

Pelvic Actinomyces associated with Intra-uterine device – a case report

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Introduction

- Actinomyces, a chronic granulomatous disease
- Caused by gram positive, anaerobic bacteria
- Known to be associated with long standing use of IUCD
- Can mimics tuberculosis, malignancy and other abdomino-pelvic inflammatory diseases
- This is a case of pelvic actinomyces associated with a long standing IUCD in a woman without other risk factors.

Case History

- 50yr old previously healthy lady with abdominal pain and loss of appetite for 1 month duration.
- History of long term IUCD use.
- Evidence of infection with negative culture studies
- CECT abdomen & pelvis - ill defined heterogeneously enhancing adnexal masses - early abscess formation or ovarian neoplasms.
- Laparotomy - left sided tubo-ovarian mass with evidence of pelvic infection. TAH & BSO done.
- Histopathology - severe salpingo-oophoritis with evidence of actinomyces infection.
- Treated with IV Penicillin 24 MU/day in 4 divided doses for 3 weeks followed by oral Amoxicillin 750mg 8 hourly for 6 months duration.

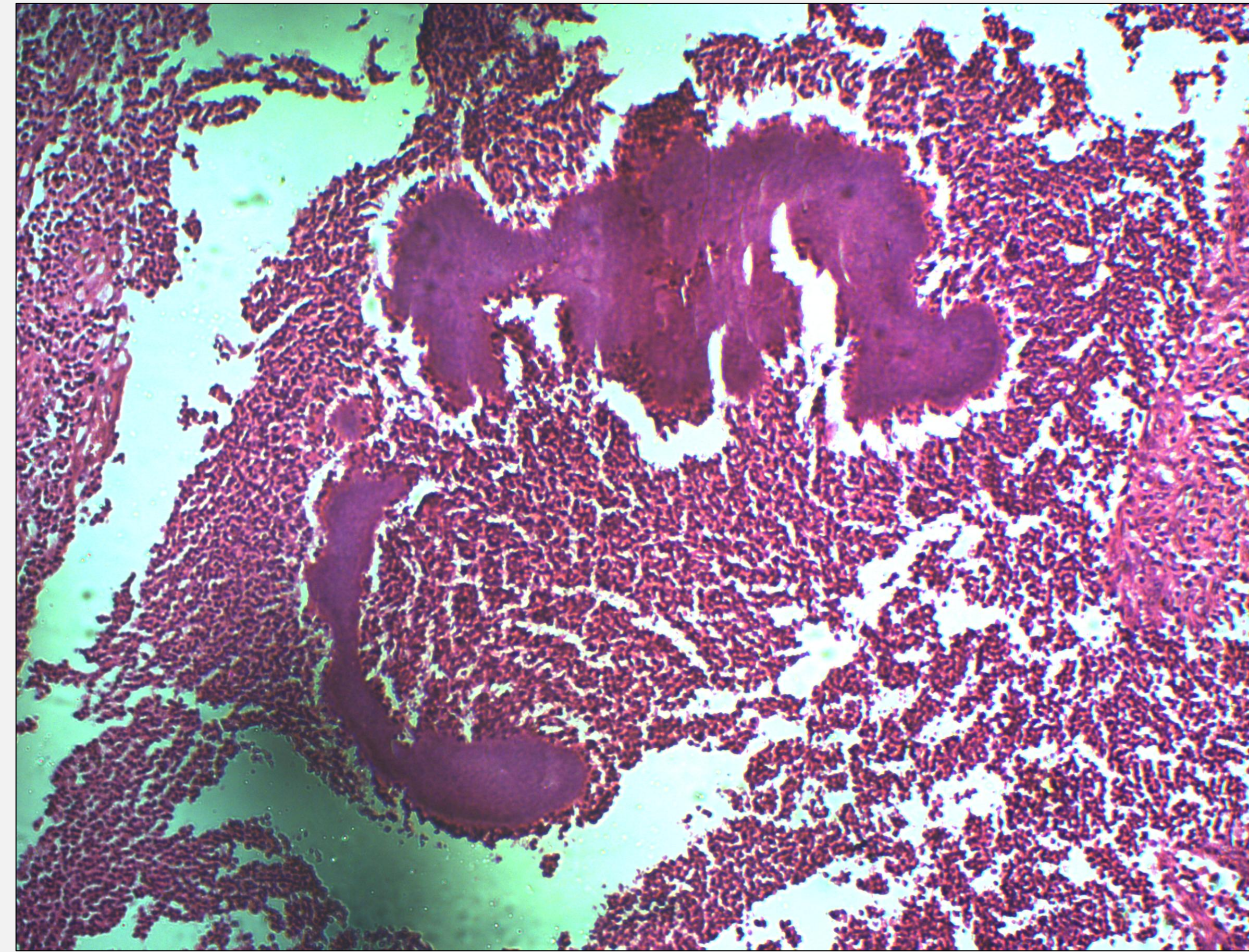
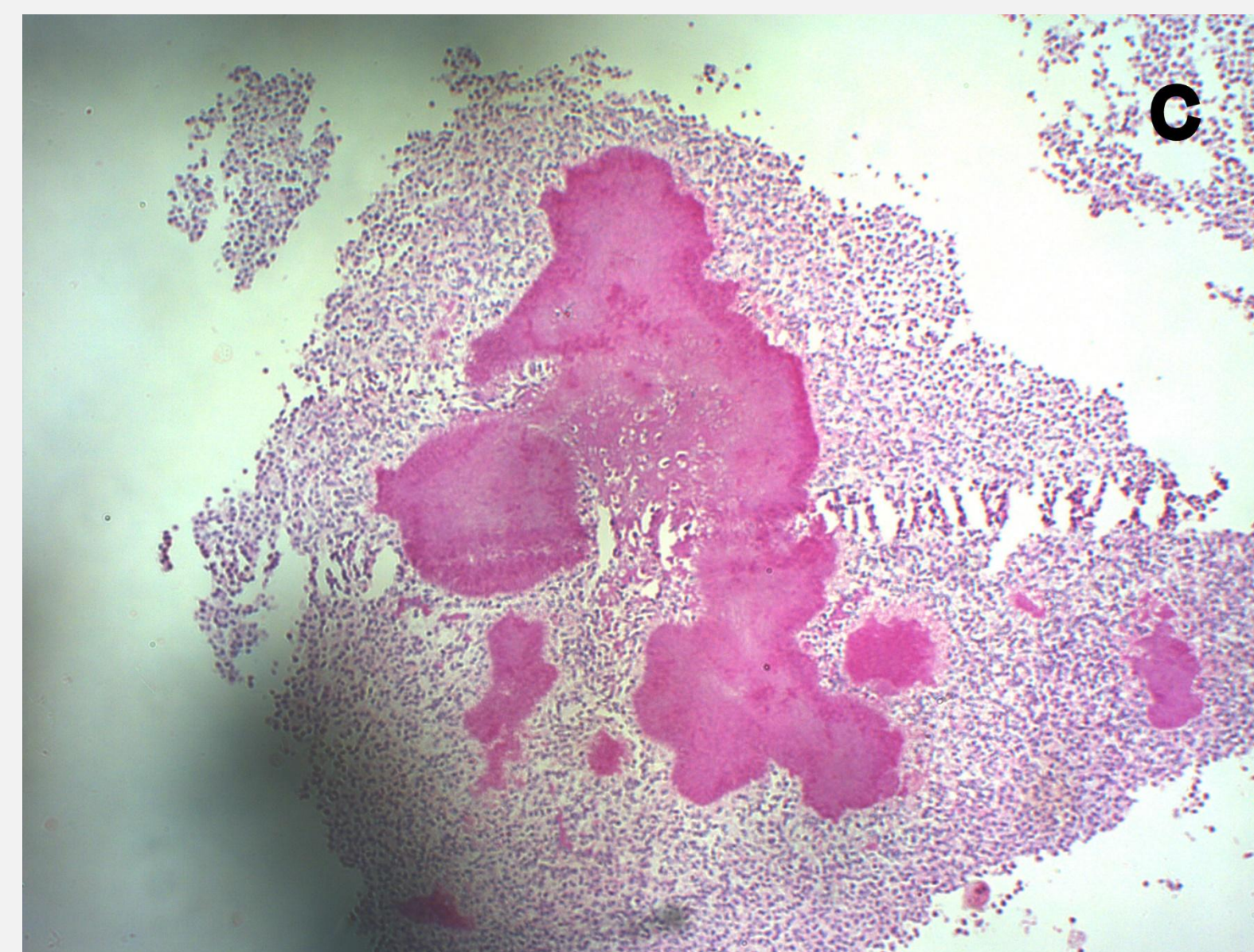
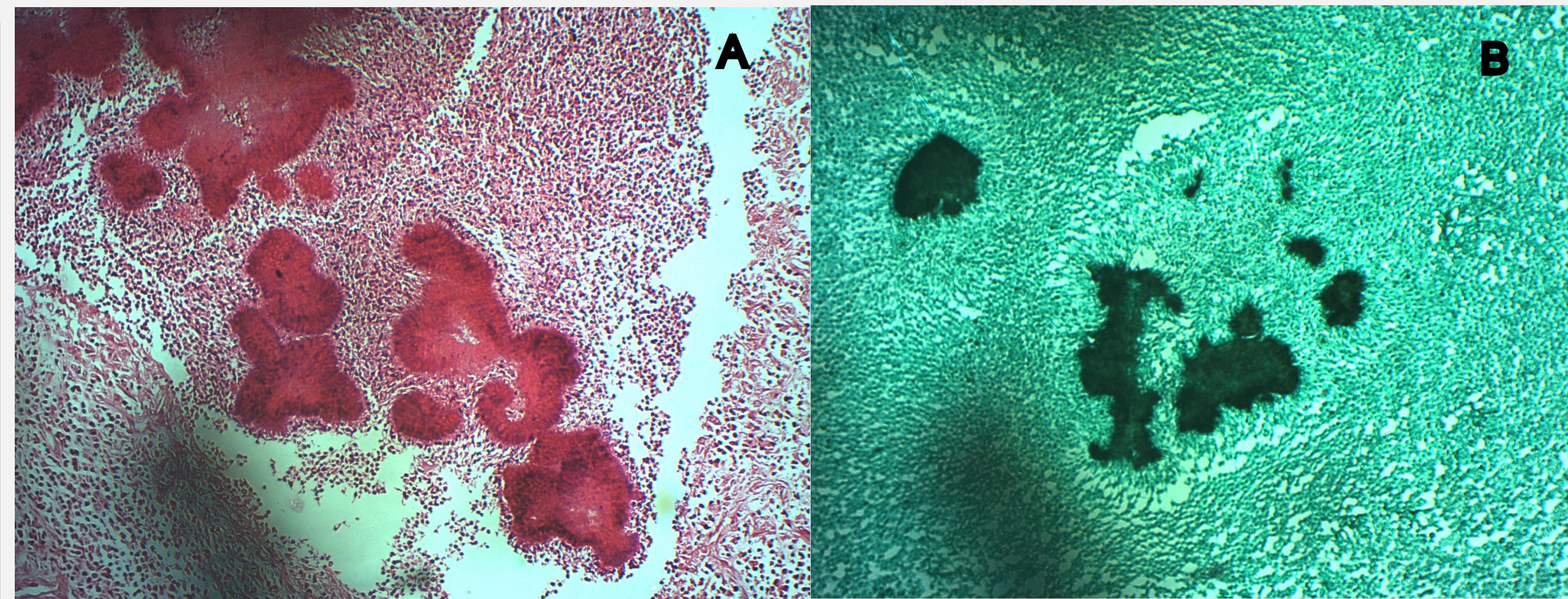


Figure 1 - H & E stain x100 – filamentous organism



- A – Gram stain x 100
B – Grocott stain x100
(negative for fungi)
C – PAS stain x100

All images show a
filamentous organism
(sulphur granules)

Discussion

- Pelvic actinomyces in female is known to be strongly associated with long standing use of IUCDs.
- In case patient, use of long standing use of IUCD was the only identifiable risk factor without evidence of immune-compromised status.
- None of the typical signs and symptoms were present to predict possibility of pelvic actinomyces.
- Inflammatory markers, imaging findings were controversial as there was no obvious abscess formation.
- Therefore as diagnosis is inconclusive with laboratory investigations and imaging, histological diagnosis with demonstration of the organism or Sulphur granules in a specimen is essential for confirmation.
- Treatment modalities should involve long-term antimicrobial therapy for 6 – 12 months. Percutaneous drainage and surgical debulking can be used as adjuvants to antibiotic treatment.

Conclusion

- Diagnosis is a dilemma needing accurate clinical correlation and histopathological confirmation.
- Early diagnosis and prompt treatment with long-term antibiotics with adjuvant surgical interventions is the main stay of treatment.