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A Rare Localization of Tuberculosis: Endometrial Tuberculosis A Case Report and Review of the Literature

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Abstract: *Tuberculosis remains a public health problem, especially in developing countries. While the pulmonary bacillary form is the most frequent, the genital form is rare and under-diagnosed. We report a case of endometrial tuberculosis in a 21-year-old woman that illustrates the diagnostic difficulties of genital forms. This case makes the clinician aware of the possibility of endometrial tuberculosis in a patient consulting for infertility or common gynecological symptoms.*

Keywords: Tuberculosis, endometrium, infertility, treatment

RESUME: La tuberculose demeure un problème de santé publique, surtout dans les pays en voie de développement. Si la forme pulmonaire bacillaire est la plus fréquente, la forme génitale est rare et sous-diagnostiquée. Nous rapportons un cas de tuberculose endométriale chez une jeune femme de 21 ans qui illustre les difficultés diagnostiques des formes génitales. Ce cas sensibilise le clinicien à avoir présent à l'esprit la possibilité d'une tuberculose endométriale chez une patiente qui consulte pour une infertilité ou des symptômes gynécologiques banals

MOTS-CLEFS: Tuberculose, endomètre, infertilité, traitement

INTRODUCTION:

Tuberculosis (TB) is one of the most widespread infectious diseases in the world and constitutes a major public health problem[1], especially in countries with limited resources. Genital tuberculosis ranks fifth in Morocco after pulmonary, lymph node, osteoarticular and digestive tuberculosis.

Genital tuberculosis in women is the cause of infertility due to the tubal and uterine lesions it causes. Diagnostic certainty is provided by biology or histology[2,3]. Since female genital tuberculosis is a paucibacillary form, these examinations may prove to be falsely negative; the diagnosis may then be made on the basis of a combination of nosological, radiological and endoscopic arguments[5,6].

The management of infertility is essentially based on in vitro fertilization after a well conducted medical treatment and a proven cure. Thanks to medically assisted procreation, the prognosis for fertility remains good, except in the case of endometrial damage which greatly reduces the chances of procreation. It is the intraoperative biopsy that often makes it possible to rectify the diagnosis, thus avoiding a radical procedure and directing the patient towards medical treatment[4].

clinical case:

The patient was Mrs. A.K., 21 years old, nulligest, without any particular history. She consulted for a primary infertility of 4 years with chronic pelvic pain without metrorrhagia or cycle disorder or associated digestive or urinary signs, all evolving in a context of apyrexia and conservation of the general state. The physical examination showed a soft abdomen with a macroscopically normal cervix and a normal sized uterus without MLU or SLU on vaginal touch. Pelvic ultrasound showed normal sized uterus with thickened endometrium and interface line seen in totality. Polymicrocystic ovaries and left hydrosalpinx measuring 49*24mm.

The hysterosalpingography was in favor of a heterogeneous aspect of the uterine cavity probably related to synechis with bilateral tubal obstruction(figure1)

A hormonal assessment of our patient and a spermogram of the spouse without anomaly

We performed a HSC dg and laparoscopy, the hysterscopic exploration of which revealed an endometrial hypertrophy with biopsy curtage of the endometrium, the laparoscopic exploration showed sulky tubes with several tubo-ovarian and tubo-parietal adhesions and aspest right tubal phimosis without passage of the methylene blue bilaterally.

The anatomopathological examination of the EBC came back in favor of an endometrial tuberculosis.

The patient was referred to CDST for medical treatment with antibacillary drugs.

