Intestinal Tuberculosis Mimicking Cecal Cancer

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Tuberculosis was a relatively common disease until the mid-20th century and remains one of the world’s deadliest communicable diseases. In 2013, an estimated 9.0 million people developed tuberculosis and 1.5 million died from the disease. Tuberculosis is slowly declining each year and it is estimated that 37 million lives were saved between 2000 and 2013 through effective diagnosis and treatment. However, the global rate of extrapulmonary tuberculosis, especially gastrointestinal tuberculosis, has recently increased. This condition is linked to acquired immune deficiency syndrome, increasing migration, and use of immunosuppressive agents. The symptoms and signs of gastrointestinal and peritoneal tuberculosis are nonspecific, and unless a high index of suspicion is maintained, the diagnosis can be missed or delayed resulting in increased morbidity and mortality. Careful diagnostic evaluation of extrapulmonary findings is needed if systemic disease is suspected in the setting of known pulmonary tuberculosis or if extrapulmonary disease is the initial presenting factor. A 45-year-old male patient presented to our hospital with general weakness. Abdominal computed tomography findings were suspicious for cecal cancer with peritoneal seeding. However, pathologic results eventually indicated tuberculous enteritis and peritonitis. Here, we report this case of gastrointestinal tuberculosis mimicking cecal cancer.

Atelectasis caused by post-PEG pneumoperitoneum

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PEG (Percutaneous Endoscopic Gastrostomy) has become the most preferred procedure for long-term enteral feeding, since it is proven to be safe and cost effective. Pneumoperitoneum is reported to be common after PEG procedure, but the frequency of serious complications is extremely low, so conservative management is suggested. We report a case of PEG-related pneumoperitoneum and right lung atelectasis, which was not improved after 24 hours and caused respiratory distress. A 76-year-old male received PEG procedure for long-term enteral feeding. Chest X-ray taken after the procedure showed pneumoperitoneum and right lung atelectasis. Since the patient was in a stable state, we decided to observe and wait for spontaneous resolution. But 1 day after procedure, respiratory distress and desaturation were observed, so mechanical ventilation was started. Needle aspiration of free air and intraabdominal catheter insertion were performed, and atelectasis was resolved after decompression. In our case, only right lung atelectasis was observed, so we waited for self resolution, but pneumoperitoneum and atelectasis were persisted. We decided to perform air aspiration and catheter insertion for decompression since the patient was hemodynamically unstable and his condition was deteriorating rapidly. Pneumoperitoneum may cause lung atelectasis in severe cases, and may have resulted in respiratory distress. If the possibility of respiratory distress is suspected, invasive managements including air aspiration or catheter placement should be considered.