

MILIARY TUBERCULOSIS, AN UNUSUAL CAUSE OF SEPSIS IN PREGNANCY IN THE UK

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Introduction

Miliary Tuberculosis (Tb) is massive lympho-haematogenous dissemination of Mycobacterium tuberculosis bacilli. The diagnosis is a challenge, even for the most experienced. It can present in adults with symptoms similar to sepsis, in people with reduced immunity. This atypical presentation could be the case with cryptic miliary Tb and result in delayed diagnosis.

It is uncommon in the UK, 1-2% of Tb cases. Also uncommon in pregnancy and when it does, is often associated with maternal history of intravenous drug use (IVDU), malignancy, alcohol misuse or HIV infection.

Known obstetric complications include:

spontaneous miscarriage

congenital Tb - rare

preterm labour (PTL)

low birth weight and small for gestational age (SGA)

increased perinatal mortality

Case report

26 year old P1, previous c/s less than a year previously. Spoke no English, in utero transfer (IUT) at 30 weeks for threatened PTL. Developed severe sepsis, initially thought to be a urinary tract infection (UTI), no respiratory symptoms, settled with antibiotic treatment. Subsequently had a placental abruption and required a preterm emergency caesarean section.

Had further recurrent episodes of sepsis, different foci of infection including genital tract, were explored, treated with initial positive response and then relapse. No respiratory symptoms initially, no history of recent travel or contact with any sick person.

Early input from medicine, microbiology and radiology obtained. Investigations done were inconclusive and Tb was thought to be unlikely at this point due to these findings.

Communication/history was affected by language barrier though interpreters were used for her care as much as possible.

Other diagnoses ruled out included malaria, endocarditis, viral, fungal and autoimmune diseases.

Care was transferred to medicine due to worsening symptoms despite treatment including antiviral and antifungal. Again, improvement therefore discharged but readmitted a few days later with severe sepsis.

Further input received from critical care, respiratory, infectious diseases and tertiary unit - Tb lead.

At the thoracic radiology meeting- bronchoscopy and lavage suggested. Tb was now the most likely diagnosis but though there was no confirmed positive test yet, empirical treatment was considered.

Investigations

Investigations	Results
Septic screen- urine, HVS, Blood cultures, HIV, Fungal screen	Negative
Imaging- CT abdomen and pelvis CXR	Splenomegaly Viral pneumonia
Immunology, including auto-immune screen	Negative
Culture from bronchial washings and biopsy	Positive
Blood Quantiferon Gold	Positive

The definite diagnosis was eventually reached after 2 weeks of admission.

She was commenced on Tb management, responded promptly and well to treatment and discharged a week later.

Discussion

Lots of red herrings on investigation - typical of miliary Tb. The language barrier was a strong factor for suboptimal communication.

Conclusion

Miliary Tb- is a challenging diagnosis, requiring multidisciplinary care, expertise escalation and persistence for the best outcome.

Usually results in adverse pregnancy outcomes. This case was further complicated by language constraints.