Mycobacterial Diseases
ISSN: 2161-1068
OPEN ACCESS Freely available online
Opinion Article

Diagnosis and Types of Tuberculosis Pericarditis

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DESCRIPTION

Mycobacterium tuberculosis is a bacterium which causes Tuberculosis (TB). The microorganism usually attack the lungs, however TB microorganism can attack any part of the body like the kidney, spine, and brain. Not everybody infected with TB microorganism becomes sick. As a result, two TB-related conditions exist: Latent TB Infection (LTBI) and TB disease. If not treated properly, TB disease will be fatal. Tuberculosis pericarditis is an important complication of tuberculosis and the diagnosis can be difficult to establish and is frequently delayed, resulting in late complications. For example constrictive pericarditis occurs when a thickened fibrotic pericardium and the increased mortality. Diagnosis for this infection is limited.

Tuberculosis pericarditis, caused by *Mycobacterium tuberculosis*, is found in approximately 1% of all autopsied cases of TB and in 1%-2% of instance of pulmonary TB. It is the most common cause of pericarditis in Africa and different nations where TB remains a major public problem. Treatment consists of the standard 4 drug anti tuberculosis regimen for 6 months. Being infected with the TB bacterium is not the same as having tuberculosis disease.

Types of infection

They are two types of infection which don't produce a cough: Bone TB and Latent TB Infection (LTBI).

- Bone TB occurs only when you contract TB and it spreads outside of the lungs. TB is usually spread from one person to another person through the air. When you contract TB, it will pass through the blood from the lungs or through liquid body substance by nodes into the bones, spine, or joints.
- Latent TB happens when someone has the TB bacterium with in the body, however the bacterium are present in small numbers. As it is present in lesser range it controls the body's system and don't cause any symptoms.

Tuberculosis pericarditis can be classified into the following pathological stages.

Dry stage: Predominant protein exudation, blood disease and abundant mycobacteria.

Effusive stage: Lymphocytic exudates with serosanguineous effusion.

Absorptive stage: Absorption of effusion and organization of the tumor caseation pericardial thickening because of protein deposition and collagen formation.

Constrictive stage: Constrictive scarring of the fibrosing visceral and parietal pericardial calcifications with cardiac encasement and impairment of diastolic filling.

Diagnosis is taken into account for the detection of tubercle bacilli within the pericardial fluid or by the detection of caseating granulomas. Tubercular pericarditis is taken into consideration if there is a confirmation of pericarditis with TB elsewhere within the body, a Chronic Lymphocytic Leukemia (CLL) exudate with increased in Adenosine Deaminase (ADA) activity or good response to anti tuberculosis medical therapy.

CONCLUSION

In conclusion, tuberculosis cardiac involvement is constant and could lead to be heart failure, constrictive pericarditis, or death. It is needed to improve the diagnosis, assess the effectiveness of dependent steroids, and determine the impact of HIV infection on the outcome of tuberculosis pericarditis. Pharmacological treatment should be performed at least 6 months in all patients with tuberculosis pericarditis, regardless of pericardiectomy. There are some limitations in the diagnosis due to low bacteriological and histological results. The presence of positive polyclonal for HIV can modify the clinical presentation and the outcome of tuberculosis pericarditis.

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Received: 05-Apr-2022, Manuscript No. MDTL-22-17492; **Editor assigned:** 08-Apr-2022, PreQC No. MDTL-22-17492 (PQ); **Reviewed:** 22-Apr-2022, QC No. MDTL-22-17492; **Revised:** 29-Apr-2022, Manuscript No. MDTL-22-17492 (R); **Published:** 06-May-2022, DOI: 10.35248/2161-1068.22.S3.003

Citation: Tami A (2022) Diagnosis and Types of Tuberculosis Pericarditis. Mycobact Dis. S3:003.

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