



A RARE CASE OF TUBERCULAR ENDOMETRITIS PRESENTING AS A LEIOMYOMA-A CASE REPORT

Obstetrics & Gynaecology

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ABSTRACT

Genitourinary tuberculosis is a common extra-pulmonary manifestation of tuberculosis. Taking into consideration that genitourinary tuberculosis may be associated with a diversity of presentations, its diagnoses may be difficult. Most of the patients may be asymptomatic; however, three major complaints have been reported which include infertility (65-70%), abdominal/ pelvic pain (50-55%) and menstrual abnormalities (20-25%). Serum CA125 may be elevated in genital TB however, it is a non-specific marker. Nonspecific presentation and non-specific markers make diagnosis difficult. Pelvic tuberculosis presenting as a fibroid is a rare presentation. Here we report one such case of a 43-year-old woman with c/o pain in abdomen, distention of abdomen, irregular menstrual cycles with USG report of a large mass in pelvis likely suggestive of uterine mass or ovarian mass with severe ascites. Patient underwent staging laparotomy with total abdominal hysterectomy along with fibroid with bilateral salpingo-oophorectomy with iliac lymphadenectomy with supracolic omentectomy. Histopathology report showed tuberculosis of bilateral fallopian tube, ovaries, omentum and iliac lymph nodes and uterine leiomyoma with proliferative endometrium.

KEYWORDS

Genitourinary tuberculosis, Uterine Leiomyoma, Malignancy

INTRODUCTION

Female genital tuberculosis (TB), following lymphatic tuberculosis, is the second most common extra pulmonary manifestation of tuberculosis¹. Signs and symptoms of pelvic TB may be diverse and nonspecific, including chronic lower abdominal, pelvic pain, abdominal or pelvic masses, anorexia, weight loss, fever, abnormal uterine bleeding and infertility. Genitourinary tuberculosis is usually caused by metastatic spread of organism through the blood stream during the initial infection. The active disease results from the primary infection or reactivation of initial infection¹. In most cases, the disease is asymptomatic or reported as menstrual irregularities such as oligomenorrhoea, hypomenorrhoea, amenorrhoea, menorrhagia, dysmenorrhoea, metrorrhagia, pelvic pain and abnormal vaginal discharge. In postmenopausal women, genital tuberculosis presents with symptoms resembling endometrial malignancy, such as postmenopausal bleeding, persistent leucorrhoea and pyometra². M. Tuberculosis affects the female genital organ especially the fallopian tubes, it can occur in any age group, but women in the reproductive age group (15-45) are the most affected³. Genital Tuberculosis can mimic or coexist with other gynecological and abdominal pathologies such as genital carcinomas, acute appendicitis, ovarian cysts, PID, or ectopic pregnancy. Varied clinical presentations of genital tuberculosis are shown^{4,5}. One such case with unusual presentation of tuberculosis is reported here.

Case Report

A 43-year-old para 2 live 2 had distension of abdomen since 2 months and pain in abdomen since 15 days. Distension had insidious onset with gradual progression and weight loss. Patient had irregular menstrual cycles since 2 months. She had 2 full term vaginal deliveries and was tubectomized. She had no other medical or surgical illness. She also received her childhood bacilli Calmette-Guerin (BCG) vaccination.

On examination patient was moderately built, pallor present and vitally stable. On per abdomen examination – Distention was present with gross ascites, a firm mass of 28 to 30 weeks size, with irregular surface, firm in consistency, non-tender, fixed mass with no mobility. On bimanual examination- bilateral forniceal fullness present.

On per rectal examination- rectal mucosa was free, without any nodularity. So, malignancy was suspected as it was acute in onset, with rapid growth, weight loss, ascites, fixed mass was seen. Her laboratory investigations were Hb-8.5g/dl with platelet count 5.5 lakh, TLC-12000/mm³

Tumor markers such as cancer antigen (CA)-125 (354) raised, alpha-feto-protein, carbohydrate antigen 19-9, carcinoembryonic antigen (CEA), and lactate dehydrogenase (LDH)] were normal. Abdominal

and pelvic USG suggestive of a well-defined, heterogenous echogenic mass lesion occupying pelvis and bilateral iliac fossa, reaching superiorly till umbilicus, vascularity noted, no cystic areas +, ascites +. Ovaries not demarcated separately. Thickening of peritoneum was noted. On CECT abdomen and pelvis was suggestive of retroverted uterus with very large solid moderately enhancing soft lesion in the mid, lower abdomen and upper pelvis predominantly on right, possibly arising from serosal surface of uterus and cervix. Possibility of sub serosal exophytic fibroid with malignant transformation was high likely.

