TUBERCULOSIS VULVA

(A Case Report)

by

D. PARANJOTHY,* F.R.C.O.G., D.G.O., D.T.M.

and

S. X. CHARLES,** M.R.C.O.G., M.B.B.S., D.R.C.O.G.

Tuberculosis of the vulva is extremely rare. This case is reported because of its rarity and its occurrence in a postmenopausal patient.

Case Report

Mrs. A., aged 61 years, attended gynaecological outpatient at the Christian Medical College Hospital, Vellore, on 2nd December 1969 for pruritus vulva, dysuria and irregular fever of seven months duration. She attained menarche at the age of 13 and cycles were regular. Menopause was 5 years ago. She had been married for 30 years and had 6 term normal deliveries and 2 abortions. Past and family history non-contributory.

She was a thin frail woman, chest and abdominal examinations were normal; B P.: 110/70. Right inguinal lymph nodes were palpable, firm rubbery, mobile, discrete.

Vaginal examination revealed a leucoplakic patch with tendency for ulceration involving labia minora, majora, clitoris and fourchette. The ulcer was serpigenous, did not bleed on touch, was not necrotic and the edges were slightly raised. The base of the ulcer was covered by granulation tissue with no induration. There were fissures and a few depigmented patches in the leucoplakic area. The appearance of the lesion gave the impression of the patient having had radiation.

Vagina was narrow and admitted one finger only; the uterus was retroverted, atrophic and mobile; cervix healthy; adnexae negative; vagina healthy. No discharge present.

A provisional diagnosis of leucoplakia vulva was made and a biopsy was taken. Microscopic section showed ulceration with many tubercular giant-cell systems. The diagnosis was tuberculosis of vulva (Figs. 1 and 2).

Direct smear from the ulcer for AFB was negative. Urine showed pus cells and cultures of urine showed scanty growth of acid-fast bacilli morphologically not typical of M. Tuberculosis, resistant to Streptomycin, PAS and INAH.

PCV 39%; ESR 22 m.m. first hour, 50 m m. second hour, VDRL-negative. Pap-smear from the vaginal pool negative for malignant cells. An endometrial biopsy was taken, but no curettings were obtained. Biopsy of the right inguinal gland showed chronic lymphadenitis. X-ray chest showed an appearance suggestive of bronchiectasis with no definite evidence of tuberculosis. Sputum and fasting juice were negative for acid-fast bacilli. Mantoux test was negative.

IVP—Normal.

Blood Group B + ve.

Patient was advised antituberculous treatment. In spite of many reminders, the patient did not come for a follow up.

Discussion

Vulval tuberculosis is an extremely rare condition. It can present as an ul-

*Professor of Obstetrics and Gynaecology.

**Lecturer in Obstetrics and Gynaecology.

From the Department of Obstetrics and Gynaecology, Christian Medical College and Hospital, Vellore—South India.

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cerative or hypertrophic form, former is commoner. The usual sites are labia, clitoris, urinary meatus and posterior commissure.

The lesion usually starts as a small dusky nodule. These nodules break down to form multiple ulcers which show signs of healing in one part and activity in another area. Bases are irregular with punched out appearance and contain granulation tissue covered with discharge or caseous material. The margins are hard with no surrounding infiltration or fixity. In advanced cases, fistulous tracts can occur with neighbouring organs. In long standing cases, there is considerable thickening, fibrosis and scars of healed ulcers with persistent sinuses.

The presenting symptoms are pruritus, dysuria, purulent discharge which may be occasionally blood stained. Most cases have palpable inguinal lymph nodes Suppuration and ulceration of these can occur. Affected lymph nodes heal by fibrosis which can cause lymph obstruction resulting in massive lymph oedema of the mons and labia which may be mistaken for filariasis or Donovanosis. A persistant negative mantoux test can be diagnostic against tuberculous elephantiasis of vulva.

The diagnosis of tuberculosis of the vulva can be very difficult. It has to be distinguished from carcinoma and from chronic granulomatous conditions like Donovanosis, lymphogranuloma venerium or bilharziasis. Genital tuberculosis is invariably secondary to tuberculosis elsewhere, the usual primary site being the lungs. With rare exceptions, tuberculosis of the vulva is always secondary to disease higher up in the genital tract. The mode of spread from the primary focus is mostly haematogenous.

It has been accepted that antituberculous drugs like Streptomycin, INAH and PAS are the best and the treatment should be continued for 18 months. Many dermatologists are of the opinion that INAH is the drug of choice for dermal tuberculosis. When drug resistant organisms are found Viomycin, Ethambutol, Rifamycin are given. Indications for surgery in tuberculosis of the vulva are hypertrophic lesions which do not respond to treatment.

Conclusion

A case of Tuberculosis of vulva in a post-menopausal woman is presented.

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See Figs. on Art Paper I