Pancreatic tuberculosis: *A rare occurrence*

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ABSTRACT

Pancreatic tuberculosis is a rare clinical entity and may present diagnostic difficulties. It can mimic carcinoma of the pancreas. However, it is a curable disease once the diagnosis is established. We report a case of pancreatic tuberculosis in which percutaneous Computerized Tomography guided biopsy confirmed the diagnosis. Patient recovered completely following a nine month course of anti-tuberculos chemotherapy. Therefore, percutaneous computerized tomography guided biopsy of the pancreas can lead to precise diagnosis without the need for laparotomy.

Keywords: Pancreatic tuberculosis.

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In Saudi Arabia where tuberculosis (TB) is still endemic, the frequency of extrapulmonary TB is increasing.[1,2] Between 1964-1976, extrapulmonary TB has increased from 7.8% to 13.7% in USA.[3] Abdominal TB is a common form of extrapulmonary TB. About 12% of patients infected with TB have abdominal involvement.[4] The most common sites are the mesenteric lymph nodes, small bowel, peritoneum, liver and spleen. However, pancreatic involvement is rare even in association with miliary TB. Furthermore, focal pancreatic TB is even rarer. The pancreas is usually affected in patients who have previously suffered from TB.

We report a case of pancreatic TB mimicking malignancy. The diagnosis was established by percutaneous CT-guided biopsy with complete response to anti-tuberculous chemotherapy.

Case report. A 30-year old male patient was referred to the Department of Surgery as a case of carcinoma of the head of the pancreas with three months history of progressive upper abdominal pain, nausea and vomiting. There were yellow discoloration of the eyes, dark urine, white stool and generalized pruritus. Patient lost 10kg during this period and his appetite was reduced. He denied any history of abdominal trauma. He gave a history of pulmonary tuberculosis 18 months prior to admission for which he was treated for 4 months. He is neither diabetic nor hypertensive. He is non-smoker and non-alcoholic. Examination was unremarkable, apart from deep jaundice and abdominal scratch marks.

Hematological and Biological investigations were within normal except high ESR (76mm/hour). Liver function tests were all elevated: Total Bilirubin 12.5 mg/dL; alkaline phosphatase 1965 u/L; serum albumin 2.8 g/dL; SGOT 95 u/L; SGPT 56 u/L and Gamma glutamyl transferase 149 u/L. Urinalysis was positive for bilirubin. Sputum and urine analysis were repeatedly negative for acid-fast alcohol-fast bacilli. Chest x-ray, ECG, PT & PTT were also within normal limits. Serology was positive for hepatitis B but negative for HIV. A tuberculin test with 5TU of PPD was negative. Carcino embryonic-antigen (CEA) and CA19-9 were normal. Ultrasound of abdomen showed an irregular hypoechoic mass 6cm in diameter in the head of the pancreas reaching the caudate lobe. The portal vein was displaced forward. The common bile duct (CBD) and the intrahepatic ducts were dilated. The gallbladder was slightly distended (Figure 1). Contrast-enhanced CT-scan of abdomen confirmed a

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aration of the prepuce from around the urethral meatus with fine blunt probe prevents the occurrence of meatal ulceration and later stenosis.

4. Circumferential marking of the optimal level of excision of the prepuce which is just distal (1-2mm) to the corona of the penis. Marking prevents circumferential inequality and over or under-estimation of the level of cut.

5. Excision of the inner (mucosal) layer, leaving a 2-3mm cuff; removal of this layer prevents the re-reflection of penile skin over the glans which might result in adhesions of the abraded glanulopreputial surfaces or between the cut edges and the abraded glans penis.

