TUBERCULOSIS OF THE VAGINA

(A Case Report)

by

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Tuberculosis of the vagina is rare though it may occasionally be encountered as a result of descending infection in advanced tuberculosis of the upper genital tract. In view of the infrequency of its occurrence and the clinical interest we wish to report this case.

CASE REPORT

Mrs. R.S.M. 26 years old Muslim female attended the gynaecology out patient department of J.J. Hospital, Bombay on 13-5-75 with the complaints of 2 months' amenorrhoae, excessive white discharge from vagina and painful coitus.

Menstrual History: Patient had attained menarche at the age of 14. Her menstrual cycles were regular with normal flow. Last menstrual period was 2 months back.

Obstetric History: Patient had one full term normal home delivery 4 years back. There was history suggestive of toxaemia during last pregnancy.

Family History: There was no history suggestive of tuberculosis in the family.

General Examination: Patient was moderately built. General condition was good. Pallor +, pulse 84/ per min. regular. B.P. 110/60 m.m. of Hg., afebrile. Respiratory, cardiovascular and abdominal examinations did not reveal anything abnormal.

On speculum examination upper 2/3rd of the anterior and posterior vagina showed granular haemorrhagic areas which bled on touch. Cervix was flushed with the vaginal vault and also showed granular haemorrhagic areas. There was unhealthy blood stained discharge from vagina (Fig. 1).

On bimanual vaginal examination cervix was felt irregular and firm. Uterus was anteverted, bulky, firm and its mobility was restricted. There was no mass felt in the fornix. With these findings provisional diagnosis of genital tuberculosis the patient was admitted in the hospital for investigations to exclude malignancy of the genital tract.

Investigations: Hb%—9.5 gms%, Total white cell count 10,800/per cmm. Differential leucocytic count showed 62% polymorph, 26% lymphocytes, 2% eosinophils and 10% monocytes. ESR was 24 m.m. 1st hour. Blood V.D. R.L. was negative. Urine examination showed nothing abnormal. Blood urea was 27 mg%. X-ray chest did not show any evidence of active or old tuberculosis lesion. Vaginal cytology showed inflammatory smear and there was no evidence of malignancy. Biopsy from anterior and posterior vaginal walls showed numerous tuberculous granulomas (Fig. 2). Cervix and endometrium also showed tuberculous lesions.

Antitubercular treatment was started, and patient was reviewed after 6 weeks. Vaginal lesion was healed well except a small raw area on left corner. Upper part of the vagina was stenosed and cervix was flushed with the vaginal vault (Fig. 3). Bimanual vaginal examination revealed uterus anterverted, bulky and with restricted mobility. Right tube and ovary was palpable but no tenderness.

Comments

The incidence of genital tuberculosis as reported by different observers from

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different centres shows wide range of variation. Earlier reports by Mitra and Sen Gupta (1952) and Bhaskar Rao (1952) showed incidence of less than 1% in gynaecological cases. Paranjothy (1971) and Ajwani (1975) reported 41.8% and 23.5% respectively. Though the incidence of genital tuberculosis is high, lesions of the vulva and vagina are rare. Lesions of the vulva, vagina and cervix were seen only in 7 out of 369 cases reported by Sutherland and Garrey (1957). Bhaskar Rao (1959) reported 2 cases of vaginal tuberculosis in his series of 116 cases. Out of 283 cases of genital tuberculosis reported by Kirloskar (1968) there were 2 cases of vaginal tuberculosis and recently Ajwani (1975) reported 3 cases of tuberculosis of vulva and vagina out of 586 cases of genital tuberculosis.

Primary tuberculosis of the cervix and vagina is extremely rare and is very difficult to prove without doubt unless the whole genital tract is histologically examined (Haines).

In primary tuberculosis the possibility of transmission of tuberculosis during coitus from the husband is suggested. It is generally agreed that although such an occurrence is extremely rare there is a definite possibility that primary tuberculosis of the cervix or vagina may develope in this manner. In this case, husband was examined for evidence of genitourinary tuberculosis; semen analysis and culture for A.F.B. was also done. There was no evidence of tuberculosis.

The importance of diagnosing the condition is evident. Vaginal tuberculosis clinically may appear like malignancy of the vagina as it was in this case. Biopsy only can differentiate the tuberculosis of the vagina from carcinoma of the vagina.

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See Figs. on Art Paper VII