formed by open or laparoscopic surgery (4-6). Follow-up is recommended for small asymptomatic cysts, up to 5 cm in diameter. In our patient, the cyst was very large and centrally located, and spleen parenchyma was thin, as it was almost completely occupied by the mass. We preferred a laparotomy, and splenectomy was performed.

In conclusion, we present a young adult case with a long-standing, huge, and asymptomatic congenital epidermoid cyst.

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Tuberculous peritonitis case at advanced age presenting with chylous ascites

İleri yaşta şilöz asit ile prezente olan tüberküloz peritonit olgusu

INTRODUCTION

Chylous ascites is defined as peritoneal fluid accumulation with milky appearance rich in triglycerides. It is detected in the abdominal cavity in association with thoracic or intestinal fluid accumulation. Our case was a tuberculous peritonitis case emerging suddenly at an advanced age and presenting with chylous ascites.

CASE REPORT

A 65-year-old male patient referred to our hospital with the complaint of progressive abdominal bloating increasing within the last month. He reported night sweating, weight loss, fatigue, and widespread abdominal pain.

Evaluation of laboratory parameters revealed mild anemia and also high C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR) levels. Of tumor markers, only Ca-125 was found to be high (500 U/ml). According to examination of the ascitic fluid, it was of chylous consistency, with a white cell count of 800/mm^3 (lymphocyte-dominant) - 386/mm^3), total protein 5.8 g/dl, albumin 2.5 g/dl, glucose 56 mg/dl (simultaneous blood glucose: 94 mg/dl), lactate dehydrogenase (LDH): 211 U/L, triglyceride: 1632 mg/dl, and adenosine deaminase (ADA): 38 IU/L. Serum-ascites albumin gradient (SAAG) was calculated to be 0.9. Test for acid-resistant bacilli (ARB), which were investigated twice in ascitic fluid, was negative, and in cytological examination, benign mesothelial cells were reported to be present.

In abdominal ultrasonography (USG), the liver was found to be of normal size with regular bor-

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ders and to have a simple cyst measuring 1 cm in subsegment 4A. There was widespread fluid in the abdominal cavity, and areas consistent with "omental caking" were detected in the omental area on the anterior wall of the peritoneal cavity. Portal Doppler investigation was normal. In abdominal computed tomography (CT), the liver was found to be normal and the size of the spleen was normal, but there were millimetric hypodense areas that were not well differentiated in the parenchyma. In the abdominal cavity, widespread fluid was present. In all fat planes, especially in the omentum major, the appearance was dirty, and in their vicinity, scattered nodularity with lymph nodes smaller than 1 cm were observed in paraaortic and aortocaval areas.

PPD was found to be anergic, and no active tuberculosis was considered by the Pulmonary Diseases Department. The General Surgery Department was consulted, and the patient underwent diagnostic laparoscopy. During operation, chylous ascites was observed, and 5000 cc was aspirated. In the right half of the parietal peritoneum, implants with miliary pattern, which were considered to be malignant, were present. Mesenteric miliary implants were observed. Biopsy was taken from the left lobe, anterior region of the liver and peritoneum. According to biopsy results, caseating granulomatous inflammation was present in the liver (Figure-1) and peritoneum (Figure-2) were reported to be present. Tuberculosis culture in ascitic fluid turned out to be positive at late period.

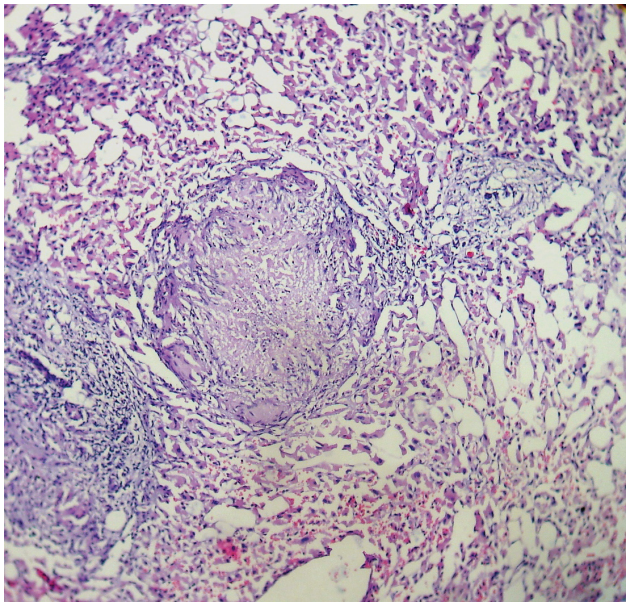

Figure 1. Caseating granulomatous inflammation in the liver.

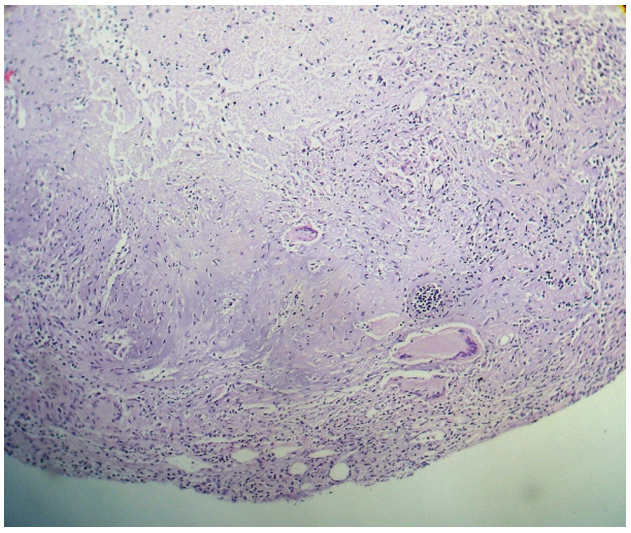

Figure 2. Caseating granulomatous inflammationi in the peritoneum.

DISCUSSION

The incidence of chylous ascites has been reported to be approximately 1/2000 (1). In its etiology, while in western countries abdominal malignancies and cirrhosis (around two-thirds) are preponderant, in developing countries, infectious etiologies (such as filariasis and tuberculosis) are more common (2).

Tuberculous peritonitis is a rare extrapulmonary tuberculosis diagnosis. In routine laboratory investigations, there may be no specific finding except for increased Ca-125 levels (3). Tuberculous peritonitis should be considered in all patients presenting with unexplained lymphocytic ascites with a SAAG of <1.1 g/dl (4). ADA activity of ascitic fluid has been proposed as a useful non-culture method of detecting tuberculous peritonitis. A meta-analysis of 12 prospective studies encompassing 264 patients found that ADA levels had high sensitivity (100%) and specificity (97%) using cut-off values from 36 to 40 IU/L; the optimal cut-off value was 39 IU/L (5).

Chylous ascites is a rare manifestation of tuberculosis. In the present case, malignancy was considered primarily due to the lack of tuberculosis history and the patient's advanced age and weight loss, but no malignancy was found in the investigations. In the ascites examination, typical chylous ascites findings were present, and although ARB was negative, ADA level was high, suggesting tuberculosis. Ascites tuberculosis culture results were obtained five weeks later.

In conclusion, in patients presenting with chylous ascites, tuberculosis should be considered given the conditions of our country, and especially in cases with ascitic fluid ADA level over 39 IU/L, antituberculosis treatment should be initiated in the early stages.

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