

CASE REPORT

Tuberculous cervicitis: A case report.

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INTRODUCTION

Tuberculous infection, which is now uncommon in western society, is still frequently observed in Third World countries in Africa and Asia. The cervix is involved in 0.1–0.65% of all cases of tuberculosis and 5-10% of cases in female genital tract. Tuberculous involvement of the female genital tract in almost all cases is secondary to extragenital tuberculosis. Affection of the female genitalia has been reported as a rare event.^{1,2,3} We report a case of tuberculous cervicitis simulating cervical cancer.

CASE

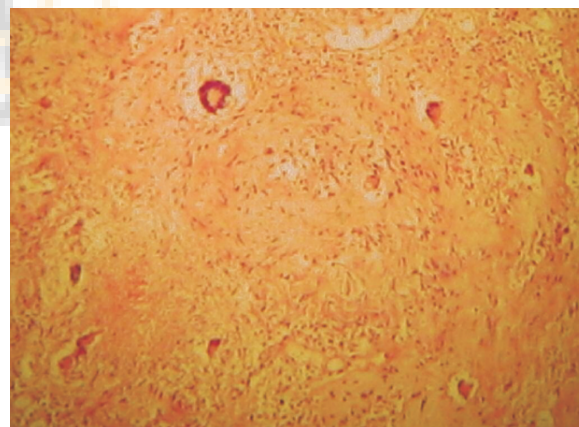
This case is of a 35 year old multiparous woman who was first seen in gynecological Clinic with a 5 months history of unprovoked irregular vaginal bleeding associated with passage of blood clots which necessitated blood transfusion and had 3 units of blood. There was no previous history of post-coital bleeding prior the onset of symptoms. Her last menstrual period dated back to prior to her last child birth two years earlier. She also observed that she was losing weight but no history of pelvic pain, chronic cough or contact with a case of pulmonary tuberculosis. On examination the cervix appeared hyperemic and irregular in outline, ulcerated, with vegetations. She had bilateral inguinal lymphadenopathies.

Antibody tests for HIV and VDRL infections were negative and the chest x-ray was normal. Pelvic ultrasonography revealed a small uterus and bilateral adnexae devoid of masses or collection. Sputum, urine and cervical secretions were negative for acid-fast bacilli and culture

was unhelpful. The erythrocyte sedimentation rate (ESR) at 2 hours was 85 and Mantoux test was 12mm. A diagnosis of cervical cancer was entertained and punch biopsy of the lesion was performed.

Histological examination showed an ulcerated endocervical epithelium overlying a lesion composed of granulomata with central areas of caseous necrosis which are composed of epithelioid cells with surrounding lymphocytes and plasma cells.

Figure 1: Histology of the cervix showing caseating granulomas, giant cells and lymphocytic infiltrates. H&E x100



There are numerous Langhans' giant cells. A special stain for mycobacterium was negative. Tuberculosis was considered as the most probable diagnosis. She had six months of anti tuberculosis therapy and after completion there was complete response. There was general improvement of physical condition and the cervix had a normal appearance. She is currently on follow up.

DISCUSSION

Tuberculosis of the cervix may occur as a primary infection or secondary (in which case

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the primary focus would have healed).^{4,5} As a general rule, genital tract tuberculosis involvement may be through : blood (90%), spread from other organs (e.g. tuberculous peritonitis), lymph node involvement, and “vertical” spread through intercourse with an infected partner.⁵

The common presentations in TB of the female genital tract are amenorrhoea, menstrual irregularities, infertility, vaginal discharge and postmenopausal bleeding. The gross appearance of the tuberculous cervix is highly variable. It may present as papillary, ulcerative, interstitial, miliary, endocervical or polypoid forms.^{3,5,6} Examination reveals a cervix that is not very different, in features, from those of invasive carcinoma with vegetative and ulcerative growth patterns.

Microscopically, there were caseating granulomas (Figure 1). These are not diagnostic of tuberculosis and therefore it is necessary to rule out other causes of granulomatous inflammation like foreign body reaction, schistosomiasis, amoebiasis, and sarcoidosis. Isolation of the mycobacterium is the gold standard for diagnosis. Approximately one third of cases are culture negative. Therefore, the presence of typical granulomata is sufficient for diagnosis if other causes of granulomatous cervicitis are excluded or a primary focus

identified.¹

The incidence of tuberculosis is on the rise due partly to rising incidence of HIV infection. Our case emphasizes that though uncommon in the cervix, tuberculosis should form an important differential diagnosis of malignant appearing lesion on the cervix. This warrants high index of suspicion among practitioners.

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