TUBERCULOSIS OF VULVA

by

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Tuberculous infection of the vulva is least common of all sites of genital tuberculosis and is rarely found. This case has been reported because of rarity and unusual mode of infection.

CASE REPORT:

Mrs. G. aged 22 years was admitted on 22nd November, 1979 in J.L.N. Hospital, Ajmer with itching and ulceration on vulva for 1 year and amenorrhoea for 2 months.

Menstrual History: Age of menarche was 14 years, her menstrual cycles were regular with normal flow. Last menstrual period was 2 months back.

Personal and family history:

She was a nulliparous woman, married 5 years back. Her past history was not significant. She belonged to low socioeconomic group. Her husband was suffering from pulmonary tuberculosis for which he was taking treatment irregularly and now he had left her and was living with some other woman.

General examination: Patient was fairly built and poorly nourished, lean and thin, moderately anaemic.

Pulse 80/mt. regular B.P. 120/80 mm of Hg. Temperature was normal. Bilateral inguinal lymph nodes were palpable which were firm, discrete and not tender. Systemic examination revealed no abnormality.

Local examination:

Both labia majora and minora were slightly oedematous. Lower halves of both the labia minora were eroded, more so on the right side, and were replaced by a serpigenous ulcer extending upto the posterior commissure. The ulcer had clear cut edges and was covered with profuse purulent discharge (Fig. I). On Bimanual examination, the cervix was irregular and directed forward. The uterus was retroverted retroflexed normal size, firm mobile and fornices were free.

On speculum examination the vaginal wall was granular in appearance and covered with purulent blood stained discharge. The cervix was congested.

Investigations:

Hb 8 gm% TLC 12080/cu mm. Polys 62% Lymphos 38%. Erythrocytic sedimentation rate --80 mm 1st hour X-ray chest NAD V.D.R.L.— Negative.

Biopsy taken from the area revealed tubercular lesion Histopathology report showed squamous stratified epithelium and fibrous subcutaneous tissue alongwith tuberculous granuloma showing typical Langhan's giant cells (Fig. 2).

Discussion

Actual frequency of genital-tuberculosis in general population cannot be determined accurately. In many it is discovered accidentally and in large

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number of symptomless patients this disease remains undiscovered. It is also based on the pulmonary lesions, surgical specimens and endometrial biopsies (George Schaefer, 1970). The reported incidence of genital tuberculosis is 0.56% (Sutherland, 1951). The world-wide incidence of genital tuberculosis in sterile patients is about 5-10% and in India 19%. The first case of genital tuberculosis was recorded by Morgagni in 1761. It may occur at any age. In a series reported by Norris (1931) the youngest patient was of 7 months and the oldest of 85 years.

Tuberculosis of the vulva is a rare condition and it accounts for less than 2% of all the cases of genital tuberculosis (George Schaefer, 1980).

The mode of infection is often difficult to determine, the majority appear to be secondary to disease higher in the genital tract. In few cases it appears probable that the male sexual partner has transmitted the disease from the infected epidydimis, seminal vesicle (D. Paranjothy, 1974).

The lesion begins as a nodule which later ulcerates, the usual seat being the labia or the vestibular region. The characteristic appearance is that of an irregular, punched out granulomatous or even caseous appearance.

The microscopic diagnosis is based upon the demonstration of the characteristic tubercles with giant cells and epithelioid cells. The demonstration of A.F.B. in the smear, guinea-pig inocculation with the infected material and the use of montoux test may assist in establishing the diagnosis.

In the present case the husband's semen analysis could not be done as he was not available but the patient gave the history of pulmonary tuberculosis in her husband, taking treatment irregularly and it was possible that, he might be an open case of pulmonary tuberculosis or the genital tuberculosis which was affected secondarily. In details of the sexual history it was elicited that he was in the habit of using saliva for lubericating the vagina during the sexual act and by the direct implantation of the bacilli the disease was transmitted to the female genital tract. The fact is again strengthened by not finding out any other primary lesion in the patient.

The patient was discharged after the antitubercular treatment and advised to come for checkup after 3 months.

After 3 months there was no discharge, ulcer healed well the cervix was healthy with pinpoint os and she was having regular menstrual periods for the last 3 months. She was advised to continue the same treatment for 18 months and to come for quarterly checkup.

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See Figs. on Art Paper VI

THE FEDERATION OF OBSTETRIC AND GYNAECOLOGICAL SOCIETIES OF INDIA

The XXVIIth All India Obstetric & Gynaecological Congress will be held at Madras (T.N.), from 21st to 23rd December 1983 (both days inclusive) preceded by various sub committee meetings, Journal Committee Meeting, Managing Committee Meeting on 19-12-83 and the Annual General Body Meeting on 20-12-1983. The subjects for the discussion will be as follows:

1. Primary Health care in Obstetrics and Gynaecology
2. Teenage pregnancy and labour
3. Menopause
4. Miscellaneous papers.

Besides these there will be (1) FOGSI Rallis Oration (ii) FOGSI Oration and lectures by some other guest speakers.

The last date of the abstract of scientific papers to be presented at the said congress is 31-7-1983 and that of full text is 31-8-1983. The same should be sent in triplicate to the Hon. General Secretary, at the Federation office. The person presenting the scientific paper must be a member belonging to any member body affiliated to our Federation and should be a registered delegate at the time of Congress. They must specify especially the name of the Obstetric and Gynaecological Society of which the person is a member, while sending the synopsis and full text of paper. Please also mention the name of the person who will be presenting the paper. Each registered delegate will be allowed to present only one paper. Those members who have passed M.B.B.S. within 7 years and want to compete for the prizes for the official themes, should mention about the same while forwarding the papers.

The registration fees will be Rs. 250 including delegate fees of Rs. 100 and Rs. 150 as food charges.

Late fee of Rs. 50 in addition will be levied on all registrations between 1st November and 10th December 1983.

All registrations on or after 11th December 1983 will be considered as spot registration and over and above Rs. 250 the extra charge of Rs. 100 will be charged.

For further details about registration, accommodation etc., kindly write to Dr. K. Bhasker Rao, Organising Secretary, the XXVII All India Obstetric & Gynaecological Congress, Institute of Obstetrics & Gynaecology, Egmore, Madras-600 008.

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