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Case Report

Tuberculous cervicitis: a masquerader of malignancy

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ABSTRACT

This case report describes a young woman initially suspected of having cervical malignancy, whose final diagnosis was confirmed by biopsy as tuberculous cervicitis, emphasizing the need for a high index of suspicion and the critical role of histopathology in achieving an accurate diagnosis.

Keywords: Cervix, Cancer cervix, Cervical tuberculosis, Histopathology, Cervical biopsy, Gynecological cancer

INTRODUCTION

Female genital tuberculosis (FGTB) accounts for a small percentage of extrapulmonary tuberculosis cases, with the fallopian tubes and endometrium being the most common sites of involvement.[1] Isolated tuberculous cervicitis is exceedingly rare, cervical tuberculosis accounts for 0.1-0.65%, often presenting with symptoms such as irregular vaginal bleeding, discharge, and postcoital spotting; which are non-specific and frequently lead to a misdiagnosis of cervical cancer.[1-3] The rarity of this condition, combined with its variable manifestations, presents a significant diagnostic challenge for clinicians.[1] This case report describes a young woman initially suspected of having cervical malignancy, whose final diagnosis was confirmed as tuberculous cervicitis, emphasizing the need for a high index of suspicion and the critical role of histopathology in achieving an accurate diagnosis.

CASE REPORT

A 31-year-old female, residing in Madhya Pradesh, presented with a chief complaint of scanty menstrual flow for three months. Her cycles were regular with a menstrual flow lasting for 2-3 days; however, she noted the menstrual flow was scanty described as spotting per vaginum. She also reported profuse watery discharge vaginally for 2 months. Patient had history of two spontaneous first trimester abortions, neither of which were followed by dilatation and curettage. Patient had no associated post coital bleeding, loss of weight, night sweats, chronic cough, constitutional symptoms, family history of tuberculosis or carcinoma of genital tract was negative, she did not have any history of close contact with known case of tuberculosis in past. Her general physical examination did not reveal any significant finding, per abdominal examination was normal.

A per speculum examination revealed an irregular, coarse, reddish cervix with a "soft friable" area that bled easily upon touch (Figure 1). Bimanual examination showed firm cervix which bleeds on touch, uterus was anteverted, normal size, bilateral fornices were free. 2D ultrasound showed a heterogenous cervical lesion measuring 5.3×4.6×5.2 cm with normal uterus and an enlarged left internal iliac lymph node of 18.3 mm. These findings, along with the clinical presentation, led to a provisional diagnosis of cervical malignancy.

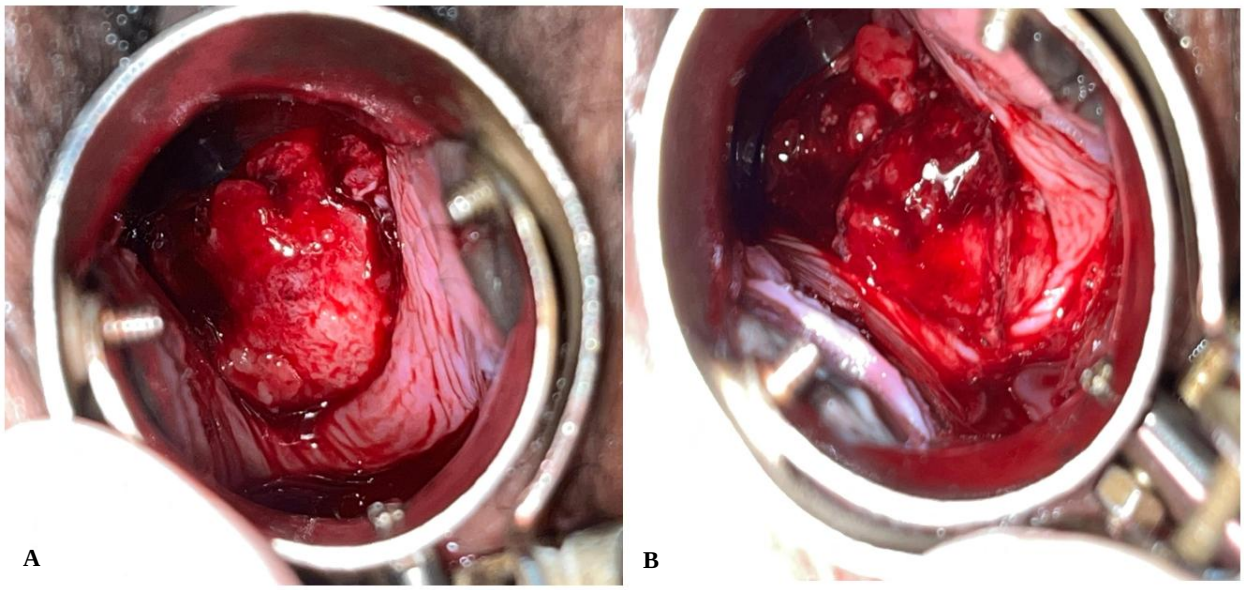

Figure 1 (A and B): per speculum view showing irregular growth over cervix, friable to touch.

