**Case Report**

**A RARE CASE PRESENTATION OF LOWER GI BLEED: A CASE REPORT**

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**ABSTRACT**

Abdominal tuberculosis is the sixth most common type of extrapulmonary tuberculosis. Abdominal tuberculosis can result from swallowing of infected sputum, ingestion of contaminated food, hematogenous spread, and direct extension from adjacent organs. Though lower GI bleed is possible in tuberculosis, it accounts for a very low percentage compared to the other causes of lower GI bleed and the most common site being ileocecal junction. Although minor bleeding has been described fairly massive hematochezia necessitating blood transfusion, such as in this case, is highly unusual. Therefore, the clinician must think of TB with history of exposure and tissue diagnosis must be done to establish diagnosis or exclude this curable disease.

**Keywords:** Tuberculosis, Lower GI Bleed

**INTRODUCTION**

Tuberculosis is a multisystemic disease with myriad presentations and manifestations, is the most common cause of infectious disease related mortality worldwide. Globally, more than 1 in 3 individuals is infected with TB. According to the WHO, there were 8.8 million incident cases of TB worldwide in 2010. India alone accounts for an estimated 26% of all TB cases worldwide. Mycobacterium tuberculosis, a tubercle bacillus, is the causative agent of TB. It belongs to a group of closely related organisms—including *M. africanum*, *M. bovis*, and *M. microti*. Extrapulmonary TB can occur as a part of a primary or late, generalized infection. Abdominal tuberculosis is the sixth most common type of extrapulmonary tuberculosis. Abdominal tuberculosis can result from swallowing of infected sputum, ingestion of contaminated food, hematogenous spread, and direct extension from adjacent organs. The intestinal lesions can be ulcerative (most common), hypertrophic, or ulcero-hypertrophic. The ileocecal area is the most common site of involvement. In 75% of the cases it involves the ileocecal junction. In this case report we share our encounter with jejunal tuberculosis presenting with massive lower GI bleed.

**CASES**

A 52 year old male with no known comorbidities presented with fever with chills for 1 month duration. He had associated non-bilious vomiting and melena on and off for the same duration. On examination he had tachycardia and pallor was present and rest of the examination was normal. On the day of admission his Hb was 8.5g/dl, stool occult blood was positive, liver function test and other coagulation parameters were within normal range. On day 2 of admission patient developed massive Lower GI bleed following which his Hb dropped to 4.2g/dl for which he was resuscitated with fluid management, blood products and other conservative measures. Upper GI scope revealed erosive duodenitis and diffuse gastritis with no active ulcer or bleeding. Colonoscopy was normal. Patient was planned for diagnostic laparoscopy with enteroscopy and it revealed multiple ulcers of entire jejunum and proximal ileum with evidence of bleeding from the ulcer, non bleeding diverticuli in DJ flexure and mesenteric lymphadenopathy. Jejunal ulcer and mesenteric lymph node was biopsied and was sent for PCR study and histopathology which revealed tuberculosis and granuloma of the lymph node. Post operatively patient was managed conservatively and was started on antitubercular drugs, following which he improved and patient was discharged on post operative day 8 and is on regular follow-up.
**DISCUSSION**

Tuberculous enteritis accounts for a minority of massive gastrointestinal haemorrhage. Abdominal tuberculosis can have varied presentation, frequently mimicking abdominal malignancy and other rare disease. Therefore, the clinician must think of TB with history of exposure and tissue diagnosis must be done to establish diagnosis or exclude this curable disease. Ulceration and erosions can occur in areas from stomach to rectum resulting in bleeding. The diagnosis can be established by endoscopic biopsy but getting tissue biopsy from jejunal lesions is a tedious job. Wireless capsule endoscopy, enteroscopy and multi-detector-row CT enteroclysis are the recently developed minimally invasive techniques that may provide a complete small bowel examination of both mucosa and mural pathology. Laparoscopy has been advocated as the ideal method in achieving definite diagnosis in patients with suspected TB. The accuracy has been reported to be 85–90% and frozen section should be routinely done for adequacy of tissue biopsy. The hallmark of extrapulmonary TB histopathology is the caseating granuloma, consisting of giant cells with central caseating necrosis. In this case scenario though patient had diverticuli in the DJ flexure the actual bleeding was from the jejunal ulcers which is quite unusual cause for a GI bleed. Gastrointestinal tuberculosis is reported to be difficult to diagnose. Possible reasons include as its symptoms are varied and sometimes overlap with a broad range of other abdominal ailments, such as colorectal cancer, Crohn’s disease, ulcerative colitis, colonic lymphoma, amoebic colitis, peripendicular abscess, and diverticulitis it can be located in any region of the gastrointestinal tract, complicating the location of infected areas. The most common presenting symptoms of this disease are abdominal pain, low grade fever, and bleeding. Although minor bleeding has been described fairly massive hematochezia necessitating blood transfusion, such as in this case, is highly unusual.

One proposed explanation is that although intestinal tuberculosis results in increased capillary vascularity, small arteries undergo obliteratorative endarteritis, making bleeding unusual. Though lower GI bleed is possible in tuberculosis, it accounts a very low percentage compared to the other causes of lower GI bleed and the most common site being ileocecal junction. All patients who are diagnosed to have gastrointestinal tuberculosis should undergo treatment with 4 drugs: isoniazid, rifampin, pyrazinamide, and either ethambutol or streptomycin. After 2 months, they are then treated with a continuation phase of 4 months with isoniazid and rifampin. All patients should be followed up regularly with endoscopy, colonoscopy or enteroscopy depending on the site of lesion.

**Conclusion**

Though lower GI bleed due to jejunal tuberculosis is a rare entity its worthwhile to consider Tuberculosis as a differential diagnosis of massive lower GI bleed. Tuberculosis is a good mimicker of other diseases and any unusual presentation should raise a high clinical suspicion of tuberculosis in our country. Tuberculosis is a curable disease and prompt diagnosis at the right time should be made for a better prognosis.

**REFERENCES**


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