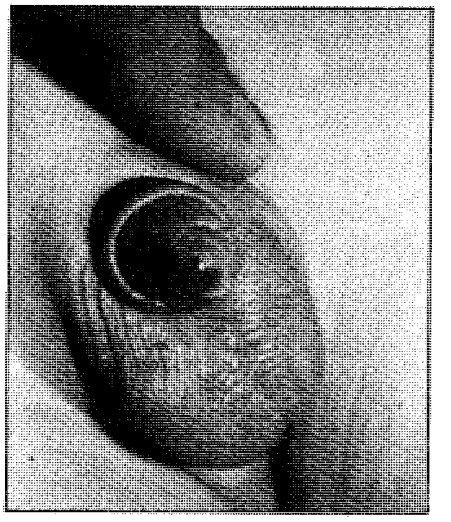

FIG. 2. Abrasions covered with fibrinous exudate close to the meatus and involving its edge.

6. Good haemostasis by careful diathermy coagulation in the circumcision performed under general anaesthesia, and by the fine absorbable ligatures of the main bleeders in the cases performed under local anaesthesia.

7. Approximation of the cut edges of circumcision wound with 4-6 fine (6/0) absorbable stitches to prevent wound dehiscence with the subsequent broad, ugly scarring (Fig. 3) and to ensure faster healing.

8. Light pressure dressing with sufra-tulle, dry gauze and elastoplast tape. This dressing should be removed after 24 hours.

9. Clear post-operative instruction to be given to parents to present to the emergency room for any emergency or enquiry (*i.e.*, bleeding, urinary retention and glanular color changes). Post-operative follow-up is offered in the outpatient clinic one week after surgery.

FIG. 3. Circumcision with broad ugly scar.

We applied these recommendations in 500 circumcisions performed in the second 2 years of this study. We evaluated the result of this group by the same clinical sheet used in the evaluation of the screened group.

Results

A. Results of Screened Group

All circumcisions (1000 cases) were done for religious reasons. A total of 459 (45.9%) were satisfactory and 541 (54.1%) were unsatisfactory circumcisions. Circumcisions performed by medical personnel accounted for 710 cases, 48.3% of which were unsatisfactory, while 290 circumcisions were performed by non-medical personnel, 68.3% of which were unsatisfactory (Table 1). The different methods used are shown in Table 2. In 542 cases, the method of circumcision was unknown

TABLE 4. Definite complications in the screened group (1000).

	No. of Cases		No. of Cases
Bleeding	18	Inadequate	96
Septicaemia	1	Penile skin loss	4
Urinary retention	2	Meatal stenosis	1
Stitch sinus	1	Post circumcision chordee	2
Iatrogenic hypospadias	1	Adhesions	36
Urethral fistula	1	Post circumcision phimosis	4
Amputation (glans)	1	Concealed penis	1
Inclusion cyst	1	Circumcision in hypospadias	3
		Total	183

B. Group Circumcised According to Proposed Guidelines

All 500 cases were done for religious reasons, and were performed by medical practitioners with satisfactory results in 499 (99.8%) cases. All circumcisions were done under anaesthesia: 122 cases were done under general, and 378 cases were done under local anaesthesia. Painless clamping of the prepuce was seen in 367 cases (97%) and comfortable, painless procedures were seen (for babies who were quiet throughout the procedure) in 259 (68.5%) cases. For the remaining 11 cases, the babies cried on clamping and throughout the procedure (Table 5).

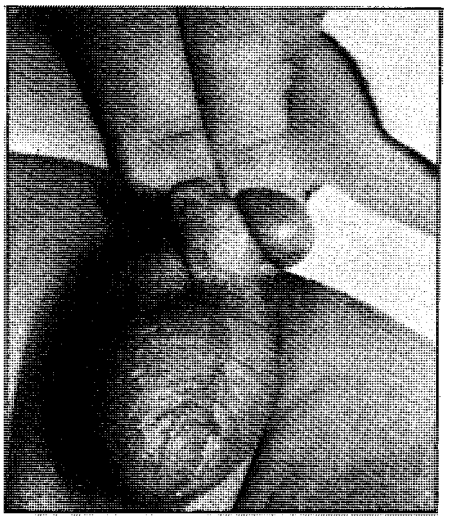

FIG. 4. Non-cosmetic circumcision with circumferential inequality and skin tag.

TABLE 5. Effectiveness of the local anaesthesia in the operated group.

