



TB in NYC: Laparoscopic small bowel resection for closed loop obstruction from intestinal tuberculosis

S Pearlstein MD; G Anand MD; V Dronsky MD

Lenox Hill Hospital Department of Surgery
New York, New York

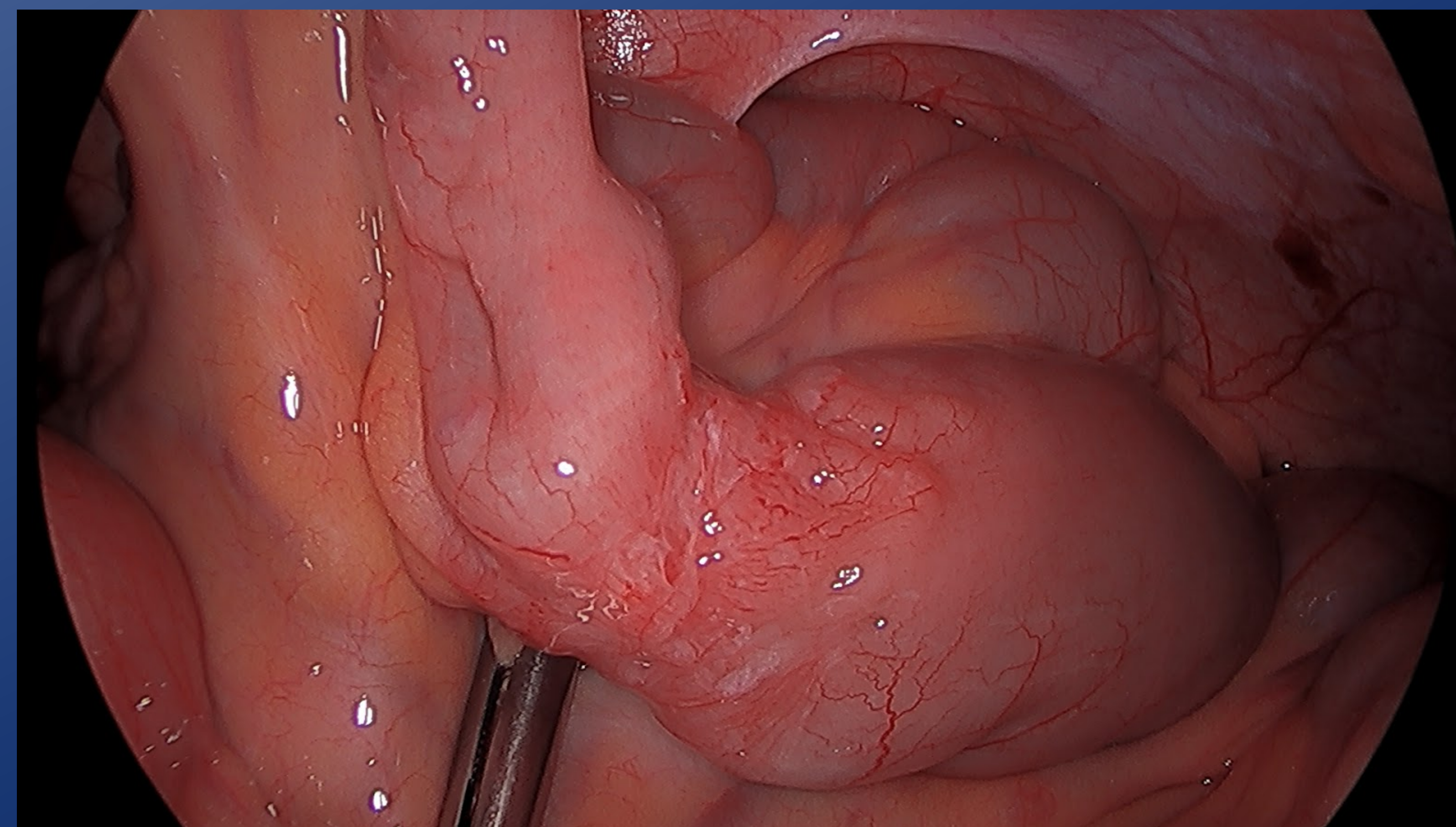
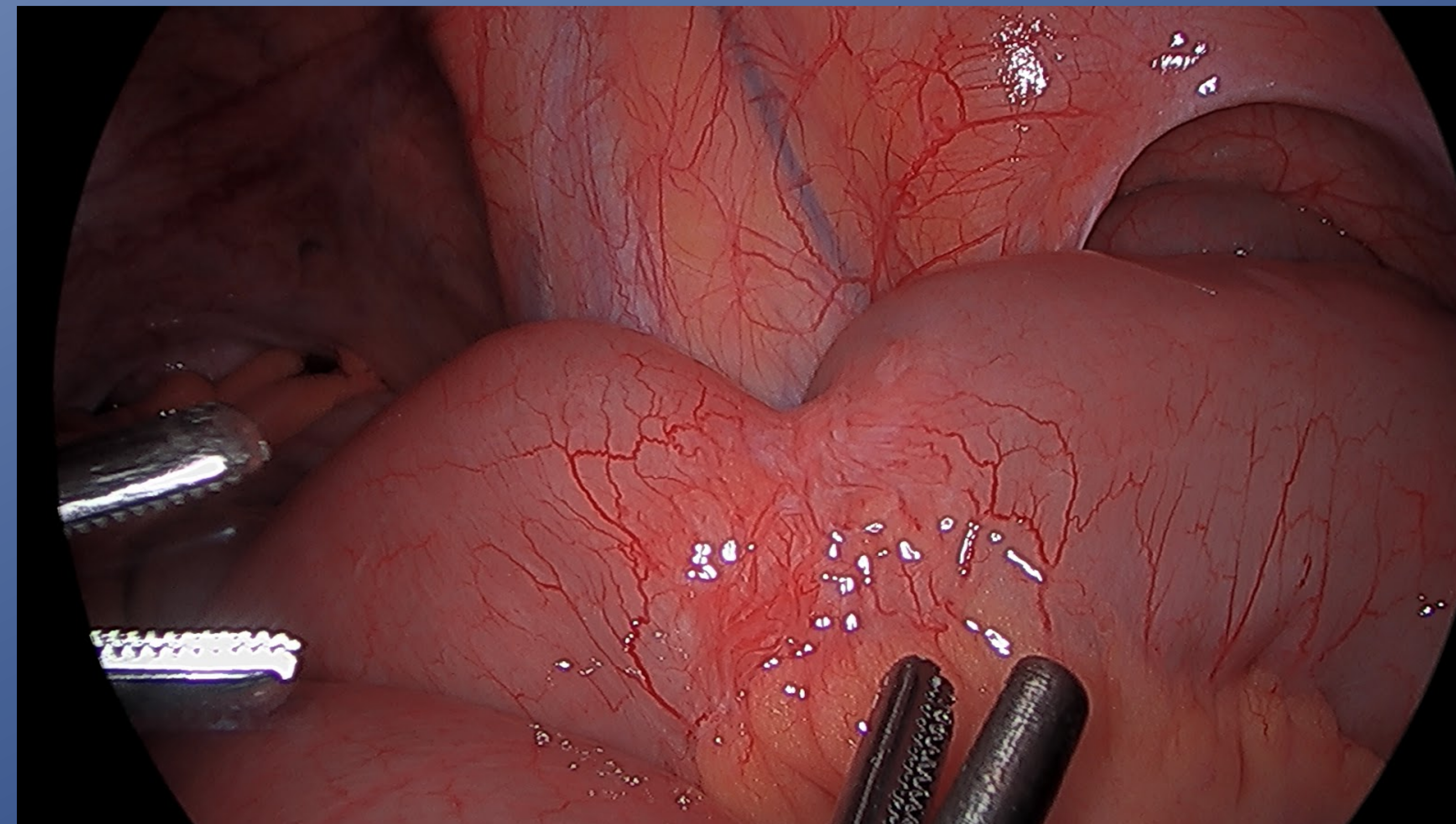


