INTRODUCTION
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Intestinal tuberculosis is the commonest form of tuberculous lesions of abdominal organs. It has been recognized as a clinical entity for a long time and several detailed descriptions of the disease are met within the literature from India (Banerjee, 1920; Manon and Anguli, 1949) and other countries (Hoern et al., 1950; Taylor, 1943). However, following the reports of Crohn, Ginsberg and Oppenheimer in 1932, interest in the granulomatous lesions of intestine shifted from tuberculosis to Crohn's disease. Warren and Emmerson (1949) after examining 120 specimens came to the conclusion that "cicatrising enteritis" has absorbed all the cases of once so-called hypertrophic tuberculosis of intestine. Wig and Bahra (1953) and later Wig et al. (1954, 56, et al.) emphasized that in India tuberculosis of intestine is the commonest granulomatous lesion and Crohn's disease is quite rare.

Intestinal tuberculosis is usually a disease of adults with relatively high incidence between 15 and
40 years of age in India. The disease has an higher incidence in females (Mig et al., 1961, Tandon and Prakash, 1972). Though such a finding is not reported from west (Mitchell and Bristol, 1954). People of low and middle socio-economic status fall an easy prey to this type but there seems to be no significant difference in its prevalence in the rural and the urban population (Mig et al., 1961).

Tuberculosis of intestine in India is caused by human type of bacillus possibly of the low virulence. Gardner (1930) suggested that it is a direct contact infection by swallowed bacteria. The disease always begins in the lymphoid tissue of intestine and earlier lesions are seen on the summit of peyer's patches, and solitary lymph follicles. Thus a tiny tubercle is formed in submucosa. This may blow up to form a characteristic tuberculous ulcer giving form to the ulcerative type of intestinal tuberculosis or may heal with fibrous tissue leading to fibrotic type of tuberculosis. The lesion may induce a marked fibrotic and granulomatus reaction resulting in hyperplastic lesion or tuberculosis. This is the most common variety seen in India and its commonest site...
in nausea though the lower ileum and descending colon may also be involved.

The mucosal pattern of small intestine can not be seen without introduction of positive contrast medium usually barium sulphate. The bowel can be examined by barium meal follow through examination which is a conventional method or by a new technique double contrast small bowel barium enema.

The double contrast small bowel barium enema gives a better radiological account of disease pattern than the conventional study. It was discovered as a better diagnostic technique by Pesquera (1926). Since it was used by Gerben Cohen and Shay (1930), Schleskin (1943), Scott harden (1960), Pajewaski (1970), Nyst (1976), Herlinger (1978) and they all established its value in correct diagnosis of disease, thus eliminating the fallacies of conventional method.

Double contrast small bowel enema and conventional barium meal follow through examination have been carried out in 45 clinically diagnosed cases of small bowel tuberculosis. The duodenal intubation
has been done with alpaca 110 cm. long radio-opaque
ryle's tube through nasopharyngeal route. Contrast
and air have been used as contrast media and X-rays
have been taken in antero posterior and right anterior
oblique positions.

An attempt has been made to get better diagnosis
of small bowel tuberculosis by employing the double
contrast technique.

A radiological evaluation of conventional barium
meal follow through examination and double contrast
small bowel barium enema in small bowel tuberculosis has
been carried out. The efficacy, merits and de-merits and
practicability of both techniques in routine examination
of bowel have also been considered.