

Fever of unknown origin due to primary tubercular splenic abscess in a low-income/middle-income country

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DESCRIPTION

A 49-year-old non-diabetic woman was admitted to our hospital with complaints of fever of unknown origin (FUO) of 2 months' duration. The patient has no recent history of exposure to tuberculosis (TB). Systemic examination revealed pallor and tender splenomegaly. Blood investigations revealed a microcytic hypochromic anaemia with haemoglobin of 7.5 g/dL, total leucocyte count of $12.7 \times 10^9/L$ and a raised erythrocyte sedimentation rate (ESR) (62 mm/hour). The rest of the FUO work-up, including blood cultures, serologies, chest radiograph, Mantoux and echocardiography, was unremarkable. Contrast-enhanced CT of the abdomen revealed multiple splenic abscesses (figure 1), from which a diagnostic and therapeutic single time aspiration was done. Around 10 mL of pus was aspirated which showed smear positivity for *Mycobacterium tuberculosis* (figure 2). The patient was subsequently started on four-drug antitubercular treatment. The fever subsided and repeat serial ultrasound imaging showed resolution of splenic abscess. Primary splenic TB in an immunocompetent patient is a rare entity but should be considered as a diagnostic possibility especially in a country where TB is endemic.

Splenic abscess has a very low incidence (0.1%–0.7% on autopsy) and tubercular splenic abscess is even rarer.¹ Usually spleen is involved in disseminated TB, and primary splenic TB is extremely uncommon with only few cases published in the literature.^{1–4} Splenic abscess is mostly seen in patients with underlying immunocompromised

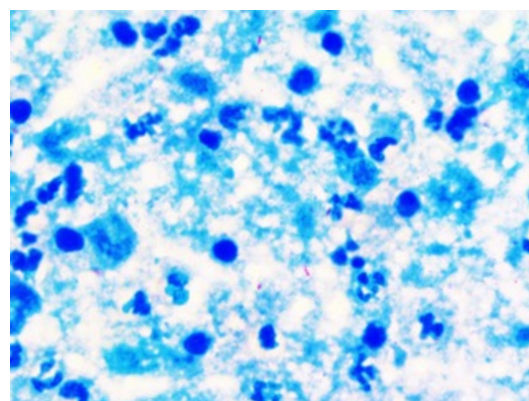


Figure 2 Smear from pus aspirated from splenic abscess showing degenerated neutrophils, macrophages in a background of necrosis and stained positive for acid-fast bacilli.

state, which includes diabetes, transplant recipients, intravenous drug abuse and retroactivity.¹ It is most commonly caused by Gram-negative organisms, with *Klebsiella* as the most commonly isolated organism.⁵ CT differentials of the splenic abscess include splenic lymphoma, metastasis, parasitic cyst, infarction, haemangioma, sarcoidosis and trauma. Differentiating tubercular from pyogenic splenic abscess on CT can sometimes be difficult; however, unilocular abscess, rim enhancement and gas formation within the lesion favour pyogenic abscess.⁶ Treatment consists of antitubercular therapy and spleen-saving surgery such as percutaneous single time aspiration.⁵ The above case is presented because of the rarity of occurrence of primary splenic TB and its successful management with single time splenic aspiration and antitubercular drugs.



Figure 1 CT scan of the abdomen showing multiple conglomerating hypodense lesions in the splenic parenchyma suggestive of abscesses.

Learning points

- ▶ Splenic tuberculosis should be considered in patients with fever of unknown origin and splenomegaly especially in our country where tuberculosis is endemic.
- ▶ Ultrasonography of the abdomen can be a useful and cost-effective mode to suspect this rare entity.

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