A CASE OF POSTMENOPAUSAL PYOMETRA CAUSED BY ENDOMETRIAL TUBERCULOSIS

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Mycobacterium infection manifesting pyometra in postmenopausal women is an extremely rare disease that hardly responds to the usual treatment of pus drainage and antibiotics therapy. We present a case of a postmenopausal woman with pyometra caused by endometrial tuberculosis. Almost all of the pus could be drained through the stenotic cervical canal, with difficulty. The result of Pipelle endometrial biopsy was negative. However, her symptoms continued and fluid gradually re-accumulated in the uterine cavity, despite successful pus drainage and sufficient antibiotics use. Therefore, the endometrial tissue was obtained by fractional curettage after cervical dilatation to identify the accurate cause of pyometra. A pathologic examination and polymerase chain reaction confirmed the diagnosis of endometrial tuberculosis. After completion of antituberculous medication, she was doing well without further development of pyometra. In a case of postmenopausal pyometra, endometrial sampling should be performed to rule out endometrial tuberculosis.

Keywords: Postmenopausal; Pyometra; Endometrial tuberculosis

Pyometra, an accumulation of pus in the uterine cavity, is an uncommon condition that has a reported incidence of 0.01%-0.5% in gynecologic patients [1]. Apart from its association with malignant disease, spontaneous rupture of pyometra can result in significant morbidity and mortality. If pyometra is diagnosed before rupture, dilatation of the cervix and drainage of pus is the treatment of choice. The most common organisms isolated through the bacteriologic study are Escherichia coli and Bacteroides fragilis [2]. Endometrial tuberculosis (TB) with pyometra in postmenopausal women is extremely rare. We present a case of a postmenopausal woman with pyometra-continued symptoms, in spite of pus drainage and empirical antibiotic therapy. However, she was cured completely with antituberculous medication after endometrial TB was confirmed in the endometrial sampling by fractional curettage.

Case Report

A 77-year-old woman, who presented with vague lower abdominal pain over a period of two months, was admitted to our hospital. She had menopause at age 50 and had never taken hormone replacement therapy. In her and her family’s medical histories, there were no medical problems such as hypertension, diabetes mellitus, or TB.

When the pelvic examination was performed, she did not show any symptoms, such as sharp tenderness of the abdomen, foul-smelling vaginal discharge, or uterine bleeding, except an atrophic lesion with desquamation of the vaginal introitus and posterior fourchette area.

Her Pap test result was normal, although she had never had one.
before. A transvaginal ultrasonogram revealed a dilated, fluid-filled endometrial cavity (Fig. 1A). Contrast-enhanced abdominal computerized tomography (CT) showed a collection of fluid in the dilated uterine cavity, without any suspicious malignant lesions (Fig. 1B). Under the guidance of thin sound, drainage of yellowish mucoid fluid was done successfully. Pipelle endometrial sampling was done. But, it could not be easily applied to the patient because of severe cervical stenosis at the time. There were just a few gram negative rods in Gram stain, and no specific bacteria grew in the culture of vaginal discharge. Pathologically, endometrial biopsy was negative. The basic laboratory tests screening, including a complete blood count, serum electrolytes, hepatic function tests, urinalysis, human immunodeficiency virus (HIV) antibody test, thyroid function test, and electrocardiogram, were normal. A chest X-