

Clinically, a diagnosis of tuberculous ascites was made on the basis of the clinical findings and our previous experience with this problem. She was put on anti-tuberculous treatment, though it was a bit difficult to convince the patient and her relatives that operation was not immediately needed.

After a month she felt a reduction in the size of the hernia and after three months of treatment, the hernia disappeared and she felt a changed lady with much vigour. By now she has completed the treatment and the umbilicus harbours a lot of cotton fibres in it.

**Case - III. N. B.** Again a female, aged 19 years and having a 3 year old child was seen in May 1983 complaining of an umbilical hernia, gradually increasing in size over the last one year. She had occasional cough and low grade fever in the evening. She also felt her abdomen was getting bigger. She had irregular treatment for "glands in the neck" 6 - 7 years ago. She was pale. There was a healed sinus scar in Rt posterior triangle of neck, but no glands could be in the neck or axillae. The lungs were clear. She had an umbilical hernia which was reducible, protruding 5 cm. when tense. The neck of the hernia measured 2.5 cm. in diameter. The abdomen was soft, distended, with evidence of ascites. No mass was palpable. A plain X-Ray of the abdomen revealed the shadows of a few calcified glands. The X-Ray chest was clear. Her Hb was 11 G/dl., TLC 8600/cmm ESR 70 mm. in the 1st hour. The Mantoux test was positive.

She was put on antituberculous treatment, in view of her past history and physical and laboratory evidence suggestive of the commonly prevailing tuberculous infection in our country. She was advised against pregnancy. Her hernia has disappeared completely by now. There is no ascites and she feels quite healthy. Her ESR was 19 mm. in the first hour two weeks ago.

## DISCUSSION:

As is well known, a small umbilical hernia is present in many infants and often disappears in about 2 years<sup>1</sup>. Umbilical hernia is uncommon between the age of 3 - 14 years<sup>2</sup>. It may again occur in some multiparous women, especially coming from a poor socioeconomic class. This is due, most probably, to general stretching of the anterior abdominal wall and the creation of an umbilical gap. In these cases the umbilical hernia is usually thin walled and reducible. A paraumbilical hernia is also seen in very obese people mostly, but with difference that the hernia is firm, irregular in shape, and has thick walls. It is not easily reducible and often contains omentum.

Certain diseases, such as cirrhosis with ascites, cholelithiasis, gastroduodenal disease, cardiovascular diseases etc. have been noted to be coexistent<sup>3</sup> with ascites, but only cirrhosis with ascites may give rise to an umbilical hernia.

In our country (where tuberculosis is very common) if an adult patient presents with a thin walled umbilical hernia, the possibility of silent tuberculous ascites should be explored by a thorough history and physical examination. If present, the patient should be reassured and medical treatment persevered with. Even when there is reluctance, on the part of our mostly illiterate and poor patients and their relatives, to accept prolonged medical treatment for a protrusion at the umbilicus, the young surgeon should withhold his knife.

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## Tuberculous Ascites Presenting as Umbilical Hernia: A report of three cases

Haider Bokhari

Department of Surgery, Khyber Medical College, Peshawar.

### ABSTRACT:

Umbilical hernia is uncommon in adults and is usually associated with intra abdominal pathology. Tuberculous ascites should be excluded as a cause in this part of the world, before embarking on surgical repair. Three cases of umbilical hernia due to tuberculous ascites are described.

**Key Words:** Adult Umbilical Hernia — Tuberculous ascites.

### INTRODUCTION:

A true umbilical hernia is uncommon in adults, whilst paraumbilical hernia is commonly seen in surgical practice.

Adult umbilical hernia is usually associated with obesity in males and follows multiple pregnancies in females. In this paper an account is given of 3 cases of umbilical hernia in adults associated with Tuberculous ascites. One was diagnosed at operation and the other two diagnosed clinically and treated medically.

### PATIENTS AND METHODS:

The following three cases are reported:

**Case 1** M.B. A female aged 25 years, para 5, presented with an umbilical hernia in October 1978. She had

maintained good health and there was no history suggestive of any disease. On clinical examination, she was found to have a reduceable umbilical hernia, protruding out 8 cm when tense. It was felt to contain gut. Her Hb was 12.5G per d L, total leucocyte count 8,400 / cu.mm., with a differential of polymorphs 63% lymphocytes 33%, eosinophils 2% and monocytes 2%. Her ESR was 22mm in the first hour. X-Ray chest was normal. She was operated under general anaesthesia. On opening the sac, straw coloured fluid came out and there were tubercles on the inside of the sac and on the parietal and visceral peritoneum. Tubercles were found on the small gut. The hernia was repaired with silk using Mayo's technique. Histological examination of the sac showed multiple tubercles. She was treated with a combination of Streptomycin, INAH\*, and Ethambutol for three months followed by INAH and Ethambutol for 1 year. She had no postoperative complication and is quite well till now. (INAH\* — Isonicotinic acid hy-drazide)

**Case II - C.B.** A female aged 22 years having 3 children Presented in March 1979 with a gradually increasing umbilical swelling for six months, she insisted on having it removed as her general practitioner had advised. She had no other abdominal complaints. She admitted on repeated interrogation that she felt weak with some loss of appetite and tiredness at the end of the day for the last 6 - 7 months). She had a reducible umbilical hernia, which contained small gut and was 10cm in length when tense and the abdomen was slightly distended with evidence of a small amount of ascites.

Her Hb was 8.0 G/dL, the total leucocyte count (TLC), 9,300 / cu.mm., and the ESR 65mm in the first hour.

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Requests for reprints to Dr. Haider Bokhari Associate Professor of Surgery, Khyber Medical College, Peshawar.