Pseudo-Meigs Syndrome with Ovarian and Abdominal Tuberculosis: A Case Report

Alla Satyanarayana Reddy, Harish Babu, Lakshmi Sowjanya Tsama and Narmadha N S

Department of Obstetrics & Gynaecology, Vinayaka Mission’s Medical College & Hospital, India

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Abstract

Tuberculosis (TB) is the second leading cause of death from infectious diseases worldwide. In non-immunocompromised women, extra pulmonary TB accounts for 20% of new cases identified. Isolated ovarian TB is an uncommon disease given that genitourinary TB usually presents with endometrial and fallopian tube involvement. We report a case of cystic ovarian mass, with ascites, pleural effusion; tuberculosis of ovary and omentum; third degree uterine vaginal prolapse in a post-menopausal woman. Ascites and pleural effusion resolved spontaneously in a week of surgery. Patient received ATT and recovered well. Diagnostic difficulties in this case are discussed.

Keywords: Extra Pulmonary Tuberculosis; Ovarian Cyst; Ovarian Tuberculosis; Pseudo Meig’s Syndrome

Introduction

Tuberculosis (TB) is the second leading cause of death from infectious diseases worldwide [1]. Genitourinary TB is the second most common site for extra pulmonary TB [2]. Extra pulmonary TB is common in immunocompromised patients. 20.2% of the new cases of TB are extra pulmonary. Nine percent of extra pulmonary tuberculosis is accounted for genital tuberculosis [2]. Isolated ovarian TB is an uncommon disease given that genitourinary TB usually presents with endometrial and fallopian tube involvement [3]. Pseudo Meigs syndrome is coexistence of pelvic tumor, hydrothorax and ascites. Pseudo Meigs syndrome is clinically important as it resembles metastatic pelvic cancer. Pelvic and peritoneal tuberculosis may resemble advanced ovarian cancer.

Case Report

Mrs. XXXX, aged 50 years, post-menopausal lady presented at Obstetrics & Gynaecology department of Vinayaka Mission’s Medical College & Hospital for mass descending per vagina since 1 year and abdominal distension since 1 year. She is from a low socio-economic status, rural, agricultural background. Her last childbirth is 34 years ago. Attained menopause 10 years ago. She is not a known case of hypertension or diabetes mellitus. H/o contact with Pulmonary TB present (neighbor-defaulter and died 6 years ago). Dull looking, thin built woman, cachetic, with BMI 16kg/m². Spine is normal. No lymphadenopathy. On systemic examination—dull note and diminished breath sounds on right lower chest. On abdominal examination—no ventral hernia, no doughy feel of abdomen. Mass of 18x20 cm arising from pelvis, extending from right iliac fossa to left iliac fossa. Mass is mobile, cystic, mildly tender and lower border of the mass couldn’t be felt. Minimal ascites.

On Gynaecological examination, third degree uterine vaginal prolapse with cystocele and rectocele with Keratinization. On bimanual examination uterus atrophic, Douglas pouch is full; mass is felt high up, continuous with abdominal mass. Colposcopy yielded straw coloured fluid. On Ultrasonography—Uterus shows postmenopausal atrophic changes, of size measuring 4.0x2.7x2.1 cm, Myometrium normal and endometrium thin. A large well defined thin walled anechoic midline abdominopelvic cystic lesion seen with multiple septae and internal echoes, with few hyper echoic areas. The mass measured 19x17x10 cm; no calcification. Both ovaries are not imaged. Minimal ascites. Serology: HIV-negative. Tumor markers found to be

(a). Alpha Feto Protein : 0.67 IU/ml
(b). Beta HCG : 5.17 mIU /ml
(c). CA 125: 213.4 units/ml
(d). CA 15-3: 25.7 units/ml

This makes CA-125 relatively nonspecific and non diagnostic in premenopausal women. CA-125 is elevated in 80% of postmenopausal ovarian carcinomas. Initial diagnosis of tubo ovarian abscess or ovarian malignancy can be mistaken given the similarities in clinical, radiologic, and serum markers such as an elevated cancer antigen-125, (CA-125) [8]. Sometimes women with pelvic-peritoneal tuberculosis may be subjected to a laparotomy for suspected ovarian cancer which is likely to increase their morbidity [9-13].

Conclusion
As the treatment of pelvic-peritoneal tuberculosis is completely different from that of ovarian cancer, it is important to reach a correct diagnosis. An effort should be made to obtain a cytological or histopathological diagnosis of either condition by ultrasound guided needle biopsy or laparoscopically obtained biopsy rather that proceeding with laparotomy for suspected ovarian cancer.

References