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Dilemma in Diagnosing Cervical Tuberculosis.

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ABSTRACT

Genital tuberculosis in females is found in 0.75 to 1% of gynecological admissions in India with considerable variation from place to place. Tuberculosis (TB) can affect any organ in the body (exceptions being skeletal muscle, cardiac muscles, pancreas) can exist without any clinical manifestation and can recur. The disease is almost always secondary to primary pulmonary TB, responsible for 5% of all female pelvic infections and occurs in 10% cases of pulmonary tuberculosis. Female genital tuberculosis (FGTB) is typically understood as a disease of young women, especially in developing countries, with 80-90% of cases diagnosed in patients 20–40 years old, often during workup for infertility. The disease has been reported in postmenopausal females as well. We are here presenting two rare case reports of cervical tuberculosis misdiagnosed as carcinoma cervix.

Keywords: Cervical tuberculosis, carcinoma cervix, primary infertility.

INTRODUCTION

Tuberculosis is one of the oldest diseases known to affect human being. Although this is a rare disease in some developed countries but it is the frequent cause of chronic pelvic inflammatory disease and infertility in the developing and under developed countries. Tuberculosis of the female genital tract is common amongst all communities where pulmonary tuberculosis or other form of extra genital tuberculosis is present.[1]

Here we are reporting two cases referred from district hospitals to our institute with diagnosis of suspected carcinoma cervix turned out as cervical tuberculosis.

CASE REPORT

Case Report: 1

A 32 years old married female attended OPD in IGMC at KNSHM&C Shimla as a referred case from district hospital with complaint of primary infertility with primary amenorrhea with discharge per-vaginum for two years and bleeding per-vaginum for two months. On examinations cervix was abnormal with ulceration which bleeds on touch with mixed discharge per vaginum and uterus was normal. Her referral slip from district hospital was documenting an abdominal ultrasonography which was showing a right tubo-ovarian mass of size 3x2 cm?? Inflammatory; and her antibody test for HIV and STS were negative. We investigated the patient. Her Hemoglobin was 10 gm%, ESR 20mm first hour, Serum protein 8.0mg/ml, TSH 2.06 µ IU/ml, FSH 3 mIu/ml, LH 1.95 mIu/ml. All blood investigations were within normal limit. Her cervical biopsy was taken and the histo-pathological report revealed: Caseous necrosis, epitheloid granulomatous langerhans type of giant cells surrounded by chronic inflammatory cells mainly lymphocytes and plasma cells.

Keeping in view of the histo-pathological report genital tuberculosis was kept as the probable diagnosis and patient was started on four drugs anti tubercular therapy and reviewed after four weeks of treatment. After the completion of four week of treatment patient was relieved off the symptoms and ulcer was completely healed. She completed the anti-tubercular treatment and was under regular follow up.

Case Report: 2

A 31 years old married women referred from district hospital with complaint of primary infertility for twelve years, bleeding per vaginum off and on for one year and anemia for two months. On examination: per-speculum was showing an ulcerative growth on anterior lip of cervix which bleeds on touch and was friable, Uterus was normal

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size and both the fornixes were thick and non-tender. On per-rectal examination rectal mucosa was free. Her investigations revealed; Hemoglobin was 7gm%, ESR 60mm 1st hour. Renal and liver function tests were within normal limits. STS and HIV were non-reactive. Test for mycobacterium tuberculosis was negative. Ultrasonography of abdomen and pelvic organ was within normal limit, On CT abdomen and pelvic organs she was diagnosed as Carcinoma cervix invading up to parametrium and rectum (Stage-IV), However to be correlated clinically and lab findings.. Her cervical biopsy was done and histopathological report revealed: granulomatous epitheloid cells, foci of caseous necrosis/ langerhans type of giant cells with marked chronic inflammatory cells, with no evidence of neoplasia. No AFB was seen. Patient was put on anti-tubercular treatment (ATT). Patient was relieved off the symptoms and ulcer was completely healed gradually as she completed the anti-tubercular treatment.

