Abstract # 639

Female Genital Tuberculosis: An unusual cause of Rectovaginal fistula in an Adolescent Girl successfully treated medically

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Introduction

Tuberculosis affects about 10 million persons globally annually out of which about 3.4 million are women. Female Genital Tuberculosis is a type of Extra Pulmonary Tuberculosis (EPTB) affecting fallopian tubes, uterus, ovaries, cervix in decreasing frequency and are usually secondary to Pulmonary or Abdominal TB spreading by hematogenous route. Vaginal and Vulval Tuberculosis are rare forms of Female Genital Tuberculosis which can even be Primary TB or rarely sexually transmitted. We present a rare case of an adolescent girl who presented with fecal Incontinence due to vulvovaginal tuberculosis.

Methods and Materials

A 14 years old adolescent girl presented to gynaecology outpatient department with history of fever , malaise and weight loss for 2 months and history of faecal Incontinence for last 1 month . She had menarche at 13 years of age but has oligomenorrhoea (scanty menses). She refused any history of sexual contact. On examination she was thin built with moderate nourishment, conscious and well oriented to time , place and person. She had mild pallor, no oedema, jaundice or lymphadenopathy. Her temperature was 37.4 degrees Celsius. Jugular venous pressure was not raised. Chest auscultation was normal and cardiovascular examination was also normal. Abdominal examination was normal with no organomegaly. On local genital examination, labia majora and minors were normal. Faecal matter was seen coming out through a tiny hole of 3 mm about 2 cm above introitus on posterior vaginal wall . On recto- vaginal examination, there was a 3 mm recto- vaginal fistula about 2 cm above anal verge. There was thickening and swelling around it. Using cervical punch biopsy forceps, a tiny biopsy was taken from the swelling near the fistula on the vaginal end. The patient was given a course of antibiotics and anti- inflammatory drugs for 5 days. The histopathology of the biopsy showed it to be epithelioid granuloma suggestive of Vaginal Tuberculosis. The patient and her parents were counselled. She was started course of Antitubercular therapy with Rifampicin, Isoniazid, Pyrazinamide and Ethambutol daily orally for 2 months followed by three drugs (rifampicin , isoniazid and ethambutol) daily orally for next 4 months in continuation phase under Directly Observed Treatment Shortcourse (DOTS) strategy free of cost. She was advised to eat nutritious diet. She was followed up and tolerated medication well. On third month follow up her faecal Incontinence had disappeared. On local examination the fistula had closed though some local swelling and induration was still present. Her liver function tests were normal and there was no side effects of the drugs. Her appetite has improved and she had gained 2 kg weight. On follow up at 6 months , she had no symptoms. Her menses were normal. Her general condition had significantly improved. On local examination, the fistula has completely healed with no induration or swelling.

Results

Female Genital Tuberculosis is a variant of Extra Pulmonary Tuberculosis which is usually secondary to Pulmonary or Abdominal Tuberculosis spreading through hematogenous route or direct continuity from adjacent abdominal tuberculosis. It usually presents with general symptoms like anorexia, weight loss, malaise, menstrual symptoms especially oligomenorrhea and hypomenorrhoea and later as infertility. Diagnosis is by endometrial biopsy for acid fast bacilli on microscopy or culture or demonstration of epithelioid granuloma on histopathology. In the present case, she was non sexually active presenting with rectovaginal fistula. The local biopsy confirmed the diagnosis of vaginal tuberculosis. Treatment is medical with 4 drugs (Rifampicin, Isoniazid, Ethambutol and Pyrazinamide) for 2 months followed by first three drugs (Rifampicin, Isoniazid and Ethambutol) for next 4 months. The fistula healed itself by anti tubercular therapy without the need of surgical closure of fistula.

Discussion

Vaginal tuberculosis is a rare cause of rectovaginal fistula.

Conclusions

Vaginal tuberculosis is a rare cause of rectovaginal fistula which can be successfully managed medically without the need of surgical intervention

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