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PERITONEAL TUBERCULOSIS IN INFLIXIMAB USER AFTER NEGATIVE SCREENING FOR LATENT INFECTION BY M. TUBERCULOSIS

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BACKGROUND

Ankylosing Spondylitis (AS) is the most severe subtype of spondyloarthritis. The main symptoms of AS are joint pain and stiffness and loss of mobility of the spine, which can result in functional impairment and decrease in the patient's quality of life.

Although the primary treatment of patients with AS is with general drugs (NSAIDs, short-acting corticosteroids) associated with physical therapy, anti-TNF-α agents promote a significant improvement in the function and quality of life of patients with AS. However, they suppress the immune system, increasing susceptibility to infections, such as reactivation of latent tuberculosis (TB) or development of active TB (50% of extrapulmonary cases, 25% disseminated disease). Abdominal TB corresponds to 5% of TB cases, with ascites, abdominal pain and fever.

CASE REPORT

Male, 45 years old, inmate, reports pain and abdominal augmentation for 30 days. It accompanies dyspnoea, nausea, hyporexia and fever. Affected by Ankylosing Spondylitis, initially used NSAIDs, satisfactory response - stopping treatment without indication. Years later, he sought a Rheumatologist for progressive low back pain and hip pain (improvement in activity and worsening at rest). Sacroiliac MRI: bilateral sacroiliitis. After sulphasalazine + NSAID use, the patient denies improvement (primary failure); Infliximabe was chosen. Smoker and ex-alcoholist. Medication: Infliximab 460mg / day, Bupropion. Feverish, pale. No lymphadenopathy. AP: MV reduced in both bases, without RA. Abdomen globose, distended, RHA reduced, painless. Swelling in the lower limbs +/4+. No flapping. US abdomen: Liver discretely enlarged, regular contours, heterogeneous, microgranular. Moderate amount of free liquid. Requested examinations. Ascitic fluid: cloudy, GASA 1, 5,810 leukocytes (73% mononuclear), glucose 80, proteins 4,7. Negative acid-fast bacilli (AFB) research, PPD non-reactive, negative serologies. CT abdomen: suggestive carcinomatosis (Figure 1). Laparoscopy: implants and peritoneal adhesions. Peritoneal biopsy: chronic granulomatous inflammatory process with caseous necrosis. Presence of AFB in the sample (Figure 2). Worsening of renal function, no response to diuretic therapy - initiated hemodialysis + tuberculostatic treatment (RHZE).

CONCLUSION

The above patient presented clinical and criteria that corroborate peritoneal TB diagnosis: ascitic fluid (GASA <1.1, leukocytes 150-4,000, lymphocytic predominance, proteins and high ADA), CT showing ascites, lymph node enlargement, peritoneal thickening, M.tuberculosis in the peritoneal fluid and biopsy showing BAAR and caseous granulomas. As indicated in the literature, management was performed with antituberculous therapy in the face of clinical-laboratory findings of peritoneal TB.