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Case Report

Pseudotumoral Tuberculosis of the Cervix: Diagnosis and Treatment - About One Rare Case

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Abstract

Cervical tuberculosis is a rare pathology, which can clinically mimick cervical cancer. Patients are paucisymptomatic and the disease is characterized by an insidious evolution, hence the delay in diagnosis. Common symptoms are non-specific contributing to therapeutic delay. The biopsy re-establishes the right diagnosis. The treatment is medical. The prognosis is primarily the infertility which is perhaps inevitable due to frequent associated general genital tuberculosis. We report a case of tuberculosis of the cervix whose diagnosis given first wasn't obvious. Indeed, a patient was referred to our training for suspicion of cervical cancer. Suspected diagnosis of cancer was then retained based on the presence of vaginal bleeding on contact. Biopsy was indicated in order to confirm the diagnosis histologically. Anatomo-pathological examination objectified epitheliogigantocellular granuloma with caseous necrosis, supporting cervical tuberculosis. The patient received TB treatment which led to healing. Diagnosis and treatment of tuberculosis of the cervix is often based on presumptive elements, hence the importance of anatomo-pathological examination.

Keywords: Cervical cancer, histology, cervical tuberculosis.

INTRODUCTION

Clinical suspicion of cervical tuberculosis is not usually first-line because of its scarcity and similarity to the cervical cancer, which is frequent and often detected in our context [1]. Because of its cervical location, the discovery of this pathology is often delayed by a wide differential diagnosis [2]. In the case that we report, we insist on the importance of the histological examination in the diagnostic approach by drawing the attention of the practitioner to the fact that any red cervix bleeding is not necessarily cervical cancer.

OBSERVATION

Mrs KO, 33 years old, married for a year, housewife, She is the only wife of a trader, without any pathological antecedent notably no notion of tuberculosis contagion, nulligeste, which presents for 6 months intermittent pelvic pain associated with metrorrhagia. She was referred to our training for suspicion of cervical cancer. Clinical examination found a good general condition with a blood pressure of 110/80, a pulse at 70 bpm and a temperature of 37 °. The speculum examination showed an enlarged cervix, thickened and indurated without ulceration, with irregular margins, bleeding on contact, covered with whitish leucorrhoea, foamy in places without a foul odor. (Figure-1), in vaginal touch, the collar was rather firm, slightly sensitive. However, a first cervical biopsy with histological study found chronic non-specific inflammation. A second biopsy found a granuloma with zone of necrosis leading to a conclusion of tuberculosis of the cervix (Figure-2). A phtysiological assessment made of a chest X-ray, search for Kock's bacillus in the sputum and intradermo-reaction, returned negative. Pelvic ultrasound did not show abnormality in the uterus or appendages. On the basis of the results of clinical, paraclinical and especially pathological examination, anti-tuberculosis treatment is undertaken for 6 months, according to the national protocol. After two months of treatment (Figure-3), bleeding has disappeared. The symptomatology had completely regressed to disappear three months later.

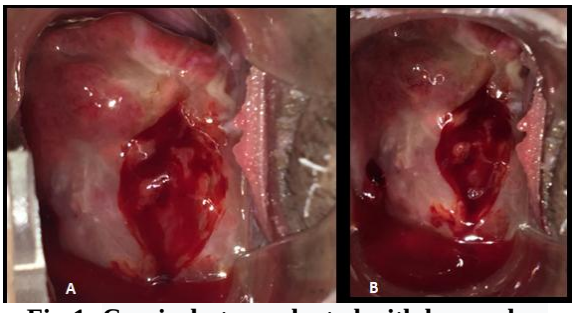

Fig-1: Cervical uterus dented with leucorrhea irregular margins, bleeding on contact

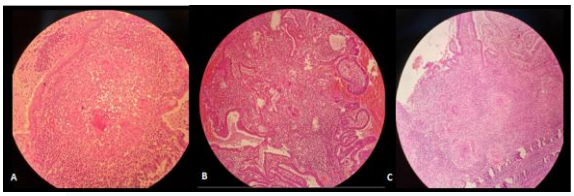

Fig-2: Histological appearance of the lesion showing granulomatous inflammation of the cervix with a cluster of epitheloid cells and a caseous necrosis

