Genital Tuberculosis Manifesting As Sinus Tracts

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Abstract

Two cases of genital tuberculosis are reported. One is a parous woman with multiple sinuses draining through forchette as well as the anal wall and the other is an unmarried young girl with a discharging sinus at the vulva. We stress upon the need to keep the possibility of tuberculosis in mind while managing women with persistent vulvo-vaginal discharge.

INTRODUCTION

Tuberculosis persists to be a leading cause of morbidity and mortality. Genital tuberculosis is prevalent in 0.7-1% of Gynecologic admissions and is 10 times more common in women with infertility. Vulval involvement is seen in only 0.2% of the cases with genital tuberculosis[1].

We report two cases of tuberculosis where the clinical presentation did not adequately hint at the possibility of tubercular etiology.

CASE 1

A 39 year old primipara presented with history of pus discharge per vagina- off and on, since one year. Discharge was preceded by appearance of painful swelling in the lower vagina. Examination under anesthesia by her clinician showed discharge both per vagina and per anus on squeezing the swelling. She was referred as a case of rectovaginal fistula.

Two years earlier, she had undergone incision and drainage for left sided Bartholin abscess. Her husband had epididymo-orchitis ten years back that responded to antimicrobial treatment. Her menstrual cycles were normal; neither did she have any difficulty at conception. There was no fecal incontinence.

Examination showed pus in the lower vagina. Rectovaginal palpation revealed tender shallow ulcers both on the lower posterior vagina near the forchette and on the anterior anal wall. There was induration on left lower vaginal wall and the perineum. There was no significant lymph node enlargement. Differential count and blood sugar evaluation was normal and erythrocyte sedimentation rate (ESR) was 75mm/hour.

She was treated with appropriate antibiotics and was taken up for surgery. Examination confirmed the findings. The area with ulcers and the sinus tracts was excised and the perineum repaired. Histopathology of the excised tissue showed the features suggestive of tubercular etiology. She was put on anti- tubercular treatment for 9 months. Husband's semen and urine was negative for tubercular bacilli.

Two years since the completion of treatment, the patient remains asymptomatic.

CASE 2

A 22 year old unmarried lady presented with a four month history of recurrent painful swelling on the right vulva followed by pus discharge through perineal region. Repeated antimicrobial treatment failed to prevent the recurrences. She had normal menstrual cycles and there was no past or family history of tuberculosis.

On examination, there was purulent discharge draining through an opening situated 4cm posterior and right lateral to the forchette. On rectovaginal examination, a 3×3cm induration was felt in the right posterior part of vulva. The case was diagnosed as chronic bartholinitis with sinus tract. A sinusogram confirmed the sinus tract that was dividing at its proximal end.

Under spinal anaesthesia, bartholin cyst along with the sinus tract was excised. Histopathology revealed granulomas with central caseous necrosis and multinucleated Langhan's giant cells, indicating tubercular etiology. She was advised antitubercular treatment.

DISCUSSION

Women with menstrual abnormalities and infertility are almost always evaluated for possible tubercular etiology. Otherwise in gynaecological practice this etiology is rarely thought of. This may delay the diagnosis and definitive treatment. The patient moves from clinician to clinician with prevailing symptoms.

Tubercular lesions of the vulva present as small shallow ulcers, multiple sinus tracts and scarring[2]. Both the cases presented here had characteristic lesions, yet the diagnosis was somewhat delayed probably because of lack of suspicion of tubercular etiology. Vulval tuberculosis is usually secondary. However, several authors have reported cases with venereal transmission of genital tuberculosis, the majority of the male patients having tubercular epididymo-orchitis[3]. In the first case we thought of husband's epididymo-orchitis as the source. But the previous reports as well as semen and urine cultures did not substantiate this. In case of the unmarried girl, it was probably a primary genital involvement as a result of nonvenereal transmission. Still the possibility of it being secondary to a resolved primary pulmonary disease can't be ruled out. We reemphasize that tuberculosis should be kept in mind whenever a particular symptom fails to respond to empirical treatment or whenever it recurs despite treatment.

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