

# ABDOMINAL TUBERCULOSIS IN HAZARA

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## ABSTRACT:

During a period of five years (1985-1990) one hundred and eighty five cases of abdominal tuberculosis were treated at Surgical 'A' unit of District Headquarter Teaching Hospital, Abbottabad.

Ninety eight (52.97%) cases were Afghan Refugees and 87(47.03%) belonged to Hazara. The peak incidence of the disease was in 20-40 years age group.

Different modes of presentation, diagnosis and treatment is presented. Data indicates high prevalence of the disease in Afghan Refugees and Pakistanis of low socio economic group.

## INTRODUCTION:

Abdominal tuberculosis, a disease with worldwide distribution, is uncommon in the West, but is still prevalent in developing countries.<sup>1</sup> Pasteurization of milk and improved treatment of pulmonary tuberculosis have rendered the diagnosis of abdominal tuberculosis unfashionable in the Western World.<sup>2</sup>

The commonest sites of involvement are the terminal ileum and ileocaecal region.<sup>3</sup> Majority of the lesions are ulcero constrictive and affect varying length of bowel.<sup>4,5</sup> Peritoneal and mesenteric lymph node involvement is not unusual.<sup>6,7</sup>

Abdominal tuberculosis may have a chronic, acute on chronic or acute presentation. It may mimic other diseases. A correct clinical diagnosis is made in only one half of the cases.<sup>8</sup>

This study was undertaken to find out the incidence and different modes of presentation of abdominal tuberculosis in this part of the country. The different procedures needed for the diagnosis and treatment will be discussed.

## MATERIAL AND METHODS:

Cases of abdominal tuberculosis admitted to Surgical 'A' Ward of District Head

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Quarter Hospital, Abbottabad during a period of 5 years (1985-1990) were included in the study.

The name, age, sex, occupation, address, social status and presenting symptoms were noted in the proforma. The laboratory tests including Hb, TLC, DLC, ESR, ascitic fluid examination (in cases of ascites) were carried out and recorded in the proforma.

Depending upon the cases, different preoperative measures were carried out like correction of hydration, electrolytes, radiological investigations e.g. x-ray chest, abdominal x-rays including supine and erect positions were carried out in acute intestinal obstruction. Barium meal and follow through were done in chronic cases.

After surgery, histopathological examination was carried out in all cases.

The presence of caseating granulomas and/or demonstration of acid fast bacilli was considered diagnostic of tuberculosis.

## RESULTS

During a period of five years (1985-90) 185 cases of abdominal tuberculosis were treated. 98(52.97%) cases were Afghan refugees and 87 (47.03%) were Pakistanis. The incidence of the disease in males and females is given in Table-I. In Pakistani patients majority of the patients were from District Kohistan and belonging to a poor socio-economic group. The peak incidence was found in 20-40 years.

**Table-I** AGE AND SEX INCIDENCE  
Age in Years

Sex	0-10	11-20	21-30	31-40	41-50	51-60
M	12	13	25	55	17	9
F	—	11	13	17	11	2
Total	12	24	38	72	28	11

Anaemia was encountered in 148 (80%) and raised ESR in 156(84.3%) cases. X-ray chest revealed active lesion in 24 (12.97%) and healed lesions in 62(53.51%) cases.

Barium meal follow through revealed in 54 (29.19%) cases, one or more of the following abnormalities: dilated loops of small bowel, multiple strictures, irregular narrow terminal ileum and shortening of ascending colon.

Lesions were restricted to small bowel in 50 (27.03%), ileocaecal region in 74 (40%) and large bowel in 104 (56.23%) cases. In 31 (16.76%) cases more than one organ was involved.

**Table-II** CLINICAL PRESENTATIONS OF THE PATIENTS

Symptoms and Signs		NO	%
Abdominal pain		163	22.2
Weight loss		148	18.4
Poor appetite		87	10.8
Tenderness of abdomen		85	10.5
	Sub acute	63	7.8
Change in bowel habits		78	9.7
Distension of abdomen		78	9.7
Vomiting		13	1.6
Intestinal Obstruction	Acute	12	1.5
Fever		65	8.1
L. node enlargement		14	1.7

Clinical presentation of the patients is shown in Table-II and the surgical procedures adopted in different cases are shown in table-III. Postoperatively all patients were given antituberculous chemotherapy. Six patients died due to pulmonary embolism. Twelve cases had a relapse of acute tuberculosis as they had stopped treatment.

**Table-III** SURGICAL PROCEDURE

	No.	%
Local ileo-caecal resection	47	25.4
Resection of small bowel	42	22.7
Bypass	40	21.6
Right hemicolectomy	39	21.1
Biopsy only	17	9.2
Total	185	

## DISCUSSION

A review of the clinical symptoms and signs together with the various hematological and radiological findings suggest that a diagnosis of abdominal tuberculosis is possible in less than 50% of the cases. But as negative results do not exclude the disease, diagnostic laprotomy and later on histological examination are the most important steps in the diagnosis.

Tuberculosis can involve any part of the intestinal tract from stomach to rectum. The common sites, however, have always been the terminal ileum and caecum.<sup>9,10</sup> In our series the localisation of disease is the same. In the localisation of the disease process to these parts of the gut different factors like stasis, abundance of lymphoid tissue and the nature of the bowel contents have been blamed.<sup>11,12</sup> A hypersensitivity phenomenon has also been suggested at this site.<sup>13</sup>

In our series; pyrexia and abdominal pain, weight loss, loss of appetite and distention of abdomen were the commonest symptoms. These findings are similar to those described by Kaufman and Donoran.

Surgical resection of the lesion alongwith antituberculous therapy is the best mode of treatment, because we found that the majority of the patients had an uneventful recovery.

In our series most of the cases belonged to people of low socio-economic group. Afghan refugees and patients from Kohistan have the same habits of living. Afghan refugees live in the camps and the Kohistanis in overcrowded small houses. Both these groups are usually careless about the hygienic conditions and use milk without boiling. They do not consult the doctor in the initial stages of the disease and usually get home treatment from the quacks. As a result they attend doctors only in the complicated stages.

Health education and proper medical facilities at the village level will reduce the incidence of tuberculosis and other infectious diseases.

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