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**Colonic wall necrosis due to tuberculosis in HIV-seropositive patient**

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We report a 40-year-old man with sloughing off of the colonic due to tuberculous infection. He presented with lump in the abdomen, distention and vomiting suggestive of intestinal obstruction. Proximal loop ileostomy with closure of colonic perforation was performed, with good recovery. This was followed by antitubercular chemotherapy. ([Indian J Gastroenterol 2001;20:**199-200]**)

**Key words: Intestinal obstruction**

Colonic tuberculosis is an uncommon condition. We report an HIV-seropositive patient with colonic tuberculosis with sloughed-off wall of the ascending and transverse colon.

A 40-year-old man presented with distention of the central abdomen, colicky abdominal pain and vomiting for two months, which had increased 4-5 days prior to admission. He had been previously diagnosed to have pulmonary tuberculosis and was prescribed four-drug anti-tuberculosis therapy, which he had taken irregularly for two months. Examination revealed pallor and tachycardia. Abdominal examination revealed distention of the central abdomen with palpable bowel loops and tenderness on deep palpation but no guarding or rigidity. X-ray revealed a few air-fluid levels in the abdomen but no free gas. X-ray chest showed right upper zone infiltration due to pulmonary tuberculosis. He was explored after correction of dehydration and electrolyte imbalance since obstruction was not relieved with conservative treatment.

At laparotomy, the anterior wall of the ascending and transverse colon was completely sloughed off, with thick adhesions between the posterior wall of the ascending colon and the posterior abdominal wall. Inseparable adhesions were also present between the transverse mesocolon and stomach. The colonic mucosa was edematous and grossly inflamed, extending from the ascending colon just beyond the cecum up to the splenic flexure. The small intestine and ileocecal junction were normal. There was no mesenteric lymphadenopathy. Proximal loop ileostomy and suturing of colonic wall was performed in view of gross fecal peritonitis and inseparable adhesions. Patient recovered well postoperatively. Anti-HIV antibody test done after surgery was positive. Histology of the colon wall showed mixed inflammatory exudates containing lymphoid aggregates with occasional multinucleate giant cells. No epithelioid cells or caseation were seen (Fig). Anti-tuberculosis treatment was continued. Two months later the patient is better and is awaiting a definitive procedure and/or ileostomy closure.

Although extrapulmonary tuberculosis is common in patients with AIDS, colonic involvement is rare. Diffuse pancolitis due to tuberculosis has been reported in one case. Obstruction and perforation of the gastrointestinal tract are rare in AIDS. Perforation of tuberculous intestinal lesions may account for 1%-10% of cases with peritonitis among the HIV-positive.

Our patient had completely sloughed off anterior wall of the ascending and transverse colon. Thrombosis of small vessels on the antimesenteric border may have caused ischemic necrosis of the colonic wall. The treatment options available were complete resection of the involved colon with terminal ileostomy and descending colostomy. Another option was proximal diverting loop ileostomy with suturing of the colonic wall followed by colonic resection and anastomosis when the inflammation subsides. The latter option was selected in this case due to local factors.

**References**


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