Tuberculosis can involve any part of the gastrointestinal tract and is the sixth most frequent site of extra-pulmonary involvement after lymphatic, genitourinary, bone and joint, miliary and meningeal TB. Both the incidence and severity of abdominal tuberculosis is expected to increase with the increasing incidence of HIV infection. Tuberculous bacteria reach the gastrointestinal tract via haematogenous spread, ingestion of infected sputum, or direct spread from infected contiguous lymph nodes and fallopian tubes. The gross pathology is characterized by transverse ulcers, fibrosis, thickening and strictures of the bowel wall, enlarged and matted mesenteric lymph nodes, omental thickening, and peritoneal tubercles. Peritoneal tuberculosis occurs in three forms: wet type with ascites, dry type with adhesions, and fibrotic type with omental thickening and loculated ascites.

The most common site of involvement of the gastrointestinal tuberculosis is the ileocaecal region. Ileocaecal and small bowel tuberculosis presents with a palpable mass in the right lower quadrant and/or complications of obstruction, perforation or malabsorption especially in the presence of stricture.

Rare clinical presentations include dysphagia, odynophagia and a mid-oesophageal ulcer due to oesophageal tuberculosis, dyspepsia and gastric outlet obstruction due to gastroduodenal tuberculosis, lower abdominal pain and haematochezia due to colonic tuberculosis, and annular rectal stricture and multiple perianal fistulae due to rectal and anal involvement. Chest X-rays show evidence of concomitant pulmonary lesions in less than 25 per cent of cases. Useful modalities for investigating a suspected case include small bowel barium meal, barium enema, ultrasonography, computed tomographic scan and colonoscopy. Ascitic fluid examination reveals straw coloured fluid with high protein, serum ascitic albumin gradient less than 1.1 g/dl, predominantly lymphocytic cells, and Adenosine Deaminase levels above 36 U/l. Laparoscopy is a very useful investigation in doubtful cases. Management
is with conventional anti-tubercular therapy for at least 6 months. The recommended surgical procedures today are conservative and the period of preoperative drug therapy is controversial.

**TAKE HOME POINTS**

1. Abdominal TB denotes involvement of GIT, peritoneum and/or draining lymph nodes.
2. Tubercular process can involve any organ in the abdominal cavity.
3. There is absence of extra abdominal lesions in the majority of patients.
4. A high index of clinical suspicion is necessary in any patient presenting with vague abdominal symptoms.
5. Radiological findings may be equivocal or merely contributory.
6. Most common site of involvement is ileo-caecal region.
7. A Histopathological confirmation is essential before making a firm diagnosis of tubercular abdomen.
8. Diagnostic laparotomy or laparoscopy necessary for histological/microbiological diagnosis in peritoneal lymph node TB.
9. Anti-tuberculous therapy forms the first line of management for patients with abdominal tuberculosis.
10. Therapeutic surgery essential for complications like int. obstruction, perforation, peritonitis.

**WHERE DOES THE WORLD STAND IN THE FIGHT AGAINST THE TUBERCULOSIS? 2015 UPDATE**

Globally, in the fight against tuberculosis (TB), the year 2015 marks as an important milestone, with the world, achieving the Millennium Development Goal (MDG) - 6 pertaining to TB (halting and reversing the trend of the disease), shifting from MDGs to the next era of Sustainable Development Goals (SDGs), and from the Stop TB Strategy to the End TB Strategy. The estimates released under the Global TB control 2015 report revealed that close to 9.6 million people were diagnosed with TB, of which 12% were HIV-positive. Since the year 1990, a remarkable reduction in TB associated mortality of close to 50% has been achieved, accounting for more than 40 million lives saved worldwide. Further, the 2015 targets pertaining to the reduction in the incidence, prevalence and mortality have been met in nine of the high-burden nations. In addition, the global TB incidence has reduced by more than 18% since the beginning of the 20th century. However, despite all the achievements and the availability of an effective diagnostic / therapeutic option through which nearly all cases can be cured, TB still remains as one of the biggest public health threat globally.

Nevertheless, 1.5 million individuals died from TB, including 0.4 million deaths among the TB-HIV co-infected in 2014, which is unacceptable as most of these deaths could have been easily prevented. The health sector is falling significantly short in closing the detection gap as only 62.5% of the patients suffering from TB were notified to the health agencies. Further, only 25.6% of the estimated multidrug-resistant TB patients were detected and reported which raises a serious question mark on the quality of care and the surveillance mechanism. Even in the incidence aspect, almost 9.6 million new TB cases have been diagnosed, which is much more than the estimates of the year 2013, when 9.2 million cases were diagnosed. In addition, significant gaps have been identified in the funding aspect to ensure sound implementation of the existing prevention & control interventions. Even though, a definitive improvement in the treatment initiation of multi drug resistant TB patients has been reported, nevertheless the global cure rate has been only 50%, which is a serious issue of public health concern. However, if the international stakeholders really want to accomplish the proposed targets under SDGs viz. minimize the TB deaths by 90% in comparison with the 2015 estimates, decrease incidence by 80% and to ensure that no household is burdened with enormous expenditure because of TB, a lot needs to be done. There is an enormous need to bridge the gap on both diagnostic and treatment initiation fronts. At the same time, quality research to facilitate the development of new diagnostics / drugs / vaccines, will bring rich dividends to the TB prevention & control activities. Most of the above gaps can be addressed, if there is a continuous monetary support towards the current strategies, so that primary health care can be strengthened. To conclude, even though the battle against tuberculosis is paying off in terms of reduction in incidence, prevalence and mortality, if the policy makers really want to end the epidemic of TB, an up scaling of the existing services and financial investment in the research arena is the need of the hour.