International Journal of Clinical Science and Medical Research
ISSN(print): 2770-5803, ISSN(online): 2770-582X
Volume 06 Issue 01 January 2026
DOI: https://doi.org/10.55677/IJCSMR/V6I1-05/2026, Impact Factor: 8.005
Page No : 20-22

Intestinal Tuberculosis Pseudo-Tumor Mimicking Crohn's Disease: A Case Report

M. Tahiri[1], F. Amkhaou[2], Z, Boukhal[3], Fz. El Rhaoussi[4], F. Haddad[5], W. Hliwa[6], A. Bellabeh[7], W. Badre[8]
[1-8]Hepato and Gastro-Enterology department, university hospital center Ibn Rochd, Casablanca, Morocco.

ABSTRACT

Intestinal tuberculosis is characterized by marked clinical and endoscopic polymorphism. In its pseudotumoral form, it may closely mimic ileocecal Crohn's disease or colonic malignancy. Establishing the diagnosis remains a major challenge for clinicians, particularly when immunosuppressive therapy is being considered or when surgical intervention is planned.

We report the case of a 50-year-old Moroccan female initially diagnosed with probable degenerated crohn's disease and referred for surgical intervention. The diagnosis was subsequently corrected to intestinal tuberculosis.

Differentiating intestinal tuberculosis from Crohn's disease is crucial, as immunosuppressive therapy may be beneficial in inflammatory bowel disease but potentially fatal in cases of misdiagnosed intestinal tuberculosis.

Published Online: January 13, 2026

KEYWORDS:

Intestinal tuberculosis, Crohn's disease, Colonoscopy; Polymerase chain reaction; HIV infection; Extrapulmonary tuberculosis.

INTRODUCTION

Intestinal tuberculosis is the sixth most common form of extrapulmonary tuberculosis [1]. It is characterised by clinical and endoscopic polymorphism, mimicking ileocecal Crohn's disease and colonic tumours in its pseudotumour form. Its diagnosis remains a real challenge for practitioners, but molecular biology could contribute to establishing the diagnosis and sparing patients from mutilating surgery and immunosuppressive treatments that can be lifethreatening.

In this article, we report the case of a patient initially referred for surgical treatment of complicated Crohn's disease, in whom the final diagnosis of intestinal tuberculosis was made.

OBSERVATION

The patient was a 50-year-old Moroccan woman with no comorbidities who had never been treated for tuberculosis and had not been exposed to tuberculosis recently. The diagnosis of Crohn's disease with probable degeneration was initially made in private practice, based on clinical findings of right-sided pain associated with chronic watery diarrhoea without rectal syndrome or subocclusive attacks, which had been progressing for two months in the context of general malaise and fever.

Laboratory tests revealed hypochromic microcytic anaemia at 11.7 g/dl, lymphopenia at 918, and elevated C-reactive protein at 244 mg/l without biological malabsorption syndrome or impact on the internal environment. Stool culture and parasitological examinations were negative.

The patient underwent an abdominal and pelvic CT scan, which revealed inflammatory gastric thickening, a 6 cm polypoid formation in the cecal fundus, and deep interaorticocaval and left latoaortic celiac mesenteric lymphadenopathy measuring 1 to 2 cm (Figure 2). An initial colonoscopy was performed in a private clinic, revealing a circumferential ulcerative process in the caecal fundus, encompassing the impassable ileocecal valve.

The histological study was consistent with subacute, chronic, progressive colic inflammation with the presence of epithelioid follicles and no evidence of tuberculoid granuloma or malignancy; the appearance is consistent with chronic inflammatory bowel disease such as Crohn's disease. The slides were re-examined in another pathology laboratory, which also concluded that the findings were consistent with Crohn's disease.

Corresponding Author: F. Amkhaou

Cite this Article: M. Tahiri, F. Amkhaou, Z, Boukhal, Fz. El Rhaoussi, F. Haddad, W. Hliwa6, A. Bellabeh, W. Badre (2026). Intestinal Tuberculosis Pseudo-Tumor Mimicking Crohn's Disease: A Case Report. International Journal of Clinical Science and Medical Research, 6(1), 20-22. https://doi.org/10.55677/IJCSMR/V6I1-05/2026

The patient was referred to us for further treatment. On admission, the clinical examination revealed a febrile patient with a temperature of 38°C and an altered mental state with a PS of 2. There was marked abdominal tenderness in the right iliac fossa. Examination of the lymph node areas was normal. The biological assessment was supplemented by HIV serology due to lymphopenia, which came back positive. Procalcitonin was elevated at 3.5 ng/ml and there was slight ASAT cytolysis at 79 IU/l. Tumour markers (CA19-9, ACE) were normal.

A colonoscopy was repeated, revealing an ulcerative mass in the lower caecum extending to the ileocecal valve, suggesting intestinal tuberculosis (Figure 2), with detection of the Koch's bacillus bacterial genome by PCR on histological samples. Fibroscopy revealed oesophageal candidiasis and antrofundic erythematous gastritis.

