EVALUATION OF ANTI-TUBERCULAR THERAPY IN GENITO-ABDOMINAL TUBERCULOSIS

by

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Tuberculosis has been known in our country since the time of Rig Veda (Rao, 1958) but it was in the middle of the 18th Century that tuberculous gynaecological manifestations first received attention when Morgani described the lesions of genital tuberculosis in women. The interest of gynaecologists in this subject was aroused after the accidental finding of tuberculous lesions in samples of endometrium obtained during routine investigations for sterility and menstrual disorders by Sutherland in 1943. Malkani and Rajani in 1959 reported that about 50% cases of genital tuberculosis are asymptomatic and the remaining 50% complained of symptoms such as sterility, scanty or profuse periods or amenorrhoea.

The incidence of genital tuberculosis as reported by different observers from different centres shows wide range of variation. The average incidence of genito-abdominal tuberculosis in Lucknow at Queen Mary's Hospital, was found to be approximately 14% of all gynaecological cases which is considerably higher than the 0.76% incidence reported from Madras amongst the general population by Bhasker Rao, 1968.

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The incidence of endometrial tuberculosis in cases of sterility also shows a wide range according to different authors. Sharman in 1944 reported an incidence of 5.2% of which 61.8% had blocked tubes. Halbreoht from Tel Aviv (1951) reported an incidence of 5.8%, Grant and Mackey from Sydney (1948) reported 0.14% and Shockaert and Ferin from Belgium (1945) 2%. Sutherland's figures from Glasgow (1943) for endometrial tuberculosis was only 1.1% while Malkani from Delhi in 1959 reported an incidence of 8.3%. In this hospital the incidence was found to be 7.1%.

The results of treatment too have been variously reported by different authors but all are now agreed that the sheet anchor of therapy comprises of different combinations of the standard antitubercular drugs. Streptomycin, P.A.S., Isoniazid. There is unfortunately no agreement about the exact dosage, duration of therapy and the best combination of drugs, but uninterrupted treatment from 9-12 months with any two conventional drugs. Streptomycin, P.A.S., and I.N.H. is recommended by most. This treatment has three main drawbacks, toxicity high cost of the drugs and repeated injections. Since 1964 another combination, that of Isoniazid with Thioacetazone has been available and found to be effective as reported by