

Tuberculous Endometritis Posing As Advanced Gynecological Malignancy: A Case Report

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ABSTRACT

Tuberculous endometritis and cervicitis is quite rare, more so in postmenopausal age group where postmenopausal bleeding warrants strong suspicion of carcinomas. Due to their nonspecific symptoms and difficult diagnosis clinically, the patient may be subject to major surgeries and laparotomies causing significant yet completely avoidable morbidity. We present a case which appeared as a carcinoma but in the end a tissue diagnosis of genital tuberculosis was made instead.

Keywords: Genital tuberculosis; Postmenopausal bleeding; Hysteroscopy; Extrapulmonary tuberculosis

INTRODUCTION

Endometrial tuberculosis is an uncommon form of extrapulmonary TB, especially in postmenopausal women [1].

The presentation is atypical, often with nonspecific symptoms, which particularly considering the age of the patient, make it virtually indistinguishable from carcinomas clinically. Even in our case the differentials pointed more towards malignancies, leading to a wild goose diagnostic chase involving multiple hospital visits before a conclusive diagnosis could be made.

CASE PRESENTATION

We present a case of 65 year old P5L5 with complaints of abdominal pain and distension associated with nausea and significant weight loss who had presented to a tertiary care centre. Initial clinical evaluation revealed abdominal distension, bulky uterus and cervix pulled up to the anterior vaginal wall.

On ultrasound imaging, moderate hepatomegaly with altered hepatic echotexture was found along with moderate to gross ascites as well as diffuse omental thickening. There was hypoechoic collection within the endometrial cavity pointing towards Hydrometra/pyometra.

Contrast enhanced CT sections confirmed the above findings, quantifying the endometrial fluids at around 12-13 cc, with moderate ascites and asymmetric parietal peritoneum enhancement on the right side. An enhanced lymph node was also found in porto-caval region measuring 3.3*1.8 cm. Two anterior abdominal wall defects were also noted in the supra-umbilical region.

Her laboratory investigations and chest X-ray were all found to be in normal limits. Patient was started on injectable antibiotics and a Dilatation and curettage with pyometra drainage planned urgently in view of the above findings. Pyometra drainage was done and endometrial sample could not be obtained due to paucity of sample. Cervical biopsy was taken.

Cytological analysis of the pyometra fluid revealed few degenerated lymphocytes. The histopathological examination of the cervix biopsy suggested Hi Grade Squamous Intraepithelial Lesion (HSIL). Thus with this background , a strong clinical suspicion of malignancy was formed and oncosurgeons were consulted, who advised additional MRI imaging which revealed an ill-defined endocervical lesion extending superiorly to endometrium with >50% stromal involvement in cervix and >50% myometrial involvement in the uterine body, with the lesion involving both parametrium and reaching up to the lateral pelvic side wall. Additionally, mild free fluid was seen in the pelvis and a suspicious pre-sacral deposit was also reported.

It is at this point that the patient developed ascites again and presented to the casualty of our hospital with pain in abdomen and significant abdominal distension.

Ultrasound guided ascitic tapping was done but the cytology came negative for any malignancy, belying the strong clinical suspicion. The patient was posted for a repeat emergency hysteroscopy guided endometrial sampling and cervical biopsy, as a definitive diagnosis was the need of the hour.

Hysteroscopy revealed a stenosed cervix but no appreciable cervical mass, however, the left lateral parametrium was involved. Intra uterine, 1 cornua obscured with heaped up endometrium. Increased vascularity seen in some areas, with some areas sclerotic.