The tuberculosis test using GenXpert in sputum samples was positive.

The patient was transferred to the infectious diseases department for comprehensive care, with the initiation of antibacillary treatment in accordance with the 2RHZE/4RH ministerial protocol. The outcome was unfavourable, marked by the patient's death in the context of sepsis.

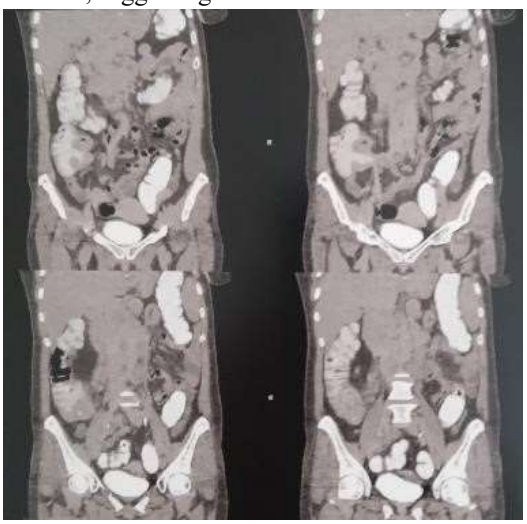

Figure 1: Abdominal and pelvic CT scan in coronal sections Polypoid formation extending over 6 cm in the cecal area, with deep coeliomesenteric, interaortocaval, and left lateroaortic lymphadenopathies measuring 1 to 2 cm.

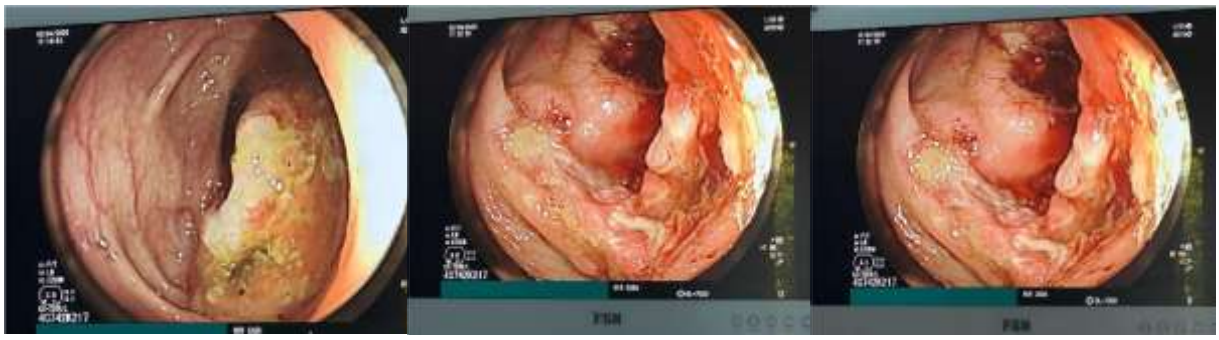

Figure 2: Ulcerated, polypoid mass extending from the cecal area to the ileocecal valve, suggestive of intestinal tuberculosis

DISCUSSION

Abdominal tuberculosis accounts for 5% of all tuberculosis cases (1), and colonic involvement is observed in 2 to 3% of patients (2).

The ileocecal region is commonly affected due to the high concentration of lymphoid aggregates in this area and possibly also due to prolonged contact between the bacilli and the mucosa (3).

The differential diagnosis of intestinal tuberculosis in its pseudotumour form is mainly with colonic cancer, but also with Crohn's disease in its ileocecal location and, more rarely, with amoeboma (4, 2, 5).

The symptoms and signs of intestinal tuberculosis are non-specific and can closely resemble those of Crohn's disease. A high degree of suspicion is necessary, otherwise the diagnosis may be missed or delayed, and the initiation of immunosuppressive therapy, which would normally be used in the management of Crohn's disease, would lead to increased morbidity and mortality in patients with intestinal tuberculosis.

Most patients with intestinal tuberculosis generally experience symptoms ranging from one month to one year (3). Pain is the most common symptom, observed in approximately 85% of patients, weight loss in 66%, fever in 35-50%, and diarrhoea in only 20% of patients (5). On physical examination, abdominal tenderness is found in most patients and an abdominal mass, usually in the right iliac fossa, in 25 to 50% of patients.

Colonoscopy with biopsies is the test of choice for diagnosing intestinal tuberculosis (6, 7). The endoscopic features of tuberculosis and Crohn's disease are very similar, as the inflammatory response of the mucosa is the same in both disease processes. It can present in different ways: circumferential infiltration, sometimes ulcerated, and nodularity, along with deformation of the caecum and ileocecal valve, strictures, the presence of multiple fibrous bands, and polypoid lesions (6).