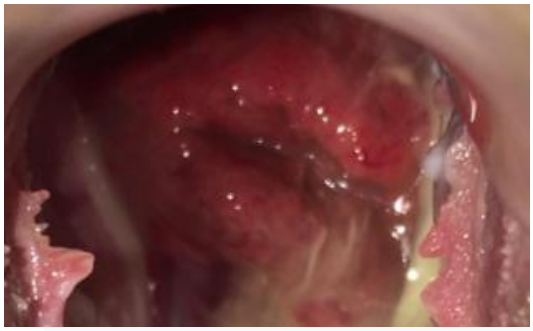

Fig-3: appearance of the cervix after two months of treatment with disappearance of bleeding and leucorrhea

DISCUSSION

We have reported a case of cervical tuberculosis in a young and Immunocompetent woman, which the first evoked diagnosis was cervical cancer. The anatomopathological results of the biopsy specimen were epithelio-giganto-cellular granuloma with caseous necrosis, which made it possible to correct the diagnosis. The success of antituberculosis treatment has supported this hypothesis.

Female genital tuberculosis accounts for 6 to 10% of all tuberculosis cases [1, 2]. The most frequently affected organs are the fallopian tubes, the endometrium and the ovaries [2]. Localization in the cervix is rather rare and accounts for 5% of genital locations [3]. The mode of contamination varies according to the authors [3, 4]. Some insisted on sexual contamination from a male urogenital origin [5]. For others, cervical involvement may be indirect, lymphatic, the first causal lesion being generally cured [5]. In this case, from the physiopathological point of view and considering the epidemiological context, one could suggest a primary pulmonary involvement, followed by a secondary genital lesion [4, 5]. Amenorrhea would suggest endometrial involvement followed by cervical involvement [4]. Genital tuberculosis is poorly clinically speaking or can mimic other pathologies, typically pelvic neoplasia (ovarian or endometrial cancer, more rarely vulvar or vaginal) or pelvic or peritoneal abscess to pyogenic [5, 6]. The clinical signs revealing a cervical localization of tuberculosis are not very specific, associating provoked or spontaneous metrorrhagia, with leucorrhea [5, 6]. The clinical expression of the cervix in our study is that of a swollen cervix, bumpy in places, bleeding on contact with whitish, foamy leucorrhea. This explains the confusion with cervical cancer, especially since there was no fever or weight loss.

Some authors are more explicit when they state that clinically cervical tuberculosis resembles cervical carcinoma [7]. They add that the same symptoms as abnormal vaginal bleeding, a pathological cervix with budding lesions can be found in cervical tuberculosis [7, 8]. But Tuberculosis should not be confused with cervical cancer for the sake of management, it should be known that both exceptionally can be associated and cases have been reported [6-8]. The place of the pathological examination in the diagnostic and therapeutic decision, in our study was decisive. Indeed the histological examination of our sample found an epithelio-giganto-cellular granuloma with caseous necrosis which allowed us to retain the diagnosis of cervical tuberculosis, by associating the other presumptive arguments. The detection of acid-fast bacilli in the histological examination of Ziehl-Nielsen staining would have further confirmed this diagnosis [9]. But according to some authors, the histological appearance of granuloma with typical caseous necrosis alone is sufficient to make the diagnosis of cervical tuberculosis in the absence of any other argument, especially as it appears that in a third of cases of cervical tuberculosis the culture is negative, authorizing the start of a test medical treatment [7-10]. The diagnosis of cervical tuberculosis with no other pathology associated in our case was supported by the fact that the search for other causes of granulomatous lesion of the sarcoidosis or parasitosis type proved negative, with the absence of foreign body refracting to light. Polarized and the negativity of PAS staining [10, 11].

In our observation, antituberculous treatment for 6 months with a spectacular regression after 4 months further confirmed the diagnosis. The use of surgical treatment remains possible, initially for the management of complications (fistulas or abscesses) or secondarily in case of resistance or relapse under well-conducted medical treatment [11, 12].

CONCLUSION

Tuberculosis, common in our country, is rarely expressed by cervical involvement. This observation allows us to recall the important place of histology in the diagnosis of cervical tuberculosis. Although this pathology is rare, we must often think about clinical lesions suspicious of cervical cancer, especially since the patient had metrorrhagia.

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