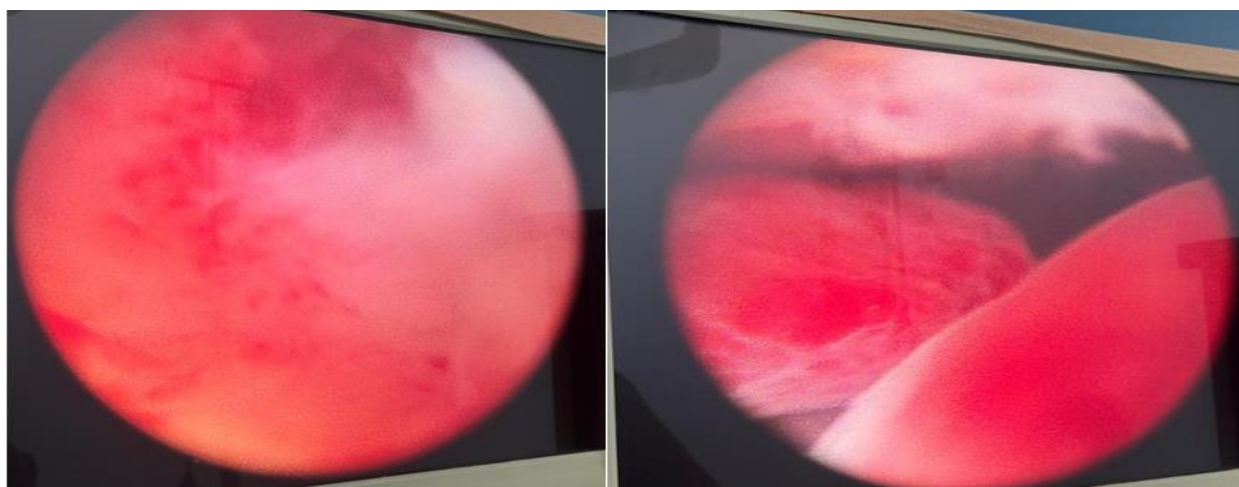


Figure 1a and b: Hysteroscopy showing proliferated endometrium with vascularity and sclerotic areas alternately.

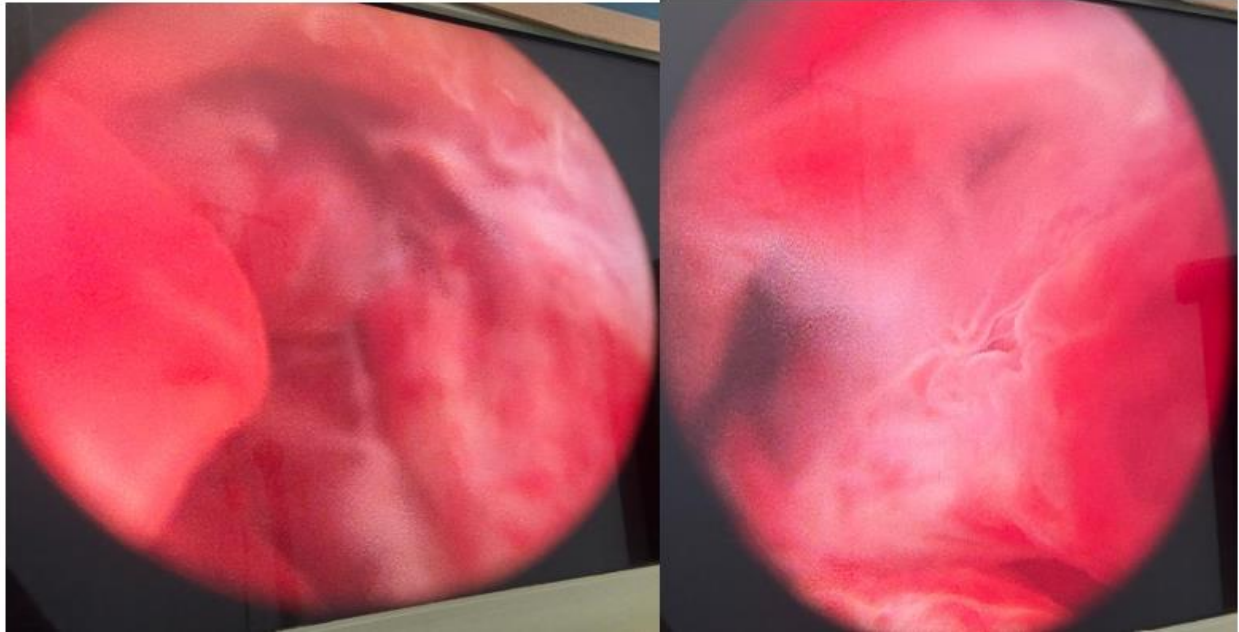


Figure 2a and b: Hysteroscopy showing typical caseating features in endometrium.

