Isolated Colonic Tuberculosis with Colovesical Fistula

Sir,

A 33-year-old male smoker had presented with recurrent episodes of burning sensation during micturition associated with frequency for last one and half years, with low grade fever and diffuse lower abdominal tenderness. Urinary examination done on several occasions revealed evidence of urinary tract infection and patient responded to oral antibiotics.

Dated two weeks back, he presented with history of fresh bleeding per rectum associated with tenesmus and urgency. There was no history of bloody diarrhoea, colicky pain in abdomen, joint pain, skin rash, jaundice, pedal edema, respiratory symptom, haematuria, or perianal lesions. Patient had lost nearly 10 kg of weight during the entire period of illness. His past, personal and family history was non-contributory.

On examination, there was moderate anemia and mild hepatosplenomegaly. There was no lymphadenopathy, ascites or skin lesion. Rest of the examination was uneventful.

Investigations revealed anemia (Hb- 8.9 gm%) with elevated ESR (90 mm 1st hour). Urine showed 8-10 pus cells, 3-4 RBC with (+++) proteinuria. Hepatic and renal biochemical parameters, as well as chest radiograph was normal. USG abdomen showed mild hepatosplenomegaly. There was no ascites or evidence of liver disease. Colonoscopy showed an ulcerated area (measuring 2 X 3cm) on the anterior wall of lower sigmoid colon approximately 20 cm from the anal verge (Figure 1). There was patchy erythema of the rectal wall and patient experienced pain on air insufflation. Rest of the visualized colon and distal 10 cm of ileum were normal. Histopathology of the mucosal biopsy showed granulomas with central caseation suggestive of tuberculosis. Micturating cystourethrogram revealed a rectovesical fistula (Figure 2). Upper GI Endoscopy, barium meal study, and computed tomography scan of abdomen and thorax did not reveal any other site of involvement. The patient was given standard four drug antitubercular therapy. His symptoms subsided, weight increased and a repeat colonoscopy done after three months showed luminal deformity at the rectosigmoid with lustreless mucosa with out any active ulceration or inflammation.

Segmental or isolated colonic tuberculosis refers to involvement of the colon without ileocecral region, and constitutes 9.2 per cent of all cases of abdominal tuberculosis. It commonly involves the sigmoid, ascending and transverse colon. Multifocal involvement is seen in one third (28 to 44%) tuberculosis. The median duration of symptoms is less than 1 Year. Pain is the predominant symptom (78-90 %) and hematochezia occurs in less than one third. The bleeding is frequently minor.

Colovesical is the most common form of the vesicoenteric fistulae and can result from diverticular disease (70-90 %), colorectal carcinoma (20 %) or Crohn’s disease (10%). It is more common in male, with a ratio of 3:1. Infections like typhoid fever, amebiasis, syphilis, tuberculosis are rare causes of enterovesical fistula. Biopsy helps in differentiation between tuberculosis and Crohn’s disease, and also excludes malignancy.

This case report highlights the importance of considering tuberculosis as a cause of colovesical fistula in developing countries like ours, as well as the efficacy of medical therapy for controlling such an advanced stage of disease. It is interesting to note that symptoms of colovesical fistula predated by one and half years.

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References