Case Report

Indian Journal of Communicable Diseases
Volume 5 Number 2, July - December 2019
DOI: http://dx.doi.org/10.21088/ijcd.2395.6631.5219.4

Author Affiliation:
[1]Senior Resident, Dept. of Internal Medicine, School of Medical Science and Research, Sharda University, Greater Noida, Uttar Pradesh 201310, India.
[2]Professor [3]Asistant Professor [4,5,]PG II year [6]Senior Resident, Dept. of Internal Medicine, [7]MBBS, School of Medical Science and Research, Sharda University, Greater Noida, Uttar Pradesh 201310, India.

Coressponding Author:
VPS Punia
Professor,
Dept. of Internal Medicine,
School of Medical Science and Research, Sharda University,
Greater Noida, Uttar Pradesh 201310, India.
E-mail: drvpspunia@gmail.com

Received on 03.07.2019
Accepted on 16.08.2019

Splenic Abscess: An Unusual Presentation of Tuberculosis

Syed Mohsin Ishaq[1], VPS Punia[2], Mehak Lamba[3], Aproov Singhal[4], Praveen Raman Mishra[5], Showkat Nazir Wani[6], Seher Kirmani[7]

How to cite this article:

Syed Mohsin Ishaq, VPS Punia, Mehak Lamba, *et al*. Splenic Abscess An Unusual Presentation of Tuberculosis. Indian J Comm Dis. 2019;5(2):63-64.

Abstract

Pulmonary tuberculosis though common in indian subcontinent, but tubercular splenic abscess is an unusual presentation. We report a 41 year old female who presented with symptoms of fever, abdominal pain, loss of appetite and weight loss for 2 months. Her examination revealed splenomegaly besides other non specific findings. Splenic tuberculosis is a differential to be considered, particularly where the disease is endemic. Labs revealed positive mantoux test. CECT abdomen showed multiple hypo-dense lesions in both liver and spleen hinting towards abscesses. Histopathological examination of CT guided biopsy specimen showed features consistent with and confirmed a diagnosis of splenic tuberculosis.

Keywords: Splenic Abscess; Tuberculosis.

Introduction

The World Health Organization (WHO) achieved a significant advancement in the control of tuberculosis in year 2015. Whereas the current TB strategy aims to stop transmission and eradicate the disease, the previous Stop TB Strategy (2006–2015) targeted to the decrease the quantum of tuberculosis by 50% compared to 1990. In year 2014, around 10 million of world population was affected by tuberculosis of which more than half the cases were concentrated in West-Pacific and South East Asia regions only with India containing around 23% of all cases,[1] a Figure too high for a country to share. Splenic involvement in tuberculosis doesn't usually occur as an isolated phenomenon in immuno-competent people.[2] However primary involvement of this organ does occur in immuno-compromised individuals like those who are HIV co-infected and in patients with miliary TB.

Case Report

A 41 year old married, non-smoker female registered at our hospital with complaints of low grade, intermittent, evening fever with left upper abdominal pain, loss of weight and anorexia for past 6 months. The patient had no history of chills, excessive sweating, weight loss, bleeding gums, epistaxis, constriction of visual field, cough, hemoptysis, breathlessness, back-ache or myalgias. There was no past history of tuberculosis, hypertension, diabetes mellitus, thyroid abnormality, rheumatoid arthritis or any other significant medical disease. Patient had no significant drug history except for over the counter acetaminophen which she took occasionally for her fever symptoms. Personal history revealed no change in bowel, bladder or sleeping habits. There was no history of any substance abuse, no history of tuberculosis in any family member. She

© Red Flower Publication Pvt. Ltd.

