Disseminated tuberculosis

Prasna Pramita, author

Abstrak

Tuberculosis is one of 6 fatal infectious diseases in the world, and causes three million deaths annually. Tuberculosis (TB) is a pulmonary and systemic disease caused by My-cobacterium tuberculosis. TB classification consists of pulmonary and extra-pulmonary TB. TB stimulates both the specific and non-specific immune systems. Disseminated tuberculosis is military lung TB with several extra-pulmonary organ manifestations. The main management for multi-organ TB is the administration of anti-tuberculosis drugs. In pleural effusion due to lung TB, corticosteroid may reduce systemic and local reactions to tuberculoprotein, reduce pleural exudate secretion and fibrosis, as well as reduce deformity of the chest wall and scoliosis that can inflict children.

We report a case of a 25 year-old woman who came with a chief complaint of progressive breathing difficulty since 2 days prior to admission. Since } year prior to admission, the patient's abdomen became bloated and there was edema in her legs. Her lost her appetite and weight, and suffered from a mild fever. The patient had a cough with thick whitish sputum. The patient had not menstruated for 7 months. She had a history of liver disease.

Physical examination results were as follows: the patient was moderately ill, fully conscious, and had malnutrition. She weighed 37 kg and was 149 tall. Her blood pressure was 100/70 mm Hg, her pulse rate 84 times/minute, her body temperature 37" Celsius, and her respiration rate 18 times per minute. Her conjunctiva were pale. Her right supra-clavicular and mandibular lymph nodes had a diameter of 2 cm, were resilient, mobile, not tender, and had smooth surfaces. Her lung sounds demonstrated weakened vesicular sounds in her left lung, with loud rales in both lungs. Her abdomen was enlarged, distended to 92 cm, with venectations. Her liver and spleen could not be assessed. There was undulation and normal bowel sounds. Her extremities were warm and edematous. Her left inguinal lymph node was enlarged to 1 cm, resilient, well-defined, mobile, and not tender. Her left inguinal lymph node was 5 mm in diameter.

Her laboratory results were as follows: Hemoglobin level 9.0 g/dl, Hematocryte level 27 vol%, erythrocyte count 3.66 juta/ul, and leukocyte count 14.500/ul. Her chest x-ray demonstrated milliary tuberculosis. Abdominal ultrasound revealed a congestive liver, exudative peritonitis, and a mass in the spleen. Ascites fluid aspiration revealed exudate fluid. Pathological cytology revealed chronic granulomatous inflammation, with the possibility ofTB, and no signs of malignant cells. Ascites fluid microbiological culture turned out negative. During the first echocardiography, no pericardia! effusion was found, and the ejection fraction was 61%. During the second echocardiography, there was thickening of the walls, and pericardial effusion. Catheterization was attempted, but failed due to cyanosis. Electrocardiography demonstrated low voltage at nodes 1, II, aVR, aVL, aVF. The patient was consulted to the retina subdivision, and no tubercle was found. Problem: disseminated TB with pericarditis, ascites due to exudative peritonitis, anemia, malnutrition, and secondary amenorrhea. The patient's condition improved under treatment ofRHZE 300/300/1000/750mg, 3x1 tablet ofB complex vitamins, 3x10 mg ofprednison, 1x100 mg ofaldactone, and 1x1 tablet of provera. Her difficulty breathing alleviated, her waist diameter was reduced to 76 cm.