

Tuberculous Peritonitis and Tuberculous Endometritis Diagnosed in the Same Patient by High Clinical Suspicion and a Minimally Invasive Approach

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Abstract

Tuberculous peritonitis and tuberculous endometritis are extremely rare entities in the Western world. In this article, we discuss a rare case of a 40-year-old Nigerian female presenting with abdominal pain, distension and secondary amenorrhea, and show that a high clinical suspicion combined with minimally invasive procedures can help physicians make the diagnosis, avoid extensive surgery, and rapidly initiate appropriate therapy.

Key Words: Tuberculous peritonitis, peritoneal tuberculosis, extrapulmonary tuberculosis, minimally invasive approach, tuberculous endometritis.

Case Report

A 40-YEAR-OLD NIGERIAN FEMALE presented complaining of increasing abdominal pain and distension over the preceding one and a half months. Upon further questioning, the patient stated that she had experienced night sweats, weight loss of 27 lb over the past three months, fevers and chills, with an intermittent minimally productive cough. She also reported symptoms of amenorrhea over the preceding six months, with scant vaginal spotting. The patient's medical history included iron deficiency anemia and her surgical history was significant for five terminations of pregnancy in Nigeria, as well as an appendectomy, which required a blood transfusion. The patient stated that she is monogamous and denied any history of sexually transmitted infections. However, her husband practices polygamy and the patient stated that she had been raped in Nigeria by several assailants. The patient

also described the presence of multiple infections with candidal vaginitis over the past year, self-treated with over-the-counter medications.

Upon presentation, the patient was febrile (oral temperature: 39.7 C). Physical examination revealed a grossly distended abdomen with voluntary diffuse guarding and tenderness to light palpation. However, there was no rebound tenderness or organomegaly. Bowel sounds were present and normoactive, and there was no fluid wave or shifting dullness. Pelvic examination, conducted by the gynecology service, was unremarkable. Routine laboratory tests showed leukocytosis (12,700) with a left-shift (poly: 85%, lymph: 1%). A chest film was obtained and was negative. A computed tomography (CT) chest scan revealed bilateral apical scarring of lung parenchyma and multiple 1–5 mm nodules that were scattered diffusely throughout both lungs. CT scan of the abdomen using intravenous and oral contrast showed loculated fluid collections within the mesentery and omentum and thickened peritoneum (Fig.). A differential diagnosis of disseminated tuberculosis with tuberculous peritonitis versus peritoneal carcinomatosis from ovarian carcinoma was considered. Sputum acid-fast bacilli (AFB) smear showed numerous bacilli, confirmed as *Mycobacterium tuberculosis* by polymerase chain reaction (PCR). Tuberculin skin test showed 9 mm induration. A rapid HIV test returned positive, and was confirmed using western blot analysis. An HIV-1 RNA PCR quantitation

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