



Genito-Urinary tuberculosis still a prevalent entity – a Case report

Vasanth N.Subbiah*¹, Anoop Sreevalsan², Kavitha³, Swayam Jothi S⁴

Professor & HOD*¹ Associate Professor², Senior Resident³, Dept. of OBG, Chettinad Hospital & Research Institute
Professor & HOD⁴, Dept. of Anatomy, Sri Sathya Sai Medical College & Research Institute, India

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 an 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 synechiae. 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:

*Corresponding Author: Dr Vasantha N Subbaih, Professor and HOD, Dept. Of OBG, Sri Chettinad Hospital and Research Institute, Chennai, India. Email: hemanthkommuri@gmail.com

Received: May 5, 2013, Accepted: July 26, 2013. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

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

Personal history: Nil relevant

Treatment History: Known Hypothyroid on regular treatment. O/E Not anemic

Clinical observations:-

Thyroid gland is not clinically enlarged

Breast –Tanner stage 5

Axillary hair –Present

CVS/RS - Normal

P/A - Normal

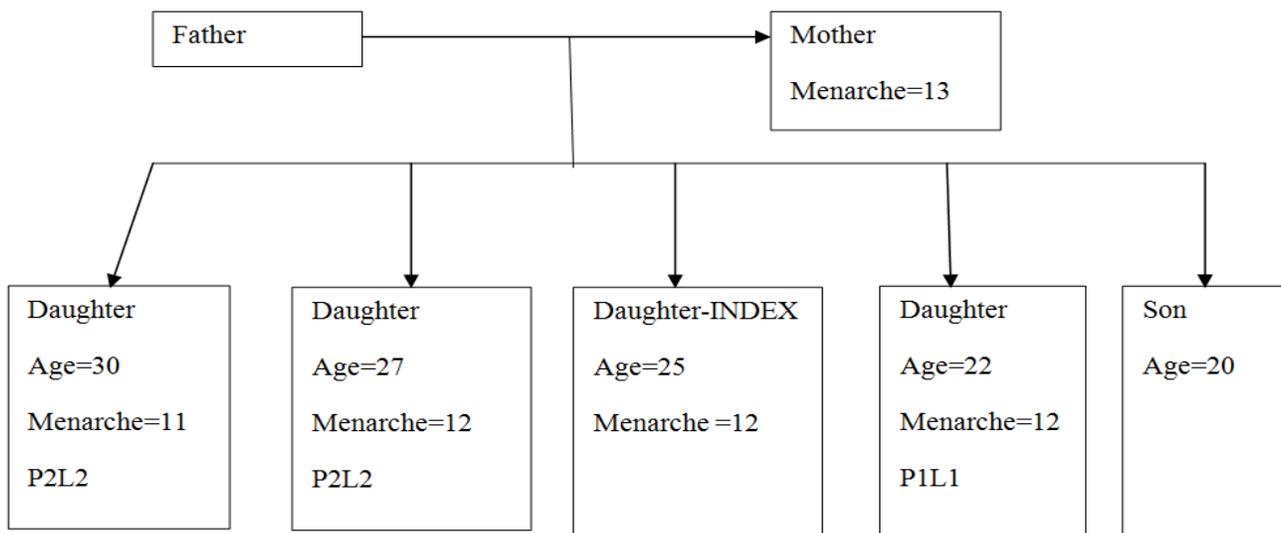
Local examination Pubic hair –Female pattern Tanner stage 5

External genitalia –Normal female

S/E Cervix healthy Vagina healthy

P/V Cervix ↓Uterus anteverted normal size fornices free

A working diagnosis of secondary amenorrhea for evaluation was made.



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:

Date	13.4.09	14.6.09	26.9.09	30.10.09
ft4	1.36	1.61	2.20	9.19
ft3	3.65			1.23
TSH	0.19	0.19	0.10	0.01

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

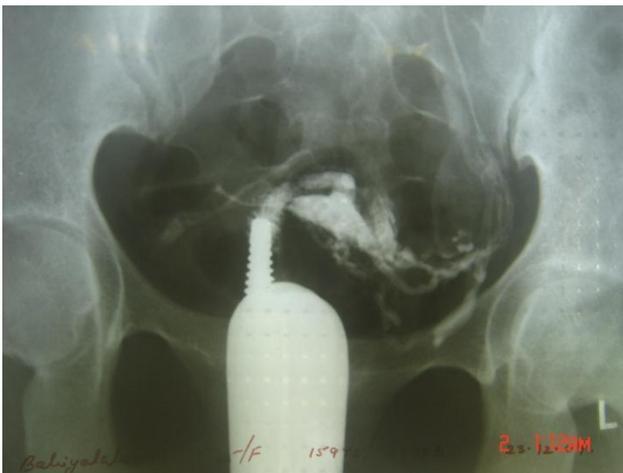
Hystero salpingogram observations

Date	11.4.09	18.6.09	19.11.09	17.12.09
Uterus	6.2 ×2.5	6.8×2.6×4.3	6.8×2.7	6.6×2.7
Endometrial thickness	4.1		5.2	6.4
Right ovary	2.7×2.5	19×18	3.4×2.7 with follicle1.8×1.5	2.6×2.1
Left ovary	3.6×2.0	20×18	3.5×2.0	3.1×2.5 with follicle 2.0×1.3

Subbaiah V N, Sreevalsan A, Kavitha, Jothis S S. (September 2013) Genito – Urinary tuberculosis still a prevalent entity – a case report. *Jour of Med Sc & Tech*; 2(3); Page No: 177 – 180.

