Case Report

Tubercular Sinus of Labia Majora: Rare Case Report

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Received 10 October 2007; Accepted 21 December 2007

1. INTRODUCTION

Tuberculosis (TB) of the vulva and vagina is very rare and it is seen in only 1-2% of genital tract TB. Tuberculosis of cervix accounts for 0.1–0.65% of all cases of TB and 5–24% of genital tract TB [1–8]. Tuberculosis more frequently affects the upper genital tract, namely, the fallopian tubes and endometrium. It usually occurs in women of childbearing age [5, 6, 9].

2. CASE REPORT

A 50-year-old female patient without active sexual life admitted to Department to Surgery with a swelling over the left inguinal area with discharging sinus from labia majora to left inguinal crease. She had history of incision and drainage for an abscess at left labia majora 6 months back. She had no history of cough, fever, or abdominal pain. She had not been in close contact with an index case of pulmonary tuberculosis in past year. Antibody tests for HIV and VDRL infection were negative.

Chest and abdominal X-rays were normal. Ultrasonography revealed that the uterus was bulky and endometrial line was not visualized and bilateral adnexae were without a mass or cyst. A full blood count showed leucopenia, and ESR at 2 hours was 55.

Then patient underwent excision of the sinus tract of labia through suprapubic approach after staining it with methylene blue. A mass of 6 x 5 cm was excised in the retropubic region (see Figures 1(a), 1(b), and 2). Histopathology report showed sinus tract lined by chronic inflammatory cells, epitheloid cells, and Langhan’s giant cells on microscopic examination suggestive of tuberculous sinus (Figure 3). Antituberculous quadruple therapy was initiated. Complete healing of the wound, with rapid relief of symptoms, followed 4-week antituberculosis chemotherapy.

3. DISCUSSION

Tuberculosis is one of the oldest diseases known to affect humans [10]. Female genital TB is a rare disease in some developing countries, but it is a frequent cause of chronic pelvic inflammatory disease (PID) and infertility in other parts of the world [11]. Symptomatic genital tract TB usually presents with abnormal vaginal bleeding, menstrual irregularities, abdominal pain, and constitutional symptom [5, 6, 9, 12, 13]. Pelvic organs are infected from a primary focus, usually the chest, by haematogenous spread [2, 4, 5, 12, 14]. The cervix is infected as part of this process, by lymphatic spread or by direct extension. The vagina and vulva are rarely involved. The primary lesion is often healed by the time of presentation [5–9, 12–15].

Chowdhury [5] has suggested that sputum, used as a sexual lubricant, may also be a route of transmission. It is uncommon for tuberculosis to involve the vulva and vagina. The gross appearance may be ulcerative with multiple sinuses, it may be hypertrophic with elephantiasis, or it may be similar to that of carcinoma. There may be hormone dependence of infection [2, 5] given that 80% of cases occur in the reproductive age.
Microscopically, there are caseating granulomata. These are not diagnostic. The differential diagnosis for granulomatous disease of the cervix includes amoebiasis, schistosomiasis, brucellosis, tularaemia, sarcoidosis, and foreign body reaction. The diagnosis of the cervical and vulvovaginal TB is usually made by histological examination of cervical and vulvovaginal biopsy specimen [3, 9, 14]. Staining for acid-fast bacilli was not found to be very useful in making the diagnosis [16]. The detection of granulomata on cervical cytology specimens [9, 14] has been documented. Isolation of the mycobacterium is the gold standard for diagnosis. One third of cases are culture negative. Therefore, the presence of typical granulomata is sufficient for diagnosis if other causes of granulomatous cervicitis are excluded or primary focus identified. The lesion should respond to 6 months of standard therapy. A lesion on the cervix, vagina, or vulva provides a marker to assess response to therapy. Histological examination of serial biopsy specimens can similarly confirm a therapeutic response.

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