

Isolated hepatic tuberculosis

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Abstract

We report a case of carcinoma stomach who had fever of three weeks duration. On evaluation he was detected to have hepatic nodules. It was initially presumed to be due to metastasis. The biopsy of the nodules showed it to be of tubercular in origin. He was treated with antitubercular treatment (ATT) and the fever resolved.

Key words: hepatic isolated tuberculosis

In the evaluation of most of the malignancies, whenever hepatic nodules are detected it is always presumed to be metastatic. This case was unique in that the hepatic nodules in a case of gastric carcinoma turned out to be tubercular. Another aspect of this case was that he did not have any evidence of tubercular focus outside the liver.

Case report

We report a case of a 75 year old male who was recently diagnosed to have adeno-carcinoma stomach presenting to us with fever of three weeks duration. On examination he had epigastric tenderness and no mass was palpable in the abdomen. There was no evidence of lymphadenopathy and respiratory system was normal. He had anaemia and his Liver function test (LFT) was deranged. Aspartate transaminase (AST): 60 IU/L, Alanine transaminase (ALT): 50 IU/L and Alkaline phosphatase (ALP): 400 U/L. He did not have jaundice. His erythrocyte sedimentation test (ESR) was 60mm/hr. Chest X-Ray was normal. His ultrasound of liver before surgery did not reveal any abnormality. He underwent a surgery for the gastric carcinoma and a liver nodule which was seen during the surgery was sent for histopathology which showed caseous necrosis and epitheloid granulomas and AFB was positive. He was put on ATT Category III as per Directly Observed Treatment Short course (DOTS). After a few days he was afebrile and was referred back to oncology.

Discussion

Three forms of tuberculous liver involvement are described: Diffuse involvement associated with miliary or pulmonary tuberculosis; diffuse parenchymal involvement without any evidence of existing tuberculosis elsewhere (Primary miliary tuberculosis of liver) ; and focal or nodular lesion in the liver which

may be multiple or solitary and present as tuberculoma or abscess¹. Tubercle bacilli reach the liver by way of haematogenous dissemination. The portal of entry in case of miliary tuberculosis is through the hepatic artery, whereas, in case of focal liver tuberculosis it is via portal vein. Irrespective of the mode of entry, the liver responds by granuloma formation². The tubercle bacilli gain access to the portal vein, from a microscopic or small tubercular focus in the bowel. Subsequent healing at the site of entry leaves behind no trace of lesion whatsoever³. Treatment is similar to that of pulmonary tuberculosis. In case of tubercular abscess formation, computed tomography (CT) and ultrasonography (USG) guided drainage has been found to be good for successful drainage, although the surgical drainage, which was used early may be required⁴.

Conclusion

In summary, liver tuberculosis has protean manifestations and must be suspected in patients coming from endemic areas with nonspecific alteration of liver function tests. This is best diagnosed on liver biopsy. All nodules in the liver even in a known primary malignancy elsewhere need not always be metastatic as illustrated by this case and hence stressing the importance of histopathological confirmation of suspected metastatic lesions.

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