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Letter to Editor

Differentiating Crohn’s Disease from Intestinal Tuberculosis: Where are we Right Now?

Sir,

I read with interest the article by Prabhu *et al*. in the recent issue of the Journal.[1] The article underscores the persistence of dilemma in differentiating Crohn’s disease (CD) and intestinal tuberculosis (ITB) due to several overlapping features.

If a patient with ITB is treated as CD (with immune-suppressive therapy), there is likelihood of worsening of disease with disastrous consequences; on the other hand, if patients with CD are treated with antituberculous therapy (ATT), they may have transient clinical response and hence appropriate treatment may be delayed. Hence, the need to differentiate the two diseases before the treatment is begun is emphasized.

There have been several efforts to distinguish these two diseases including clinical, endoscopic, and histologic findings[2] and the development of predictive models.[3] Despite this, dilemma between CD and ITB persists in a significant proportion of patients.

Unfortunately, symptoms, colonoscopy findings, and histology may not be able to differentiate between these two diseases in large proportion of patients. In Asia-Pacific consensus on CD, it was suggested that the patients in whom ITB and CD cannot be differentiated should be treated with ATT for 8–12 weeks and should be assessed with colonoscopy and repeat biopsies irrespective of clinical response. Endoscopic persistence of disease in such scenario is a predictor of CD as a likely diagnosis. These guidelines also discourage treating for CD and ITB simultaneously.[4]

In an elegantly designed study, where the data were prospectively validated, it was found that high proportion (38%) of patients eventually found to have CD were initially treated with ATT. Importantly, similar percentage of patients with CD may have clinical response with ATT. Therefore, the authors recommended a repeat colonoscopy with biopsy in patients with diagnostic dilemma after 2–3 months of ATT in case of no clinical response and after 6 months despite clinical response as endoscopic healing excluded CD and vice versa.[5]

In a tuberculosis-endemic region like India, initially treating with ATT is more likely to be a realistic and safer way to distinguish patients with diagnostic dilemma.

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Conflicts of interest

There are no conflicts of interest.

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