Effectiveness	No. of cases (%)
Quiet throughout* the procedure	259* (68.5%)
Quiet on clamping	367 (97%)
Crying on clamping	11 (3%)

*These patients included in the 2nd group (quiet on clamping).

There was only one case of post-circumcision bleeding, which could be controlled by pressure and redressing. None of this group showed wound scarring or cosmectic failure.

Discussion

Circumcision is an essential part of every male Muslim's body hygiene, but unfortunately, the procedure has not attracted a great deal of medical attention. This lack of interest is indicated by :

Firstly: Paucity of the reports on the practice of this procedure in our community, compared to the extensive reports from other cultures which share a high rate of circumcision, but have different backgrounds, such as the U.S.A., where the rate of circumcision is 80-90% of male neonates[8,9].

Secondly: The attitude of our medical professionals, as they either consider circumcision to be a minor procedure to be referred to juniors who usually lack adequate training, or leaving it to traditional practitioners, who have had neither correct supervised training, nor had any source of medical education to improve or update their knowledge and practice.

Therefore, we recommend that circumcision be done by medical professionals. Despite the high incidence of unsatisfactory circumcision (541 cases or 54.1%) in the screened group; the definite complications account for 1/3 only of the unsatisfactory cases (183 cases or 18.3%), while the remaining 2/3 (358 cases or 35.8%) of these cases were the cosmetically unsatisfactory circumcisions including the broad ugly scarring.

The variety of definite post-circumcision complications (18.3%) which are seen in the screened group (Table 4), had been reported previously[8-31]. It is generally accepted that the majority of these complications are minor but a few are disastrous such as penile loss or iatrogenic hypospadias. These serious complications, as well as the high incidence of the other minor complications, have induced the medical authorities in other communities (non-religiously practiced circumcision) to restrict the procedure to medically indicated cases only, abandoning routine neonatal circumcision and recommending proper penile hygiene as an alternative[11,14,32-34]. The literature is full of controversial reports on circumcision, some of which recommend its practice because of several advantages[1,35-43], while other reports condemn it because of the risk involved, and a variety of other reasons[11,14,32-34]. In a community such as ours, where circumcision is performed for religious reasons and no other alternative is acceptable, it is more logical and practical to recommend guidelines aimed at performing a satisfactory circumcision, than to condemn it altogether. In addition, past experience in countries such as the U.S.A., where non-religious circumcision is practiced, has revealed that, in spite of attempts to abolish it as a routine procedure, circumcision is still practiced at a constant rate[8,49,44-46].

We have established guidelines which, when applied in an integrated manner, will lead to a correct and safe practice irrespective of the technique or the experience of the medical practitioner, (except minimal complications which could be expected for such a procedure). The recommended guidelines are described above, however, some points deserve further discussion.

ıaesthesia

The contribution of anaesthesia can be seen clearly in the satisfactory results of ur surgical cases (99.8%), as compared to the high percentage (64%) of unsatisıctory outcomes in the non-anaesthesized cases in the screened group (Table 3). 'hese results, together with other evidence of painful circumcision without anaesıesia, such as the baby screaming, increased heart rate, increased respiratory rate nd decreased P_{O_2}[47,48], as well as increased serum cortisol[49], preclude the incorrect elief that neonates and infants do not feel pain[50-52]. In spite of this, children do ot usually need post-operative analgesia as frequently as adults[50]. We recommend ıe use of the subcutaneous ring anaesthesia at the proximal shaft of the penis, hich proved to be as effective as the other penile nerve blocks, which were escribed by other authors[52,53], but without the risks of compartmental compression f the vessels by deeply infiltrated anaesthetic solution or deep haematomas, or y mechanical or chemical damage to the main penile vessels with consequent enile gangrene[54].

