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Gynecology

TUBERCULAR PUERPERAL SEPSIS- A RARE PRESENTATION

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ABSTRACT Puerperal sepsis is very common in developing countries like India. Puerperal sepsis is an infection of the genital tract which occurs as a complication of delivery. The incidence of puerperal sepsis is 0.1 % to 10% with maternal mortality rate ranging from 2% to 11% in developing countries. In this case report,28 years old female who underwent emergency LSÇS 5 weeks back came with chief complaints of pain lower abdomen on and off and pus like discharge from vagina since last 20 days. She was given a full course of antibiotics outside but did not get any symptomatic relief. Pus sent for culture sensitivity, AFB smear and culture and high vaginal swab was taken. In Zeil Neelsen staining slender rod, beaded appearance acid fast bacilli was present. Then the patient was treated with antitubercular drugs and was totally cured.

KEYWORDS : Tuberculosis, puerperal sepsis, mycobacterium

Introduction

Late puerperal sepsis is extremely rare entity. The time of onset of the infection and sepsis in the postpartum period is related to the stages of normal puerperium, with immediate events occurred within the first 24 hours, mediate events between the second and seventh day after delivery and late events from the second to the sixth week postpartum (42 days)[1].Although there is no clear definition of puerperal sepsis but according to world health organization, uterine puerperal sepsis is defined as the infection occurred between the rupture of membranes and the first 42 days postpartum, with at least two of the following conditions: pelvic pain, fever —oral temperature equal to or higher than 38.5 °C— and purulent, cloudy or fetid vaginal discharge or delayed uterine involution[2]. It is an important public health problem contributing to maternal morbidity and mortality[3]. The incidence of puerperal sepsis is 0.1 % to 10% with maternal mortality rate ranging from 2% to 11% in developing countries, wide disparity of the estimates may be due to the difference in diagnostic criteria between different sources of study[4]. Most maternal deaths occur due to substandard care such as failure or delay in the diagnosis and late referral to hospital. So proper clinical evaluation, timely diagnosis and evidence based treatment must be given to the patient to minimize the morbidity and mortality related to puerperal sepsis.

Case report

28 years old female,P3L2 came to department of obstetrics and gynecology at adesh medical college, bathinda with chief complaints of pain lower abdomen on and off and pus like discharge from vagina since last 20 days. She had undergone emergency LSCS 5 weeks back in view of hydrocephalus baby who died 15 minutes after birth. She was given a full course of antibiotics outside but did not get any symptomatic relief. She had previous 2 normal vaginal deliveries which were uneventful. The patient had no significant past history.

On general examination
Pulse rate-80 beats/min
Blood pressure-110/80mm Hg
Pallor present
Afebrile

On chest auscultation- bilateral normal vesicular breathing. No added sounds

Per abdomen examination

LSCS pfannenstiel scar present, stitch line healthy, uterus 18 weeks size (subinvoluted)

On per speculum
Pus like discharge coming from os, non foul smelling
Per vaginum

Os 1cm dilated, uterus 18 weeks, anteverted, mobile, bilateral fornix free, pus like discharge present on gloved finger, pus sent for culture sensitivity, AFB smear and culture and high vaginal swab was taken.

Investigations
Hb- 10.8gm%
TLC-11000
DLC-65/30/04/01
LFT-WNL
RFT-WNL
INR-1.12

HVS- Staphylococcus pseudinter medius sensitive to gentamycin and linezolid

Pus c/s- no growth

AFB smear & culture- mycobacterium tuberculosis detected

USG- upper abdomen NAD, uterus bulky with heteroechoic echo texture along the anterior wall. Endometrial cavity filled with heterogenous collection measuring 6.3×8.3 cm. Bilateral adnexa normal.

Patient was started on antitubercular therapy and showed dramatic improvement in symptoms and was cured after the full course of treatment.

Discussion

Genital tract sepsis is a polymicrobial infection in which aerobic and anaerobic bacteria ascend from the lower genital tract to the endometrium, fallopian tubes, pelvic peritoneum and incised edges of the uterine myometrium following cesarean section[5]. The source of infection may be endogenous, exogenous or autogenous. The most common pathogens identified in genital tract sepsis are: β-hemolytic Streptococcus pyogenes; Lancefield group A streptococcus; Escherichia coli; Enterococcus faecalis; Pseudomonas; Staphylococcus aureus; Proteus; Streptococcus pneumoniae; Morganella morganii; Citrobacter koseri; Acinetobacter and Listeria. Mixed infection with two or more organisms can also occur. Methicillin-resistant Staphylococcus aureus (MRSA) infection can develop in some women during a prolonged stay in a critical care unit[6]. However, healthcare related infections caused by mycobacterium due to contaminated materials have been reported in several studies[7,8]. Diagnosis and management of postoperative mycobacterium tuberculosis poses a great challenge for both physician and laboratory personnel. Most laboratory experts perform routine bacterial cultures of pus, thus giving a misleading result. Therefore along with performing routine bacterial cultures, AFB smear microscopy and AFB culture should be performed wherever patient fails to respond to conventional antibiotic therapy as reported in our case. Our case report focuses on the fact that clinician should consider the possibility of mycobacterium tuberculosis infection in cases presenting as delayed

or non healing puerperal sepsis. Such patients should be treated with full course of antitubercular drugs.

Conclusion

This case report highlights the necessity of being aware of mycobacterium tuberculosis infection as causative agent for delayed or non healing genital tract infection, not responding to conventional first line antibiotics in postpartum period.

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