

positive organisms but the culture was sterile. The child showed remarkable improvement clinically as well as on CT scan and was discharged. No behavioral problem or neurological deficit was identified on follow up of two years.

Brain stem abscess can occur at any age and in any part of the brain. Boys are affected more often than girls. An abscess in the brain stem is rare and carries grave prognosis, if not treated promptly(1). The clinical presentation is variable and depends on the site of abscess. Headache and focal neurological signs may be the sole presentation without fever or leucocytosis(2). A primary focus of infection could not be detected in this case. CT scan is an important diagnostic tool to detect brain abscess(3). A combination of chemotherapy and surgery results in a dramatic recovery with no neurological deficit(4). In the long term follow up behavioral disturbances have been noted in some of these cases but it is too early to comment in this case(5). In conclusion a high index of suspicion, early diagnosis especially with availability of CT scan, conservative and surgical management have resulted in a better outcome in this condition.

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Unusual Presentation of Tuberculous Peritonitis

We read with interest the case report 'Unusual Presentation of tuberculous peritonitis' by Raghu Raman and Jalpota(1). We would like to comment, as below:

It is not clear from the case report whether the ascitic fluid tapped was exudative or transudative and the raised total leucocyte count with polymorphonuclear leucocytosis, Gram Positive cocci and culture growth of *Staphylococcus aureus* was from blood or peritoneal fluid. The authors have not mentioned histopathology of mesenteric lymph nodes and peritoneum that confirmed tuberculosis (caseating granuloma and/or acid fast bacilli) in their case.

The authors suggestion of explorative laparotomy as a primary diagnostic procedure in suspected cases of acutely presenting tubercular peritonitis (ascitic variety) appears to be inappropriate. Tubercular etiology should have been thought of as a strong possibility as this child had presented with fever, generalized lymphadenopathy, hepatosplenomegaly, exudative

ascites and had milliary mottling on chest X-ray. In such a setting antitubercular drug therapy was fully justified without subjecting this case to unnecessary diagnostic laparotomy. Diagnosing abdominal tuberculosis by definitive criteria, i.e., tissue demonstration of caseation granuloma and/or AFB positivity is not always possible; instead one may go by probable criteria(2,3).

Further the value of ascitic fluid adenosine deaminase (ADA) determination has been highlighted in the diagnosis of tubercular peritonitis. A raised level of ascitic fluid ADA has a very high sensitivity (98-100%) and specificity (96-97%) in diagnosing tubercular peritonitis(2). Therefore, antitubercular drug therapy in an appropriate clinical setting, exudative ascites with high ascitic fluid ADA level will obviate diagnostic laparotomy and its attendant morbidity and mortality in patients with tubercular peritonitis.

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Reply

The child had features of acute abdomen with toxic paralytic ileus. Analysis of ascitic fluid was confirmatory of spontaneous primary peritonitis (SPP) due to *Staphylococcus aureus*. Histopathology of mesentric lymph nodes and peritoneal tissue confirmed tuberculosis as mentioned in the report.

Though the patient had clinical features to suggest disseminated tuberculosis, factors like acute and rapidly progressing illness, presence of SPP with paralytic ileus, and failure to respond to conservative therapy even after 72 hours, prompted us to subject the child to exploratory laprotomy. The procedure served the main purpose of performing peritoneal toiletting and to carry out tissue diagnosis. Surgical exploration in SPP is indicated if multiple organisms are seen on Gram stain, free air is demonstrated on abdominal roentgenogram, or after 48 hours of parenteral antibiotics either the child's condition deteriorates or the physical findings persist and show localization(1).

The priority for treatment in this patient was for SPP. Anti tubercular therapy alone would not have benefited the child. We have not generalized the statement that diagnosis of tubercular peritonitis is by exploratory laprotomy. It is only in those cases where the onset is acute mimicking, acute abdomen and other positive evidence for tuberculosis is not present.

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