Sections examined showed large confluent necrotizing granulomas in the pancreas and adjacent duodenal wall. The granulomatous inflammation was seen to affect both the pancreatic acini and ducts. Some of the dissected lymph nodes also showed necrotizing granulomatous inflammation. Special stains performed for acid fast bacilli (Ziehl Neelson and Auramine Rhodamine) did not reveal any bacilli. Based upon the histomorphology, a final diagnosis of tuberculous inflammation was given. Postoperative course of the patient was uneventful. She was started on anti-tubercular therapy.

Discussion

Primary abdominal tuberculosis is not uncommon. Tuberculosis easily disseminates to gastrointestinaltract, liver, spleen and mesenteric lymph nodes; however the involvement of pancreas by tuberculosis is rare, with a worldwide incidence reported to beless than 4.7 percent.[1] Signs and symptoms are variable and include abdominal pain, weight loss, anorexia, fever, vomiting, jaundice and pancreatic mass. Patients may also present with obstructive jaundice and a pancreatic mass lesion that is clinically indistinguishable from a pancreatic neoplasm or pancreatic cyst or an abscess which can be mistaken fora cystic neoplasm or an infected pseudocyst as in our case.[2]

Feng Xia et al described several clinical characteristics of pancreatic TB as follows: (1) pancreatic TB is mostly seen in young people, especially female, while pancreatic tumor is more common in old persons; (2) some patients have a history of TB in past, and most often come from areas having high incidence of active tuberculosis; (3) the patients often present with epigastric pain, fever and weight loss; (4) ultrasound and CT scan show pancreatic mass and peripancreatic nodules, some with focal calcification.[1]

To conclude, isolated pancreatic tuberculosis presenting as cystic mass is rare and patients generally complain of non-specific symptoms. In areas with high incidence of active infection and clinical or radiological evidence of lymphadenopathy, a high index of suspicion must be kept. Furthermore, preoperative EUS guided FNA/biopsy may be performed both from the main lesion and adjacent lymph nodes to avoid extensive surgery. If still, a pre or intra-operative diagnosis cannot be made, surgical excision may be required. However, this is usually associated with low morbidity and mortality and good longterm outcome after adequate ATT.

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References

1. Rong YF, Lou WH,Jin DY. Pancreatic tuberculosis with splenic tuberculosis mimicking advanced pancreatic cancer with splenic metastasizes: a case report. *Cases Journal*. 2008;1:84 doi:10.1186/1757-1626-1-84.
2. Chatterjee S, Schmid ML, Anderson K, Oppong KW. Tuberculosis and the Pancreas: A Diagnostic Challenge Solvedby Endoscopic Ultrasound. A Case Series. *J Gastrointestin Liver Dis*. 2012;21(1):105-7.

Sigmoid colon endometriosis presenting as acute colonic obstruction

We present a case of sigmoid colon endometriosis presenting as large bowel obstruction in a perimenopausal women.

Case Report

A 46 year old female admitted with complaints of vomiting, constipation, loss of appetite and loss of weight of one month duration. She also had abdominal distension with obstipation for one week. She was a known case of hypertension for 10 years and diabetes mellitus for one month duration. She had seizure disorder and was on phenytoin. She underwent caesarian sections at the age of 22 and 29 years of age and had regular menstrual periods. X ray abdomen showed multiple air fluid levels. CECT abdomen showed gross dilatation of large bowel loops with air fluid levels noted. Small bowel loops are filled with fluid. Two weeks before she underwent colonoscopy for her symptoms which showed severely inflamed rectum with linear telangiectatic spots and ulceroproliferative growth involving the sigmoid colon at 30 cm from the anal verge. The endoscopic biopsy showed nonspecific colitis. Since the patient had features of acute colonic obstruction she underwent emergency laparotomy. Through lower midline incision abdomen opened and the following findings were noted. Stricturous lesion at the level of sigmoid colon with grossly dilated caecum, ascending, transverse and descending colon upto the level of stricture with dilated small bowel. The rectum was collapsed. The stricturous lesion with 5 cm margin distally and end colostomy was done. The macroscopic appearance showed an infiltrating lesion involving the wall of colon measuring 4.3x4x2.1 cm. The overlying mucosa was stretched out without any gross ulceration. The lesion involved the entire thickness of the colon extending into the pericolic adipose tissue. Microscopic examination revealed colonic wall with submucosa and muscularispropria showing scattered tubular glands lined by stratified columnar epithelium surrounded by spindle cell stroma. Some of the glands are cystically dilated. There was extensive fibrosis with muscularis hyperplasia with unremarkable mucosa.The lesion extends upto the pericolic adipose tissue with no evidence of malignancy. The above features were suggestive of sigmoid colon endometriosis.

Discussion

Endometriosis is defined as presence of endometrial glands and stroma outside the uterine cavity. It can involve pelvic and extra pelvic organs. The most common site of extra pelvic endometriosis is intestine followed by pleura, pericardium, umbilicus, previous operative or episiotomy scars, etc. Intestinal endometriosis occurs in 3-37% of these patients and the commonest site is rectosigmoid area.[1-3] The clinical presentation is usually asymptomatic, but gastrointestinal bleeding, nausea, vomiting, cramp-like abdominal pain, painful defecation, diarrhoea, constipation, recto-vaginal colonic mass, intussusception, bowel obstructions and intestinal perforation can be seen. Classically, in around 40% of the cases, symptoms get worse during menstruation. Radiological imaging and endoscopic evaluation of the intestinal tract may be suggestive of other inflammatory and malignant lesions of bowel. Currently, MRI is considered as the best imaging tool for detection and evaluation of intestinal endometriosis.[1-3] Bowel endometriosis begins by implantation on the serosa followed by invasion of the muscularispropria, but the mucosa is rarely involved. Large endometriotic lesions may cause thickening and fibrosis of the wall of the bowel resulting in stricture formation and mechanical bowel obstruction.

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References

1. Arafat S, Alsabek MB, Almousa F, Kubtan MA. Rare manifestation of endometriosis causing complete recto-sigmoid obstruction: A case report. *Int J Surg Case Rep*. 2016;26:30-3.
2. Bascombe NA, Naraynsingh V, Dan D, Harnanan D. Isolated endometriosis causing sigmoid colon obstruction: A case report. *Int J Surg Case Rep*. 2013;4(12):1073-5.
3. Varras M, Kostopanagiotou E, Katis K, FarantosCh, Angelidou-Manika Z, Antoniou S. Endometriosis causing extensive intestinal obstruction simulating carcinoma of the sigmoid colon: a case report and review of the literature. *Eur J Gynaecol Oncol*. 2002;23(4):353-7.