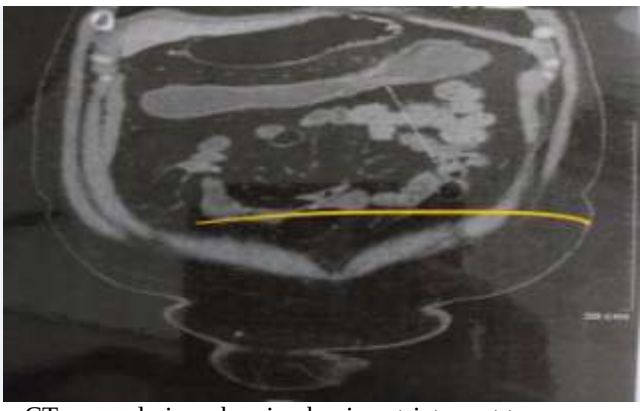
Keywords: benign stricture, ATT, high index of suspicion, colonoscopy, investigation

1. Introduction

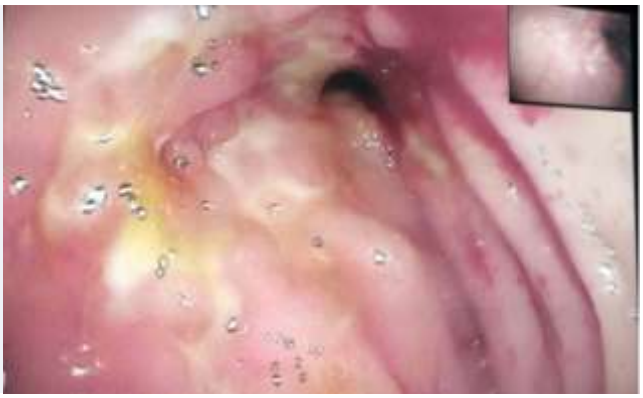
Radiological findings observed were in the form of strictures (54%), colitis (39%) and polypoidlesions (7%). 1 It is difficult to make a precise diagnosis of intestinal tuberculosis and to differentiate it from Crohn's disease.2The purpose of this study was to investigate the changing disease pattern and to determine some possible surgical prognostic factors for large bowel tuberculosis.

2. Case Report

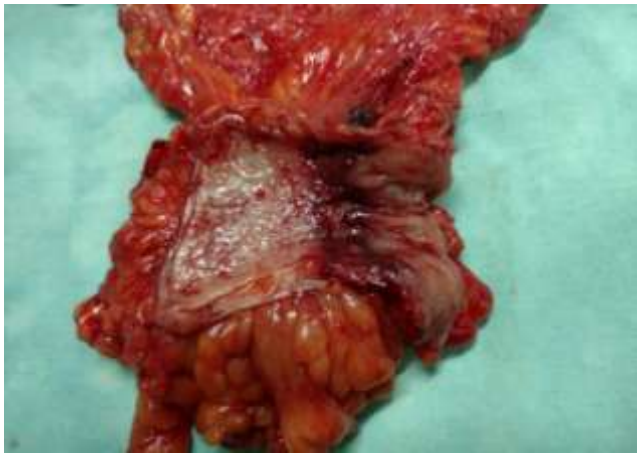
A male patient of 50yrs old came with complaining of recurrent constipation since 5 months, recurrent pain in abdomen since 5 months. Patient had no history of weight loss and no diarrhea and no past history suggestive of tuberculosis in past. Clinical examination revealed soft abdomen without guarding and rigidity and no organomegaly and no lump. Patient was investigated thoroughly, his Hemoglobin was normal, WBC counts were normal, raised ESR, and CEA was 2.3 which was within normal limits. Ultrasonography (USG) of abdomen and pelvis was insignificant. Hence patient underwent Contrast enhanced Computed Tomography scan which reported there is localized transverse colonic wall thickening with luminal narrowing, suggestive of stricture formation. There was no free fluid or mesenteric and retroperitoneal lymphadenopathy.Colonoscopy done, showing stricture at the midtransverse colon. Biopsy taken from the stricture, HPR s/o of colonic mucosa with ulceration and granulation tissue formation, no evidence of dysplasia or malignancy. Hence, decision was taken to operate the patient and considering the negative biopsy report, limited local resection with colo-colic anastomosis was done. Histopathology report of the surgical specimen suggestive of colonic tuberculosis. Post op patient was started on anti-tuberculous treatment, Isoniazid+ Rifampicin +Ethambutol+ Pyrazinamide. Patient recovered well. Patient followed after one month and was symptom free. Complete 9 months of ATT was given and patient followed at one year with symptom and disease free.



CT coronal view showing benign stricture at transverse colon



Colonoscopy showing stricture at transverse colon at 10cm from splenic flexure, beyond which scope could not be negotiated. Multiple biopsies were taken from stricture site.



Cut open Resected specimen of transverse colon stricture

3. Discussion

Ileocecal region is one of the most common sites of tuberculosis enteritis [3 -5, 6]. Segmental involvement of the transverse colon is relatively uncommon. Only 28 cases have been reported in the world literature till 1971 [3,5]. Patients with abdominal tuberculosis present with pain in abdomen and acute or subacute obstruction. But certain patients have no significant complaint and no physical signs to suggest tuberculosis. High index of suspicion for tuberculosis of colon is important for diagnosis.The possible routes of spreading tuberculosis include hematogenous, lymphatic, direct spread from adjacent structures, and ingestion. Since Mycobacterium tuberculosis has a predilection for lymphatic tissue, one might postulate that involvement of the transverse colon is uncommon due to the paucity of lymphatic tissue in this part of the gut.7 Colonic tuberculosis usually presents as acute or subacute intestinal obstruction. Most of the times surgeon suspects colonic malignant stricture.8 Ultrasonography usually is not useful but the computed tomography with oral contrast can easily diagnose colonic stricture. Colonoscopy plays a vital role in diagnosis and to differentiate between malignant and benign stricture.

In our case, patient had recurrent episodes of constipation and pain in abdomen, but there was no weight loss and intestinal obstruction. Computed tomography done as ultrasonography was insignificant, computed tomography showed transverse colon stricture without ascites and lymphadenopathy suggestive of benign stricture. Colonoscopy guided biopsy of the stricture did not show caseous necrosis and no cellular atypia and no malignancy. As patient had recurrent episodes of constipation with pain in abdomen hence, decision to explore the patient was taken and intraoperatively stricture found at 10cm from splenic flexure. Being sure of nonmalignant stricture and no lymph nodes seen enlarged, hence, local resection with colo-colonic anastomosis was done. Histopathology report was suggestive of tuberculous stricture. Patient had no history of tuberculosis in past, Hence, it turned out to be primary transverse colonic tuberculous stricture which is rare. In our case, patient with just constipation and pain in abdomen without weight loss and previous history of tuberculosis, only a high index of suspicion could reach to diagnosis.

4. Conclusion

Ileocecal tuberculosis is the most common, but isolated primary transverse colon tuberculosis is a rare entity.

1) Insignificant complaints and no complication make diagnosis difficult but
2) High index of suspicion and proper investigation can help in early diagnosis which can avoid
3) Unnecessary major resection of colon.

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