

Pelvic Abscess In A Patient With Hiv Infection In A Nigerian Hospital: Case Report

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Citation

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Abstract

We report a case of pelvic abscess in a 27 year old HIV infected multiparous woman who presented in our hospital with abdominal pain, fever and offensive vagina discharge of one week duration. She had laparotomy with drainage of abscess and antibiotic treatment. Her recovery was uneventful and she was discharged home on the tenth postoperative day. Pelvic abscess is a complication of delayed or inadequate treatment of PID. HIV may be an added problem in the presence of immune depression. Early and adequate antibiotic treatment of all cases of PID including surgical intervention should be considered.

INTRODUCTION

Pelvic abscess, also known as Cul – De-Sac abscess is an uncommon complication of chronic or recurrent pelvic inflammation. It may occur as a result of post-abortal sepsis or pelvic inflammatory disease (P.I.D.) which is an ascending infection from the endocervix causing endometritis, salpingitis, parametritis, oophoritis, tubo-ovarian abscess and/or pelvic peritonitis.¹ While sexually transmitted infections such as Chlamydia trachomatis and Neisseria gonorrhea have been identified as causative agents,² mycoplasma genitalium, anaerobes and other organisms may also be implicated.^{2,3} Abscess formation is frequently caused by organisms such as anaerobes, especially bacteroides⁴ and other gram – negative bacteria.

Women who are HIV infected were previously thought to get clinically more severe PID but recent studies suggest that the differences may be minor and that they respond as well to treatment as patients who are not HIV infected.⁵

We present an HIV infected multiparous woman with pelvic abscess who had laparotomy and drainage. This article is an attempt to remind general practitioners, gynaecologists and other specialists of the consequences of delayed and/or inadequate treatment of PID especially in the presence of the HIV pandemic in resource constrained countries.

CASE REPORT

A 27 year old multiparous woman presented to the gynecological out patient unit with a one week history of progressive suprapubic abdominal pain which became

generalized and associated with dysuria two days before presentation. She had also noticed an offensive vaginal discharge which was, brownish and pruritic. There had been episodes of fever and generalized weakness, for which she was treated elsewhere with over-the-counter anti malaria drugs and some antibiotics. There was also associated anorexia and passage of watery stools. Her last menstrual period was about two weeks before onset of symptoms and there was no history of sexual intercourse. She had tested positive during a routine screening test for HIV – 1 one month earlier. She had no history of previous blood transfusion or sexually transmitted disease or chronic cough.

Physical examination revealed an acutely ill – looking woman, who was febrile (T-39°C), mildly pale, anicteric with moderate hydration. Her blood pressure was 110/70 mmHg and the pulse rate was 82 beats/minute. She had an abdomino-pelvic mass of about 20 weeks size, which was soft and tender with guarding and rebound tenderness. The liver, spleen and kidneys were not palpably enlarged. Pelvic examination revealed a centrally located closed cervix with offensive brownish discharge oozing from the os. The abdomino-pelvic mass was slightly shifted to the right. There was positive cervical motion tenderness with bilateral adnexal tenderness. Rectal and other systemic examinations did not yield additional findings. A working diagnosis of pelvic abscess in an immune-suppressed HIV infected woman was made. She was admitted and counseled for possible exploratory laparotomy.

Laboratory analysis included a hematocrit of 25% (0.25);

total white blood cell count of $14.6 \times 10^9/l$. HIV screening was reactive for HIV-1. Hepatitis B surface antigen test was negative. Her CD4+ count was 350 cells/ml. The VDRL was non reactive, blood culture yielded no growth, and high vagina swab culture yielded *Escherichia coli*. Abdomino-pelvic ultrasound scan showed an enlarged (12 weeks pregnancy size) empty uterus, with a multiloculated mass arising from the pelvis. She was resuscitated with intravenous fluids, intravenous ceftriaxone 1 gm 12 hourly and metronidazole 500 mg 8 hourly for the first 48 hours. Analgesia was achieved with parenteral pethidine.

At laparotomy, a large multiloculated abscess was found. The intestines and pelvic organs were held down in fibrinous, filmy and thick adhesions of bowel and omentum attached to the anterior abdominal wall. About 800 mls serosanguinous fluid were drained from the cavities after the loculi were digitally broken down. The uterus was edematous with both tubes inflamed while the pouch of Douglas was obliterated. The appendix was normal.

Peritoneal lavage was done with two liters of warm Ringer's lactate solution with placement of two corrugated drains, one in each iliac fossa. Her recovery was uneventful with both drains removed on the fifth day. She was discharged home on the 10th postoperative day after removal of all stitches.

DISCUSSION

In the presence of clear evidence of pelvic abscess as seen in this woman, surgical treatment should be considered.

Laparotomy/laparoscopy may help early evaluation of PID by division of adhesions and drainage, of pelvic abscesses⁶ as was done in this case. Ultrasound guided aspiration of pelvic fluid collections is less invasive and may be equally effective⁷ in less complicated cases. Colpotomy incision for drainage of the abscess^{8,9} was not suitable due to adhesions. Among woman of child bearing age, HIV/AIDS is the leading cause of morbidity and mortality worldwide. This is because of late diagnosis in many cases, with treatment often started too late resulting in high rate of early mortality and associated opportunistic diseases.⁸ Although the severity of symptoms is often directly proportionate to the size of the abscess, occasionally, even a large pelvic abscess may be totally asymptomatic⁴ especially in extra pulmonary tuberculosis usually associated with immunosuppression in

HIV infection. Female genital tract infection may be contracted by hematogenous spread from a pulmonary nidus (the fallopian tube is a predominant site of infection) or from gastrointestinal infection. In this woman no caseous material or tubercles were seen on the serosa of the organs as is usually found in early cases of tuberculosis. Although she had adequate clinical recovery, the long term complication's usually associated with delayed treatment especially in Chlamydia infection such as ectopic pregnancy, sub fertility and pelvic pain^{9,10} cannot be predicted in this patient. It is therefore imperative for medical practitioners to ensure quick and efficient medical treatment and/or surgical intervention for all women with PID in order to forestall the ugly consequences usually associated with delayed treatment, especially in the presence of the HIV pandemic.

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