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Introduction: Intestinal tuberculosis (TB) is a rare disease in modern developed Western civilization. It can occur from reactivation of latent TB, ingestion of tuberculosis mycobacteria, or hematogenous or lymphatic spread from active miliary tuberculosis. The ileocecal region is most commonly affected due to increased lymphoid tissue in this area. These patients can present with acute or subacute obstruction due to stricture.

Case Description: This is the case of a 24 year old male from India with a history of intestinal tuberculosis discovered on colonoscopy four months prior to presentation, for which he was on treatment with rifampin, pyrazinamide, ethambutol and moxifloxacin. He presented with nausea, vomiting and abdominal pain for one day. He was afebrile and tachycardic to 103 beats per minute but otherwise hemodynamically stable. His exam was nontender. White blood count was normal at 6K/ μ L. Computed tomography of the abdomen and pelvis was concerning for closed loop obstruction. He was taken to the operating room that evening for a diagnostic laparoscopy which yielded three points of stricture obliterating the lumen of small bowel. These were taken with two small bowel resections; approximately 15 cm total was resected.

The infectious disease service was consulted and started a hospital course of intravenous rifampin, linezolid, and levofloxacin. Acid-fast bacilli (AFB) stool, urine and sputum cultures were sent and all returned negative for tuberculosis.



Chest x-ray was negative for pulmonary tuberculosis. The patient had return of bowel function on postoperative day two and tolerated advancement of diet. Infectious disease recommended an oral regimen of ethambutol, pyrazinamide, and rifampin. He was discharged on his oral regimen with normal diet on postoperative day four. Final pathology yielded segments of small bowel with ulcers, erosions, acute and chronic inflammation, and serosal fibrosis. There was no evidence of granulomatous inflammation, and AFB was negative.

Discussion: This is a case of closed small bowel obstruction secondary to stricture from tuberculosis. Although pathology showed no granulomatous change and was negative for AFB, the scarring from tuberculosis still resulted in stricture without active infection.

Conclusion: Intestinal tuberculosis can present as a surgical abdomen when strictures form a closed loop. Surgical judgement should be used based on distance between strictures when deciding whether to resect en bloc or perform stricturoplasty, as intestinal tuberculosis can result in small bowel obstruction even after treatment of TB.