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CASE REPORT

Vulval Tuberculosis

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Introduction

Tuberculosis of vulva and vagina is very rare and it is seen in only 1–2% of genital tract TB [1]. Tuberculosis more frequently affects upper genital tract, mainly fallopian tubes and endometrium. It usually occurs in women of child bearing age.

Case Report

A 22 year old married female presented to the OPD on May 6th 2008 with complaints of ulcerative lesion of vulva since 8–9 months and difficulty in walking. Ulcerative lesion progressively increased in size and was painful. She had history of weight loss and decreased appetite since 1 year. Her menstrual cycles were regular. She was PI LI with 1 full term normal delivery 8 months back at home. Baby was alive and healthy. There was no history suggestive of tuberculosis in past or in the family.

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On examination she was lean and thin, poorly built and nourished. Her weight was 38 kg, height 5 ft. Local examination of vulva revealed ulcerative lesion of left labia majora, left labia minora was eaten up. Right labia majora, right labia minora and clitoris had nodular lesions. There were no palpable inguinal and supraclavicular lymphnodes. Routine investigations and X-ray chest were normal (Fig. 1).

Montoux test was positive 35 × 25 mm, ESR 60 mm. HIV and VDRL of husband and wife were negative. After routine investigations examination under anaesthesia was done. Cervix vagina and uterus were found to be normal. Punch biopsy was taken from ulcerative and nodular lesion and sent for histopathology. Microscopy showed granuloma comprising of cluster of epitheloid cells with Langhans type giant cells (Fig. 2), suggestive of tuberculosis. Patient was started on AKT. 1 month after the treatment, patient had drastic improvement in symptoms and the local lesions regressed by 50 %. 4 months after the treatment normal anatomy of vulva was restored. AKT was continued for 9 months.

Discussion

Tuberculosis is one of the oldest diseases known to affect humans. Of all forms of tuberculosis of female genital tract, lesions of vulva are the least frequent [2]. Female genital TB is a rare disease in some developed countries,

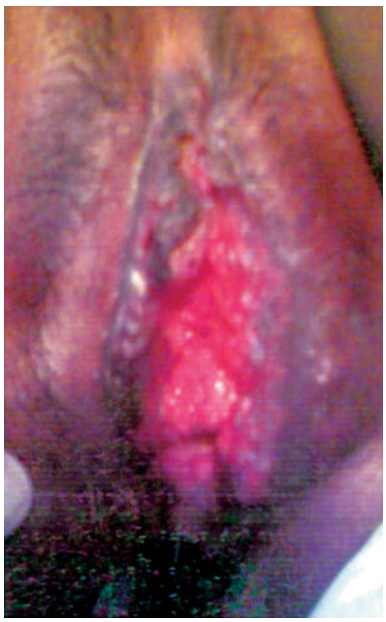

Fig. 1 Ulcerative lesion of vulva

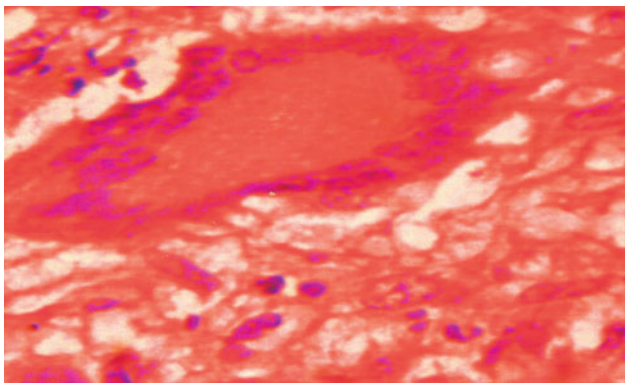

Fig. 2 Granulomatous inflammation on histopathology

but it is a frequent cause of chronic PID and infertility in other parts of world [1]. Women with menstrual abnormality and infertility are almost always evaluated for possible tubercular etiology. Otherwise in gynaecological practice this etiology is rarely thought of [3]. Pelvic organs are infected by hematogenous spread from a primary focus, usually the chest. Vulval tuberculosis is also usually secondary, however several authors have reported cases with venereal transmission of genital tuberculosis. The majority of the male partners having tubercular epididymo-orchitis [1].

The presentation can be quite variable and a vulvul tubercular ulcer may be misdiagnosed as sexually transmitted disease like syphilis or chancroid. High index of suspicion coupled with a thorough histological review will usually give the correct answer. Without the latter, the patient may be undertreated as chronic infection overtreated as vulval malignancy. Radical surgery in such a case will lead to a non healing wound. The optimum duration of treatment of vulval tuberculosis is not known. Most will follow the treatment-duration of non pulmonary tuberculosis 6–9 months [2]. In brief tuberculosis should always be kept in mind whenever a young patient comes with ulcerative lesions of vulva.

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