

CERVICAL TUBERCULOSIS—THE CLINICAL PROFILE

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SUMMARY

The clinical profile of 40 women with cervical tuberculosis was evaluated. Endocervical tuberculosis was seen more frequently than ectocervical. The infertility and menstrual abnormalities were the predominating symptoms in endocervical tuberculosis. The possible etiological factors were discussed.

Introduction

Tuberculosis of female genital tract is an uncommon entity in the developed countries of the west, it is not so in the developing countries. It is diagnosed in about 8-12% of infertile women in India, (Malkani, 1966). However, tubercular affection of the cervix is very uncommon. Sutherland and Garrey found it in only 1.36% of their 369 cases. Here we are reviewing the clinical profile of 40 cases of tuberculosis of cervix diagnosed from our gynaecology out-patients clinic.

Material and Methods

Over the last 10 years (1977-1986) a total of 40 women were diagnosed as having tuberculosis of the cervix at the Dept. of Obstetrics and Gynaecology, All India Institute of Medical Sciences, New Delhi. The reproductive history, menstrual pattern and the presenting symptoms were retrospectively studied.

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Tuberculosis of the ectocervix was diagnosed by undirected cervical biopsy performed on patients with clinically suspicious cervixes. On the other hand tuberculosis of endocervix was detected from tissues obtained at curettage which included the endocervix in women in whom genital tuberculosis was suspected.

Results

Out of these 40 cases, 26 had endocervical tuberculosis, while 14 had tuberculosis of ectocervix. Of the 14 patients with tuberculosis of portiovaginalis 8 patients (57%) had a proliferative lesions with friable papillary projections and a hypertrophic cervix closely simulating cervical carcinoma. The other 6 patients (43%) had either an ordinary erosion or a shallow well demarcated ulcer.

Distribution of these cases according to age group is shown in Table 1. More than half the cases (62.5%) occurred in the age group of 20-29 years. There was no significant difference in the age distribution between patients with endocervical and ectocervical tuberculosis. The mean age at diagnosis for endocervical tuberculosis was 27.5 years while that

for ectocervical tuberculosis was 31.5 years. However, 10 patients (25%) were above 35 years of age.

TABLE I
Age and Parity Distribution of Patients With Cervical Tuberculosis

Age Groups (Yrs.)	T.B. Endo cx	T.B. Ecto cx
20-29	17	8
30-39	6	3
40-49	1	2
50-59	2	1

Parity	T.B. Endo cx	T.B. Ecto cx
0	16	6
1-2	7	4
3	3	4

There were 19 women out of the 40 (46.5%) who conceived before the diagnosis of tuberculosis of cervix was established. They had borne a total of 46 children, 5 had spontaneous abortion and one ectopic pregnancy. Although patients with endocervical tuberculosis constituted only 35% of the total, 25 out of the 46 pregnancies (54.4%) occurred in the group of 14 women.

Distribution according to parity is shown in Table I. Only 6 patients with tubercular ectocervicitis were nulliparous while 4 of them had borne 3 or more viable babies. Sterility was a problem in 8 patients with tubercular ectocervicitis (57%) while it was the complaint in 19 patients with endocervical tuberculosis (73%).

Foul smelling vaginal discharge was the presenting complaint in 6 of these women. Of these 5 had tuberculosis of ectocervix while only one had tubercular endocervicitis.

The presenting menstrual complaint of these patients are shown in Table II.

Amenorrhoea of more than 6 months duration or oligomenorrhoea was present in 22 patients with tubercular endocervicitis while it was seen in only 6 patients with tuberculosis of portiovaginalis. Conversely irregular bleeding and post-coital bleeding was a complaint in 5 patients with tubercular ectocervicitis whereas only 2 cases of tubercular endocervicitis had the same complaint. Interestingly, only 4 of these 40 women had normal menstrual periods and all of them belonged to the ectocervical group.

Seventeen out of the 26 cases with endocervical tuberculosis also had evidence of endometrial tuberculosis.

TABLE II
Presenting Symptoms in Cervical Tuberculosis

	T.B. Ecto Cx	T.B. End Cx
Amenorrhoea	6	17
Primary	0	3
Secondary	6	14
Oligomenorrhoea	0	5
Irregular bleeding	3	1
Post coital bleeding	2	1
Post menopausal bleeding	2	2
Normal Periods	4	0

All but two patients were treated medically with conventional antitubercular 3 drug combination therapy for 18 months. Two women underwent abdominal hysterectomy, one case of tubercular ectocervicitis for associated fibroid and the other patient with tuberculosis of the endocervix and endometritis, for endometrial stromal sarcoma. Sixty per cent of the patients have not reported back for follow-up while the rest are clinically and histologically disease free.

Discussion

Tubercular lesions of the cervix are among the least common manifestations

of genital tuberculosis. Ectocervical tuberculosis frequently simulate carcinoma (Coleman 1969). Diagnosis is usually unsuspected till a histological report of a cervical biopsy performed to confirm the clinical diagnosis of malignancy or an endocervical curettage done in the course of investigation for infertility and amenorrhoea is obtained. Histological diagnosis requires, as in other organs, the finding of Langhan type giant cells and surrounding epithelioid cells forming tubercles or the detection of Acid-fast bacilli (AFB) by special staining techniques.

Snaeffler in 1970 reviewed 7000 cases of gynaecological tuberculosis and found fertility rate of approximately 5%. In the present series the 14 women with ectocervical tuberculosis had already borne a total of 26 viable babies. Thus the fertility rate does not seem to be grossly affected in these woman, unlike tuberculosis of other parts of genital tract. Muehler and Minkowety (1971) in their review inferred that infertility was not invariably associated with genital tuberculosis particularly in older patients. Infertility was the sole reason for presentation in 73% of our patients with endocervical tuberculosis while it was a problem in a little more than half of the women with ectocervical tuberculosis. Amenorrhoea or oligomenorrhoea was present in majority (84.5%) of cases with endocervical tuberculosis. Interestingly, amenorrhoea or oligomenorrhoea was present in less than half of the cases (43%) with ectocervical lesion. The mean age at diagnosis for ectocervical tuberculosis (31.5 yrs) was slightly higher than that for tuberculosis of endocervix (27.5 yrs). It can be explained by the more frequent association of endocervical lesion with infertility and amenorrhoea

which derives these women to present earlier for investigations.

In the present series 25% of women were more than 35 years of age which supports Hutchin's observation that genital tuberculosis affected an older group of patients than described earlier especially since 4 of our patients were postmenopausal. All of these post menopausal women presented with postmenopausal bleeding, thus making cervical tuberculosis an important differential diagnosis in this condition.

Kirloskar *et al* (1968) reviewed 28 cases of tuberculosis of cervix and found persistent leukorrhoea as the most common presenting symptom. However, vaginal discharge was the presenting complaint in only 6 patients in the present review.

It appears from the clinical profile of patients with endocervical tuberculosis that these lesions are a result of direct spread by continuity of endometrial involvement with tuberculosis. On the other hand, basing on the fact that sterility and amenorrhoea are relatively uncommon in exocervical lesions and they have fairly good past obstetrics records, it can be argued that etiologically ectocervical tuberculosis may be a distinct entity and the possibility of an external source of infection for the exposed cervix cannot be ruled out.

References

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