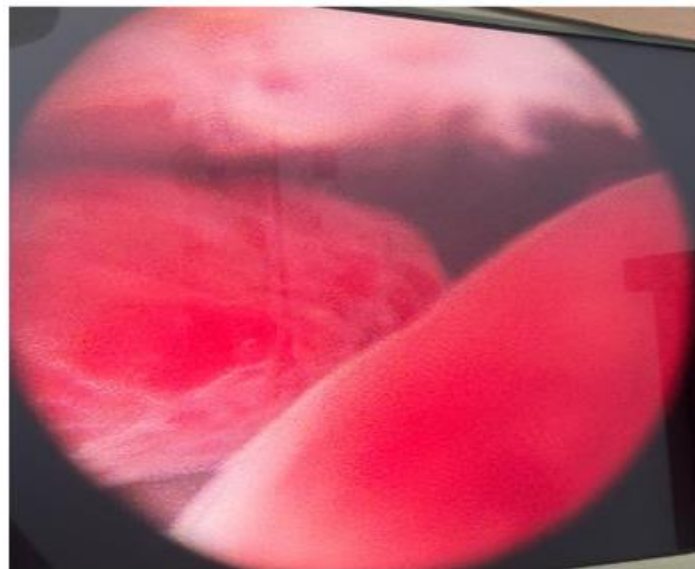


Figure 3: Polypoidal endometrium seen on hysteroscopy.

The histopathological examination revealed granulomatous endometritis and cervicitis. Furthermore, gene pert studies on the tissue detected Rifampicin-sensitive *Mycobacterium tuberculosis*. The definitive diagnosis that had so far eluded us thus far had finally revealed itself and she was started on Category 1 Anti tubercular drugs (ATT) right away. She followed up subsequently and her symptoms were resolved and her ATT was continued for 12 months.

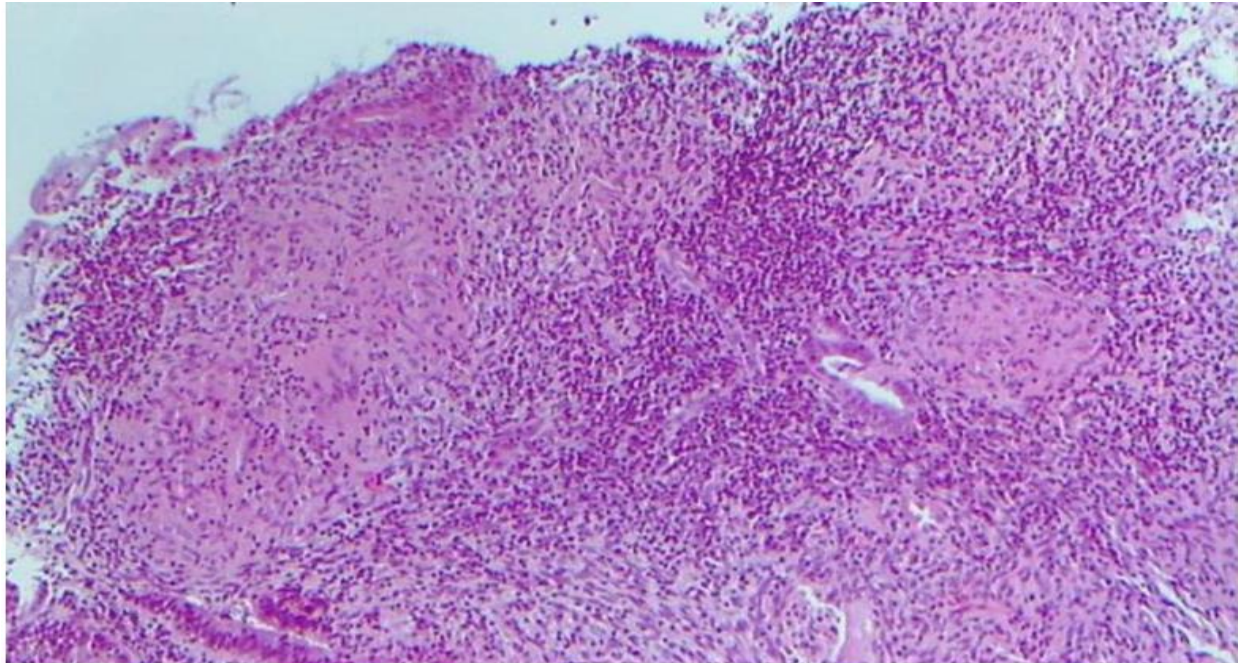


Figure 4: Histopathological view of tubercular endometritis

DISCUSSION

Endometrial tuberculosis in postmenopausal age group is extremely rare, more so because of decreased vascularity of the postmenopausal endometrium [2]. Tuberculosis accounts for only about 1% of all postmenopausal bleeding in endemic countries.

