A RARE CASE OF VULVAL TUBERCULOSIS
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ABSTRACT

A patient with tuberculosis of the vulva is reported. A 50 years old unmarried female had complaint of persistent vaginal discharge for 10 years. On examination her vulva was hypertrophied and there were papillary growths on clitoral and rectal region. Biopsy showed chronic caseating granulomatous inflammation suggestive of Tuberculosis. The lesions healed completely after giving antituberculous chemotherapy for 6 months.

KEY WORDS: Female Genital Tuberculosis, Vulval Tuberculosis, Anti-Tuberculous Drugs.

INTRODUCTION

Tuberculosis of the genital tract is a chronic disease and usually presents with non-specific symptoms. It can occur in isolation or secondary to a pulmonary focus. It accounts for 15% of all the extra pulmonary cases. Most frequently it involves the upper genital tract and asymptomatic. It usually affects the women of reproductive age. Vulval TB is very rare and accounts for 0.2% of the cases with genital TB. There are only 10 reported cases in the literature (mainly in developing countries). The presentation can be quite variable, and it can present at any age ranging from 7 months to 85 years. The diagnosis is very challenging due to unusual presentations. Tuberculous lesions are either hypertrophic, ulcerative or present with multiple sinuses with discharge. Vulval TB ulcer is usually misdiagnosed with syphilis or chancroid. There should be a high index of suspicion and the findings should be confirmed by histology to reach the correct diagnosis. There is usually a good response to 6 months of antituberculous chemotherapy. The disappearance of the lesion is used as a marker to assess response to chemotherapy. Therapeutic response can also be assessed by histology of serial biopsy specimens.

CASE REPORT

A 50 years old unmarried woman presented in gynecology clinic with complaint of persistent vaginal discharge for 10 years. The discharge was yellowish white discharge, non-itchy, profuse and non-foul smelling. She denied any history of fever, weight loss, anorexia, cough, menstrual irregularity or abdominal pain. There was no history of contact with a case of tuberculosis. The source of infection in this patient was not known as she had neither travel history nor family history of TB. She had never consulted any physician during this time period in modesty. The patient was not sexually active and was not immunocompromised. On general examination she was of average built, afebrile and there was no lymphadenopathy. On local examination there were deep fissures in the groins and labia were swollen and deformed with polypoidal growths. There was hypertrophy of the clitoris and an awkward looking tag was projecting from anal region (Fig - 1). Complete blood picture showed raised lymphocyte count and erythrocyte sedimentation rate. Mantoux test and CXR were unremarkable. Examination under anesthesia was performed which showed healthy looking, nulliparous cervix, normal sized uterus and no palpable adnexal mass. Biopsy was taken from vulval region and while biopsy was being taken cheesy material came out of lesions. Histopathology showed chronic caseating granulomatous inflammation most likely due to tuberculosis (Fig - 2). No malignant cells were seen on biopsy specimen. Smear test and culture was not performed. In view of the caseous necrosis demonstrated on histology, tuberculosis was considered as the most likely diagnosis. Antituberculous quadruple chemotherapy was started with regular monthly follow up. There was rapid relief of symptoms with clinical improvement. Treatment was continued for a period of 6 months. The response to therapy was assessed clinically and good response was seen (Fig - 3).

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DISCUSSION

Genital Tuberculosis can present clinically with varying signs and symptoms ranging from fertility problems, pregnancy complications, menstrual irregularities, vaginal discharge, abdominal pain, chronic pelvic pain or constitutional symptoms. Female genital tuberculosis is mostly the result of hematogenous or lymphatic dissemination from a primary focus of infection elsewhere. Primary vulval tuberculosis can occur as a result of sexual transmission from a male partner suffering from tuberculosis of the epididymus or seminal vesicles. Except for very few cases, tuberculosis of the vulva is usually associated with tuberculosis elsewhere in the body.

The presentation of vulvovaginal tuberculosis is very variable. It can present with shallow small ulcers with multiple sinuses or rarely with elephantiasis of the vulva. In the case reported by Tiwari et al., there was a hypertrophic lesion of the vulva and good outcome was obtained with antitubercular chemotherapy along with surgical reduction of the lesion for aesthetic concern. In our case there were multiple ulcers with polypoidal growths which responded well to chemotherapy.

The diagnosis is usually confirmed by biopsy of the suspicious lesions. Staining for acid fast bacilli is not very useful in making the diagnosis. Isolation of the mycobacterium is the gold standard for diagnosis. Mostly the biopsy specimens are culture negative. Therefore, the presence of caseous granuloma is sufficient for confirming the diagnosis. As tuberculosis of the vulva is very rare, the clinicians mostly treat it as a sexually transmitted infection. A high index of suspicion is required for the diagnosis. In the case reported by Arakeri et al., partial vulvectomy was done and on biopsy granulomas and Langhans giant cells were seen. ZN stain for AFB was negative. In our patient biopsy of the lesions was done which showed caseating granulomas. AFB staining and culture was not performed.

It is not known that what should be the optimal duration of treatment. A four-drug regimen of antituberculous drugs consisting of isoniazid, ethambutol, rifampicin and pyrazinamide is used for the first two months, followed by triple or dual therapy. The total duration of treatment should be six months to a year. Excellent cure rates are reported. Combined therapy is found to be effective as it ensures compliance and reduces the risk of secondary drug resistance. Relapse rate after treatment is 1%. In the case reported by Kaur T et al., the response was seen after 1 month and therapy was continued for 9 months. In our patient the therapy was given for 6 months with good clinical response. The clinical condition of the vulva (taking serial clinical photos for comparison), and the regular vulval biopsy is an indicator whether to continue or terminate the treatment.

CONCLUSION

Vulval tuberculosis is very rare and can present as a primary focus of infection as occurred in our patient. It responds effectively to antituberculous chemotherapy.

REFERENCE

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