

Tuberculous endometritis in a post menopausal patient – A Case study with review of literature.

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Abstract

Genital Tuberculosis is rare, yet important cause of morbidity and infertility. It commonly presents in women of reproductive age group and is rare in post menopausal women. Patients may present with lower abdominal pain, abnormal uterine bleeding, menstrual bleeding or infertility. We present a case of tuberculosis involving endometrium and bilateral fallopian in a 55 year old female patient to highlight its rare occurrence and clinicopathological features.

Keywords: Endometritis, Post menopausal, Salpingitis, Tuberculosis.

Introduction

Genital Tuberculosis was first described by Morgani¹. The infection is secondary to disease elsewhere or may be introduced with previous surgery or from sexual partner².

It is a rare disease which causes chronic pelvic inflammatory disease and infertility³. We present a case of tuberculous endometritis and salpingitis in a postmenopausal female patient to highlight its rarity and clinical presentation.

Case Report

A 55 years old female patient presented with complaint of lower abdominal pain and post menopausal bleeding since 2 months. Patient was postmenopausal since 15 years. Her previous menstrual history was regular, her HIV status was non reactive. Obstetrics history revealed two full term normal vaginal deliveries and third was abortion. Past history and family history was not significant on per abdominal examination there was tenderness, no evidence of abdominal mass or ascites. Per speculum examination revealed healthy cervix and vagina on per vaginal examination there was foul smelling discharge with bleeding. Blood reports revealed Hb 10g/dl, TLC and DLC were within normal limits. Xray chest was normal. USG abdomen report showed increased endometrial thickness for age that is 2.5mm with debris in endometrial canal and hematometra. Abdominal hysterectomy was done, we received a specimen of panhysterectomy with omentum for histopathological examination. On gross examination uterus was bulky. External surface was unremarkable. Cut section showed increased endometrial thickness that is 2.8mm. Endometrial canal was filled with caseous

material and blood clots. Both fallopian tubes were thickened and dilated, while ovaries were unremarkable. Microscopic examination of endometrium revealed atrophic endometrial glands. Stroma showed numerous granulomas composed of epithelioid cells, Langhan's giant cells, lymphocytes with central caseation. Both fallopian tubes revealed similar granulomas while ovaries and omentum was unremarkable. 20% ZN stain did not reveal acid fast bacilli. Considering these features a diagnosis was given as endometrial tuberculosis with tuberculous salpingitis .

Discussion

Tuberculosis of genital tract represents 5% of pelvic infections and comprises 10% cases of pulmonary tuberculosis. It is frequent in reproductive age group and is rare in post-menopausal female. The reason may be atrophic endometrium, being poor environment for growth of mycobacteria⁴. It may affect HIV infected patients being as opportunistic infection.¹ Fallopian tubes are affected in almost all cases, followed by endometrium in 50% cases, ovaries in 20% cases, cervix in 5% cases and vagina and vulva in <1% cases. Tuberculous endometritis is associated with tuberculous salpingitis⁵. Similar observation was noted in our case. Clinical presentation of endometrial tuberculosis may be indolent infection. Commonest clinical features are infertility, abdominal pain, vaginal bleeding, amenorrhea and postmenopausal bleeding⁶. There may be ascites or tubo-ovarian mass. Genital tuberculosis may be suspected from the abnormal blood reports, increased ESR and chest Xray suggestive of tuberculosis. In 75% of patients chest Xray is normal as seen in our case. Hysterosalpingography may reveal tubal blockage, hydrosalpinx, or filling defect in uterine cavity⁷. Pelvic USG detects adnexal mass, thickened omentum, adhesions and fluid in pelvic cavity. Diagnosis can be

made on histopathological examination of endometrial tissue. Microscopic feature are granulomas composed of epithelioid cells, Langhan's giant cells and lymphocytes. Caseation is rare in reproductive period. In postmenopausal women tuberculous granulomas have enough time to develop caseation as there is no periodic loss of endometrium during menses. Microscopic detection of acid fast bacilli on ZN stain requires atleast 10⁴ bacilli/ml in the sample, where as culture is more sensitive. PCR serves as a rapid, sensitive as well as specific method for diagnosis of genital tuberculosis⁸. Conservative treatment with anti tuberculosis drugs is offered for these patients. Surgical treatment is total abdominal hysterectomy and salpingo ophorectomy. The indication for surgery is persistence of pain or bleeding after nine months of medical treatment⁹.

Conclusion

Endometrial tuberculosis remains an uncommon extrapulmonary manifestation of tuberculosis. It should remain an important consideration for evaluation of women presenting with pelvic symptoms and infertility.

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