Tuberculosis genitourinaria fisiopatologia pdf

?? THE SPECIES grouped in the Mycobacterium TUBERCULOSIS complex are: M tuberculosis, M. africanum and M. bovis. In our environment, M. tuberculosis is a common etiological agent of urological diseases. It is a strict aerobic bacillus, which has as its characteristics acid-alcohol resistance, sensitive to sunlight, heat, ultraviolet light and some disinfectants, but resistant to drying. Mycobacterium tuberculosis reaches the genitourinary system hematogenically from the lungs. Once the first infection has occurred, in 90% of cases the immune response is triggered enough to prevent the development of clinical diseases; Bacilli remain dormant in small spotlights.1 Renal tuberculosis is the most common additional pulmonary disease and accounts for 15 to 20% of all non-majority cases.2.3In overall genitourinary tuberculosis is responsible for 14% of non-breast-cancer manifestations and 20% has been reported in white race.4In the Western world between 8% and 10% of patients with pulmonary tuberculosis. , and in underdeveloped countries, the proportion of people with mycobacteria tuberculosis in urine can reach from 15% to 20%.4-6 Bacillus is usually found in the cortic-medular region in the form of granuloma, and when a person is immunologically affected by bacillus is activated as a result of the spread in the bone marrow, causing papilloite.3 The disease progresses slowly and leads to extensive necrosis of the dry and can even form frank cavities with abscesses and cause the destruction of the renal parenchima. Typically, the form of presentation is one-sided, lesions can ulcers collecting tubes that cause baciluria. The effects of progress and fibrosis with scars, scars or partial atrophy of renal parenchem can occur, with hypertension being its main complication. All other genitourinary organs then suffer, either up or down. It may even cause stenosis of the urethropile compound. There are two mechanisms by which renal failure can be caused; first, an internal infection causing the destruction of endarteritis and the second mechanism of renal atrophy of secondary obstruction due to stenosis of the ure monitor or multiple stenosis infund'bulo.6 Symptoms and signs of genitourinary tuberculosis have variable intensity and duration.3 Patients usually refer to an increase and painless polaquiuria that does not respond to regular treatment with antibiotics. Other clinical manifestations: general, intermittent hematuria (10%), microgematuria (50%), jade colic (calcified fragment, clot, lithium), HTA (5% to 10%, and 25% in monorenes), asthenia, anorexia, weight loss, and feverish and toxic (rare) pyonephrosis.1.6 Ultrasound can reveal a catechal enlargement system and other obstruction data, with a sensitivity to the diagnosis of renal tuberculosis 58.9%. The findings can be classified into six types: 1. ectasia; 2. hydronephrosis; 3. Empyima; 4. atrophy and inflammation; 5. Calcification and 6. The combination above.7 Excremental urography has great diagnostic support, can detect several signs consisting of distortion of calixes, even calcification, stenosis of the ureter and bladder fibrosis.2 Differential diagnosis should be made with acute pyelonephritis for interstitial lesions, occupying abscesses masses, potassic diverticulosis in caves and cystic ureter in the ureter.5Meha medical treatment currently includes initiated with short antiphyrics. They are based on starting with four anti-phymiki for two months, using rifampicin, isoniazin, pirazine, and etambutol (or streptomycin) this pattern is accompanied by another four months using only rifampicin and isoniazid.2 ?? CLINICAL CASE A 30-year-old man, Catholic, married, working class, smoking and alcoholism denied. As an inherited history of importance, he said his father was being treated for pulmonary tuberculosis. Pathological personal history: appenotomy 15 years ago. He began his condition two years ago with terminal dysuria, polaquiuria, pujo and bladder tenemus, which they spontaneously call. Subsequently, an episode of general hematuria was added with amorphous clots and a sharp urine retention event. Since then, it has persisted intermittently, without improving the administration of antibiotics. There was no evidence of changes during the medical examination. Initial laboratory tests: haemoglobin 13.1 g/dL, hematocrit 39%, white blood cells 4.4 1000/l, neutrophils 61%, monocytes 13%, eosinophils 1%, platelets 321 thousand, glucose 128 mg/dL, L 24 mg/dL, creatine 1.4 mg/d. General urine analysis: brown, density 1025, pH 6.5, white blood cells 100 x field, proteins (yap.), hemoglobin (yap.), abundant bacteria. BAAR in urine: positive in five of the six samples. ELISA test for non-reactive HIV. Simple chest plate: Soft and bone parts are unchanged, no changes were seen in the rest of the study. A simple plaque of the abdominal cavity of soft and bone parts of the unalted, left renal silhouette increased in size compared to the lateral counter; The rest of the study: ok. Abdominal ultrasound: liver, gallbladder, spleen, normal pancreas, right kidney 10.9 cm by 4.3 cm morphology left kidney 11.2 cm by 5.3 cm with two simple renal cysts on the upper pole 2.7 cm and 2.5 cm respectively, as well as hydronephrosis. In excretion urography, an increase in the left renal silhouette was observed in a simple plaque; Left renal insulation was assessed with contrast; contralateral kidney intact (Figure 1). Image 1. Highlighting urography. In the use of contrast media, there is a left renal exclusion; counter-side kidneys unchanged (plates, Taken in five left and 90 der minute Computer tomography simple and contrasting abdominal cavity: The increase in left kidney size was seen with moderate exeasia, heterogeneous parenchemoma with calcification, not to concentrate or eliminate contrast (Figure 2). where the hematuria study protocol was completed. Anti-phymia (rifampicin, isoniazid, pyrzinamide) was introduced; subsequently, due to the advanced stage and degree of involvement of the left kidney, he underwent a left nephrectomy. As the findings of the surgery were described the kidneys increased in size 18 cm 10 centimeters, with the case material inside, a ureter with thickened walls in the upper third. The macroscopic histopathological result reported a left-wing nephrectomy product 22 cm by 12 cm by 5.5 cm, with a small amount of adipose tissue, multiple retractable scars, grayish tubular ureter, permeable light, trabeckulated mucous pelvis, cystic area of the upper pole. Microscopic results are noted: cuts with hematoxyline-eosine in the renal parenchem and pyelonic system of chronic inflammatory process of granulomatic case and areas of glomerular sclerosis and thyroidization of renal tubes, persisting in the surgical edges (urinary), necrosis and destruction of the urity. Conclusions: Chronic granulomatous pyelonephritis with fimic process, surgical edges with chronic granulomatous inflammatory process (Figure 3). Kidney secretion culture: positive for mycobacteria tuberculosis. Figure 3. Histological incision of the surgical piece showing chronic granulomatous schinonephrit with a fimic process.??? DISCUSSION renal tuberculosis, as mentioned above, is a rare person that can mimic many of the diseases that affect the urinary tract, because of this, it is a challenge for a urologist to diagnose this type of pathology in a timely manner to prevent kidney loss when diagnosis of timely conservative treatment is one of the choices. The case under discussion shows non-specific symptoms, but with images y microsc'picas cl'sicas de una tuberculosis renal anvanzad. Reporter: Dr. Juan Carlos Castro Duarte. Cerdizio de Urology. Avenida Fidel Velazquez and Abraham Lincoln, s/n, Monterrey, Nuevo Leon, Mexico City. Telefond: (81) 83714100 Ext. 41315. Correspondent ElectricO: juancarloscd@hotmail.com AMBRER DOWNLOAD THIS BOOKS INTO AVAILABLE FORMAT (2019 Update).....

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