

Case Reports

TB of the Gall Bladder Causing Biliary Obstruction- An Unusual Case (1st reported case in Jordan): Case Report with Review of the Literature

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Abstract

A 65-year-old woman presented with pain in the right hypochondrium and jaundice of 5 days duration. A diagnosis of obstructive jaundice due to GB tumor was made. On exploratory laparotomy, the gall bladder was found to be forming a hard mass adherent to the CBD. A diagnosis of tuberculosis was made postoperatively by histopathological examination. Excision of the mass and a bypass surgery alongside the anti-tuberculous treatment resulted in complete recovery.

Keywords: Obstructive jaundice, Tuberculosis, Anti-tuberculous treatment.

(J Med J 2007; Vol. 41 (3): 179-183)

Received

September 18, 2006

Accepted

March 22, 2007

Introduction

Recently, tuberculosis has been merged as an important disease in both the developed and the developing countries, especially with the rising incidence of HIV infection.^{1, 2} The abdomen is one of the common sites of extra-pulmonary tuberculosis,³ but gall bladder involvement is extremely rare, and the diagnosis of gallbladder tuberculosis is not often suspected prior to surgery or biopsy. The first case of tuberculosis of gall bladder in the world literature was described in 1870 by Gaucher.⁴ Since then, more cases of the disease have been added to the world literature and 41 cases were reported up to 1970.⁵ Biliary obstruction from GB TB as a cause of jaundice is also very rare. We here report the 1st case of biliary tuberculosis presented with obstructive jaundice in Jordan as no similar case was reported in Jordanian literature.

Case Report

A 65-year-old woman presented with a 5-day history of right hypochondrial pain associated with yellowish discoloration of the skin and sclera, tea-colored urine, and clay-colored stool. No fever, sweating, or weight loss were reported. She denied any history of hepatitis or tuberculosis. A review of the family history was unremarkable. Physical examination was entirely normal apart from the yellowish discoloration of the sclera and skin and slight tenderness in the right upper quadrant. There was no evidence of peripheral lymphadenopathy or hepatosplenomegaly.

Laboratory Findings

Hemoglobin was found to be 12.2 g/l, white blood cell count was $16.8 \times 10^9/L$, erythrocyte sedimentation rate 115 mm/h, SGOT and SGPT were within normal range, total bilirubin 8.4mg,

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direct bilirubin 4.7mg, alkaline phosphatase 1042 IU (normal 65-100 IU), and HBsAg was –ve.

Imaging Findings

Abdominal ultrasound showed the gall bladder to be irregular, deformed, with a thickened wall, and engulfed by a hyper echoic mass, while the CBD was shown to be irregular and involved within the mass, with a normal appearance of the pancreatic head.

The chest X-ray was normal.

Liver CT scan showed a prominent liver with no mass lesions, no enlarged lymph nodes, and a normal pancreas.

i.e.: no evidence of extra hepatic TB.

Operative Findings

The gall bladder was found to be small, contracted, and forming a hard mass adherent to the CBD, which was involved and completely obstructed with a normal-looking liver.

Treatment

Cholecystectomy was done followed by resection of the common hepatic duct at its bifurcation, then roux-en-Y hepaticojejunostomy with trans liver drainage, and finally Anti-TB medications was given to the patient postoperatively.

Histopathology

The histopathology report showed that the gall bladder wall is largely replaced by caseating granulomata, exhibiting a few epithelioid granulomas, with multinucleated giant cell. There was also much edema and inflammatory cell reaction with prominent macrophage cell component in the surrounding tissue. Special stain for tubercle bacilli is positive.

The conclusion was that there existed a tuberculous infection of the gall bladder.

Discussion

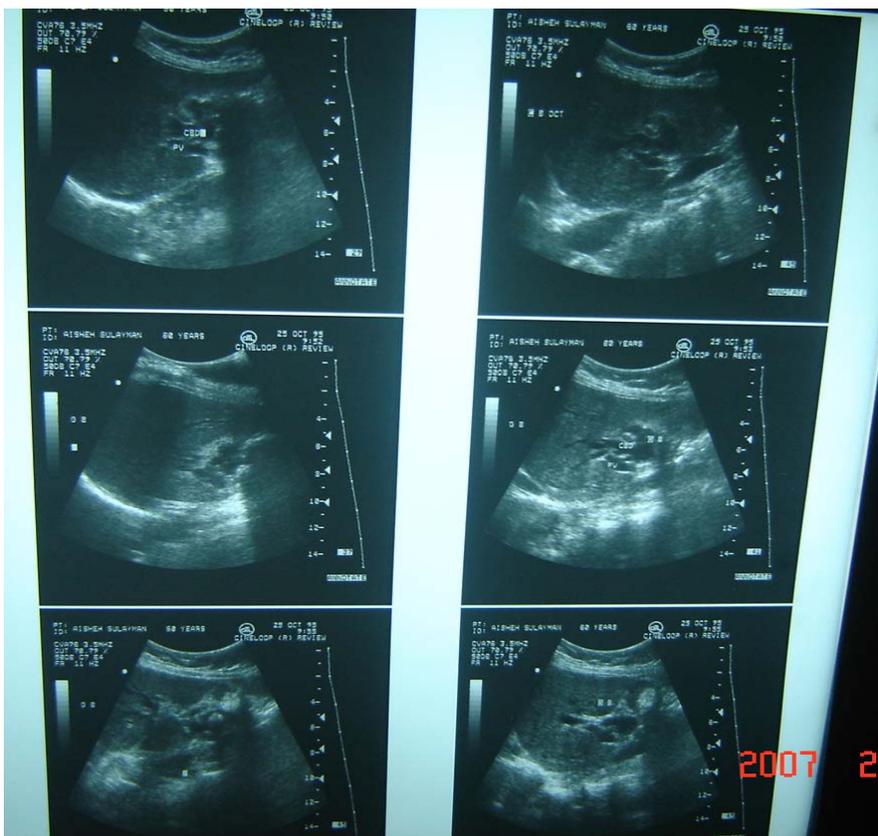
Gallbladder tuberculosis is very rare worldwide. Up to now, less than 50 cases have been reported in the English or Chinese literature. Most of these cases had stones in the gall bladder or had obstruction of the cystic duct or common bile duct (as in our case). Gallbladder tuberculosis often occurs in combination with other intra-abdominal tuberculosis. Gallbladder tuberculosis occurs most commonly in women over 30 years of age. Generally speaking, the gallbladder is highly resistant to tubercular infection, possibly due to the inhibitory function of bile.^{6,7} Patients may present with a wide spectrum of symptoms such as abdominal pain, weight loss, low-grade fever, anorexia, vomiting, and abdominal mass. Right upper abdominal pain and mass may be the main sign.⁷ In this case, the patient presented with a history of right-sided abdominal pain, and obstructive jaundice. The most common causes of biliary tract obstruction are choledocholithiasis and neoplastic disease. When obstruction is due to mass in the region of the head of pancreas, the most likely etiology is malignant disease.