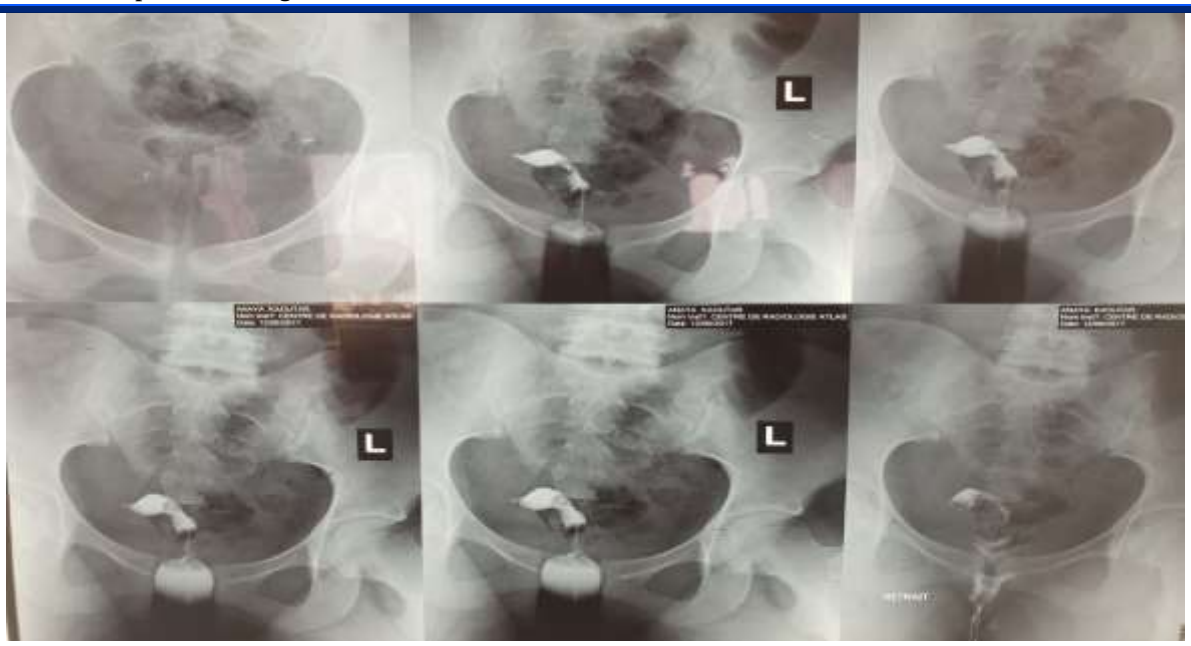

Figure 1: Hysterosalpingography of Mrs A.K with bilateral tubal obstruction

Discussion:

The incidence of genital tuberculosis is not known as many cases remain undiagnosed due to the frequency of latent and inapparent forms.[7,10] It is always secondary and follows either hematogenous dissemination from an initial tuberculosis site, with initial involvement of the fallopian tubes (100% of cases) resulting in a picture of salpingitis from which the infection progresses to the other genital organs; or contamination by the lymphatic route from the pelvic lymph nodes; rare cases secondary to direct inoculation by venereal contact have been reported by Weinstein. It predominantly affects young women, at the height of their genital activity. There are forms declared in peri- or post-menopausal period [8,9]. Our patient was 21 years old at the time of diagnosis. This form of endometrial tuberculosis in young women is often associated with tuberculous salpingitis.

The circumstances of discovery of female genital tuberculosis are very varied. The most reported reasons for consultation were infertility (44%), pelvic pain (25%), vaginal bleeding (18%), amenorrhea (5%), leucorrhea (4%) and postmenopausal metrorrhagia (2%). The revealing mode of our patient was a 4-year infertility.

The diagnosis is not obvious, requiring imaging techniques, biological and histological examinations. On imaging, the chest X-ray may show parenchymal or pleural sequelae. [12,13]Hysterosalpingography, the examination of choice, often shows two aspects characteristic of tuberculosis origin: uterine synechiae and tubal obstructions (figure 1) the case of our patient.

The diagnosis of certainty can be direct by the demonstration of mycobacterium tuberculosis on direct microscopic examination, or after culture of pathological specimens. It can also be indirect by anatomopathological analysis of the material obtained by endometrial biopsy. In our case the diagnosis was indirect.[15-16]

The treatment is currently well codified and is based on the daily administration of isoniazid and rifampicin for 6 months, associated with pyrazinamide and ethambutol for the first 2 months. Clinical and paraclinical monitoring is carried out regularly throughout the treatment. Surgical treatment of the genital form is indicated in case of: persistence of adnexal masses despite medical treatment, in particular in case of cold abscess, relapse of endometrial tuberculosis after one year of treatment, persistence of pelvic pain after 3 months of treatment or when it has not completely disappeared after one year of treatment, in case of metrorrhagia persisting after anatomical and clinical healing, fistulas which do not dry up. Our patient was put on antitubercular treatment had a good evolution. There was no indication for surgical treatment.[17,18,19]

CONCLUSION:

Tuberculosis remains frequent but rarely manifests as endometrial involvement. Young women of low socioeconomic status, consulting for infertility, are most concerned. However, it is important to know how to evoke it in the presence of persistent pelvic symptoms, whatever the age, and to carry out examinations to help make the diagnosis.

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