The differential diagnosis of intra-abdominal tuberculosis

Sir,

For the sake of completeness, the differential diagnosis of tuberculous peritonitis, as discussed by Roberts et al (https://doi.org/10.12968/hmed.2018.79.6.C86), should include ascites attributable to constrictive pericarditis (Howard et al, 2012). In the latter case report, ascites (with protein concentration of 39 g/litre) was the presenting symptom in a 77-year-old man in whom an initial mistaken diagnosis of tuberculous peritonitis resulted in inappropriate administration of a course of antituberculous chemotherapy. The correct diagnosis of constrictive pericarditis was only made after documentation of markedly raised jugular venous pressure (Howard et al, 2012).

The differential diagnosis of other manifestations of intra-abdominal tuberculosis includes IgG4-related sclerosing mesenteritis (Hasosah et al, 2014) which can simulate peritoneal tuberculosis. IgG4-related disease can also present with mesenteric lymphadenopathy (Goag et al, 2015), intra-abdominal lymphadenopathy itself being a well-recognized manifestation of intra-abdominal tuberculosis, as discussed by Roberts et al.

The differential diagnosis also includes the coexistence of tuberculous peritonitis and Crohn's disease (Bonse-Geuking and Kraus, 2012). This was the case in a 64-year-old man without evidence of latent tuberculosis when infliximab was initiated for management of Crohn's disease. He subsequently developed tuberculous peritonitis, characterized by computed tomography documentation of ascites and 'densification of the mesentery and peritoneum'. Peritoneal biopsy showed marked granulomatous inflammation and epitheloid granulomas with central necrosis. A tuberculous aetiology was validated by polymerase chain reaction evaluation of the peritoneal biopsy specimen (Bonse-Geuking and Kraus, 2012).

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