Obstructive Jaundice Due to TB Lymphadenitis: A Rare Case Report

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Abstract- Abdominal tuberculosis commonly affect intestines, lymph nodes, peritoneum. [1] However abdominal tuberculous lymphadenopathy as a cause of obstructive jaundice is rare.

Keywords: Abdominal tuberculosis, obstructive jaundice, cholangiocarcinoma, tuberculous lymphadenitis.

I. Introduction

Abdominal tuberculosis may cause obstructive jaundice but it is extremely rare. It may be cause due to enlargement of head of pancreas, stricture of CBD, pericholedochal lymph nodal enlargement or primary biliary tuberculosis. [2] It is often confused with malignancy as both conditions present as mass on contrast enhanced CT scan. However early diagnosis will help in better outcome and hence tuberculosis should be considered as differential diagnosis for obstructive jaundice after malignancy has been excluded.

II. CASE REPORT

We describe case report of a 23 years old female patient presenting with complaints of jaundice and pain in abdomen which on serial investigations was diagnosed as extrinsic compression on CBD due to pericholedochal tubercular lymph nodes.

III. CASE DESCRIPTION

A 23 years old female patient presented with pain in abdomen and jaundice since 4 months. On clinical examination abdomen was unremarkable, blood investigations were within normal limits except for deranged LFT which showed total bilirubin 4mg/dl, SGOT/SGPT 72/44 respectively, and alkaline phosphatase 392. Her viral markers HIV, HBsAg , HCV were negative.

Patient was investigated further with USG which showed mild hepatomegaly with central and peripheral IHBR dilatation with? mass lesion in CBD. On further investigation CECT showed dilated CBD of 16.9 mm and moderately large mass like lesion near pancreatic head region with few internal calcifications and involving lower end of CBD measuring 25.7x24.7 mm suggestive of moderately large periampullary mass lesion? etiology ? cholangiocarcinoma. However it showed a lymph nodal mass and tumor markers were within normal limits.

As CECT could not give definitive diagnosis in this case patient underwent EUS (endoscopic ultrasound) which showed hetrogenously enlarged lymph node of 2.1x1.9 cm extrinsic to CBD and involving distal end of CBD. On EUS [Figure 1] guided FNA caseous material was aspirated however final cyotological report couldn't give definitive diagnosis.

10 French stent was inserted which relieved obstruction and patient improved symptomatically. [Figure 2]

Figure 1EUS picture showing hetrogenously enhancing LN extrinsic to CBD and causing compression.

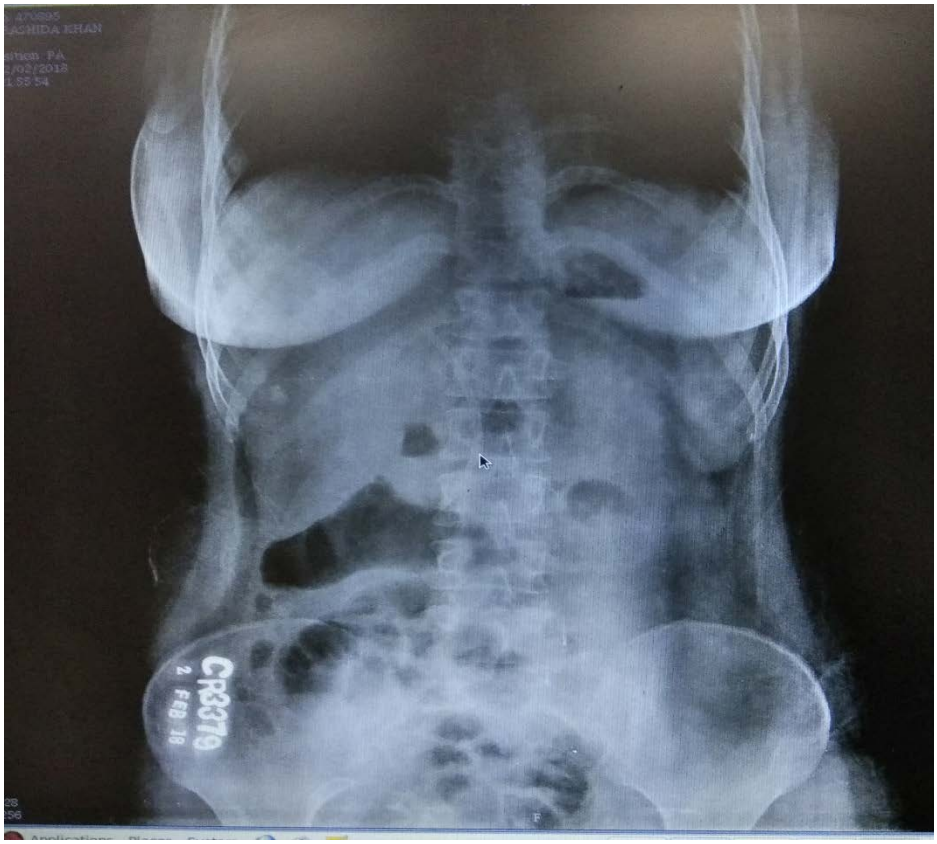

Figure 2AXR with arrow pointing at CBD stent in situ after ERCP

However for the definitive diagnosis patient was planned for diagnostic laparoscopy. On diagnostic laparoscopy hard lymph node of size approximately 2.5x2.2 cm was found near distal end of CBD of which biopsy was taken.

Histopathological report showed presence of calcification and no definitive opinion was possible. Patient was started empirically on Cat 1 AKT. On follow up CT after 2 months showed decrease in size of mass at distal CBD and patients well-being was also improved.

IV. DISCUSSION

Obstructive jaundice due to abdominal tuberculosis is extremely rare. Tuberculous lymph node often cause periadenitis and intense inflammation. In case of pericholedochal lymph nodes due to intense inflammation and matting these lymph nodes often gets impinged on CBD causing external compression. Sometimes due to severe inflammation fistula may develop between lymph nodes and biliary tract.

Often tuberculous lymph nodes are confused with biliary malignancy.[3] In both cases there will be non enhancing mass on contrast enhanced CT scan with smooth narrowing of distal CBD. Often history is of short duration and is non conclusive. Tumor markers may or may not be raised in case of malignancy although they do carry prognostic importance. FDG PET scan cannot differentiate between tuberculosis and malignancy as both show increased uptake.However if accurate diagnosis is not made pre operatively often patients undergo morbid procedure as it is mistakenly diagnosed as neoplastic mass.[4]

Often ERCP guided FNAC/brush cytology helps in diagnosis. In case of ambiguous diagnosis on histopathology, diagnostic laproscopy and sos empirical AKT trial can be given in case of strong suspicion of tuberculosis especially in areas where tuberculosis is endemic.

The greater benefit of diagnosing abdominal tuberculosis at earlier disease stage lies in fact that more conservative management can be followed in case of early abdominal tuberculosis. If stenting is not possible in case of mass of matted lymph nodes causing obstruction laparoscopic LN removal so as to relieve obstruction and allow stenting can be done followed by anti tubercular drug treatment. Whereas if definitive diagnosis cannot be made pre operatively and in late stages where CBD scarring has been occurred due to long standing lymph nodes treatment usually includes morbid operative procedures like Whipple's surgery/Roux-en-Y choledochojejunostomy. It

V. CONCLUSION

Abdominal tuberculosis though rare cause of obstructive jaundice, should be considered as differential diagnosis especially in country like India where it is endemic. Careful history taking and appropriate investigations helps in differentiating it from hepatobiliary malignancy. Early diagnosis of abdominal tuberculosis helps in conservative management and better outcome. [5]

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