Abstract
Genito-urinary Tuberculosis is an entity that used to be very common in India in olden days. But we still come across it even now as the following case illustrates. A 25 year old Mrs. B presented to our OPD with secondary amenorrhoea following menarche at the age of 12 years. She gives h/o D&C in 2007 details were not available. She was worked up by blood investigations including hormonal & karyotyping which showed normal thyroid and FSH & LH and female karyotype. Ultrasound of the pelvis was normal. She did not respond to either a progesterone challenge or to a estrogen challenge test. She then had a hysterosalpingogram done which showed bilateral cornual block with intravasation of dye. A tentative D.D.of Asherman’s syndrome /tuberculous endometritis were made and she was then subjected to a hysterolaparoscopy. The hysteroscopy showed bland endometrium with both ostia visualized with no syneciae. The laparoscopy showed adhesions all over the abdomen with right tube hydrosalpinx & Left tubo-ovarian mass. Omental biopsy and endometrial biopsy taken which confirmed tuberculosis. She was then put on ATT & is at present on ATT. The case is presented as tuberculosis still is a cause for amenorrhoea and infertility in India

Keywords:

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Case history
25 year old Mrs. B. presented to our OPD with complaints of not having had any period since her menarche. Menarche at the age of 12 [had 3 days normal bleeding]. After this she had not had any periods.
Marital history : She was married for the past 5 years, non-consanguineous marriage
Obstetric history: Nil
Past history: Had a dilatation & curettage in 2007 at a private hospital in Karnataka –details not available
Laboratory values
Hb%-12.8, PCV =38.9, tRBC-4.28, TC-8800, DC-P42L37B0.5E14M5, ESR at ½ hr= 8 & at 1 hr= 17,
Proteins total-6.5 Albumin -3.8 Bilirubin T-0.4 Direct -0.1, SGOT-17, SGPT-75, SAP-75, SGT-28

Thyroid profile:

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<th>Date</th>
<th>13.4.09</th>
<th>14.6.09</th>
<th>26.9.09</th>
<th>30.10.09</th>
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<tbody>
<tr>
<td>fT4</td>
<td>1.36</td>
<td>1.61</td>
<td>2.20</td>
<td>9.19</td>
</tr>
<tr>
<td>fT3</td>
<td>3.65</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>TSH</td>
<td>0.19</td>
<td>0.19</td>
<td>0.10</td>
<td>0.01</td>
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</tbody>
</table>

AntiThyroglobulin Ab -76.3 Positive

Thyroid peroxidase antibodies anti Ab 118.4 Positive [in view of these 2 results, patient was advised by our general physician to keep the endogenous thyroid suppressed]

Blood group & type- A positive, RBS-91, BUN-8, S.Creatinine-0.5, HIV-Nonreactive, HbsAg-negative, RPR-Nonreactive

FSH-15.6, LH-10.5, Prolactin-17.1

Cholesterol Total 107, TGL 55, HDL-41, LDL -55, VLDL-11, Chol/HDL-2.6

Hystero salpingogram observations

<table>
<thead>
<tr>
<th>Date</th>
<th>11.4.09</th>
<th>18.6.09</th>
<th>19.11.09</th>
<th>17.12.09</th>
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</thead>
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<tr>
<td>Uterus</td>
<td>6.2×2.5</td>
<td>6.8×2.6×4.3</td>
<td>6.8×2.7</td>
<td>6.6×2.7</td>
</tr>
<tr>
<td>Endometrial thickness</td>
<td>4.1</td>
<td></td>
<td>5.2</td>
<td>6.4</td>
</tr>
<tr>
<td>Right ovary</td>
<td>2.7×2.5</td>
<td>19×18</td>
<td>3.4×2.7 with follicle 1.8×1.5</td>
<td>2.6×2.1</td>
</tr>
<tr>
<td>Left ovary</td>
<td>3.6×2.0</td>
<td>20×18</td>
<td>3.5×2.0</td>
<td>3.1×2.5 with follicle 2.0×1.3</td>
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</tbody>
</table>
A progesterone challenge test was given and it was negative. Following this an Estrogen Challenge test was given and this was also negative. Then hysterosalpingogram was done which showed a bilateral cornual block with intravasation of dye. (Fig-1 & 2) In view of this picture a differential diagnosis of Tuberculous Endometritis/ Asherman’s syndrome was made.

**Figure 1&2:** Hystero salpingogram showed bilateral cornual block

![Hystero salpingogram](image1)

Then we proceeded to do a diagnostic hystero laparoscopy. Under general anaesthesia, with patient in lithotomy position, hysteroscopy tried with a 20f cystoscope. As the internal os was stenosed could not do in spite of attempting dilatation. Hence the same procedure done with a pediatric 14f cystoscope. The endometrium was bland and white in colour (Fig-3) with both ostia visualized (Fig-4)

**Figure 3:** Endometrium was bland and white in colour. Right tube was beaded with hydrosalpinx (HS)

![Endometrium with hydrosalpinx](image2)

**Figure 4:** Both the Ostia were visualized

The left tube and ovary showed a complex mass of adhesions (Fig-5). The endometrial biopsy came as Tuberculous Endometritis. (Fig-6) She was therefore started on antituberculous treatment in consultation with chest & tuberculosis specialist and is at present on follow-up.
Figure-5 & 6: The left tube and ovary showed a complex mass of adhesions. 6. Section from the Endometrium

**Conclusion**

Tuberculous endometritis is due to haematogenous spread of acid fast bacilli, with primary focus somewhere else in the body, and is usually detected on routine examination of the endometrial curettings for some gynaecological or other problems. About 2-46% present with amenorrhoea and still tuberculosis is one of the cause for this and for sterility\(^1\),\(^2\).

Tuberculous endometritis is far more common in India compared to the U.S.A. and U.K. though the incidence is going down in view of better diagnostic and better management. The patient usually presents with the problem of sterility.

**Acknowledgement**

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**References**
