LETTER TO THE EDITOR

Genital tuberculosis presenting as pyrexia of undetermined origin.

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Abstract.
A case of Genital tuberculosis in a female patient is presented. The key presenting features in this lady were chronic weight loss, colicky lower abdominal pains, fever, and amenorrhea.

The fact that tuberculosis is still very much around and could present in unpredictable ways is emphasised.

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Introduction
Tuberculosis is the commonest chronic infectious disease in the tropics, the tubercle bacillus affects about a third of the world’s population and causes more death worldwide than any other single infectious disease¹-³. Although the respiratory system is the commonest and preferred site for the infection, all systems of the body are susceptible. Its manifestations are also protean depending on which system(s) is / are affected⁴-⁷. We present a case of Genital tuberculosis in a female whose presentation was mainly pyrexia of undetermined origin and amenorrhea.

Case presentation
MI a 40-year-old house wife who had no formal education , was admitted to Ahmadu Bello university teaching hospital, Zaria in August 2002. Her complaints were those of colicky lower abdominal pains for one year, and intermittent fever for 6 months. There was associated history of amenorrhea for six months, and progressive weight loss. She denied any respiratory symptoms or contact with a known case of open pulmonary tuberculosis of a chronically coughing person.

Clinical examination revealed a young chronically wasted lady, with temperature of 38.4 °C and oral candidiasis. The rest of the physical examination was not remarkable. Abdominal and pelvic ultrasound scans were normal. The uterus was normal in size and contours and 3-5 cm in its maximal diameter, adnexae and the pouch of Douglas were normal.

Endometrial biopsy revealed few endometrial glands, extensive tissue necrosis with numerous multinucleated giant cells of the Langerhans type.

She was commenced on directly observed therapy short course (DOTS) comprising INH, Pyrazinamide, Ethambutol and Rifampicin. Serial weights, ESR and general well being continued to improve on this regimen. She resumed normal menstrual periods two months after commencement of therapy which culminated in the resumption of her normal menstrual flow two months after commencement of therapy.

Discussion
The key presenting features in this lady is a chronic wasting disease with colicky lower abdominal pains, fever, and amenorrhea. There was no change of bowel habits noted or cardio-pulmonary symptoms. There are several disease states, which could present just like this. Notable among them are disseminated tuberculosis, chronic fungal infections such as histoplasmosis, HIV infection with the AIDS syndrome, and neoplastic conditions such as non-Hodgkin’s lymphoma among others.

In the pre-AIDS era, genito-urinary tuberculosis accounts for 6% of extra pulmonary TB⁴. Genital tuberculosis results from haematogenous spread from a primary pulmonary focus or secondary to urinary involvement by tuberculosis of adjacent structures⁵. In this patient the source is most likely from the lungs as urine microscopy did not show evidence of infection.

Pelvic pain is the commonest symptom in females with genital tuberculosis. However, 50% of women present due to infertility, and those who present primarily with infertility, rarely have any symptom⁶. Our patient had both pelvic pain and secondary infertility (last confinement was 3 years). The endometrial biopsy evidence of numerous multinucleated giant cells of the Langerhans type and clinical improvement on anti tuberculosis medication which culminated in the resumption of her normal menstrual flow two months after commencement of therapy leaves no doubt as to the diagnosis. The negative mantoux reaction may be due to an overwhelming infection and her poor nutritional status, even then a higher dose of the PPD might have elicited some response.

References.