Ascitic fluid examination was negative for gram stain, ZN stain, revealed raised proteins with normal glucose, 95% lymphocytes and negative for malignancy. Patient underwent staging laparotomy followed by total abdominal hysterectomy along with bilateral salpingo- oophorectomy, iliac lymphadenectomy and supracolic omentectomy. Intraoperative finding- had ascites of 2 liters and 22*21*24 cm huge fibroid arising from the anterior wall of uterus and cervix weighing around 3.5 kg. Bilateral ovaries had simple cyst of 2*2 cm in size. Evidence of enlarged iliac lymph nodes 3*2 cm, matted omentum +. The above specimens along with ascitic fluid was sent for histopathological examination. Report came as granulomas with caseous necrosis, devoid of malignant cells. Bilateral fallopian tubes, ovaries, omentum sections showed granulomas. Lymph nodes sections showed well-formed granulomas. Endometrium was proliferative type. Uterine mass showed histology of leiomyoma with hyalinization and myxoid degeneration with granulomas. So, all the above features suggested of tuberculosis of endometrium, bilateral fallopian tubes, ovaries, omentum, lymph nodes and diagnosed as Pelvic Tuberculosis. Post operative period was uneventful. The Anti-tubercular therapy was started. The patient underwent 18 months course of quadruple anti-TB therapy including isoniazid, rifampicin, ethambutol and pyrazinamide. Patient responded well to the treatment and during 2 years of follow-up, no relapse was detected.



Figure 1. Specimen of intra-operative huge fibroid.

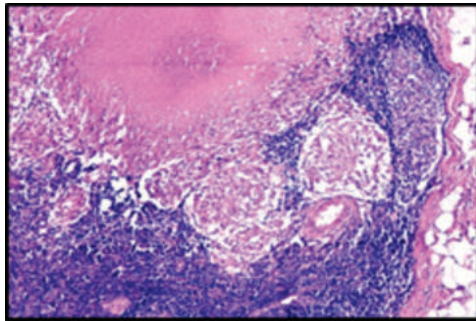


Figure 2. Uterine mass showed histology of leiomyoma with hyalinization and myxoid degeneration with granulomas

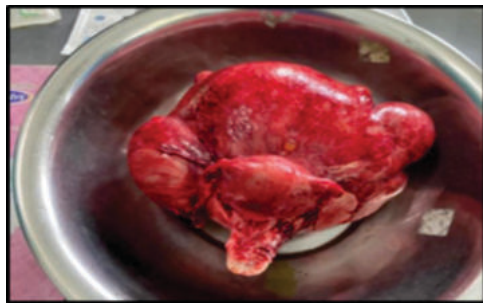


Figure 3. Specimen of uterus with cervix with bilateral fallopian tubes with fibroid.

DISCUSSION

Most of the patients may be asymptomatic; however, three major complaints have been reported which include infertility (65-70%), abdominal/ pelvic pain (50-55%) and menstrual abnormalities (20-25%)⁶. Serum CA125 may be elevated in genital TB (like in our case). However, it is nonspecific marker. Therefore, it might mimic ovarian cancer, endometriosis, Meig's syndrome, ovarian hyperstimulation etc. Other serum markers have limited value⁷. Imaging studies also has limited value as they fail to determine the site of origin of mass (like in the present study) and provides differential diagnosis only. Definitive diagnosis is mainly by tissue biopsy following laparoscopy or laparotomy. Anti-tubercular treatment is the treatment of choice in diagnosed cases. If the patient does not respond to medical therapy, a total abdominal hysterectomy with bilateral salpingo-oophorectomy is recommended⁸. An infection caused by by tubercle bacillus that affects the lungs and then spreads to the other organs is called tuberculosis. Endometrial TB is when it affects the endometrium. Endometrial TB may not show many symptoms. Sometimes, it may remain silent without producing any symptoms or signs. In some cases, symptoms below can be shown: Pelvic pain, irregular vaginal bleeding, abnormal vaginal discharge, inability to conceive⁹. Tests to diagnose endometrial biopsy may include: Endometrial tissue biopsy, Laparoscopic Hysterosalpingogram, culture of tubercle bacillus. There is medical as well as surgical procedures to treat TB in women. Anti TB drugs are suggested for mild cases. Medication may be required for few months to cure the disease. Severe cases can only be treated through surgical procedure called Hysterectomy¹⁰. The uterus is removed in this procedure. Though surgery is not indicated in active tuberculosis, and as it was diagnosed as possibility of malignancy, surgical laparotomy was done.

CONCLUSION

Mere hysterectomy is not an option in all cases of fibroid. Histopathology report helps in tailoring the further treatment. The diagnosis of genital TB should be considered in all women with pelvic masses and constitutional symptoms and signs, especially in endemic areas like India.

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