revention of Meatitis and Meatal Ulceration

Gentle and careful separation of the prepuce from around the external urethral ıeatus is an essential step in the prevention of meatitis and meatal ulceration, articularly in the case where congenital glanulopreputial adhesions are in close roximity to the meatus. On separation, this may lead to abrasions of the glans; ude retraction may extend these abrasions to involve the meatal epithelium with ɔnsequent meatitis and meatal ulceration and possible meatal stenosis due to catricial contracture or meatal cross healing. In such cases, where abrasions are ose to the meatus, it is necessary to maintain separation of the meatal edges by ɛntle retraction and daily probing of the meatus, and applying an ointment 3 times aily until the abrasions have healed completely (Fig. 5, 6).

lectrocoagulation

The use of electrocoagution, during circumcision ıs been repeatedly conɛmned, as it might cause ɛnile necrosis[55-57]. In our ɛperience, electrocoagulaɔn (preferably bipolar) ıs proven to be a safe ethod of controlling eeding, provided it is used ɔrrectly (*i.e.*, correct conɛctions, precise picking of e bleeders, avoiding big ıd deep bites of tissue). There is no definite report in the literature indicating at the simple use of the electrocoagulation has resulted in penile necrosis, but

FIG. 5. The same patient on Fig. 2 with partially healed abrasions.

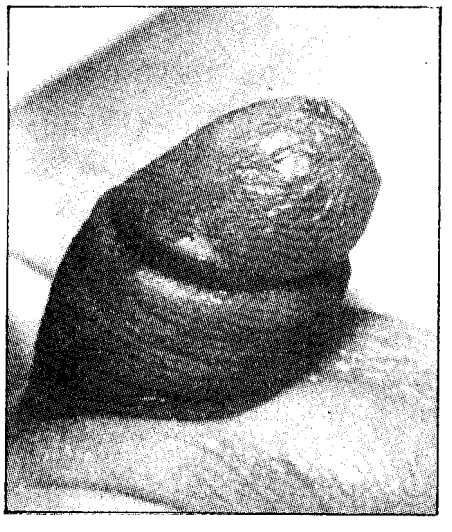

FIG. 6. The same patient on Fig. 2 shows complete epithelialization of the abrasions.

under no circumstances should it be used in cutting tissue, or applied to the large metallic clamps (Gomco), as the last two faulty applications reported in the literature resulted in penile gangrene[56,57]. Perley *et al.*[10] had similar favorable experience with electrocoagulation, which they recommended as an alternative to control bleeding.

Circumcision Wound Dehiscence

Healing, by secondary intention, after dehiscence of a circumcision wound takes a longer period and results in broad, ugly scarring. This dehiscence occurs with repeated post-operative erections leading to retraction of the proximal skin. Dehiscence is primarily due to failure to apply approximating stitches to the prepuce cut edges, and secondarily to the excessive removal of penile skin, where the remaining skin is sufficient to cover the flaccid, but not the erected, penis. Penile scarring is a cosmetic failure but we consider it as a distinct group, as Bissada *et al.*[58] reported a remote risk of development of squamous cell carcinoma in extensive scar tissue, as seen in 15 cases of tribal circumcision (mostly from the southern province), which has been abandoned for years. The broad scarring which is seen in 198 cases (non had approximating stitches) of screened cases might lead to similar consequences. This extensive, ugly scarring can be prevented by the approximating stitches and marking the adequate level of cut.

Techniques

Several techniques of circumcision are in current practice, but the main methods are the circumferential clamps (*i.e.,* Gomco and Plastibel), straight clamps such as bone cutting forceps, and the dissection technique. Previous reports indicated that complications occurred with all techniques, and each specific technique had particular advantages and disadvantages[8,31]. For example, the circumferential clamp is simple, and controls the level of cut at both layers of the prepuce, however, the Gomco clamp has the disadvantage of post-circumcision wound dehiscence and bleeding. These two complications are less likely to occur with Plastibel, however, other disadvantages result: the retained plastic ring increases the incidence of infection[24-26] and may lead to penile constriction with consequent gangrene or permanent grooving on the glans or the shaft[24-30]. On the other hand, the straight clamp is a simple and quick technique, but its disadvantage is that it may leave an excess inner layer (mucosal), and if any attempt is made to include it in the clamp, it might result in injury to the glans.