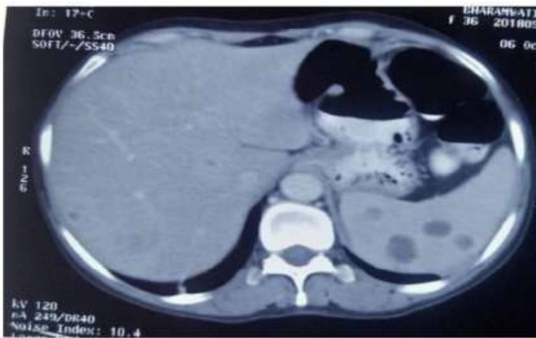

Fig. 1:

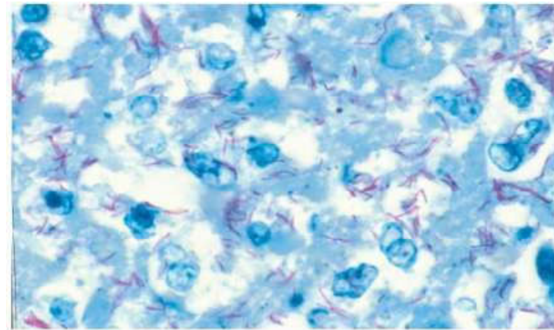

Fig. 2:

was G2P2A0 and her menstrual cycles were regular. A detailed examination of the patient showed she was an average built; conscious, oriented woman with stable vitals. She had pallor. There was no icterus, cyanosis, oedema or lymphadenopathy. CNS examination was normal. Chest examination showed normal air entry in both lungs with vesicular breathe sounds. Cardiac examination showed normal S1, S2 and no added heart sound. Abdominal exam. revealed tender splenomegaly and liver was palpable about 6 cm below the costal margin. Initial CBC showed Hb 8.2 gm/dl, TLC 5500/mcL, Plt 1.6 lac/mcL, MCV 72 fL, MCHC 26 pg. Mantoux test showed induration of 20 mm at 48 hrs of standard dose PPD. Her ESR was 88. All other baseline investigations including LFT, KFT, BSR, Chest X-ray, ECG, fluid cultures and HIV serology were negative for the patient. USG abdomen showed splenomegaly and Grade 2 fatty liver. CECT abdomen was ordered which revealed hepatomegaly and small, multiple hypo-dense lesions in the spleen suggestive of abscesses. Splenic puncture under CT guidance was done and HPE showed granulomatous inflammation consistent with TB. ZN staining of the aspirate showed AFB +ve bacilli. A diagnosis of splenic tuberculosis was made. Patient was started on Anti-Tubercular treatment and responded well to it.

Discussion

Splenic tuberculosis as a differential for pyrexia of unknown origin is an established entity.[3] Abscesses due to tubercular involvement of spleen usually presents with left upper abdomen discomfort, pyrexia, chills, decreased appetite and weight loss. Splenic dissemination of tubercle bacillus is primarily due to hematogenous spread from a primary source.[4] Diagnosis starts with clinical suspicion of the disease in a patient with symptoms consistent with tuberculosis (Grade B symptoms). Once TB is suspected, splenic involvement can be confirmed by radiological investigations like ultrasonography and CECT abdomen coupled with histological study of splenic tissue. Once diagnosis is confirmed, treatment with anti-tubercular drugs is started with vast majority of people responding to drugs.[5]

Conclusion

Splenic TB should be included as one of the differential diagnosis of splenic abscess , more commonly from tuberculosis endemic region like india presenting with fever upper abdominal pain, and splenomegaly.

References

1. Global Tuberculosis report; Sep 2018 edition; World Health Organization.
2. Joshi S, Bankar M, Kagal A, *et al*.; Splenic tuberculosis. Internet Journal of Medical Update. 2007 Jul-Dec;2(2):38-41
3. Gupta PP, Fotedar S, Agarwal D, *et al*., Tuberculosis of Spleen presenting with pyrexia of unknown origin in a Non Immuno-compromised woman. Lung India, 2008 Jan Mar;25(1);22–24.
4. Kumar A, Kapoor VK, Behari A, *et al*. Splenic tuberculosis in an immunocompetent patient can be managed conservatively. Gastroenterology Report. 2018 Feb;6(1):72–74.
5. Adil A, Chikhaoui N, Ousehal A, *et al*. Splenic Tuberculosis Apropos of 12 cases. Ann Radiol (Paris). 1995;38:403–407