Tuberculosis of Liver

With the advent of modern chemotherapy spectrum of tuberculosis of liver has dramatically changed. In the pre-antibiotic era, autopsy studies in patients dying from tuberculosis showed that the liver was involved in 80-100 per cent cases (1,2). Autopsy studies of last 2 decades show a dramatic fall in the incidence of liver involvement to around 21-32 per cent (3,4,5). The incidence varies with the type of tuberculous disease and is highest in miliary tuberculosis followed by disseminated tuberculosis and gastrointestinal tuberculosis.

Reported incidence of hepatic tuberculosis as judged by needle liver biopsy has varied from 0 to 100 per cent (6,8). However most reports suggest an incidence of about 10% in cases of pulmonary tuberculosis (6,7,4) and 60% in cases of miliary tuberculosis (4,7).

The lesions in most instances take the form of generalized miliary tubercles scattered all over the liver, occasionally accompanied with granulomas, tuberculosis, or even abscesses (4). Infrequently the lesion may be localized in the form of a large tuberculosis or an abscess, or tuberculous cholangitis or pericholangitis (8).

Several non-specific changes in liver tissue including fatty change, cellular infiltration, Kupffer cell hyperplasia, fibrosis, reactive hepatitis, histiocytic granuloma, amyloid degeneration and cirrhosis have been reported in association with tuberculosis elsewhere in the body. Seife et al (6) and Korn et al (2) have reported non-specific histological changes in the liver in all the cases of tuberculosis of other organs studied by them. However Vakil et al (4) reported an incidence of twenty three per cent. The non-specific changes may be related to debility, or to drugs used to treat tuberculosis rather than due to the disease.

The suggested association between tuberculosis and cirrhosis is probably due to the life-style of the alcoholic rather than to a common pathogenic factor. The increased hepatitis B surface antigen (HBsAg) carrier rate in patients with tuberculosis may be another contributory factor for the hepatic abnormalities (9).

Clinical features are few and not significant, often masked by features of the primary tuberculous disease. Fever with chills, hepatomegaly and pain in right hypochondrium are common features. Jaundice is rare. It is uncertain if primary tuberculosis of liver occurs. Most cases of liver tuberculosis are secondary to a microscopic or macroscopic tuberculous focus elsewhere in the body. However from time to time cases are reported in literature claim-
ing that the patient had no detectable focus in the body (10,11). Cleve et al (11) calls this variety ‘atypical tuberculosis’ of the liver.

Liver function tests show non-specific changes and do not help in the diagnosis. Diagnosis is only established by histology. In miliary tuberculosis, a blind needle biopsy will very often establish the diagnosis even before the miliary mottling is visible on chest x-ray. When the pathological process is more localized viz a tuberculoma, blind needle biopsy is often unsuccessful in picking up the tuberculoma. In such cases biopsy will have to be done under direct vision at laparoscopy, or under monitoring of a liver scan.

Involvement of liver in tuberculosis does not seem to alter the prognosis of the primary lesion. With specific therapy liver lesions regress completely.

REFERENCES