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CASE REPORT

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# Bilateral tubal tuberculosis as a cause of chronic pelvic pain and sterility

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**Abstract** A 29-year-old woman presented with a 12-month history of subfebrile chronic pelvic pain. Prior to this she had no previous medical history of pelvic inflammatory disease. On gynecological examination, bilateral adnexal masses were palpable. Ultrasonographically, bilateral adnexal masses 8×6 cm were visible with different echogenicity, and the Douglas space was totally filled with masses. On power Doppler examination, blood flow was detected bilaterally through the masses with a resistive index of 0.42. Neither ovary was visible. Laparoscopically we found bilateral tubal tuberculosis with no other pathology. Bilateral salpingectomy was undertaken. After surgery the patient received tuberculostatic therapy for 6 months.

**Keywords** Tuberculosis · Chronic pelvic pain · Ultrasound · Laparoscopy

## Introduction

Chronic pelvic pain is one of the biggest problems for women in their fertile years. This can result in sterility and moderate to severe pelvic pain. Genital tuberculosis as a cause of sterility and chronic pain is very rare nowadays, especially in young patients with no previous history of pelvic inflammatory disease. We report a case of bilateral tubal tuberculosis as a cause of chronic pelvic pain and sterility in a young patient following a chronic subfebrile condition.

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## Case report

A 29-year-old patient complained to her general practitioner about a chronic subfebrile condition, general weakness, and pelvic pain similar to a urinary tract infection. For 12 months she was treated several times as for a urinary tract infection. On gynecological examination, bilateral adnexal masses were palpable. The Douglas space was protruding and foul with palpable masses. Vaginal sonography showed bilateral adnexal masses 7×8 cm. The Douglas space was obliterated with masses of different echogenicity. The uterus was normal in size, and the endometrium was 8 mm thick. On power Doppler examination, blood flow was detectable with a resistive index of 0.42. There was no sign of free fluid in the Douglas space or abdomen. Ultrasonic examination of the upper abdomen was normal. Preoperative laboratory findings included sedimentation rate 30/76, C-reactive protein 87, and CA-125 antigen 98.7.

The patient was admitted, and on the 3rd day diagnostic laparoscopy was done. Laparoscopic findings confirmed the ultrasonic finding of bilateral adnexal masses filling the whole minor pelvis. The finding is typical for tubal tuber-

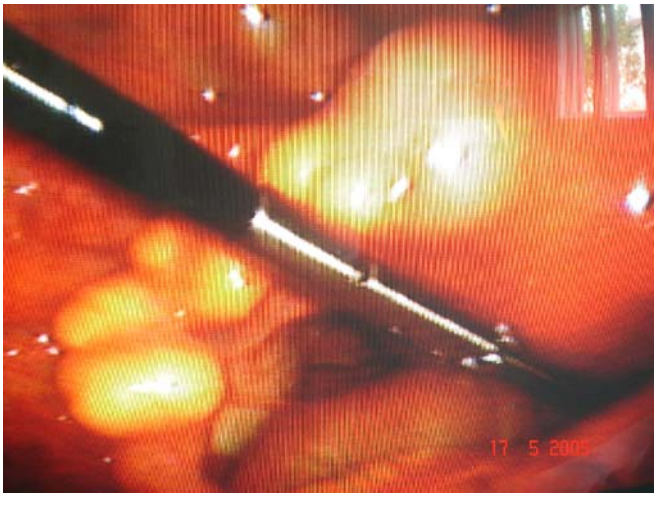


**Fig. 1** Tubal tuberculosis

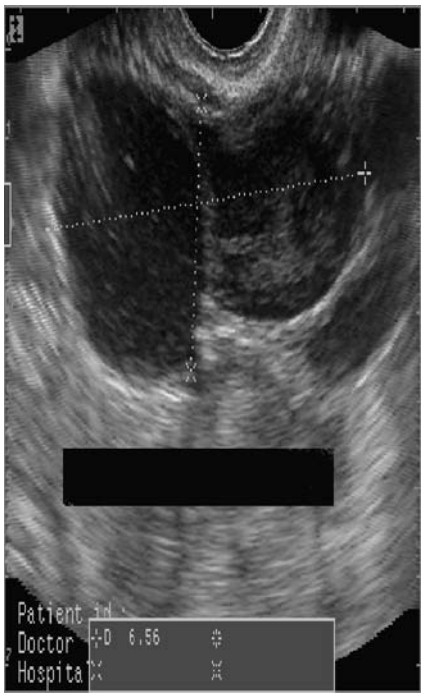


**Fig. 2** Ultrasonic picture of tubal tuberculosis

culosis presenting with characteristic "pearls" (Figs. 1 and 2). Other findings on the uterus, ovaries, minor pelvis, and upper abdomen were normal. Bilateral salpingectomy was performed. Tuberculosis was confirmed directly from tissue and serologically.

After operative treatment, the patient received tuberculostatic therapy for 6 months. Follow-up ultrasonic findings were normal, and second-look laparoscopy confirmed remission of the disease.

## Discussion

Chronic pelvic pain is very often associated with pelvic inflammatory disease [1], especially in young patients in their fertile years. Nowadays, cases of chronic pelvic pain associated with genital tuberculosis are very rare [2], particularly bilateral tubal occlusion as a consequence of genital tuberculosis [3]. This leads to primary or secondary sterility or chronic pelvic pain and a chronic subfebrile state [4]. In the past, genital tuberculosis was one of the most frequent causes of primary or secondary sterility or chronic pelvic pain and a chronic subfebrile condition. In our experience (more than 600 diagnostic laparoscopies), all patients having chronic pelvic pain of unknown etiology, especially with ultrasonic findings showing adnexal masses with or without free fluid in the Douglas space, should have diagnostic laparoscopy to allow decisions on further therapeutic steps [5–9].

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