Endometrial tuberculosis: a clinical case

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Summary

Genital tuberculosis is a bacterial infection still frequent in less developed countries where lots of cases are not diagnosed nor treated. In this work we describe a rare case of primary endometrial tuberculosis in a woman of 50 years old. The diagnosis was confirmed by an ultrasonography of the pelvis and an endometrial biopsy followed by a histological examination. The patient after the diagnosis was put under antiturbecular treatment for six months with complete healing.

Key words: Endometrium; Tuberculosis; Mycobacterium tuberculosis.

Introduction

Up to the latest report of "Global Tuberculosis Control" of the OMS, 9,270,000 new cases of tuberculosis (TB) were registered throughout the world during 2007. The greatest part of the cases were concentrated in Asia (55%) and in Africa (31%). Moreover, one death out of four for TB is connected to HIV. Genital TB represents only 2.5-7% of the cases of TB. Cases observed in the childhood period are an exception. Most cases occur during the reproductive age, while menopause cases, although rare, are increasing. The principal way of contamination is haematogenous, followed by lymphatic and contiguity. Primitive genital localisation is very singular and is a reason to check for a venereal infection [1-3].

Case Report

A 45-year-old unemployed and illiterate woman living in Abidjan had been examined in November 2008 at the Gynaecology Department of "Saint Louis Orione" Medical Center of Anyama (Ivory Coast) for abundant and malodorous vaginal secretions with swelling and abdominal pain of eight months' duration. She had had six natural deliveries and had been married twice.

Physical examination showed a swollen and painful abdomen. Gynaecological examination revealed that the internal genital organs were not easily discernible and the speculum examination showed the spillage of yellowish and malodorous secretions from the external uterine orifice.

Transvaginal ultrasonography revealed an uterus of increased volume with a thickened and non-homogenous endometrium infiltrating one-third of the myometrium. In addition a notable quantity of free fluid (ascites) was observed in the abdominal cavity.

Chest X-ray appeared negative. Blood test revealed an increase of C-reactive protein (CRP) (30 mg/l), a low rate of haemoglobin (8.3 g/dl), and moderate leukocytosis (14.8 x 10^9/l). Indexes of liver and renal functionality appeared normal. HIV serology was negative. Renal ultrasonography resulted normal.

Biopsy samples of the endometrium were collected by curettage of the uterus and then analysed. The typical histological aspect indicated endometrial TB.

Medical treatment, based on antitubercular medications using isoniazide, rifampicin, pyrazinamide and streptomicine was administered for six months by the Pneumology Department of Abidjan. Ultrasonography of the pelvis after seven months from the beginning of antitubercular medical treatment showed a complete *"restitutio ad integrum"*.

Conclusion

Due to frequency of endometrial TB cases in less developed countries, this pathology should be considered in to the differential diagnosis of proliferative pathology of the uterine cavity. In our clinical case, the exclusion of a pri-

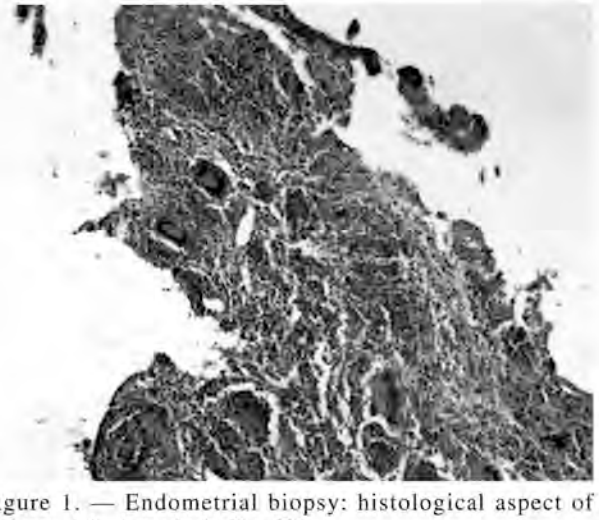

Figure 1. — Endometrial biopsy: histological aspect of endometrial tuberculosis (2 x 10).

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mary pulmonary localisation of TB suggested that the woman had probably been infected by venereal contamination from an infected partner [4-6].

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