

Pulmonary Tuberculosis Complicated by Anal Tuberculosis

Hilal Altınöz, MD; Elif Köse, MD; Özhan Kula, MD; Bekir Keser, MD; Turan Karagöz, MD

SSK Süreyyapaşa Thoracic Diseases Center, İstanbul, Turkey

Abstract

We report a case of anorectal tuberculosis of the lupoid type. By presenting this rare case, we want to remind our colleagues that since tuberculosis is a disease that can involve any organ in the body, the possibility of tuberculosis

must be considered in the differential diagnosis of even anal lesions.

Turkish Respiratory Journal, 2003;4:(3):142-143

Key words: tuberculosis, anal tuberculosis, extrapulmonary tuberculosis

Introduction

Tuberculosis is one of the first diseases to receive recognition and intelligent treatment. It can involve all organs in the body, but anorectal tuberculosis is a rare disorder (1). Bacon et al, classified perianal tuberculosis in four types, as ulcerative, verrucous, lupoid and miliary (2). Ulcerative tuberculosis is the most common type and usually secondary to a focus in the lungs or intestines. Verrucous tuberculosis is characterized by a warty vegetation. These lesions slowly increase in size. *Mycobacterium bovis* is the causative organism. Lupoid tuberculosis is secondary to a tuberculous condition elsewhere in the body. It begins as a small, round nodule, reddish brown in color and somewhat soft. Gradually a clean-cut ulcer, with an indurated base and showing a mucopurulent discharge, develops in the center of the nodule. Miliary lesions of the anus occur as part of disseminated tuberculosis, involving many organs.

In this paper we present a patient with anorectal tuberculosis of lupoid type. By presenting this rare case, we want to remind our colleagues that tuberculosis is a disease that can be seen anywhere in the body and should be considered in the differential diagnosis of even anal lesions.

Case Report

A 52 year old male presented to our center complaining of cough, yellow sputum discharge, dyspnea and pain in the lumbar region. One month ago he had discovered a tumor and a painful lesion in the anal region. The incisional biopsy had revealed an ulcerated necrotising granulomatous inflammation and the patient was referred to our hospital.

Correspondence: Dr. Hilal Altınöz
SSK Süreyyapaşa Thoracic Diseases Center
Başbüyük, Maltepe, İstanbul, Turkey
Tel: +90 (0) 216 441 23 50/1230
e-mail: hilal@hekim.net

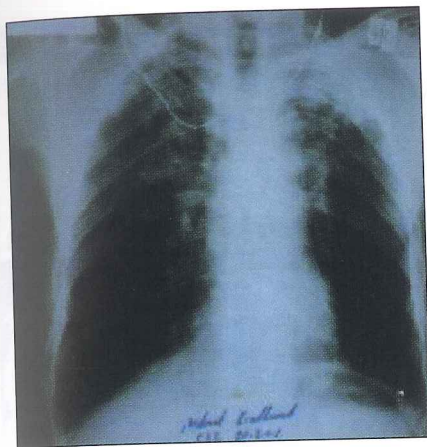


Figure 1. Chest x-ray before therapy (unchanged after therapy)



Figure 2. Anal lesion before therapy



Figure 3. Anal lesion after therapy

The patient had a history of pulmonary disease which had occurred 25 years ago but the diagnosis was unknown. He had a smoking history of 51 pack/years of cigarettes and the past 5-6 years had consumed approximately 35 ml alcohol daily in.

Physical examination was normal except for the ulcerated lesion in the anal region. In the chest x-ray, heterogeneous infiltrations were seen in the upper zones of both lungs. Acid fast bacilli was detected in the sputum examination and no antituberculosis drug resistance was shown. A diagnosis of pulmonary tuberculosis complicated by anal tuberculosis was made and antituberculosis therapy was started. Six months later, no bacilli were seen in the sputum and the anal lesion had regressed. The chest x-ray showed only a minimal change with persistence of the initial fibrotic lesions.

Discussion

The tuberculosis lesion in our patient was lupoid type and showed characteristics almost identical to cases reported in the literature (1,2). In patients with anal lesions of this type, tuberculosis must be differentiated from Crohn's disease. However, Crohn's disease is seen mostly in teenagers and young individuals, while anorectal tuberculosis is seen in patients older than 30 years (3).

Recurrence is rare. In our case no recurrence was seen in the two years of follow up after which the patient stopped coming.

Following the introduction of routine treatment of tuberculosis with antituberculosis drugs, tuberculosis incidence declined. Among tuberculosis cases, the frequency of tuberculosis in the anorectal region was reported as 1% in Great Britain in 1967 (3). Different figures are given in different parts of the world, but this frequency never exceeded 17% for those years.

The epidemic of acquired immunodeficiency syndrome has caused a worldwide resurgence of tuberculosis. A case of acute tuberculosis with anorectal involvement presenting at an urban

American hospital is discussed by Koniaris and Seibel (5). Three cases, encountered over a period of 10 years, were reported from Prince of Wales Hospital in Hong Kong (6). However, more recent studies on the incidence of anorectal tuberculosis are not available. Our patient was not positive for HIV.

Nearly all reported cases of anorectal tuberculosis are patients with old tuberculous lesions or with active pulmonary tuberculosis in the lung (3). Diagnosis can be delayed, because physicians may neglect to perform a general physical examination in patients with a positive sputum smear and the typical chest x-ray. Leval et al, emphasize that a chest x-ray must be taken in all patients with anal fistulae, that all patients with pulmonary tuberculosis must undergo a complete physical examination (7). Chest physicians must remember that patients may not mention anal complaints if not asked. In the study of abdominal tuberculosis patients, Jakubowsky et al (8), found that anorectal tuberculosis presented generally with fistulae or abscesses and that these patients had concomitant pulmonary tuberculosis. The possibility of tuberculosis must never be forgotten in the etiology of anal nodular and ulcerated lesions, regardless of the presence or absence of pulmonary tuberculosis. And, most importantly, all patients with pulmonary tuberculosis must have a complete physical examination.

References

1. Lieberman JM, Blinkhorn RJ, Sharma B. CT findings in anorectal tuberculosis. *AJR* 1991; 156(4): 870-1.
2. Nepomuceno OR, Grady JFO, Eisenberg SW, Bacon HE. Tuberculosis of the anal canal: report of a case. *Dis Col & Rec* 1971; 14(4): 313-16.
3. Logan D. Anorectal tuberculosis. *Proc Roy Soc Med* 1969; 62: 1227-30.
4. Kraemer M, Gill SS, Seow-Cohen F. Tuberculous anal sepsis: report of clinical features in 20 cases. *Dis Colon Rectum* 2000; 43(11): 1589-91.
5. Konaris LG, Seibel JL. Tuberculosis presenting as a perirectal mass: report of a case. *Dis Colon Rectum* 2000; 43(11):1604-5.
6. Chung CC, Choi CL, Kwok SP, et al. Anal and perianal tuberculosis: a report of three cases in 10 years. *J R Coll Surg Edinb* 1997 Jun;42(3):189-90
7. Leval P, Balozet P, Xau P. *Rev Tuberc (Paris)* 1962; 26: 330
8. Jakubowski A, Elwood RK, Enarson DA. Clinical features of abdominal tuberculosis. *J Infect Dis* 1988; 158(4): 687-92.