Pelvic Abscess In A Patient With Hiv Infection In A Nigerian Hospital: Case Report
S Hembah – Hilekaan, S Ngwan, T Swende

Citation

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 gynaecological 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-39oC), 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);
Pelvic Abscess In A Patient With HIV Infection In A Nigerian Hospital: Case Report

总白细胞计数为14.6 x 109/l。HIV筛查
was positive。Her CD4+ count was 350 cells/ml。The VDLR was
to reactive, blood culture yielded no growth, and high
vagina swab culture yielded Escherichia coli。Abdomino-
ultrasound 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。
Analgosia was achieved with parenteral pethidine。

At laparotomy, a large multiloculated abscess was found。The intestines and pelvic organs were held down in
fibrous, 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
diluted 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
in 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 abscess5
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 abscess8,9 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 diseases8。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 immunosupression 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 inflection。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 pain9,10 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。

References

6. Reich H, McGraw F。Laparoscopic treatment of tub
or ovarian and pelvic abscess。J Reprod Med 1987;32:747-52
7. Abouilghar MA, Mansour RT, Serour GI。
Ultrasonographically guided transvaginal aspiration of tub
ovarian abscesses and pyosalpinges: an optional treatment
8. Odukogbe AA, Ola B。Current concepts in the
management of pelvic inflammatory disease。Annals of Ibaadan postgraduate medicine。2005，3:1:63-68。
10. Laurine B。WHO Issues New Hiv Recommendations
medscape CME Clinic Briefs Heep/CME。Medscape。Com/viewarticle/713325？Src = cmenewsauac = 95541SG。12/14/2009
Author Information

S. Hembah – Hilekaan, MBBS,FWACS
Department of Obstetrics and Gynaecology, Federal Medical Centre

Stephen D. Ngwan, MBBS
Department of Obstetrics and Gynaecology, Federal Medical Centre

Terrumun Z. Swende, MBBS,FMCOG,FWACS
Department of Obstetrics and Gynaecology, Federal Medical Centre