Pancreatic Tuberculosis following Renal Transplantation

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Dear Sir,

Tuberculosis (TB) is increased after renal transplantation [1, 2] and usually presents as pulmonary, disseminated or cutaneous TB. However, abdominal TB is uncommon after transplantation but is increasingly recognised in the general, particularly Asian, population [3]. The pancreas is rarely affected even in those with disseminated disease, being identified in less than 2% of autopsies for miliary TB [4]. Reports of focal pancreatic TB are even less common [5,6]. We describe here the development of a pancreatic tuberculoma in a renal allograft recipient of Asian origin, immunosuppressed with ciclosporin A.

A 49-year-old Kenyan Asian female presented with chronic renal failure and bilateral small scarred kidneys. There was no past history, radiological or microbiological evidence of TB. Her renal function progressively declined over a 5-year period and she was commenced on haemodialysis. Full evaluation was again negative for TB. One year later she received a cadaveric renal transplant which functioned immediately and she was immunosuppressed with ciclosporin A alone, but required a 3-day pulse of methyl prednisolone 1g for histologically confirmed acute rejection on day 17. Nine weeks later she complained of right upper quadrant pain, anorexia and a weight loss of 2 kg. She had a low-grade fever (37.8°C). Her haemoglobin had remained low at 9.4 g/dl but the other haematological and biochemical parameters were normal. Blood and urine cultures were negative and gastric washings were negative for acid fast bacilli. Upper gastrointestinal endoscopy was normal. An ultrasound scan disclosed a pancreatic mass and endoscopic retrograde cholangiopancreatography demonstrated stricturing, disruption and complete blockage of the pancreatic duct. At laparotomy the mass in the head of the pancreas appeared malignant, it extended to the porta hepatitis and involved the superior mesenteric vein. Histopathology, however, revealed caseating granulomata and acid fast bacilli. Her immunosuppression was changed to azathioprine and prednisolone, she received a standard course of antituberculous therapy (isoniazid and rifampicin for 9 months with ethambutol for the first 2 months), and made a full and uneventful recovery, her renal function remains normal.

This is the first report of focal pancreatic TB in a renal allograft recipient. Despite extensive investigation because of her ethnic origin, there was no evidence of pretransplant TB. Nevertheless, we speculate that there was antecedent infection and that tubercle bacilli reached the pancreas by lymphohaematogenous dissemination. Immunosuppression presumably led to reactivation, but it remains unclear why the pancreas was the site of

tuberculoma formation. Previous isolated reports have suggested that pre-operative pancreatic imaging and laparotomy findings can be suggestive of a neoplastic lesion in focal pancreatic TB [5]. Similarly, tuberculous intestinal lesions in renal allograft recipients can mimic bowel tumours [7, 8], emphasising the importance of histological examination. In our patient, early diagnostic and antituberculous therapy led to a prompt and complete response, but in the presence of obstructive jaundice, biliary bypass may also be required [6]. In contrast, delayed diagnosis can be associated with miliary spread, failure to respond to therapy and a fatal outcome [2, 5].

References

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