

14th Euro-Global Gastroenterology Conference: Parietization of colon following Tuberculosis Ascites - Shailesh Kumar - Post Graduate Institute of Medical Education & Research**Shailesh Kumar***Post Graduate Institute of Medical Education & Research, India*

A 46 years old menopausal female presented to surgical OPD with the complaints of recurrent pain abdomen with vomiting and fever off and on. Pt was a treated case of Koch's abdomen. There was no history of jaundice and other co-morbidities. On examinations, she had tenderness in Right hypochondrium (RHC) on deep palpation. Rest of the parameters were normal. On Investigation, ultrasonography of abdomen revealed multiple gallstones with Normal CBD. Rest of the abdomen and pelvis were normal. Her blood and urinary examinations were within normal limits. X-ray chest revealed features suggestive of healed tuberculosis. Pt was posted for laparoscopic cholecystectomy. After pneumo-peritoneum, 10 mm optical port was placed in periumbilical area. On diagnostic laparoscopy, whole of the colon was densely adhered to the pariety. Liver, gall bladder and spleen were nor not visible. As falciform ligament and liver was not visible, two working port were inserted in the mid clavicular line both side around 3 inches below the costal margin in an anticipation to de-parietization of the transverse colon to assess the feasibility to proceed. We broke the adhesion between the transverse colon and pariety in the midline and preceded to de-parietisation the whole transverse colon with the help of ultrasonic scissor. After that we could visualised the Liver and Gall bladder and preceded with the laparoscopic cholecystectomy abdominal cavity is the sixth most common extra peritoneal site of tuberculosis. There are different studies that support the crucial role of diagnostic laparoscopy in the diagnosis of abdominal tuberculosis. The diagnostic laparoscopy revealed ascetic fluid, violin string adhesion of peritoneum and omental thickness. Peritoneal involvement is a common features and more than half of the patients presents with ascites, lymphadenopathy and stranding of the mesenteric fat. Laparoscopy is normally

accepted as an accurate and prompt diagnostic tool in case of suspected abdominal tuberculosis.

Tuberculosis (TB) is a perilous illness which can for all intents and purposes influence any organ system. Worldwide weight of tuberculosis is about 12 million. As indicated by World Health Organization report 2013, there were an expected 8.6 million yearly occurrence of TB all inclusive and 1.3 million individuals passed on from malady in 2012. India has the world's biggest tuberculosis cases which is around 26% of the world TB cases, trailed by China and South Africa. There were an expected 0.45 million new instances of multi-tranquilize safe TB worldwide in 2012. The greater part of these cases were in India, China and the Russian Federation. Also, there is increment in the frequency of TB in created nations because of expanding pervasiveness of immunocompromised people for the most part because of (AIDS) pandemic, migrant's populace, disintegrating social conditions and reductions in general wellbeing service. The commonness of TB has expanded in both immunocompetent and immunocompromised and it can influence for all intents and purposes any organ. The essential site of TB is normally lung, from which it can get dispersed into different pieces of the body. Different courses of spread can be coterminous contribution from nearby Tuberculosis lymphadenopathy or essential association of extrapulmonary organ. The finding of extrapulmonary TB can be troublesome as it presents with vague clinical and radiological highlights and requires serious extent of doubt for conclusion. The stomach TB, which isn't so ordinarily observed as pneumonic TB, can be a wellspring of critical bleakness and mortality and is normally analyzed late because of its vague clinical presentation. Roughly 15%-25% of cases with stomach TB have accompanying aspiratory TB. Subsequently, it is very

significant in distinguishing these injuries with high record of doubt particularly in endemic regions.

The stomach TB as a rule happens in four structures: Tuberculosis lymphadenopathy, peritoneal tuberculosis, gastrointestinal (GI) tuberculosis and instinctive tuberculosis including the strong organs. Generally a blend of these discoveries happens in any individual patient. By and large, registered tomography (CT) seems, by all accounts, to be the imaging methodology of decision in the location and evaluation of stomach TB, other than gastrointestinal TB. Barium reads stay predominant for showing intestinal mucosal lesions. In this survey we stress on the different radiological highlights of the gastrointestinal TB with a notice on different sorts of stomach TB too. There are a few different ways by which tuberculosis can include mid-region. Initially, the tubercle bacilli may enter the intestinal tract through the ingestion of tainted milk or sputum. The mucosal layer of the GI tract can be contaminated with the bacilli with arrangement of epithelioid tubercles in the lymphoid tissue of the sub mucosa. After 2-4 week, caseous corruption of the tubercles prompts ulceration of the overlying mucosa which can later spread into the more profound layers and into the contiguous lymphnodes and into peritoneum.

Once in a while, these bacilli can go into the gateway flow or into hepatic vein to include strong organs like liver, pancreas and spleen. The subsequent pathway is haematogenous spread from tubercular concentration from somewhere else in the body to stomach strong organs, kidneys, lymphnodes and peritoneum. The third pathway incorporates direct spread to the peritoneum from contaminated contiguous foci, including the fallopian cylinders or adnexa, or psoas boil, auxiliary to tuberculosis spondylitis. In conclusion it can spread through lymphatic channels from contaminated hubs. Ascites is characterized as an anomalous aggregation of liquid in the peritoneal depression, the nearness of serous liquid between the instinctive and parietal peritoneum. The word ascites is gotten from the antiquated Greek word "askos" which means a pack or a sack. Under typical conditions, the measure of peritoneal liquid relies upon a harmony between plasma streaming into and out of the blood

and lymphatic vessels. This equalization, once being disturbed, prompts irregular collection of liquid. Ascites can be a result or a complexity of contaminations, danger, and numerous serious sicknesses: heart, endocrine, hepatic, or renal. The visualization is normally poor; however it relies upon the fundamental causes. Lab trial of ascitic liquid, clinical, paraclinical, and neurotic information are required for the differential finding.

Tuberculosis ascites, one of the clinical indications of stomach TB, suggests gathering of liquid in the mid-region, a swollen midsection, and somewhat raised tubercles of 1–2 mm everywhere throughout the peritoneum. In EPTB, ascites creates optional to "exudation" of proteinaceous liquid from the tubercles, like the component prompting ascites in patients with peritoneal carcinomatosis, and it's regularly misdiagnosed in old patients. Most patients with Tuberculosis peritonitis have ascites at the hour of conclusion, while the rest present the propelled stage, the dry or fibroadhesive type of the diseases.