UNUSUAL PRESENTATIONS OF TUBERCULOSIS IN THE FEMALE GENITAL TRACT

By

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Three interesting and unusual cases of TB in the female genital tract are presented here.

The first case is one of TB Vaginitis. TB of the vagina is rare and the mode of infection is often difficult to determine. The majority of cases appear to be secondary to disease higher in the genital tract. In a few cases it appears probable that the male sexual partner has transmitted the infection from infected epididymis or seminal vesicles.

CASE REPORTS

Case 1

A 26 year old patient attended the gynaec. OPD with the c/o 2 months amenorrhoea, excessive vaginal discharge and painful coitus. Her last menstrual period was 2 months back with the previous cycles being regular with normal flow. The patient had a full term normal delivery 4 years ago. There was no past history nor family history suggestive of TB. Nothing abnormal was detected on general and systemic examinations of the patient. On speculum examination the upper 2/3rds of the anterior and posterior vaginal wall showed haemorrhagic granular areas which bled on touch. The cervix which was flushed with the vaginal vault, also revealed haemorrhagic granular areas.

On bimanual examination, the cervix felt irregular and firm. The uterus was firm and bulky with restricted mobility. There was no mass palpable in the fornices. The patient was hospitalised with provisional diagnosis of malignancy or venereal warts of the lower genital tract.

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The routine laboratory investigations were within normal limits except for a raised ESR and lymphocytosis. There was no evidence of TB lesions in the chest on X-ray. Vaginal cytology showed an inflammatory smear without any evidence of malignancy. Biopsy from the anterior and the posterior vaginal walls showed numerous TB granulomas, underlying the vaginal epithelium. The cervix and the endometrium also showed TB lesions. The vaginal lesions had subsided when the patient was reviewed after 6 weeks of antitubercular treatment. However the upper part of the vagina was stenosed and the cervix was flushed with the vagina vault. There was no evidence of genito-urinary TB in the husband both on clinical examination and laboratory investigation (urine and semen culture for AFB).

TB vaginalis is a rare entity and in this case it is evident that the vagina was involved as a result of descending infection. In this patient TB of the vagina simulded malignancy or venereal disease and the diagnosis was clenched by histopathology.

Case 2

The case is that of TB endometritis the patient presented with post-menopausal bleeding. Diagnosis is usually made during the child-bearing age when the patient is being investigated for infertility. The incidence of TB endometritis in post-menopausal bleeding is 2%.

A 45 year old menopausal lady was admitted to the hospital with the C/O something coming out per vaginum since many years and post-menopausal bleeding for the last 10 days. The patient was menopausal since 5 years with her previous cycles being normal. The patient was a widow and had a full-term normal delivery and one abortion many years ago.

Nothing abnormal was detected on general and systemic examinations. On speculum examina-

tion there was second degree prolapse and there was bleeding through the OS. A cystocele and rectocele were present with a dificient perineum. On bimanual examination the uterus was retroverted normal in size and freely mobile.

A diagnosis of prolapse with post-menopausal bleeding was made. Excepting for lymphocytosis and a raised ESR, the routine laboratory and radiological investigations were normal. Malignancy is the commonest cause of post-menopausal bleeding. We suspected Carcinoma of the endometrium in this patient and hence she was subjected to an examination under anaesthesia and fractional curretage. Surprisingly the histopathological report of the curetings revealed TB endometritis. There was no evidence of TB foci elsewhere the body. The patient was started on anti-tubercular treatment and surgical treatment for the prolapse was postponed.

Case 3

The case was an unusual type of involvement of TB of the genital tract—a case of TB Oophoritis. Since there was no evidence of involvement of the fallopian tube the same side nor were there TB foci elsewhere in genital tract or body, the affliction of this organ was probably by the blood stream. Ovarian involvement by Tuberculosis is often bilateral and is by direct extension from an infected tube. Lymphotic or blood stream spread is less frequent. Tuberculosis may be demonstrable in the ovary in 2 forms. In one there is surface infection consisting of granulations containing TB foci. As a rule these are confined to the outer part of the cortex of the ovary. The lesion may be microscopic, a Caseous nodule or an abscess. Occasionally there is a progressive accumulation of liquefied Caseous material and a fibrous walled cyst results, resembling a dermoid cyst macroscopically, as was seen in our case.

An 18 year old patient came to the hospital with the c/o profuse frequent periods since the last 2 years. She was bleeding profusely every 15 days for 3-5 days. The patient had been married for 10 months and had primary sterility. There was no history of TB in the past nor in her family. General examination did not show any abnormality and the chest was clear.

On abdominal examination a firm mass was felt arising from the pelvis, 14-16 weeks size. The surface of the mass was smooth, it was non-tender with restricted mobility. There was no evidence of free fluid in the peritoneal cavity. On speculum examination the cervix and vagina were healthy. Bimanual examination revealed that the mass was felt more in the anterior and left fornix. The uterus was felt separately from the mass while the other fornices were clear. A tentative diagnosis of an ovarian cyst was made. All the routine investigations were within normal limits except for the raised ESR and different WBC Count. The impression on USG scanning was that of an ovarian cyst. On Laparotomy there was a tumour on the left side measuring 4″ x 4″ in diameter, which was adherent to the Omentum, uterus and bowel [illegible] uterus, tubes and the ovary on the other side appeared normal with no tubercles on their surfaces.

The impression on histopathological examination of the specimen was simple serous cyst with TB granulomas. There was no evidence of TB on histopathological examination of the fallopian tube and the curetting from the uterus, or from the other ovarian biopsy. The post-operative period was uneventful and the patient was started on Anti-Koch's therapy after the histopathological diagnosis of TB Oophoritis.

Taking into consideration the age and clinical presentation of the patient, our provisional diagnosis was that of dermoid cyst of the ovary. Our diagnosis was further substantiated by the thick yellowish cheesy material obtained on bisecting the tumour. However there were no ectodermal element present in the cyst. Despite absence of TB foci elsewhere in the body or the genital tract the histopathological diagnosis of the cyst was ovarian tuberculosis.

In conclusion in developing countries like ours Tuberculosis still remains one of the most prevalent infectious diseases and there should be an awareness in gynaecologist of possible involvement of the genital tract by Mycobacterium TB, in cases of unexplained infertility, amenorrhoea or chronic pelvic pain.

As genital tubeculosis may simulate other lesions especially malignancy, the diagnosis can only be clinched by histopathology.

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