

Late Diagnosis of Pelvic Tuberculosis Presenting as a Tubo-Ovarian Abscess

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OBJECTIVE

Pelvic tuberculosis (TB) presenting as a Tubo-Ovarian Abscess (TOA) is a rare and often missed diagnosis, as it mimics other pathologies. This case report aims to raise awareness of tubo-ovarian TB which will aid in earlier diagnosis and treatment.

CASE REPORT

A 38 year old P7+2 presented with lower abdominal pain, fever and a yellow vaginal discharge. She had a neutrophilia, negative HIV and COVID-PCR as well as urine, blood and vaginal cultures. CT imaging showed a (8×9×7)cm multi-loculated cystic collection with fat stranding, free fluid and regional lymphadenopathy suggestive of a TOA. She underwent an exploratory laparotomy, after no improvement with combination antibiotic therapy. Large pus filled bilateral TOAs, adherent to the posterior uterus, fundus, pelvic side wall and small and large bowel were present. The uterus was friable and oozing pus. A subtotal hysterectomy, bilateral salpingo-oophorectomy and repair of a serosal tear on the ileum was done. Histology later confirmed bilateral TOAs, an inflamed endometrium with purulent material and caseating granulomas, with acid fast bacilli on Ziehl Neelson staining. She was referred to a Thoracic Medicine specialist for further treatment with antitubercular drugs.

DISCUSSION

Pelvic TB affects 12% of women with pulmonary TB, spreading via the lympho-haematogenous route. It presents commonly among women of reproductive age. They may be asymptomatic or present with systemic symptoms. Pelvic symptoms include infertility, menstrual abnormalities and pelvic pain. The formation of a TOA originates in the tube, spreads to the ovary and is likely to form adhesions to other pelvic structures. In immunocompetent persons with a TOA, in non-endemic areas, pelvic TB is a less considered diagnosis. Pelvic inflammatory disease or ovarian malignancy are more likely differentials which delays treatment

and increases morbidity. A tuberculin skin test has a sensitivity of 55% and specificity of 80% with multiple conditions causing false negative or positive results. There are also no ultrasound or MRI findings that are specific to ovarian tuberculous abscesses and Ca-125 levels can be elevated. All these factors can hinder an early diagnosis. Definitive diagnosis is achieved from histopathological examination of specimens with microscopy for acid fast bacilli with Ziehl Neelson staining or cultures for M.tuberculosis. Collection of multiple specimens are advised as the organism is scarce in pelvic TB.

CONCLUSIONS

Pelvic TB presenting as a TOA can easily masquerade as other ovarian pathologies, as its symptoms as well as investigations are non-specific. Physicians should have a high level of suspicion especially in cases where treatment measures show no improvement In clinical status.

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