International Journal of Science and Research (IJSR)
ISSN (Online): 2319-7064
Index Copernicus Value (2015): 78.96 | Impact Factor (2015): 6.391

Tubercular Tubo-Ovarin Abscess Mimicking Malignancy– A Case Report

Dr. M. D. Kerketta[1], Dr. Vivek Bhasker[2]

[1]Assistant Professor, Department of General Surgery, RIMS, Ranchi, Jharkhand, India

[2]Senior Resident, General Surgery, RIMS, Ranchi, Jharkhand, India

Abstract: ***Pelvic inflammatory disease (PID) is a common disorder of the female genital tract which commonly occurs due to ascending infection[1].If not treated properly, it can lead to formation of abscesses and peritonitis[1,2]. Neisseria gonorrhoeae and Chlamydia trachomatis are the two most common causative micro-organisms. Tubercular involvement of genital tract is occasionally seen and rarely it present as tubo-ovarian abscess[4]. Here we present a case of pelvic mass which was considered to be an ovarian tumor preoperatively. On exploration tubo-ovarian abscess was found and on histo-pathologic examination of the excised tissue; diagnosis of tubercular tubo-ovarian abscess was made.***

Keywords: tubo-ovarian abscess, malignancy, laparotomy, adhesiolysis, oophorectomy

1. Case Report

A 30 years old unmarried female came to surgical emergency with pain abdomen and abdominal lump. On examination abdominal lump of about 10x10 cm in size was found to be arising from pelvis. Patient was admitted and investigations were done. Routine investigations were within normal limit. Ultrasonography of abdomen showed a cystic lesion of 13x11cm in pelvis and both the ovaries could not be delineated. Mild fluid collection was also noted in pelvis. Suspecting the mass to be malignant, serum CA-125 level was checked and it was found to be raised (147.5 U/ml).Serum B-HCG was within normal limits. Contrast enhanced CT showed cystic lump of 13x11 cm in size, with internal echoes and septation with few calcifications. Both ovaries could not be delineated and mild ascites was also found.

After pre-anaesthetic fitness, abdominal exploration was done. Small intestinal loops were found to be adherent with tubo-ovarian lump. After careful adhesiolysis large left cystic ovarian lump was seen. The cyst wall was showing areas of necrosis and on slight manipulation, cyst wall ruptured and pus came out. Right ovary was adhered with the cyst. Right ovary was carefully separated from the cyst and left oophorectomy was done. Generous peritoneal lavage given, abdominal drain placed and abdomen closed. The excised specimen ws sent for histo-pathological examination and pus was sent for culture sensitivity.

Postopertive recovery was not smooth. Broad-spectrum antibiotics were given to the patient but the patient was not showing signs of improvement. On fourth postoperative day histo-pathologiocal examination of the excised specimen showed multiple granulomas with epithelioid cells and caseation necrosis which confirmed tuberculosis. Pus culture showed no growth. Based on these reports, antituberculer therapy was started. Patient responded well and we were able to discharge her on 12th postoperative day. She was prescribed standard extrapulmonary TB treatment and was advised to come for follow-up regularly.

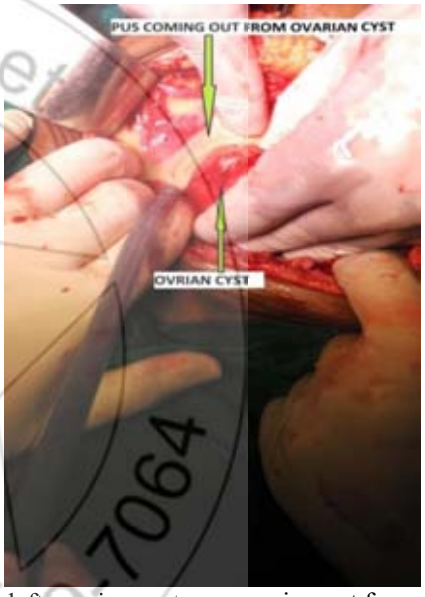

Figure: left ovarian cyst, pus coming out from the cyst

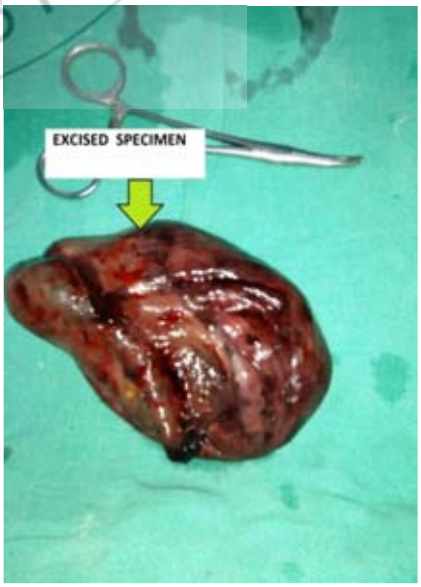

Figure: Excised pathologic left ovary

2. Discussion

Tuberculosis is a global burden since one-third of the world's population is estimated to be infected with *Mycobacterium tuberculosis*[11]. Female genial tuberculosis is not very common and is often underdiagnosed. Most clinical features of Female genial tuberculosis are non-specific leading to late diagnosis[3]. Rarely female genital tract TB may present in form of tubo-ovarian abscess. Diagnosis is very difficult in such cases and clinical features as well as investigation report mimic malignancy[4]. After diagnosis, standard treatment as done in extrapulmonary TB shows good response in such cases.

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