

# Ascitic Type of Abdominal Tuberculosis in a 40 Year Old Female

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Received: July 18, 2017; Published: July 28, 2017

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## Abstract

Disseminated tuberculosis can cause a lot of damage to an individual if there is no early diagnosis. In Africa, about 70% of patients with abdominal tuberculosis present with ascites and most of these cases are missed diagnostic cases. The case in question is of a 40 year old women from one of the rural areas of Zimbabwe who had previously presented with severe coughing but had denied sweating at night and the sputum results were negative on screening. After 2 weeks she presented again at the clinic with a swollen abdomen and the X-ray showed flooding of the lungs and difficulty in breathing.

## Introduction

Disseminated tuberculosis can cause a lot of damage to an individual if there is no early diagnosis. In Africa, about 70% of patients with abdominal tuberculosis present with ascites and most of these cases are missed diagnostic cases [1,2]. The patient presents with a swollen abdomen containing many litres of straw-coloured fluid. The fluid accumulates as the result of large numbers of miliary tubercles on the peritoneum. The only certain way to make the diagnosis is to do a minilaparotomy ("minilap"), which will also enable you to diagnose cirrhosis, peri portal fibrosis (due to Schistosomiasis mansoni), carcinomatosis of the peritoneum and hepatoma (usually with cirrhosis). Experts can usually diagnose miliary tuberculosis with their naked eyes; but even they can be wrong, so take a biopsy of his parietal peritoneum and/or his liver. [3] The case in question is 40year old women from one of the rural areas of Zimbabwe who had previously presented with severe coughing but had denied sweating at night and the sputum results were negative on screening.

## Case

40 year old female presented to the clinic with abdominal discomfort, shortness of breath due to the increased pressure on your diaphragm from all the fluid build-up. The X-ray showed *pleural effusion* and cosmetically disfigured large belly. Mental confusion was significantly present as much as relatives said it was her normal way of behaviour. The laboratory test of the ascites indicated a very high albumin levels and Ziel Nielsen stain was positive for acid fast

bacteria characteristic of tuberculosis. HB was significantly low at 9.0 and peripheral smear showed polymophonuclear cells at 60%

## Conclusion

Ascite build up was concluded to be due to disseminated tuberculosis which had initially caused pleural effusion in the lungs, the TB had not been treated and thus the patient's condition worsened [3]. The patient was also immune suppressed and her status had been overlooked as she had complained mainly of her heart when she visited the clinic as she had difficulty in breathing. The serum Albumin-Ascites Gradient (SAAG) WAS 6.1 Serum Albumin (40.0g/l) and ascites Albumin (33.3g/l). Urea and creatinine were 14.5 and 289.9 respectively total bilirubin and direct bilirubin were 26.4 $\mu$ mol and 13.7 $\mu$ mol respectively. The results indicated a total liver failure and cirrhosis was now stage 4 with heavy swollen legs loss of appetite and disorientated. The underlying problem was Disseminated Tuberculosis.

## References

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