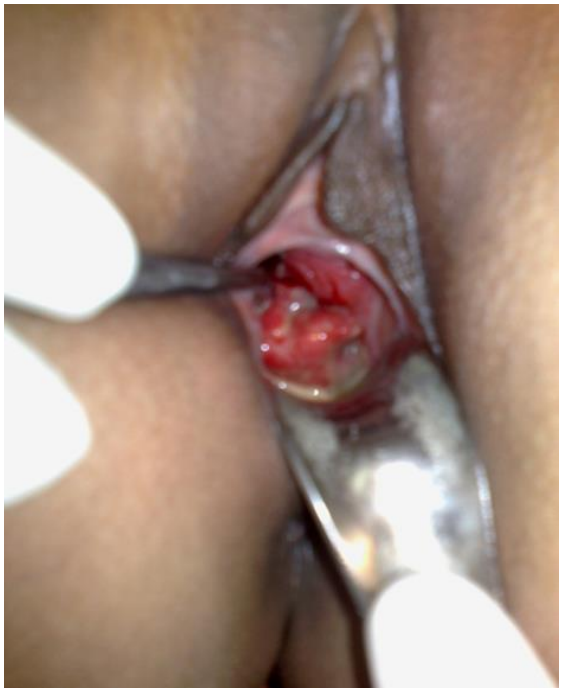

Figure 1: Tubercular Cervical Lesion.

DISCUSSION

Although the actual incidence of genital tuberculosis cases cannot be ascertained, as the large number of patient remain asymptomatic and disease is usually diagnosed accidentally.[2] Tuberculosis of vulva and vagina is very rare and is seen as secondary to pulmonary tuberculosis. Spread is usually through haematogenous and lymphatic channel.[3] Tuberculosis of cervix accounts for 0.1% to 0.65% of all the cases of tuberculosis. Tuberculosis more frequently affects the upper genital organs, tubes and endometrium. It usually occurs in women of child bearing age group. Symptomatology varied from abnormal vaginal bleeding, menstrual irregularity, and infertility to chronic vaginal discharge.[4] Incidence of tuberculosis has increased recently. There should be high index of suspicion of tuberculosis in women with especially from area where TB and HIV are prevalent.[4]

Cervix when involved by TB can look normal or inflamed, may resemble invasive carcinoma cervix both grossly and through colposcopy. In these patients also the cervix was inflamed and appeared suspicious for carcinoma cervix.[4]

Material for laboratory diagnosis should be collected with two objective that is histopathology and culture. Tissue should be divided into two equal parts. One in the fixative solution and other in the sterile container containing normal saline .Histological diagnosis is made with traditional hematoxyline and eosins staining as well as Z-N staining with basic fuschin dye.Classic features are: caseous necrosis, giant cells epithelial cell clusters and lymphocyte infiltration. The lesions are highly indicative of but not exclusive to TB unless tubercle bacilli are seen. Culture methods are still gold standard. Culture is traditionally performed on solid egg or agar based media such as Lovenstein Jenson (LJ) or Middlebrook thio and microinoculated at 37□ c under 5% co2 growth is detected after 4-5 weeks.[3]

Diagnosis of disease is difficult, apart from varied clinical presentation past h/o tuberculosis or h/o contact may not be forthcoming and an evidence of tubercular lesion elsewhere may be lacking. ESR and a positive Monteux tests are non-specific. The chest skiagram is usually normal in these cases.[5]

In view of the problems in making a definitive diagnosis of genital TB in females, many physicians tend to adopt the therapeutic test for elimination of any type of TB including genital tuberculosis by prompt execution of ATT for a required period .But a prescription error or poor compliance can delay the response to treatment leading to failure, thereby resulting in continued morbidity despite the fact that good quality ATT is available under RNTCP and results are quite encouraging.[5]

CONCLUSION

TB is an age old disease, is making comeback with HIV as a pandemic. There is an urgent need for developing definitive diagnostic method and criteria to be applied to make a conclusive diagnosis of genital tuberculosis.

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