

Letter: Bleeding and Pain—When Tuberculosis Licks the Pancreas and Bites the Intestine

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A 29-year-old male presented with dull aching epigastric pain and 6 kg weight loss over 6 weeks. He had been diagnosed to have acute pancreatitis (based on elevated lipase and bulky pancreas in ultrasound) 6 weeks back. However, he continued to be unwell with progressive weight loss and persistent abdominal pain. Past history included focal seizures since childhood for which he was on oxcarbamazepine 300 mg twice daily. Prior to admission at our unit, he developed multiple episodes of melena. At admission, he was pale with stable vital parameters. He had anemia (hemoglobin: 8 gm/dL). His erythrocyte sedimentation rate was 20 mm/hour with normal C-reactive protein, lipase, liver, and kidney function tests. His chest X-ray was normal. His esophagogastroduodenoscopy revealed a 1.5 × 1 cm ulcer with clean base and indurated margins along superior wall of D1–D2 junction with mild oozing of blood. Endotherapy was not attempted.

A contrast-enhanced computed tomography demonstrated a poorly enhancing lesion in the region of head/uncinate process of the pancreas (►Fig. 1A). Endoscopic ultrasound revealed a large hypoechoic mass measuring 6 × 5 cm in the region of head of pancreas extending toward liver hilum (►Fig. 1B). On post-procedure day 1, patient developed multiple episodes of hematochezia. Colonoscopy showed multiple ulcers in the ascending colon, cecum, and ileocecal valve (►Fig. 1C). Gastrointestinal bleeding settled spontaneously and blood transfusion was not given. Endoscopic ultrasound-guided fine-needle aspiration biopsy revealed caseating granulomas with Langhans giant cells consistent

with tuberculosis (►Fig. 1D). Cartridge-based nucleic acid amplification test (CBNAAT) from colonic tissue was positive for *Mycobacterium tuberculosis*. Acid-fast bacilli culture grew mycobacterium tuberculosis after 8 weeks. Ascending colon and cecal biopsy also showed granulomatous reaction consistent with diagnosis of colonic tuberculosis. Finally, a

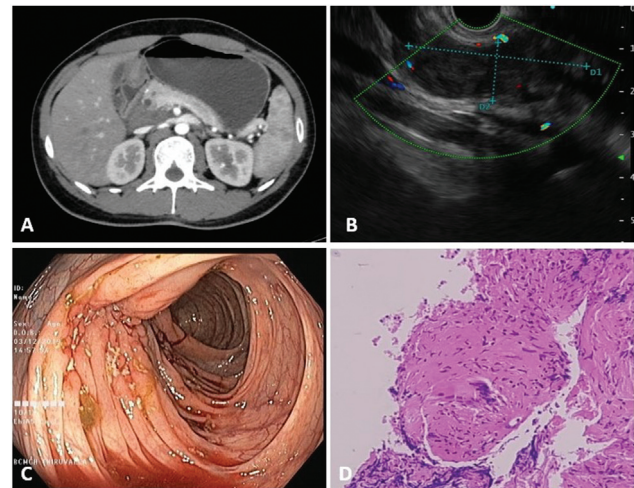


Fig. 1 (A) Computed tomography showing hypoechoic lesion in pancreatic head-uncinate. (B) Endoscopic ultrasound (EUS) shows hypoechoic large mass in head of the pancreas. (C) Colonoscopy shows multiple deep right colon ulcers with bleeding. (D) EUS biopsy showing caseating granuloma with Langhans giant cells (hematoxylin and eosin stain, high power magnification).

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diagnosis of disseminated tuberculosis with pancreatic involvement resulting in pancreatitis, duodenal infiltration, and upper gastrointestinal bleeding along with colonic tuberculosis causing lower gastrointestinal bleeding was made. The patient was started on weight-based antitubercular therapy. He completed 6 months of antitubercular therapy from an outside center and is currently asymptomatic based on over-the-phone follow-up.

We report the case for multiple interesting facets—pancreatic tuberculosis is a rare entity even in tuberculosis endemic region and mimics pancreatic carcinoma.^{1–3} It could be asymptomatic or manifest as lymph nodal or pancreatic mass and may even form abscess or cyst-like lesion.² Another interesting facet of the present case was that both upper gastrointestinal and lower gastrointestinal bleeding were noted in the same patient. The role of CBNAAT-based tests in quick diagnosis is also highlighted, although the reported sensitivity may be low.⁴ In conclusion, gastrointestinal tuberculosis can have myriad presentations causing delay and confusion in diagnosis.

Ethical Statement

Informed consent to publish was obtained.

Author Contributions

D.K.J.: Procedures and initial draft; V.P.: Patient care, revisions. A.K.: Histopathology; J.M.K.: Patient care and initial draft. All authors approved the manuscript.

Data Availability Statement

The relevant data are provided in the manuscript.

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Conflict of Interest

None declared.

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