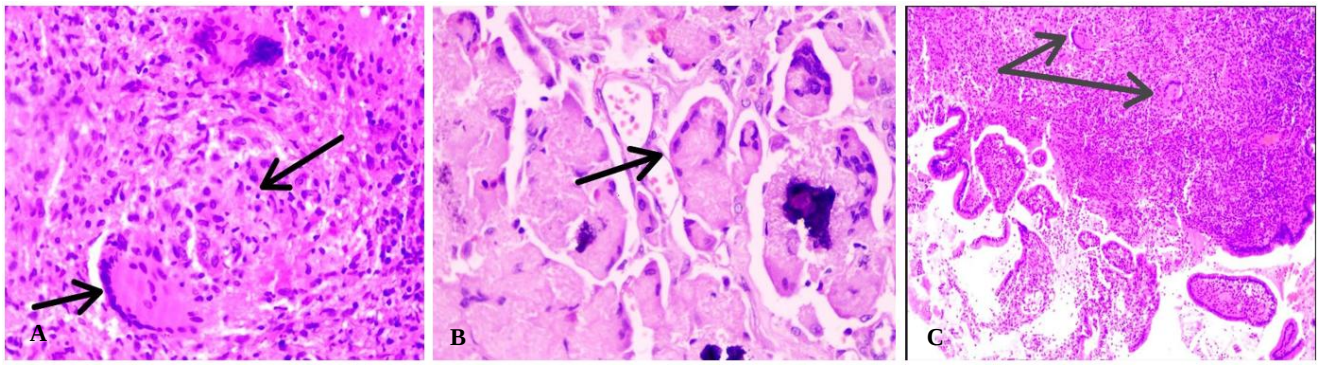

Figure 2 (A-C): Histopathology showing granulomas with caseous necrosis and Langhans giant cells.

A cervical biopsy was performed from the margins of the lesion by Gellhorn cervical biopsy forceps. Histopathological examination of the tissue revealed endocervical glands and stroma with an extensive inflammatory infiltrate composed of lymphocytes, polymorphs, and histiocytes (Figure 2). Multiple well-formed granulomas, consisting of epithelioid histiocytes and multinucleated giant cells. No evidence of cellular atypia or malignancy was found. While a Ziehl-Neelsen (ZN) staining for acid-fast bacilli (AFB) was negative, the biopsy findings were highly suggestive of granulomatous inflammation consistent with tuberculous cervicitis.

DISCUSSION

This case of tuberculous cervicitis illustrates a classic diagnostic dilemma where a rare infectious disease presents clinically and radiologically as a common and more aggressive pathology.[2]The clinical signs of irregular bleeding and contact bleeding, coupled with a large cervical mass and pelvic lymphadenopathy on ultrasound, strongly suggested a malignant process. However, the histopathological examination proved to be the key to the correct diagnosis.[3,4]

The negative ZN stain is not uncommon in such cases, as the bacillary load in extrapulmonary sites, especially the cervix, can be low.[2,5]The presence of well-formed granulomas is the hallmark of tuberculosis, and its identification on biopsy is critical.[4] This highlights the importance of obtaining a tissue biopsy and considering granulomatous infections in the differential diagnosis of cervical lesions, particularly in endemic regions like India.

A misdiagnosis of cervical malignancy in this case could have led to unnecessary radical surgery, with profound implications for the patient's reproductive and overall health. The appropriate management for tuberculous cervicitis is a course of anti-tuberculous chemotherapy.[6,7]

CONCLUSION

Tuberculous cervicitis should be considered a differential diagnosis for a cervical mass, even when the clinical and radiological findings are highly suggestive of malignancy.

Histopathological evaluation is the cornerstone of diagnosis. This case underscores the need for careful clinical assessment and thorough investigation to prevent misdiagnosis and ensure that patients receive the correct, non-surgical treatment for this rare but curable condition.

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