Bahrain Medical Bulletin, Vol. 23, No.4, December 2001

MEDICAL QUIZ

Fayek Al-Hilli, DPath, PhD Ashok Kumar Malik, MD, FRCPath

Fig.1

Fig.2

Forty years old man from Bangladesh, who gave history of intermittent central colicky abdominal pain. Prior to hospitalization he complained of constipation and four episodes of vomiting. There was no past history of diarrhoea. On admission the patient was afebrile with a pulse rate of 82 per minute. Clinical examination revealed a soft, distended abdomen with mild tenderness. A vague ill-defined mass was palpable in the right iliac fossa.

Investigations

Haemoglobin was 12gm/dL. Total and differential leucocyte counts were within normal limits. Abdominal ultrasound was non-diagnostic. CT scan revealed concentric thickening of bowel in the region of ascending colon. There was no ascites. Several nodular opacities up to 8 mm in diameter, possibly lymph nodes, were noted in the pericolic mesenteric fat. Later, barium enema revealed a localized stenotic lesion in the ileo-caecum with apple core deformity. The rest of the large bowel was normal. Subsequently the patient underwent colonoscopy. Biopsy from the narrowed segment showed only non-specific ulceration with no evidence of malignancy. Two weeks after admission, he underwent an extended right hemicolectomy. Post-operative period was uneventful.

Pathological findings

The ileocolectomy specimen measured 25 cm long with excessive mesenteric and pericolic fat seen around the caecum. The terminal ileum was mildly dilated. There was marked narrowing of the ileo-caecum caused by irregular stenotic lesion measuring 5 x 2

cm in diameter and the overlying mucosa appeared roughened and ulcerated (Figure1). The bowel wall was indurated and few tiny greyish white tubercles were seen on the serosal aspect. The regional mesenteric lymph nodes were enlarged. Representative samples from the stenotic lesion and the lymph nodes were processed for histological examination. Microscopy showed, apart from ulceration, numerous irregular confluent epitheloid granulomata of variable sizes with characteristic Langhan's type and foreign body multinucleated giant cell reaction and foci of caseation necrosis (Figure 2). Associated fibrosis of the bowel wall noted. Ziehl- Neelson (ZN) stain showed positive acid fast bacilli (AFB) within the granulomas. Regional lymph nodes also showed similar granulomata.

Q 1. What is the differential diagnosis of this lesion ?

Q 2. What is the characteristic microscopic finding in this case?

Q 3. What is your diagnosis?