The differential diagnosis of gallbladder tuberculosis includes acute and chronic cholecystitis, gallbladder carcinoma⁷ [which was the first impression during laparotomy in our case], and polypoid lesions. Gallbladder carcinoma occurs most commonly in women over 50 years, contiguous infiltration of the liver by the gallbladder lesion, and hepatic metastases.

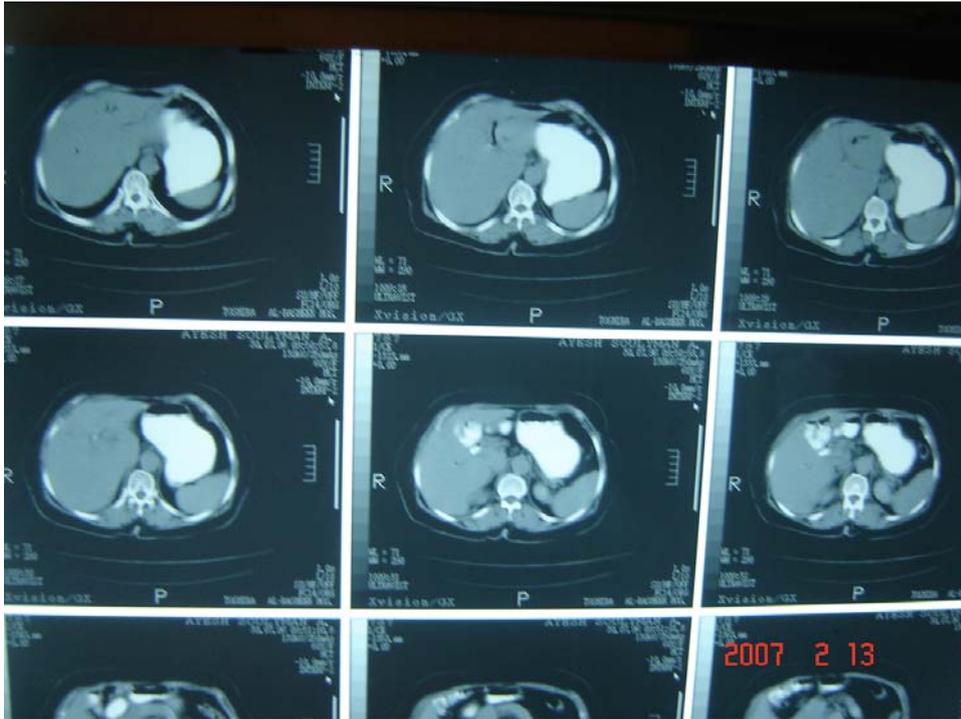
The case presented herein underscores the importance of having a high index of suspicion for tuberculosis in patients with obstructive jaundice, especially in areas where TB is relatively common; even if their clinical diagnosis shows a case of carcinoma.



Chest X- Ray



Pre op. ultrasound liver biliary tract.



Post OP. trans tube cholangiogram.

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انسداد في القنوات الصفراوية نتيجة تدرن في المرارة: دراسة حالة

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الملخص

اقدم في هذا التقرير دراسة لحالة هي الاولى في الاردن، وهي انسداد في القنوات الصفراوية نتيجة تدرن في المرارة لانشى تبليغ من العمر 65 سنة، حولت من قسم الباطنية في مستشفى الشونة الجنوبية في عام 1995 كحالة انسداد في القنوات المرارية، حيث كانت تعاني من اصفرار والم في البطن استمر لمدة 5 ايام دون وجود ارتفاع في درجة الحرارة او زيادة في التعرق او نقص في الوزن، وبعد الفحوصات المخبرية والصور الشعاعية تم تشخيص الحالة كانسداد في القنوات الصفراوية نتيجة ورم سرطاني في المرارة.

تم اجراء عملية جراحية للمريضة حيث تبين ان المرارة تشكل كتلة متلاصقة مع القنوات المرارية تم خلالها ازالة الكتلة مع المرارة واعادة وصل القنوات المرارية مع الاثنى عشر. و قد تبين من الفحص النسيجي ان الكتلة عبارة عن تدرن في المرارة و ليس ورماً سرطانياً كما كان معتقداً. و قد تم اعطاء المريضة مضادات حيوية ضد التدرن.

الكلمات الدالة: إنسداد في القنوات الصفراوية، تدرن في المرارة، مضادات حيوية ضد التدرن.