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Colovesical Fistula: A Rare Presentation of Colonic Tuberculosis

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Abstract

Colovesical fistula is a rare clinical condition encountered in gastroenterology practice. A 24-year male with 6 months history of fever, pain abdomen and weight loss, was on antitubercular treatment for 2 months. He developed fecaluria and on colonoscopic examination there was a fistulous communication between sigmoid colon and bladder. Squash cytology and biopsy results were consistent with tuberculosis. The patient developed the fistula while on antitubercular therapy.

KEYWORDS: Fecaluria, Enterovesical fistula

Introduction:

Colovesical fistula is the most common form of the enterovesical fistulae and occurs mostly due to diverticular disease (70-90 %), colorectal malignancy (20%) or Crohn's disease (10%). Infections like typhoid fever, amebiasis, syphilis, tuberculosis are rare causes of enterovesical fistula.¹ We report a case of colovesical fistula as a consequence of colonic tuberculosis that developed when the patient was on antitubercular therapy.

Case Report:

A twenty four year old male presented with history of fever, pain abdomen and loss of weight for 6 months. He was on antitubercular therapy for the last 2 months prescribed by the primary care physician. In spite of treatment, there was gradual deterioration in his clinical condition, and he developed severe pain abdomen for which he sought gastroenterology consultation. There was high fever associated with chills and rigor and pain in lower abdomen. His routine biochemical examination was normal except for a hemoglobin of 7gm% and high total leucocyte count of 13,500 cells/cmm with 90% neutrophils. Ultrasound of abdomen revealed bowel wall thickening and colonoscopy showed stricture with nodular mucosa at 35 cm above anal verge. Patient developed high fever, cachexia, and urine examination revealed pus cell >100/HPF in clumps, was of feculent odour and fecal material sedimented on standing. Repeat colonoscopy revealed stricture and ulceration at 35 cm from the anal verge and a fistulous opening between sigmoid colon and bladder. On squash cytology, there were scattered epithelioid histiocytes, lymphocytes and many polymorphs, clustered epithelioid cells good number of multinucleated foreign body giant cells and langhan's giant cells on a background of normal looking intestinal cells. No malignant cells were detected. On biopsy, there was focal aggregation of epithelioid cells and granulomas and histological appearance was suggestive of tubercular etiology (Fig-1). The patient was in a moribund state and was not fit for any kind of surgical intervention. The patient deteriorated rapidly with high fever and septicaemia and succumbed before any surgical intervention could be contemplated.

Discussion:

Colovesical fistula mainly arises from diverticular disease, malignancy and Crohn's colitis. It is less common in female, with a male-to-female ratio of 3:1, due to interposition of the uterus and adnexa between the bladder and the colon.¹ Diverticulitis is a common cause of colovesical fistula in the West, as tubercular infection is rarely seen.^{2,3} This patient with bowel symptoms presented with recurrent urinary tract infection and later on developed fecaluria. This clinical presentation along with the colonoscopic finding of a fistulous opening in sigmoid colon is suggestive of a colovesical fistula. Despite ongoing antitubercular therapy patient had developed the fistula. Although there are many reports of fistula-in-ano and enterocutaneous fistula of tubercular origin from India,⁴ there are only few reports on tubercular enterovesical fistula. Colonic tuberculosis presenting as Colovesical fistula is extremely rare.⁵

Conclusion:

Segmental colonic tuberculosis presenting as colovesical fistula is a rare clinical entity despite the fact that tuberculosis is the most prevalent infectious disease in our country. These patient may not respond to conservative therapy and may need surgical intervention at appropriate time to prevent complication and death.

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Figure Legends:

- A. Fecal sediments in urine**
- B. Colovesical Fistula**
- C. Langhans giant cell in squash cytology**
- D. Granuloma in colonic biopsy**