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



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)Then

diagnostic laparoscopy done using a 10 mm laparoscope double puncture method. The uterovesical fold showed adhesions. The right tube was beaded with hydrosalpinx (Fig-3) and the sigmoid colon was adherent to anterior abdominal wall.

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

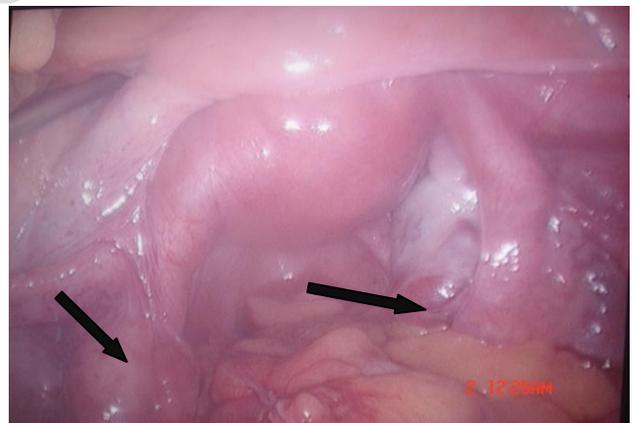
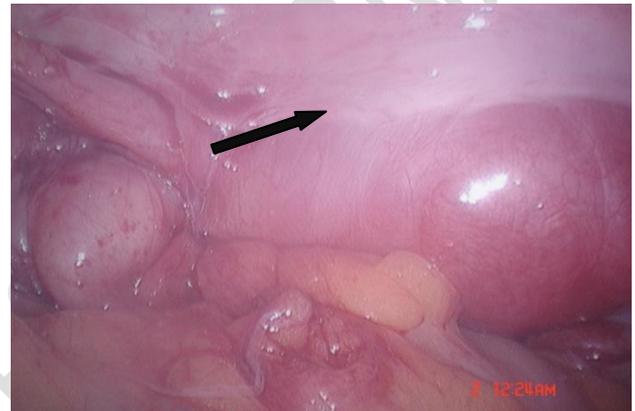
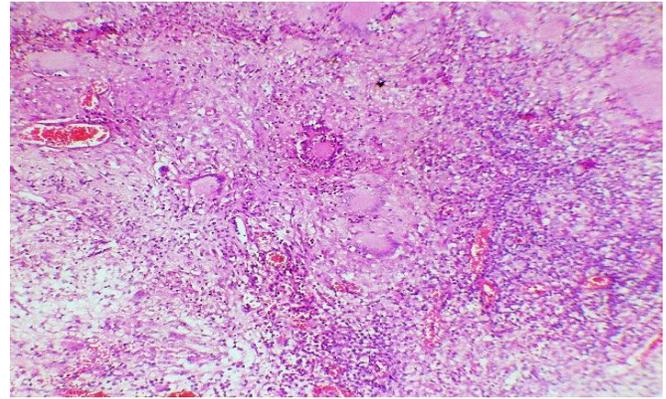
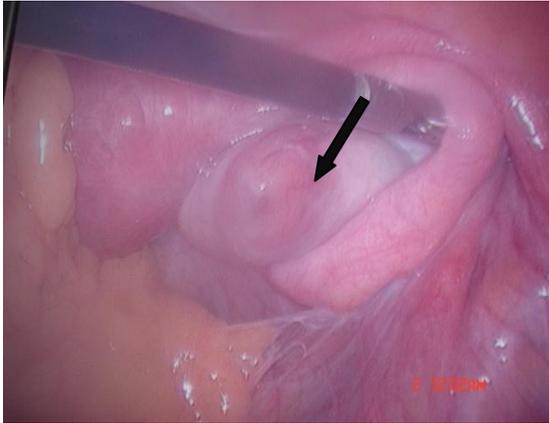


Figure -4: Both the Ostia were visualized

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



Section from the endometrium shows replacement of normal endometrium by multiple well defined epithelioid granulomas (H&E, 100X)

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

Acknowledgement

Authors would like to thank their colleagues who helped us in this especially Prof. Ramalingam [Professor of Radiology, Dr. Ranganathan [Urologist] who readily offered us the use of all his cystoscopes, Dr. Subramanian [Chest and Tuberculosis specialist] and Prof. Ganesan [Medical Superintendent] who allowed us to do all this.

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.

References

1. Manjari et al Tuberculous endometritis in sterile females- a clinicpathological and bacteriological study in *Ind. J.Tub.*, 1995, 42,227
2. Mukherjee et al A study of endometrial tuberculosis in hospitalised patients with pulmonary tuberculosis *Ind.J.Tub.* 1991, 38,197