Colonic lesions vary in type: ulcerative, stenotic, hypertrophic or diffuse (1). Certain endoscopic features may point to a tuberculous origin of the lesions: transverse ulcerations with regular contours surrounded by erythema and friable pink nodules; short strictures not exceeding 30 mm; and pseudotumoral masses, as in our case (3).

As mentioned above, one of the major advantages of endoscopic examination is the ability to perform biopsies, which should be taken from the margins of the ulcers. Biopsies should always be sent for culture and should also be sent for BK PCR.

Histological examination of biopsies may be negative due to the submucosal location of the caseating granuloma (8). They were not contributory in our observation.

The presence of giant cell epithelioid granulomas with caseous necrosis is suggestive (1). This caseous necrosis rules out the possibility of Crohn's disease. Granulomas are more frequently identified when biopsies are taken from the margins of ulcers than from nodular lesions (9). Nevertheless, granulomas with or without caseation are observed in less than 50% of cases of intestinal tuberculosis, and the diagnostic challenges are all the more complex as Crohn's disease can also present with non-caseating granulomas (10)

PCR testing has shown up to 95% specificity and 82.6% accuracy for the diagnosis of intestinal tuberculosis (3). Some studies have found no variation in the performance of PCR testing, regardless of whether histology shows granulomas and whether the granulomas show caseation. One of the advantages of using the PCR test is the speed with which the diagnosis can be made. In one study, a definitive diagnosis of tuberculosis was made using PCR within 24 hours.

Radiographic data are useful but non-specific. Abdominal computed tomography has a sensitivity of approximately 67% (11). It is an essential tool because it can show the location of the disease, the extent of the inflammatory process and the involvement of the intestine, mesentery, peritoneum, lymph nodes, solid organs and retroperitoneal disease. In one study, asymmetric thickening of the colonic wall and enlarged necrotic lymph nodes were strongly suggestive of intestinal tuberculosis (3).

Medical treatment is often effective, and rapid resolution of symptoms within 1 to 2 weeks is typical. Surgical treatment is not standardised. It is mainly indicated for diagnostic purposes or in complicated forms (massive haemorrhage, perforation, obstruction, fistula, abscess).(12)

CONCLUSION

The case presented highlights the importance of considering intestinal tuberculosis despite negative diagnostic tests, especially in an endemic country such as ours.

It is crucial to distinguish intestinal tuberculosis from Crohn's disease, as immunosuppressive treatment can be beneficial in inflammatory bowel diseases but potentially fatal if intestinal tuberculosis is misdiagnosed.Additionally, the psychological impact of an initial cancer diagnosis on patients and their families should not be underestimated.

REFERENCES

1. Sharma SK, Mohan A. Extrapulmonary tuberculosis. Indian J Med Res. 2004;120(4):316–353.
2. Tahiri M, Goh KL, Abbas Z, Epstein D, Min-Hu C, Mulder CJJ, et al. Digestive tract tuberculosis guideline. J Clin Gastroenterol. 2023;57(7):643–650. doi:10.1097/MCG.0000000000001819
3. Myers AL, Colombo J, Jackson MA, et al. Tuberculous colitis mimicking Crohn disease. J Pediatr Gastroenterol Nutr. 2007;45:607–610.
4. Foster BD, Buchberg B, Parekh NK, Mills S. Case of intestinal tuberculosis mimicking Crohn's disease. Am J Case Rep. 2012;13:58–61.
5. Almadi MA, Ghosh S, Aljebreen AM. Differentiating intestinal tuberculosis from Crohn's disease: a diagnostic challenge. Am J Gastroenterol. 2009;104:1003–1012.
6. Misra SP, Misra V, Dwivedi M, Gupta SC. Colonic tuberculosis: clinical features, endoscopic appearance and management. J Gastroenterol Hepatol. 1999;14:723–729.
7. Collado C, Stirnemann J, Ganne N, Trinchet JC, Cruaud P, Barrat C, et al. Gastrointestinal tuberculosis: 17 cases in northeastern Paris. Gastroenterol Clin Biol. 2005;29:419–424.
8. Collado C, Stirnemann J, Ganne N, et al. Gastrointestinal tuberculosis: 17 cases... [duplicate reference corrected in final manuscript].
9. Bhargava DK, Kushwaha AKS, Dasarathy S, et al. Endoscopic diagnosis of segmental colonic tuberculosis. Gastrointest Endosc. 1992;38:571–574.
10. Chatzicostas C, Koutroubakis IE, Tzardi M, et al. Colonic tuberculosis mimicking Crohn's disease: case report. BMC Gastroenterol. 2002;2:10–14.
11. World Gastroenterology Organisation. WGO Practice Guideline – Digestive Tract Tuberculosis. March 2021. Review Team chaired by Mohamed Tahiri
12. Horvath KD, Whelan RL. Intestinal tuberculosis: return of an old disease. Am J Gastroenterol. 1998;93(5):692–696.