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FEMALE GENITAL TUBERCULOSIS: ABERRANT PRESENTATION OF TUBERCULOSIS IN INDIA

Dermatology

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ABSTRACT

Genital tuberculosis is the second most common extra pulmonary manifestation of tuberculosis. It results from primary reactivation of latent bacilli by secondary spread from the already infected organ. Tuberculosis, disease per say is characterized by tissue destruction and fibrosis, thus an early diagnosis may prevent function and organ loss. The gold standard for diagnosis is the isolation and culture of mycobacterium tuberculosis bacilli. Almost all body fluid specimens from accessible sites of infection and aspirates from nodules ought to be examined. Radiologic investigations such as ultrasonography and contrast enhanced imaging help in arriving at the diagnosis. Anti-tubercular treatment is the first line of management for all types of genital Tb and a 6 months course is the gold standard of care. Infertility resulting from the tubercular involvement of the genitalia is polygenic in origin and may persist even after successful chemotherapy. Therefore, assisted reproduction is usually recommended. Post treatment, regular annual follow up is suggested even though, with the current multi drug therapy, the chances of relapse are very low.

KEYWORDS

Genital tuberculosis, Extra pulmonary, Endometrial biopsy, Anti tuberculous treatment

INTRODUCTION:

Tuberculosis (TB) is caused by Mycobacterium tuberculosis. It remains a public health concern especially in developing countries. Pulmonary infection is generally the main presentation. Extrapulmonary TB is not uncommon especially with the increase in human immunodeficiency virus (HIV) infection. Genitourinary TB is one of the common forms of extrapulmonary tuberculosis, which affects 12% of patients with pulmonary TB. It is more common in women less than 40 years of age and rarely occurs in postmenopausal[1]. We report a case of atypical genitourinary:

Case Report:

A 24-year-old unmarried lady presented with persistent left flank pain and discharge per vagina which lasted for about 1month. There was no history of any foul smell/ blood staining in discharge.There was no history of evening rise of temperature, no history of loss of appetite, no history of weight loss. The physical examination, along with the per abdomen examination did not reveal any findings. Saline wet mount of vaginal discharge turned out be negative for bacterial vaginosis and trichomoniasis. The patient tested negative for both VDRL and HIV. The chest x-ray film did not show signs of tuberculosis. Ultrasound of the pelvis revealed mild amount of fluid in the endometrial cavity. The Mantoux test result was positive. An endometrial biopsy revealed caseating granuloma with multinucleated giant cells and stained positive for AFB stain.patient was started on Anti Tuberculosis Treatment. A 2-month intensive phase regimen of isoniazid, rifampin, pyrazinamide, and ethambutol was administered, followed by 4 months continuation phase of isoniazid and rifampin. The patient was symptomatically releaved following the treatment after 6months.

DISCUSSION

Genitourinary TB is one of the common extrapulmonary TB. But its actual incidence is difficult to ascertain, as 11% of patients were asymptomatic. Its occurrence differs in both developed and developing countries. Fallopian tube involvement in genital TB was in at least 95–100% of cases and mainly from haematogenous spread[2]. The uterus was the site of positive mycobacteriology in 220 of the 350 female genitourinary cases. Cases occur more habitually (64%) in postmenopausal women in urbanized countries compared with developing countries; only 25% of cases were in this group. Genital TB infection is typically caused by reactivation of organisms from systemic distribution of Mtb during primary infection.Direct transmission between sexual partners has been acknowledged .Spread from other intraperitoneal foci is atypical. Since genital TB tends to be an apathetic infection, the disease may not manifest for years after initial seeding. The most common presentations reported were infertility (47%), pelvic pain (23%), vaginal bleeding (16%), amenorrhea (6%), vaginal discharge (5%), and postmenopausal bleeding (2%). Less common presentations included vague lower abdominal pain, abdominal mass, ascites, tuboovarian abscess.Genital tract TB may be suspected from the medical history, including abnormal test results such as high erythrocyte sedimentation rate, erroneously elevated CA-125 level, and chest x-ray film with lesions suggestive of TB. Combination of antituberculous agents for 9–12 months duration provides more than 95% cure rate [3].

CONCLUSION:

Though genital TB is not frequent, it remains a contagious disease. The above case represented the early detection which prevented the late and remote complication. It also highlighted the problems of healthcare in most of the developing countries. Lack of patient education, awareness, and access to a healthcare system my result in a complicated situation. In an endemic area or in an immunocompromised individual, a higher index of suspicion would allow early recognition and treatment institution to minimise its late consequences as well as disease spreading. Genital tuberculosis (TB) in females is by no means uncommon, particularly in communities where pulmonary or other forms of extragenital TB are common. TB can affect any organ in the body, can exist without any clinical manifestation, and can recur. Anti-TB is the mainstay of treatment. Surgical intervention may be needed in selected cases.

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