

Short Communication

Genital tuberculosis with predominant involvement of cervix: A case report

Savita Rani Singhal*, Pooja Chaudhry and Smiti Nanda

Departments of Obstetric and Gynecology, Pt. B.D.Sharma, PGIMS, Rohtak-124001 (Haryana) India.

Accepted 17 July, 2019

Tuberculosis of the cervix is a rare form of genital tuberculosis. The symptomatology does not have any particular specific features; but the macroscopic appearance may be of cancer at first impression. A biopsy followed by histology differentiates between the two. A 19 year old married female being investigated for primary amenorrhea with history of contact bleeding had an exophytic growth on cervix, which turned out to be cervical tuberculosis. In a young patient with suspicious cervical lesion and history of contact bleeding a benign pathology like cervical tuberculosis should be kept in mind. The incidence of cervical involvement in genital tuberculosis is extremely low. The outlook is good with full recovery if the treatment is carried out properly and promptly.

Key words: Contact bleeding, cervical cancer, histopathology, cervical tuberculosis.

INTRODUCTION

Granulomatous diseases of the cervix include tuberculosis, syphilis and granuloma inguinale. Tuberculosis of cervix is an uncommon finding. Fallopian tubes are involved in almost all the cases of pelvic tuberculosis, endometrium in 50 to 60% and ovaries in 20 to 30% (Chowdhury, 1996). Disease is usually secondary to a primary focus elsewhere in the body most commonly from lungs. Spread to cervix is either by hematogenous, lymphatic dissemination or by direct extension. Symptomatic genital tract TB usually presents with abnormal vaginal bleeding, menstrual irregularities, abdominal pain and constitutional symptoms (Chowdhury, 1996; Sinha et al., 1997). The lesion on the cervix can be either exophytic, ulcerative although interstitial and endocervical polypoid form may also occur. Patients with genital tuberculosis present with infertility, menstrual disturbances, pain abdomen and offensive discharge per vaginum.

CASE REPORT

A 19 year old female married for 10 months reported at gynecology outpatient department with the complaints of

primary amenorrhea and postcoital bleeding since two months. She was five feet and five inches, weighed 65 kg, secondary sexual characters were well developed, there was no galactorrhoea and thyroid was not palpable. Abdomen was soft, per speculum examination revealed an abnormal cervix, which exhibited marked contact bleeding; the anterior lip of cervix was an irregular with exophytic fleshy lesion of 1 cm x 1 cm. On pervaginal examination uterus and adnexa were normal. Complete blood count, montoux test, erythrocyte sedimentation rate (ESR), Chest-X-ray, thyroid hormone levels, Luteinizing hormone (LH), follicle-stimulating hormone (FSH) and prolactin were within normal limits. In view of suspicious cervix a fractional curettage and cervical biopsy was performed. The endometrial and endocervical tissue was negative for tubercle bacilli. The histopathology revealed epitheloid cell granulomas with occasional necrosis seen distributed in the entire thickness of endometrial tissue. Similarly, the ecto and endocervical curettings also had large number of epitheloid granuloma with few showing giant cells and caseating necrosis compatible with tuberculous inflammation. Consequently sputum examination, three midstream early morning urine samples and gastric lavage failed to reveal any tubercle bacilli. The patient was put on antituberculous therapy (ATT) for six months. A repeat endometrial biopsy performed at the end of treatment showed resolution of granulomas. Patient resumed menses four months after initiation of ATT. She

*Corresponding author. E-mail: savita06@gmail.com. Tel: 01262 213643.

was advised to await spontaneous conception for a period of 3 months following therapy and return thereafter in case of failure to achieve pregnancy.

DISCUSSION

The incidence of tuberculosis cervix varies in different countries ranging from 0.1 to 0.65% and the disease is more prevalent in India (Carter, 1990). Patients with cervical tuberculosis present with persistent offensive discharge, abnormal bleeding, malaise and other constitutional symptoms of infection. If the upper genital tract is involved they may have pain, menstrual disturbance including amenorrhea and rarely postcoital bleeding. Considering the latter symptomatology erroneous diagnosis of malignancy is thought of like in the present case. It may be present with tuberculosis of vulva and vagina (Akhlaghi and Hamedi, 2004).

Diagnosis depends upon the isolation of tubercle bacilli on microscopy and culture. Although presence of characteristic granuloma is sufficient to make the diagnosis (Falk et al., 1980). There is rarely any need of surgery except in cases resistant to medical treatment. A case similar to present case which has been confused with cervical malignancy has been reported (Agarwal et al., 2009).

Future fertility after genital tuberculosis is poor. Patients with cervical tuberculosis invariably have widespread disease involving the endometrium and fallopian tubes precluding favorable obstetric outcome. Rarely if the disease is localized and treatment is promptly started, childbearing capacity is retained. Spontaneous conception of this patient is awaited. Hence, awareness of this entity is necessary while dealing with cervical lesions especially in developing countries with high incidence of tuberculosis.

We conclude that a young patient with suspicious cervical lesion and history of contact bleeding, a benign pathology like cervical tuberculosis should be first thought of rather than malignancy.

REFERENCES

- Agarwal S, Madan M, Leekha N, Raghunandan C (2009). A rare case of cervical tuberculosis simulating carcinoma of cervix: A case report. *Cases J.*, 2: 161.
- Akhlaghi F, Hamedi AB (2004). Postmenopausal tuberculosis of the cervix, vagina and vulva. *Int. J. Gynecol. Obstet.*, 3: Online publication.
- Carter JR (1990). Unusual presentation of genital tuberculosis. *Int. J. Gynecol. Obstet.*, 33: 171-176.
- Chowdhury NNR (1996). Overview of tuberculosis of the female genital tract. *J. Indian Med. Assoc.*, 94: 345-361.
- Falk V, Ludviksson K, Agren G (1980). Genital tuberculosis in women. Analysis of 187 newly diagnosed cases from 47 Swedish Hospitals during the ten-year period 1968 to 1977. *Am. J. Obstet. Gynecol.*, 138: 974-977.
- Sinha R, Gupta D, Tuli N (1997). Genital tract tuberculosis with myometrial involvement. *Int. J. Gynaecol. Obstet.*, 57: 191-192.