Author's response to reviews

Title: Caecum perforation due to tuberculosis in a renal transplant recipient: a case report

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Responses to the concerns

Dear Editor,

When our patient had evaluated in our Chest Medicine Department 10 months before the cecal perforation, the test that Graham H Bothamley mentioned (blood culture, urinary antigen, tuberculin skin testing, chest X-ray, and chest computed tomography) had been performed but the results were negative. The nephrologists did not want to start an empiric therapy for a probable tuberculosis infection without any evidence for diagnosis. The patient recovered with ceftriaxone 2 g/ day therapy. An empiric therapy would be started at the Chest Medicine Department but we do not know why they did not. Tuberculosis infection could be masked due to recovery with ceftriaxone therapy and negative tests results. Furthermore, during the surgical exploration omentum and abdominal cavity was not reminding tuberculosis. The rectal ulcers were recovered with the anti tuberculosis therapy which is started after diagnosis. This article was corrected by a native English.

In this case report, we pointed that in renal transplanted patients sigmoid perforation is more common and diverticulitis is the reason for the perforation. Tuberculosis could be seen any part of the body and presented different symptoms. It has been known that tuberculosis places ileocecal area in individuals, but it is different in renal transplant receptent. Our case is rare accoding to the literature data. It is not easy to diagnose tuberculosis in immunosuppressive patients. Empirical treatment is usually started according to clinical findings and tests results without proving exact diagnosis. Histological diagnosis could not be achieved in most cases. We show the tuberculosis bacillar in histological evaluation. We present a renal transplant receptent of acute abdomen due to cecal perforation, we treated the case successfully and diagnosed tuberculosis definitely. This concept is rare in a case.