A 30 years old male with a history of intravenous drug user came with abdominal pain since 3 weeks before admission. During the last month he lost 10 kg of his body weight. He had mild fever and night sweat, without diarrhea or change in bowel habit. He had not complaint any cough. He looked pale and cachectic. Pulse rate was 100 times per minute and axilla temperature was 37.2 C. Abdominal examination revealed mild tenderness in epigastrium without organ enlargement. His bowel sound was normal. Laboratory findings were mild anemia (10.2 g/dL), low platelet count (120,000/dL), elevated ESR (45 mm/h), and elevated CRP (102 mg/dL). Liver transaminase was normal. His anti-HIV was reactive and anti-HCV was positive. CD4+ cell count was 45 cells/mL. Abdominal ultrasonography showed in figure 1.

Biopsy of the paraaortic lymph nodes were inconclusive. The patient then started standard antituberculous regimen followed by antiretrovirus four weeks after. The patient showed good response to antituberculous treatment within the first six weeks. Ultrasonography evaluation showed normal paraaortic lymph nodes.

Tuberculosis (TB) is the second commonest infection among human immunodeficiency virus (HIV) infected adults in Indonesia.1 Findings all possible opportunistic infections before starting HAART is one of the key success for HIV management. Extrapulmonary tuberculosis (EPTB) comprises 10-50% of all tuberculosis in HIV negative patients and about 35-80% in HIV infected patients.2,3 The risk of extrapulmonary tuberculosis and mycobacteremia increases with advancing immunosuppression.4

The diagnosis of extrapulmonary tuberculosis in HIV infected patients, especially in deeply located inaccessible area, is often difficult. In resource-limited settings, facilities for mycobacterial culture and histopathology are often unavailable. These facts make diagnosis of EPTB are often based on presumptive diagnosis.2,5
Wilson, et al had evaluated expanded case definition for smear negative pulmonary TB and EPTB in HIV infected patients from WHO and South African National Guidelines. The case definition for visceral lymphadenopathy is visceral nodes (mediastinal/hilar or abdominal nodes seen on imaging) PLUS fever >38C on two occasions OR drenching sweats for >2 weeks, with positive predictive value of 94%. This patient had abdominal nodes and drenching sweats for 4 weeks and had shown good improvement with antituberculous treatment.

This case shown that the use of expanded case definitions for the diagnosis of EPTB could be an effective strategy in HIV-infected adults.

REFERENCES