

## Tuberculous pericarditis - diagnostic challenges

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**KEYWORDS:** tuberculous pericarditis, constriction, polymerase chain reaction test, adenosine deaminase test.

**CITATION:** Cardiol Croat. 2025;20(9-10):253. | <https://doi.org/10.15836/ccar2025.253>

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**Introduction:** Tuberculosis is uncommon in Croatia (~6/100,000), and tuberculous pericarditis (TBP) occurs in only ~1% of cases, making it exceptionally rare. By contrast, in endemic areas such as North Africa, TBP accounts for up to 90% of effusive pericarditis.<sup>1-3</sup> The rarity in low-incidence countries often delays diagnosis and increases complications and mortality. Establishing the diagnosis is particularly challenging because the clinical presentation is atypical and not accompanied by the usual indicators of active tuberculosis, as in our patient. In this context, echocardiography and computed tomography (CT) play a key role in raising the initial suspicion.

**Case report:** We report a 78-year-old patient admitted with pericardial effusion after three months of progressive fatigue and exertional dyspnea, without fever or chest pain. Past history included arterial hypertension. Multislice CT revealed pericardial thickening with fat stranding, mediastinal lymphadenopathy, calcified hilar nodes, and fibrotic lung changes. Echocardiography confirmed pericardial thickening with extensive deposits, mild effusion, and impaired filling. Pericardiocentesis yielded cloudy yellow fluid, exudative and lymphocytic (LDH per/ser 16.4; protein per/ser 0.8). The adenosine deaminase (ADA) test was markedly elevated (78.1 U/L), and polymerase chain reaction (PCR) test for *Mycobacterium tuberculosis* confirmed TBP. Standard anti-tuberculous therapy (isoniazid, rifampicin, pyrazinamide, ethambutol) was initiated. We decide to start with corticosteroids to reduce the risk of constriction despite unclear guidelines and the conflicting position in literature. Workup excluded active pulmonary disease, indicating reactivation of latent infection without obvious risk factors beyond advanced age.

**Conclusion:** TBP remains a rare but potentially underrecognized diagnosis in Croatia. Isolated forms can be subtle, with nonspecific symptoms and no overt pulmonary disease. Clinical suspicion is essential, particularly as immigration from high-incidence countries rises. Pericardiocentesis is the cornerstone of diagnosis, allowing rapid confirmation through ADA and PCR, while culture provides definitive proof. Early recognition and timely treatment are critical to prevent progression to constrictive pericarditis and improve patient outcomes.

RECEIVED:  
September 17, 2025

ACCEPTED:  
October 6, 2025



### LITERATURE

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