ISOLATED APPENDICULAR TUBERCULOSIS - A CASE REPORT

Paras INuwal1, Ramakanl Dixit2, Sudlta Jain3 and Vandana Porwal1

(Received on 28.4.2000. Accepted on 13 7.2000)

Summary: I-iolaic append icular tuberculosis is a comparative rarity. We are reporting a patient with provisional clinical diagnosis of acute on chronic appendicitis who was finally diagnosed its tuberculous appendicitis.

INTRODUCTION

Although appendicular involvement in intestinal tuberculosis has been reported in 1.5 - 3.0% cases1,2 the prevalence of isolated appendicular tuberculosis is only 0.1-0.3%3-5. We report a case of isolated appendicular tuberculosis with no detectable focus elsewhere in the body.

CASE REPORT

A 35 year old Muslim female was admitted to J.L.N.Hospital, Ajmer with severe abdominal pain in right iliac fossa along with fever of 5 days’ duration. Past history of vague abdominal pain, off and on, for one year was also given by the patient.

On examination, patient was found to be poorly nourished but of average build. Examination of respiratory and cardiovascular systems was essentially normal. Local examination of abdomen revealed tenderness in right iliac fossa but no palpable mass. Laboratory studies on blood, urine and sputum were normal. Skiagram chest and ultrasonography of abdomen showed no abnormality.

With provisional diagnosis of acute on chronic appendicitis, the patient was taken up for surgery. On abdominal exploration the appendix was found to be thickened, in flamed and with adhesions in peri appendicular tissues. No pathology was observed in ileum, caecum and mesenlry. Lymph nodes were not enlarged. Pelvic organs also did not show any pathology. Appendicectomy was performed and the specimen was sent for histopathological examination.

Pathological findings

Appendix and periappendicular fibrofatty tissue measuring 5 cm in length were of greyish white appearance. On cut surface, the lumen of appendix was narrowed and had thickened wall. No mucosal ulceration was seen.

Microscopic appearance revealed tuberculous granulomas in the mucosa, submucosa and muscle layers of appendix consisting of epithelioid cells, giant cells of Langhans type, lymphocytes, mononuclear cells and central area of caseous necrosis (Fig.1). Periappendicular tissue did not show any tuberculous lesion.

The final diagnosis of tuberculous appendicitis was made and anti-tuberculosis treatment was started with four drugs in conventional doses. Post operative period was uneventful and patient was discharged after a week. She successfully completed the anti-tuberculosis therapy with marked clinical recovery.

DISCUSSION

Prevalence of primary tuberculosis of appendix in appendectomies performed at general hospitals varies from 0.1-0.3%6-8. Technically, such a diagnosis can only be made after post mortem examination. Secondar) involvement of appendix from iliocaecai tuberculosis is also uncommon and
varies from 1.5 to 3.0% cases\textsuperscript{12}. Most of the literature regarding tuberculous appendicitis pertains to pre-chemotherapeutic era and the disease is seldom reported now-a-days. In our own experience, this is the second case of tuberculous appendicitis among all surgically removed appendices over the last 12 years.

The rarity of primary tuberculosis of appendix may be due to the fact that there is minimal contact of appendicular mucosa with intestinal contents\textsuperscript{7}. Though gastro-intestinal tuberculosis is mostly secondary to pulmonary disease, the route of infection is by swallowing \textit{i.e.} it is intraluminal\textsuperscript{3}. The open cases of pulmonary tuberculosis in our country are likely to contaminate food and other objects, the use of which may lead to primary intestinal tuberculosis in people who have unhealthy sanitary habits. This was the probable mode of infection in our case.

Three clinical types of tuberculous appendicitis have been described in literature\textsuperscript{7}. The first type presents as an acute form indistinguishable from pyogenic appendicitis until histologically proven. The second clinical type is a chronic form presenting with vague pain, occasional history of vomiting, diarrhoea and a mass in right iliac fossa. These cases are indistinguishable from cases of ileocaecal tuberculosis. The third type is a latent one found accidentally on histopathological examination. Our case appears to be of the second clinical type.

Isolated tuberculosis of appendix may or may not be associated with specific clinical features, and diagnosis is often made only after histopathological examination. Therefore, it is strongly stressed that all surgically removed appendices should be sent for histopathological examination to exclude tuberculosis before prescribing treatment.

REFERENCES

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