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P78. ABDOMINAL TUBERCULOSIS OF A BANGLADESHI WOMAN : A CASE REPORT

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Context: TB is a life threatening disease which can virtually affect any organ system .The primary site of TB is usually lungs. From which it can get disseminated into other parts of the body. The diagnosis of extrapulmonary TB can be difficult as it present with nonspecific clinical and radiological features.The abdominal TB which is not so commonly seen as pulmonary TB , can be a source of significant morbidity and mortality and is usually diagnosed late due to its nonspecific clinical presentation. Approximately 15-25%of cases with abdominal TB have concomitant pulmonary TB. The abdominal TB usually occurs in 4 forms: Tuberculous Lymphadenopathy, Peritoneal TB, GI TB and visceral TB involving the solid organs. Objectives: Abdominal TB is an increasingly common disease that poses diagnostic challenges, as the nonspecific features of the disease which may lead to diagnostic delays and development of complications. Case Report: A 30 yrs old lady, para 2(cs)+0 normotensive and nondiabetic hailing from Joydebpur, Gazipur admitted at Mugda Medical College Hospital on 15.01.17 as a case of right large complex adnexal mass with huge ascites. She had low-grade fever. On physical examination, she was mildly anaemic, her abdomen was distended, both flank full, umbilicus is centrally placed and everted, shifting dullness and fluid thrill positive. Pervaginal Examination – a large mass was felt through right and posterior fornix size about (10Ã—5 cm). There was a past history: Her second C/S was done on 2010. At that time, her wound was infected and secondary stitch was given after 15 days. Again, wound was infected and healed by only dressing at 40th (POD). After 1 and half month, she developed abdominal discomfort and diagnosed as a case of abdominal tuberculosis and she was treated by anti-TB drugs for 6 months which was taken irregularly. Methods: Her investigations shows: *Hb % – 10gm/dl ESR-72mm at 1st hour WBC-7480/cmm *Blood group – B(+ve) *S. creatanine – 0.6 mg/dl *RBS – 5.2 mmol/L *S. Albumin – 4.29 gm/dl CA – 125: 155 u/l CXR – Normal IVU – Normal excretion of both kidney. A Persistent smooth indentation is seen at left-lateral wall of urinary bladder. Most likely due to pelvic mass. USG findings: A large multiloculated cystic lesion having small thick walled nodular component measuring about 11.2Ã— 6.1cm is noted in right adnexal region. Huge ascites. Peritoneal fluid cytology: D/C-Neutrophil -2% Lymphocyte-98% ADA -50u/l Gene expert for detection of mycobacterium TB-detected. AFB- not found. CT scan of abdomen: Large right ovarian complex mass. Huge ascites. Cyst wall histopathology- corpus luteaum cyst. Interventions: This patient managed jointly by Gynaecology, Surgery and Medicine department. After proper counseling her laparotomy was done on 26.01.2017

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under general anaethesia by giving a midline incision. Main outcome measures: Findings were dense adhesion with ovary and omentum. Strenuous ascitic fluid came out and taken for cytological study. There were huge tubercle on intestine, peritoneum, omentum ,undersurface of diaphragm and surface of ovary. Biopsy was taken from omentum, peritoneum and ovary. There was huge encysted cyst which was punctured. Tubes and left ovary healthy and preserved. Right ovarian cystectomy was done. Exploration was done undersurface of diaphragm, liver and stomach.After proper haemastasis abdomen was closed in layers and drain tube kept in situ. Her postoperative period was uneventful and she was discharged on 5th POD. She has been advised to consult with medicine specialist for anti TB treatment. Results: Now she is having anti tubercular drug therapy of 6 month regime. Conclusion: Early diagnosis and initiation of anti TB therapy and surgical treatment are essential to prevent morbidity and mortality as it is a treatable disease. Abdominal TB is generally managed with medical therapy with anti TB drugs and surgery are usually conservative and are done only if absolutely indicated.