We modified the straight clamp technique by using the clamp to cut the prepuce at the required level of the outer skin, giving a neat cut all around with no bleeding from the proximal cut edge. The excess inner layer (mucosa) is then excised with scissors, and approximate stitches are made at the cut edges, with careful control of bleeding. This modification ensures safety and excellent cosmetic results, comparable to the Gomco clamp, provided that the guidelines mentioned above are taken into consideration. These simple instruments (straight clamp and scissors) are available in any medical unit.

Conclusion

In our experience with patients reviewed in this paper, circumcision is associated ith a high incidence of definite and relative (cosmetic) complications, the aetiology : which were discussed. The various methods of circumsion were reviewed, and veral guidelines were suggested to minimize complications. These guidelines were plied to 500 cases of circumcision in our hospital; satisfactory results were achieved the 99.8% of the cases, and the method was proven to be safe and effective.

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تقويم نقدي لختان الذكور في المنطقة الغربية من المملكة العربية السعودية

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المستخلص : يعتبر ختان الذكور في المجتمعات الإسلامية من السنن الدينية المؤكدة . لذا ، فإنه أكثر العمليات الجراحية شيوعًا . وعلى الرغم من ذلك ، فإن النظرة له على أنه عملية صغرى أدت إلى عدم وجود دراسة وافية لتقويم الممارسة الحالية لهذه العملية بوساطة الأطباء والممارسين التقليديين (المطهرين) وبالتالي فلا توجد معايير تقويمية للختان المثالي ، كما لا توجد إرشادات للتقليل من المضاعفات الممكن تجنبها .

لذا ، فقد قمنا بدراسة استقصائية لتقويم الأداء الحالي للختان في مجتمعنا (المنطقة الغربية من المملكة العربية السعودية) بفحص ١٠٠٠ (ألف) طفل مما أظهر وجود مضاعفات في ١٨,٣٪ ، ونتائج غير مرضية تجميليا في ٣٥,٨٪ . من خلال هذه النتائج ، قمنا بوضع معايير للختان السليم ، واقترحنا الإرشادات التي تؤدى إلى تجنب المضاعفات مع تخفيف معاناة الأطفال أثناء العملية . وقد طبقنا تلك الإرشادات في ختان ٥٠٠ (خمسمائة) طفل في مستشفى جامعة الملك عبد العزيز بجدة ، أدت إلى نتائج مشجعه في ٩٩,٨٪ من هذه الحالات .

إجراء مسحة للعقد الليمفاوية العنقية في مستشفى الملك عبدالعزيز الجامعي

زهور الفيشي، عدنان مرداد، عبدالرحمن مكاوي
قسم الجراحة العامة، كلية الطب والعلوم الطبية، جامعة الملك عبدالعزيز، جدة، المملكة العربية السعودية

المستخلص. لقد تم إجراء مسحة للعقد الليمفاوية العنقية لمئتين واثنين وستين مريضاً (٢٦٢) في مستشفى الملك عبد العزيز الجامعي خلال سبع سنوات. لقد وُجد أن ١٤٥ من إجمالي الحالات كانت تعاني من الدرن، و٥٩ حالة (٢٢,٥٪) كانت تعاني من الأورام الخبيثة، و٥٠ حالة (١٩٪) كانت تعاني من فرط النمو النسيجي، و٦ حالات كانت تعاني من الالتهاب الحبيبي اللاتجبني المزمن، وحالة واحدة كانت تعاني من التهاب العقد الليمفاوية القيحي الحاد. لقد تم إجراء السحب بالإبرة الدقيقة على ٢٣ حالة فقط (٨,٧٪)، مما أظهر تناسباً طردياً (٧٨٪) مع نتائج العينة المفتوحة. نستخلص من ذلك أن التهاب العقد الليمفاوية هو من أكثر حالات اعتلال العقد الليمفاوية العنقية شيوعاً في مؤسستنا، ، كما أنه لم يتم الاستفادة من طريقة السحب بالإبرة الدقيقة على الوجه الأفضل، مع أنها أظهرت تناسباً طردياً مع العينة المفتوحة.