Case Report

**Synchronous colonic malignancy and tuberculosis: a rare histologic surprise**

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**ABSTRACT**

Coexistence of colorectal cancer and tuberculosis of same site is described in few of case reports. Tuberculosis (TB) is known to involve any part of the body. Intestinal TB accounts for the majority of extra pulmonary TB, ileocecal region being the most common site. TB has been known to be associated with various types of malignancy. The most common association is malignancy and pulmonary TB. However, association of extra pulmonary TB and malignancy at the same site is relatively uncommon. This case report describes synchronous colonic malignancy and tuberculosis on histopathological evaluation of the resected specimen in a 42-year female patient.

**Keywords:** Adenocarcinoma, Colon malignancy, Tuberculosis

**INTRODUCTION**

Tuberculosis (TB) is a global health problem, which can involve any part of the body. Majority of extra-pulmonary TB is related to intestinal tuberculosis and ileocecal region is the most common site. Synchronous colonic malignancy and tuberculosis is an uncommon event. Intestinal TB can cause chronic inflammation, but the exact relationship between intestinal TB and colon cancer is currently not well delineated. We report an interesting case of synchronous colon cancer and TB where the diagnosis of tuberculosis was reported incidentally on histopathological examination.

**CASE REPORT**

A 42-year woman presented to Outpatient department OPD) with complaints of intermittent, moderate to severe intensity pain abdomen in the right lower quadrant for one year. Pain increased in severity and intensity over the last month. She also complained of altered bowel habits in the form of increased stool frequency. She underwent colonoscopy, which revealed distorted anatomy in ileocecal region with cauliflower like polyoidal growth occupying whole of caecum and part of ascending colon. Biopsy showed high-grade dysplasia. Carcinembryonic antigen (CEA) level was 40 ng/ml. Following this, a contrast enhanced computed tomography (CT) scan was done. CT findings showed presence of marked asymmetric circumferential mural thickening (maximum 2.5 cm) in the caecum and Ileocecal (IC) junction causing luminal compromise. Few sub centimetric adjacent lymph nodes were present in the mesentery. Patient underwent right hemicolecctomy. A 6x6 cm hard mass was present at the IC junction. Multiple mesenteric lymph nodes were also palpable. There was no evidence of ascites or metastatic peritoneal deposits. Cut section of the specimen showed a fungating growth at IC junction. Histopathological examination revealed moderately differentiated adenocarcinoma. Lymphovascular emboli were absent and the all resection margins were free of tumor. 2/13 lymph nodes were involved by tumor. Three of the lymph nodes showed hyalinized epithelioid cell granuloma consistent with TB. Postoperative recovery was uneventful, and the
patient received a full course of anti-tubercular therapy (category I) for 6 months with 6 cycles of Oxaliplatin + 5 Fluorouracil (FU) + Leucovorin (FOLFOX) chemotherapy concomitantly. Patient was followed up on Outpatient department (OPD) basis every 3-6 monthly. CEA level after 3 months of surgery was 7 ng/ml, which is a good prognostic sign.

CONCLUSION

The coexistence of TB and carcinoma in the colon may be simply a coincidence. Patients in high incidence parts of the world like India have a higher risk of latent and therefore active TB. Further immunocompromised status of the cancer patients adds the risk of flare up. Therefore, we should be cautious of this when dealing with colon cancer patients.

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REFERENCES

