Figure 1 Upper lip nasogastric catheter fastening.

prevented as well. A comparative study of this procedure with other methods demonstrates its good tolerance and maintenance of the tubes safely during the necessary time.²

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Colonic tuberculosis with colonic carcinoma – a rare association

Sir,

We read with interest the two articles on intestinal tuberculosis describing the pathogenesis of the association between ileal tuberculosis and carcinoma and the rarity of isolated distal colonic tuberculosis.^{1,2} We recently had a patient with intestinal tuberculosis confined to the sigmoid colon associated with adenocarcinoma at the same site.

A 60 year old Chinese man presented with bleeding per rectum and altered bowel habits for 2 months and pneumaturia for 2 weeks. He was on treatment for diabetes mellitus for the past 3 years. A non-tender firm mass of 10 cm × 5 cm was palpable low down in the left iliac fossa. Sigmoidoscopy showed a large ulcer in the lower sigmoid. Chest X-ray showed patchy opacities in the right upper zone. Smears and cultures of sputum and urine for acid-fast bacilli were negative. Barium enema

revealed irregular narrowing of the lower sigmoid with colovesical fistula. Cystoscopy confirmed the vesical fistula but there were no features of tuberculous cystitis. Multiple biopsies from the bladder wall at the site of fistula and the sigmoid ulcer showed non-specific inflammation. Despite the negative biopsies, the diagnosis of carcinoma of the colon with colovesical fistula was made because of localized involvement of the sigmoid colon and rarity of regional enteritis and diverticulitis of the colon in Malaysia.

Laparotomy revealed a large mass in the lower sigmoid which was adherent to the bladder. Other viscera were normal. Resection of the sigmoid and upper rectum along with partial cystectomy was done. Histology revealed adenocarcinoma of the sigmoid along with caseating granulomas containing epithelioid cells and Langhan's giant cells. The paracolic nodes also showed large confluent granulomas with Langhan's giant cells. Acid-fast bacilli could not be demonstrated in the sections. When the patient was reviewed 3 months following anti-tuberculous therapy, the pulmonary lesion had regressed.

In the case report on ileal carcinoma with tuberculous ileitis, it was suggested that tuberculosis was premalignant.¹ In our case, we believe that tubercle bacilli from the lung secondarily involved the site of colonic carcinoma, based on the following reasons: (a) tuberculosis of the distal colon without ileocaecal involvement is rare;² (b) the short duration of colonic symptoms does not favour tuberculosis being premalignant and (c) the reduced immunity resulting from diabetes and local factors in a malignant ulcer favour the establishment of tuberculous infection.

Presence of caseous granulomas in the resected bowel and regional lymph nodes are accepted as sufficient criteria for diagnosis of tuberculosis.³ Both criteria were present in our patient. Demonstration of acid-fast bacilli in histological sections or on culture is not always possible.⁴ The occurrence of colonic tuberculosis and adenocarcinoma at the same site may lead to histological misdiagnosis of either lesion and deserves to be remembered.

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