



AN INTERESTING CASE REPORT ON PYOSALPINX WITH PELVIC ABSCESS.

Obstetrics & Gynaecology

**Dr. Mohana
Lakshmi. P***

Post Graduate, Department of Obstetrics & Gynaecology, Sree Balaji Medical College & Hospital*Corresponding Author

Dr. Vidhya Selvam

Associate Professor, Department of Obstetrics & Gynaecology Sree Balaji Medical College & Hospital

ABSTRACT

A pyosalpinx, also known as a tubal abscess, is an accumulation of pus in the fallopian tube that causes acute inflammation of the tube due to obstruction and frequently arises as a result of spread of bacteria from the lower genital tract. It is a side effect of acute pelvic inflammatory illness that is untreated or poorly treated. A pelvic abscess is a collection of infected fluid in the parametric tissue, fallopian tube, or pouch of Douglas. The possible cause of pelvic abscess is mostly secondary to STI, pelvic inflammatory disease, appendicitis, diverticulitis, inflammatory bowel disease, etc.

KEYWORDS

Pelvic Abscess, Pyosalpinx, Pelvic Inflammatory disease, Tuberculosis, Reproductive age group

INTRODUCTION

The second most prevalent form of extra-pulmonary tuberculosis is genitourinary tuberculosis (GUTB). Involvement of the genitourinary organs is nearly invariably subsequent to Tb elsewhere in the body. In developing nations, female genital tuberculosis (GTB) is a widespread health issue. It frequently results in infertility, menstrual irregularities, and chronic pelvic inflammatory disease, pyosalpinx, hydrosalpinx. Because GTB frequently goes undiagnosed and only 50% of cases are identified without surgery, the true incidence of the condition cannot be determined with accuracy. According to reports, the incidence fluctuates and can range from 0.69 percent in some wealthy nations to 19 percent in India. It accounts for between 15 and 20% of extrapulmonary TB. The majority of cases of GTB are secondary infections brought on by hematogenous transmission from extragenital sources such as pulmonary or abdominal tuberculosis. GTB occurs between the age group of 15–54 years, causing infertility in 44–74% of the women affected

CASE REPORT :

28 years old Female, married since 12 years, Para 2 Live 1, Last child birth- 10 yrs ago, came to our casualty with complaints of abdomen pain since 1 day. Sudden onset, intermittent type, spasmodic in nature, non radiating, with no aggravating or relieving factors. She also had complaints of burning micturition and fever since 1 day, not associated with chills and rigor. Patient had no history of nausea, vomiting, diarrhea.

Patient was treated elsewhere for the same with Analgesic.

On examination, patient was febrile with a temperature of 101 degree fahrenheit, pallor present and poorly hydrated.

Diffuse tenderness present in all quadrants, lower > upper quadrant, guarding and rigidity present and bowel sounds absent. Per vaginum examination was unremarkable. CT Abdomen done showed, a large cystic lesion in right adnexa with focal abdominal extension, measuring ~ 6.0*5.1*7.0 cm, inferior extension of the lesion abutting the right ovary and posteriorly lesion causing mild compression of right ureter, resulting in proximal mild hydroureteronephrosis. Mild free fluid in pelvic cavity. Mesentric and omental haziness present. Few subcentric mesenteric lymph nodes noted, largest measuring ~ 9mm. Uterus and left ovary appears normal.

After obtaining General surgery and Surgical Gastroenterology opinion, Patient was taken up for Emergency Exploratory Laparotomy proceeded with Right salpingectomy and cyst wall excision. Following intraoperative findings were noted :

1. Blood stained peritoneal fluid
2. Dilated bowel (fig.1)
3. Bulky uterus
4. Dense adhesions between Rectum, posterior surface of uterus
5. Mildly dilated left fallopian tube

6. Right fallopian tube – Pyosalpinx
7. Purulent collection in the Pouch of Douglas (Fig.2)
8. Bilateral ovaries normal but adherent to posterior surface of uterus.

Abdomen was closed in layers, after placing an intraperitoneal and subcutaneous drain.

Pus sent for AFB culture & CBNAAT. While awaiting reports, patient was started on Inj. Piptaz 4.5 gm bd and her immediate post operative period was uneventful. Patient's SAAG SCORE (serum albumin – ascitic albumin gradient) was calculated that indicated an exudative fluid. Patient was diagnosed with EXTRAPULMONARY TUBERCULOSIS (female genital tract) and started with ATT.

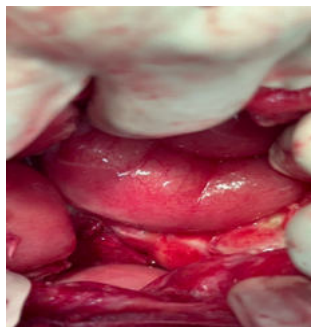


Fig. 1

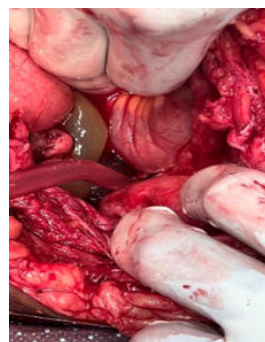


Fig. 2

DISCUSSION :

The term "pelvic inflammatory disease" (PID) refers to an infection-related inflammation of the upper genital tract in females. The uterus, Fallopian tubes, and/or ovaries are all affected by the illness. It often spreads from the lower vaginal tract and is an ascending infection. While tuberculosis can potentially cause PID, sexually transmitted infections account for the majority of cases.

A pelvic abscess is a localized accumulation of infected fluid, resulting from liquefaction necrosis. Its formation arises from an imbalance in the body's defense mechanisms and inadequate antibiotic treatment, particularly when faced with highly virulent bacterial strains. The necrotic tissues surround the infectious fluid, forming a dense fibrous wall. Failure to drain the pus can lead to the concentration of microbes and toxins, posing risks to the host and impeding the effectiveness of antimicrobial drugs by making it challenging for them to penetrate the fibrous capsule. Additionally, enzymatic breakdown of immunoglobulins and the release of complements locally contribute to persistent pus formation.

Pelvic abscesses often stem from gastrointestinal, genitourinary, post-surgical, or occasionally idiopathic causes.

In young women, pelvic abscesses often develop as complications of pelvic inflammatory disease (PID). This typically begins as an infection ascending from the vagina and cervix, spreading to involve the uterus, fallopian tubes, ovaries, and peritoneum. This process induces damage to the endothelium and swelling of the fallopian tubes, ultimately leading to blockage. Imaging techniques such as ultrasound (US), computed tomography (CT), or magnetic resonance imaging (MRI) play crucial roles in diagnosing and assessing the severity of abscesses. In cases of extensive or complex abscesses, like those seen in our patient, open surgical drainage and debridement of the infected area were not only successful but necessary for effective resolution.

CONCLUSION :

This extra-pulmonary form of tuberculosis, called genital Tb has the potential to be seriously morbid. Although its total incidence is low, the high burden of Tb, particularly in poorer nations, places a heavy load on the health care system. Due to its vague, nonspecific symptoms and the low sensitivity of the existing microbiologic testing, it is more likely to cause irreparable organ damage and necessitate ablative therapy down the road. In cases where the diagnosis is unclear, prompt surgical intervention is preferred. 4 medications during the first two months of the intense phase and 2 drugs for the remaining four months of the continuation phase make up a brief course of multidrug therapy lasting for a total of six months. Response must be assessed at 3–4 weeks clinically, with addition of imaging if indicated and those not responding must be re-assessed for infection with drug resistant strains.

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