lished material for preparing our manuscript, using the phrase “celiac disease AND India”. We did not manually search journals which are not indexed with Medline (Pubmed) nor did we search proceedings of conferences. This is possibly why we were unable to refer to two important articles.1,2 Amongst the articles published in indexed journals from Chandigarh, only two articles3,4 were published between 1971 and 1984, though a substantial number were published in the preceding years.

References

Image

CT appearance of primary localized nodular hepatic tuberculosis in an immunocompetent patient

Primary, macronodular and pseudotumor forms of hepatic tuberculosis are rare.

A 35-year-old man presented with fever since one month. He had hepatomegaly, raised SGOT, negative Mantoux test and negative Elisa for HIV.

Chest radiograph was unremarkable. US abdomen revealed hepatomegaly with multifocal, ill-defined, hypoechoic hepatic lesions along with portal lymphadenopathy. CECT abdomen revealed hepatomegaly with multiple nodular, hypodense, ring-enhancing hepatic lesions in discrete and cluster forms (Figure) adjacent to porta hepatitis. Subcapsular lesions with capsular thickening and perihilar fluid collection were also noted. Multiple, hypodense, ring-enhancing lymph nodes were noted at porta hepatis.

Liver biopsy revealed hepatic parenchyma diffusely infiltrated with mononuclear cells, areas of caseating necrosis with epithelioid cells and acid fast bacilli. The cultures for Mycobacterium tuberculosis were positive.

Tubercle bacilli reach the liver by hematogenous route: hepatic artery in miliary tuberculosis and portal vein in primary form. Serohepatic, parenchymal (commonest form) and cholangitic type are different forms of hepatic tuberculosis. Parenchymal type is subdivided into miliary, nodular and mixed tuberculosis.1,2 Caseating and non-caseating granulomas are most frequently seen in the periporal areas. When these granulomas coalesce, a tuberculoma results. A large tuberculoma with extensive necrosis forms tubercular abscess. Thus, coexistence of multiple, variably appearing lesions is seen on CT in hepatic tuberculosis. Presence of caseating portal lymph nodes potentiates the diagnosis.

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References

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