As the disease can deceptively mimic malignancies, including features like peritoneal involvement and ascites, it is extremely difficult to diagnose, with chest x ray being mostly unremarkable due to no history of TB [3].

Due to fibrosis tuberculous endometritis may cause irregularity of cavity [2]. Hysteroscopy helps in visualisation of granulomas and taking targeted biopsies [4].

In LMICs with endemicity of tuberculosis, a high clinical suspicion should be maintained and genital tuberculosis should always be kept in mind to avoid unnecessary major surgeries adding to patient morbidity [5]. CT findings are frequently nonspecific, with MRI being better suited to delineate soft tissue involvement, fibrosis and the like [2]. Genital TB might frequently present as adnexal masses, adhesions, omental thickenings and ascites, thus making radiological differentiation with carcinoma virtually impossible.

The hematogenous or lymphatic spread of *Mycobacterium tuberculosis* to the endometrium can occur both as primary genital infection or due to latent TB reactivation, and due to the paucibacillary load of endometrial tuberculosis, standard acid fast staining /mycobacterial cultures is not very sensitive in picking up the diagnosis [5,6]. PCR studies may be sensitive, but are prohibitively expensive [5]. Histopathological diagnosis demonstrating granulomatous lesions with or without Langhans Giant cell is the only way for definitive diagnosis [9].

This case demonstrated an initial strong bias favouring a diagnoses of malignancy, particularly due to the patient's age, postmenopausal status, presence of ascites and the extensive myometrial and lateral parametrial involvement on

imaging. The decision to go for endometrial and cervical sampling the second time was of paramount importance as the patient was consequently spared unnecessary radical surgeries and/or chemoradiation and all the sequelae and loss of quality of life that follows such interventions. In contrast, once a proper diagnosis of tuberculous endometritis and cervicitis is made, simple appropriate anti-tuberculous treatment is usually sufficient for complete resolution without the need for any invasive surgery or additional investigations [7]. Surgical management include excision of adnexal masses or even a total abdominal hysterectomy with bilateral salpingoophorectomy based on the individual cases, and indicated only if pelvic mass persists after 9 months of treatment or recurrence of pelvic pain or bleeding [10].

CONCLUSION

In conclusion, tuberculous endometritis should always be kept as a differential diagnosis of a diffuse enhancing endometrial lesions with ascites/peritoneal involvement especially in low and middle income countries (LMIC) where there is high prevalence of tuberculosis [8].

REFERENCES

1. Garci M, Makni M, Abdelmoula G, Abdeljabbar A, Babay W, Ben Saada N, et al. Case Report: Unveiling the hidden: a rare case of endometrial tuberculosis presenting as peritoneal carcinomatosis. Front Oncol. 2025;15:1607025.
2. Karich Nassira, Miry Achraf, Bennani Amal. Endometrial tuberculosis: report of a case and literature review. Int J Adv Res. 2019;7(05):1299-1303.
3. Chow TW, Lim BK, Vallipuram S. The masquerades of female pelvic tuberculosis: Case reports and review of literature on clinical presentations and diagnosis. J Obstet Gynaecol Res. 2002;28(4):203-210.
4. Gatongi DK, KayV. Endometrial tuberculosis sresenting with postmenopausal pyometra. J Obstet Gynaecol. 2005;25(5):518-20.
5. Mukherjee T, Panchbudhe SA, Pathade SS, et al. Genital Tuberculosis: Myriad Presentations and Clinical Scenarios. J South Asian Feder Obst Gynae. 2023;15(1):120–124.
6. Tzelios C, Neuhausser WM, Ryley D, Vo N, Hurtado RM, Nathavitharana RR. Female genital tuberculosis. Open Forum Infect Dis. 2022;9(11):ofac543.
7. Devi L, Tandon R, Goel P, Huria A, Saha PK. Pelvic tuberculosis mimicking advanced ovarian Malignancy. Trop doctor. 2012;42(3):144-6.
8. Jimo K, Miachieo N, Jamir B, Momin R, Yephthomi N. Endometrial tuberculosis mimicking endometrial malignancy-histopathology key to management: a case report. New Indian J OBGYN. 2023;10(1):236-238.
9. Saracoglu OF, Mungan T, Tanzer F. Pelvic tuberculosis. International Journal of Gynecology and Obstetrics. 1992;37(2):115-120.
10. Sutherland AM. Surgical treatment of tuberculosis of the female genital tract. Br J Obstet Gynaecol. 1980;87(7):610-612.