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Perforative Duodenal Tuberculosis

A six-year-old female presented with severe abdominal pain and bilious vomiting since 6 hours. For the last 6 months she was being treated with antihelminthics, anti-spasmodics and antacids for intermittent/colicky abdominal pain.

Examination showed a cachexic, pale child with tachycardia and tachypnea. Abdomen was mildly distended with no visible loops. Palpation revealed tenderness and guarding in upper abdomen. Liver and spleen were not palpable. Per rectal examination showed bogginess.

Investigations showed hemoglobin of 7.8 g/dL Erythrocyte sedimentation rate was 31 mm/hr. All other serum investigations were within normal limits. X-ray abdomen showed massive gas under diaphragm. X-ray chest

was normal. Ultrasonography showed free fluid in Morrisons and Douglas pouch.

Exploration revealed a stricture in the terminal part of duodenum, tubercles and a (*Fig. 1*) perforated ulcer proximal to the stricture. Mesenteric lymph nodes were enlarged and appeared caseating. Rest of the viscera were normal. The perforation was closed in two layers and omentopexy was done. Side to side duodeno-jejunostomy followed, for non-passable stricture. Mesenteric lymph nodes were biopsied. Histopathology confirmed tuberculosis. Antitubercular treatment was initiated. Postoperative course was uneventful.

Tuberculosis of stomach and duodenum is rare(1) even in patients with pulmonary tuberculosis. Duodenal perforation proximal to tubercular stricture is exceptional. Extreme variety of gastric and duodenal tuberculosis is attributed to factors like sparsity of lymphoid



Fig. 1. Stricture in the terminal part of duodenum with tubercles (marked with two arrows) and a perforated ulcer. (marked with one arrow) and duodenum marked with black single arrow.

structures, intact mucosa, rapid passage of ingested organisms and acidity of the stomach.

The possible routes of infection are directly through mucosa, hematogenous, lymphatic and from adjacent structures in continuity(2) through serosa. Extensive lymphadenopathy is common. The above two reasons make our case more rare.

The treatment of gastric and duodenal tuberculosis is primarily medical with anti-tuberculosis drugs(3). Surgery is indicated in cases with obstruction or perforation of an ulcer.

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Esophageal Perforation in Neonate

Perforation of the esophagus or pharynx of a neonate is an uncommon emergency. It may be misdiagnosed as a case of tracheo-esophageal fistula due to overlapping clinical features.

A female neonate delivered by normal vaginal delivery, with a birth weight of 2500 gm, underwent oral suctioning soon after delivery to clear secretions. Shortly thereafter, excessive salivation was noted and an attempt to pass an orogastric tube failed.

X-ray of chest demonstrated coiling of tube in the neck. The child was referred with a diagnosis of esophageal atresia with tracheo-esophageal fistula. At admission the child had tachycardia and dyspnea. Attempt at gently passing an 8 Fr. orogastric tube failed and a repeat radiograph revealed the coiled tube in the neck. There was right upper lobe consolidation but no evidence of pneumothorax or pneumomediastinum. Preoperative bronchoscopy could not be performed due to lack of facility. At surgery, esophagus was found to be normal without any communication between the trachea and esophagus.