AN UNUSUAL CASE OF BLEEDING PER RECTUM

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Abstract:
A fourteen year old female presented with bleeding per rectum, abdominal pain and distension of one month duration. Rectal biopsy revealed tuberculosis. Patient showed remarkable improvement with anti tuberculous treatment.

Keyword:
Rectum, Tuberculosis, Hematochezia

A fourteen year old female presented to us with complaints of
1. Abdominal pain
2. Low grade continuous fever
3. Abdominal distension and
4. Rectal bleed all for the past one month duration. She had no significant past history and gave no similar complaints in the past. General examination revealed a thin built individual with BMI of 18.
Abdominal examination showed hepatomegaly and ascites.
A provisional diagnosis of
1. Chronic liver disease with rectal bleed
2. Tuberculous abdomen with rectal bleed of unexplained cause was made and patient was evaluated further. Ascitic fluid analysis showed a high protein low SAAG ascites with lymphocytosis Adenosine deaminase level of 120 IU.
Upper gastro intestinal endoscopy was normal up to second part of duodenum. Serology for HIV was negative. Colonoscopy showed a circumferential ulcerated lesion at about 8 cm from the anal verge extending proximally to about 15 cm. Rest of the colon up to caecum was normal. Multiple biopsies were taken and sent for histopathological examination.
X ray chest PA view was taken which showed right apical infiltration and sputum examination for acid fast bacilli was positive.

Biopsy of the rectal lesion showed epitheloid cells, giant cells and caseating granulomas suggestive of tuberculosis.

Final diagnosis of disseminated tuberculosis was made and patient was started on category I anti tuberculous treatment. Patient was followed up regularly and he showed remarkable improvement with disappearance of ascites and complete healing of rectal lesions.

This case is reported for its unusual presentation of disseminated tuberculosis as bleeding per rectum.

**DISCUSSION**

Tuberculosis of gastro-intestinal tract can involve any portion of bowel extending from oesophagus to anus. However, involvement of bowel distal to ileo-caecal junction is infrequently seen. Rectal involvement is rare (4—5%). In endemic areas 3 to 4% of lower gastro-intestinal bleeding is attributable to tuberculosis. Massive bleed is uncommon as tuberculosis causes endarteritis obliterans. Rectal tuberculosis usually manifests with symptoms like hematochezia - 88%, constitutional symptoms - 75%, constipation - 37%. It can present with annular strictures with ulceration of mucosa and fibrosis. It often mimics malignancy and both may co-exist. Most of them respond dramatically to anti tubercular drugs. Surgery is needed mainly for complicated strictures or co-existing malignancy.

**HISTOPATHOLOGY**

There are six morphological types of anorectal tuberculosis:

- A) Fistula in ano - the commonest
- B) Ulcer with undermined edges - the next frequent
- C) Stricture - short, annular and firm with a typical nodular surface and needs to be differentiated from malignancy & granulomatous stricture
- D) Multiple small mucosal ulcers as a part of disseminated miliary disease,
- E) Lupoid form presenting as submucosal nodule with mucosal ulceration and
- F) Verrucous form with smooth warty excrescences.
Rectal biopsy confirmed the etiology in our case, strongly supported by sputum positivity, right apical infiltrates on chest skiagram and ADA positivity in ascitic fluid analysis. Response was dramatic with cessation of hematochezia and resolution of constitutional symptoms.

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