Sir,

There has been an increase in the global prevalence of tuberculosis (TB), with a rate of increase of approximately 1.1% per year.[1] Abdominal involvement occurs in about 11%–12% of patients with extrapulmonary TB.[2] Abdominal TB may affect practically any organ. However, gastrointestinal tract, omentum, and lymph nodes are the most commonly involved sites.[3] Splenic TB is rare and usually occurs in the setting of disseminated disease.[4] Isolated splenic involvement is rare. We present a rare case of isolated splenic TB that mimicked a mass.

A 62-year-old female was managed conservatively for moderately severe gallstone-induced acute pancreatitis 6 months back. There were no similar episodes. The past medical history was significant for well-controlled Type II diabetes mellitus. There were no other comorbidities. During her hospital stay of 2 weeks for the management of pancreatitis, she had transient acute lung injury and local complication in the form of acute necrotic fluid collection (ANC). No percutaneous or endoscopic drainage was done for the ANC. Computed tomography (CT) performed during the 2nd week of her illness showed ANC in the lesser sac. A well-defined hypodense lesion in the spleen was also reported. She was discharged from the hospital and was advised follow-up to evaluate the splenic lesion. This time, she reported with low-grade fever and vague pain in the left upper quadrant. A biphasic CT scan performed at the time of discharge showed a well-defined hypodense mass in the spleen measuring 5 cm × 4.5 cm [Figure 1a]. There was mild peripheral contrast enhancement in the arterial and venous phases. The splenic vessels showed normal contrast enhancement. The peripancreatic collection had resolved. She had mild anemia (hemoglobin – 8.8 g/dL) and elevated total leukocyte count (17,800/μL, neutrophil predominant – 86%). Other laboratory parameters were unremarkable. An initial possibility of abscess was considered. A course of antibiotics was given. Follow-up ultrasound showed no change in the size of lesion. A contrast-enhanced ultrasound (CEUS) was performed. There was thick peripheral arterial-phase enhancement that showed progressive washout on venous- and delayed-phase images [Figure 1b]. Based on CEUS, the possibility of a neoplastic lesion was considered and ultrasound-guided fine-needle aspiration (FNA) was performed.

Cytological evaluation revealed few ill-formed epithelioid cell granulomas and multinucleated giant cell [Figure 2]. Ziehl–Neelsen stain for acid-fast bacilli was positive [arrow, Figure 2a]. A diagnosis of isolated splenic TB was made and the patient was started on antitubercular treatment. At 1-month follow-up, the patient was afebrile.

Splenic TB is rare.[4] Clinically, it occurs either as a part of disseminated TB or an isolated process. The latter is rare and only few cases have been reported in literature. There are no characteristic symptoms and as for other extrapulmonary forms of TB, constitutional symptoms dominate. Radiologically, splenic TB presents in miliary form or macronodular form.[5] Miliary form is characterized by multiple small nodules that sometimes may not be discernable and lead only to splenomegaly.[5] The macronodular form on the other hand presents either as multiple large nodules or a single large nodule. Most of the times, these nodules may appear as abscesses on imaging. A single large nodule may mimic a mass as in the index case. Backer et al. described the features of splenic TB on magnetic resonance imaging.[6] They described peripheral contrast enhancement with centrally nonenhancing area as one of the typical manifestations in their study. The CEUS pattern of enhancement in our patients was similar. However, largely, the findings are nonspecific, and image-guided FNA and cytology play an important role in diagnosis.

**Figure 1:** Axial computed tomography image (a) shows a well-defined hypodense mass in spleen (arrow). Contrast-enhanced ultrasound image (b) shows thick peripheral enhancement (arrow) with a small nonenhancing central part

**Figure 2:** Cytological evaluation (a) reveals few ill-formed epithelioid cell granulomas and multinucleated giant cell (arrow). Ziehl–Neelsen stain (a, inset) for acid-fast bacilli was positive (short arrow)
Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest
There are no conflicts of interest.

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