An Unusual Case of Obstructive Jaundice


Abstract
Tuberculosis of the pancreas is a rarity, reported in a handful of literature. We enumerate the case of a young girl with high fever, jaundice, and right hypochondrial pain, whose investigations revealed a mass at the head of the pancreas. FNAC from the mass astoundingly proclaimed tuberculosis.

Introduction
Obstructive jaundice as a presentation of tuberculosis is extremely rare and may be due to tubercular lymphadenitis, tubercular stricture of the biliary tree, enlarged head of pancreas or a mass in the retroperitoneum due to tuberculosis. Therefore, when our patient presented to us with fever, jaundice and abdominal pain our thoughts were stuck on a probable cholangitis, malaria, or at the most a complicated viral hepatitis. However further work up revealed otherwise.

Case Report
Our patient was an 18 year old girl who had developed low grade fever one month back which gave way to hectic rise of temperature and jaundice in the last ten days. She had right upper abdominal pain, vomiting and pruritus. There was no history of incriminating drug intake, addictions, blood transfusion, or past history of jaundice, tuberculosis or diabetes.

O/E there was mild pallor and moderate icterus. The pulse was 100/min, BP 110/70 mm Hg. Cyanosis, clubbing, edema, lymphadenopathy and neck vein engorgement were absent. Examination of the GI System revealed a tender, soft, hepatomegaly.

Complete hemogram revealed TC 27,000, N -86% L -10% E -2% B-1% HB9.4 gm% with normocytic normochromic morphology. Malarial parasite was not found. HIV, HbsAg were also negative. Blood sugar, urea, creatinine were normal. Chest X ray showed bilateral diffuse infiltrates. The liver function test showed – Total bilirubin 8.3mg/dl of which 6.5 mg/dl was conjugated. ALT was 161 IU/l, AST -27 IU /l and ALP- 4772 IU/l. Prothrombin time was 52 secs (control – 13 secs) and albumin 3 gm /dl. In view of the cholestatic picture we went for a USG abdomen which documented hepatomegaly with dilated common bile duct with a soft tissue mass obliterating lower part of the lumen. The pancreatic head was enlarged with a hypo echoic SOL and a dilated main pancreatic duct (8.4 mm) We immediately went for a CT abdomen with a guided FNAC from the pancreatic mass counseling the family members about the poor prognosis of pancreatic malignancies. The CT abdomen echoed the ultrasonographic findings (Fig. 1) but to our pleasant surprise, the histopathological report enumerated epitheloid granulomas with hyper plastic clusters of duct epithelial cells and chronic inflammatory cells (Fig. 2). Now, we went back to the chest skiagram with renewed interest and sent for sputum smear and culture. This showed acid fast bacilli and BACTEC culture gave a positive report for Mycobacterium tuberculosis. The patient was put on a modified anti tubercular regimen along with antibiotics in view of the raised WBC count. Her fever subsided and the count normalized. The bilirubin is steadily declining. The repeat USG abdomen shows a still dilated CBD and MPD though the diameters have become 9.2 mm and 4.4 mm respectively. However in view of the persistently elevated ALP (last value 2206 iu/l), and residual duct dilatation referral to a higher centre is being contemplated for endoscopic intervention.

Discussion
A patient with a mass at the head of the pancreas and peripancreatic lymphadenopathy, prompts the clinician to jump to conclusions. It has been reported that such patients have even been subjected to RenY surgery before the biopsy report revealed tuberculosis (TB). However, TB should be considered as a differential diagnosis in high endemic zones and preoperative tissue diagnosis should be attempted before labeling them as malignancy.

Pancreatic TB is rare and the available literature is mostly in the form of case reports or series. In a 5 year long retrospective study with 267 pancreatic FNA samples TB was detected in only one. On the other hand, analysis of a series of imaging reports of 384 abdominal TB cases pancreatic involvement was found in 32 (8.33%).

This condition is usually associated with miliary tuberculosis and more commonly found in immunocompromised patients. Pancreas is affected either by lymphohematogenous dissemination or by direct spread from contiguous lymph nodes. The clinical presentation of hepatobiliary and pancreatic TB is slow and insidious, with non-specific symptoms and signs. The spectrum comprises FUO, obstructive jaundice and even relapsing pancreatitis as an initial presentation.

Xia et al. showed in a series of 16 patients with pancreatic TB, abdominal pain (75%), anorexia/weight loss (69%), malaise/weakness (64%), fever (50%) and jaundice (31%) were the common symptoms.

Diagnosis primarily requires a high index of suspicion. CT abdomen usually shows an enlarged pancreas with focal hypo dense lesions and irregular borders, most commonly in the head region or enlarged peripancreatic lymph nodes on CT. The definitive diagnosis rests on histological and bacteriological evidence of tuberculosis.

Once the diagnosis is established, antituberculous therapy (ATT) will cure the disease in nearly all patients. However, patients with evidence of biliary obstruction would need either endoscopic or surgical intervention to relieve the obstruction as the ductal narrowing might persist despite treatment with ATT.
Our patient revealed both a tubercular mass at the head of pancreas as well as a small growth at the base of the common bile duct. Both these entities are rare events but reinforce the fact that in high endemic zones, a high index of suspicion is mandatory for young patients with fever of some duration and atypical associated presentations.

References


