The patient was a male aged 37 and presented with the complaints of loose stools (3–4 times a day). Physical examination of the patient showed anorexia, fever, 1 week of mild pains in the abdomen and he confessed to be a long–time alcoholic. This patient had hypertension over the last 6 months and was previously diagnosed with pulmonary tuberculosis was treated with antituberculous drugs 6 months ago. As a result, he got leukopenia and liver dysfunction as a complication of his treatment. A patient under antitubercular chemotherapy was reported to have leukopenia in case he exhibits any of the following:(1) White blood cell (WBC) was lower than 3000/mm3 during the chemotherapy of the patients who had pretreatment of WBC over 4000/mm3 or (2) WBC was lower than 1000/mm3 during the chemotherapy of the patients who had pretreatment WBC of 3000 to 4000/mm3. When he was under antituberculous chemotherapy and pretreatment, his leukocyte count was less than 3000/cc3. Parenchymal liver dysfunction was also observed in the ultrasonography report and confirmed by liver function test (where the amount of gamma globulin was elevated and the amount of albumin was found to be lower than normal). Aspartate aminotransferase of the patient was more than 31 IU/l and alanine aminotransferase was more than 34 IU/l. The patient presented a freshly passed loose stool sample in the parasitology section, Department of Microbiology, JIPMER. The stool sample was fluid and had blood and mucus. Stool microscopy was carried out right after reception of the sample and it revealed the presence of motile trophozoites with a length of about 65 mm and width of about 30 mm together with cysts of different sizes, 15mm to 30 mm in diameter. The B. coli and cysts were determined to be the active ciliated trophozoites and cysts of Entamoeba coli respectively. The determination of the confirmation of the wet mount findings and the further visualization of the internal structures were done through trichrome staining (Wheatley modification to the fecal specimen) to the wet mount results. The treating team was notified instantly about the condition and was recommended to initiate the treatment and check his antitubercular treatment since the latter was the reason behind the patient being comparatively immunocompromised in addition to his alcoholic condition. Additional work up on the patient revealed no extraintestinal disease (peritoneal spread or other necrotizing lung infections), or any lesions of the genitourinary. The patient was put on metronidazole 750 mg thrice daily and the patient got better with time and took 5 days. After a period of 1 week, the patient gradually responded to therapy and his antitubercular therapy was also checked. He was released on condition of 5 days with recommendation of following up after 1 month and changing his life style.