ILEO-CAECAL TUBERCULOSIS

CASE REPORT

By A. E. MORTIMER WOOLF, M.B., F.R.C.S.

Consulting Surgeon, Queen Mary's Hospital for the East End

In March, 1942, I was asked to see a man aged 34 with pain in the region of the umbilicus, which had persisted for three and a half months. The pain was colicky in nature and at the onset occurred chiefly in the evenings. During some days he was quite free, but when the pain came on the passing of wind made no difference. About six weeks after the onset the pain came on every night and at times during the day. At this time there was no vomiting and his bowels were open regularly. He saw a physician who advised his going for a holiday, but the pain got worse and eventually an X-ray by a barium meal and enema showed a filling defect in the region of the caecum. I was then asked to see him again. For the past three weeks he had gone off his food, partly because he was somewhat afraid that food might cause the pain. He had lost weight and looked ill.

On examination a very definite mass could be felt in the right iliac fossa. It was firm, irregular and somewhat nodular. It could be moved from side to side and also moved on respiration. The diagnosis seemed to rest between a carcinoma of the caecum and a tumour of inflammatory nature. On re-examining the X-ray, although there was a filling defect there seemed to be little, if any, infiltration. This was unlike malignant disease and suggested that the mass might be inflammatory. He was admitted to hospital. During the week he was in, before operation, he vomited.

Previous History

Apart from an operation for left inguinal hernia six months before the onset of the present symptoms, he had had no previous illness of note.

Operation

The abdomen was opened by an incision in the right linea semilunaris. The caecum, small intestine (for about a foot) and a portion of the ascending colon were infiltrated with small nodules which were especially marked over the caecum and the small intestine. The ileum showed no suggestion of a 'hose pipe.' This did not look like regional ileitis nor did it look like

malignant disease. My opinion was that the lesion was tuberculous. About a foot and a half of small intestine, together with the caecum, ascending colon and hepatic flexure were resected and the cut end of the ileum was anastomosed to the transverse colon by end-to-end anastomosis. Recovery was uneventful and the wound healed by first intention. The pathological report showed a characteristic tuberculous lesion.

Ileo-caecal tuberculosis is a much rarer disease than was formerly thought. This case, however, is a true example of it and differs in many respects from Crohn's disease.

RADIOLOGY

By J. M. CORALL, M.B., CH.B., D.M.R.

Investigation. This should include *barium meal* and *barium enema*, each being complementary to the other. The former provides for examination of the lower ileum as well as the caecum and ascending colon, in addition to giving evidence of hypermotility of the intestinal tract. The head of the meal may be in the rectum while some is still in the stomach (Brown, 1930) (see also Fig. 1). The enema gives a truer picture of the actual degree of narrowing of the caecum and ascending colon since the pressure mitigates to an appreciable extent deformities due to irritability and spasm which the meal cannot overcome. The extent of actual organic contracture is therefore more easily assessed. A marker is placed on any palpable mass felt. The degree of fixation or otherwise of the area is determined on screen examination together with tenderness and its distribution on palpation. The mucosal pattern is studied fluoroscopically and multiple spot films are preferable to show mucosal changes and the constancy of the filling defects.

Interpretation. (a) The most important X-ray evidence of ileo-caecal tuberculosis is the marked intolerance of the caecum to barium. With the barium meal the ileum and transverse colon are seen filled, while the caecum is mostly empty (Fig. 2).

(b) *Stierlin's sign* shows either a gap or a thin trickle of barium in the caecum due to spasm or combination of spasm and narrowing of the lumen by encroaching granulation tissue. Fig. 3 illustrates a classical Stierlin's sign. Although considered nearly pathognomonic of caecal tubercu-