

PELVIC ACTINOMYCOSIS

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Pelvic actinomycosis was considered to be extremely rare in the early 19th century. Now a days and specially since the late 1970s, pelvic actinomycosis in association with intrauterine contraceptive devices has been regarded as a not infrequent disease in Europe and in the United States.¹ One hundred and ninty cases have been reported in the western literature and over 300 in the world literature.

Case Report

A thirty years old woman was admitted through casualty with pain in right abdomen and history of amenorrhoea for 2 months. The pain increased gradually, it was colicky and continous. She felt a lump in her right iliac fossa. Her last menstrual period was 2 months ago. She was mother of 2 children. She used intrauterine contraceptive device (Lippes loop) after the delivery of the last baby which was removed after 3 months due to excessive vaginal bleeding.

On examination she was pale, pulse was 120/min, BP 120/80 mm Hg and temperature was 102F. Abdominal examination revealed presence of an irregular mass occupying the right iliac fossa which was hard, tender and fixed. Bowel sounds were audible. Pelvic examination showed soft and fixed cervix,

uterine size could not be assessed due to presence of complex mass which was occupying the posterior as well as right fornix. Perspeculum examination did not show any abnormality. On rectal examination a hard mass was felt in the pouch of douglas.

Haemogram showed Hb% 8.6 gm, TLC 14000/cmm, neutrophils 88%, lymphocytes 12%. Pregnancy test was negative. Ultrasonography revealed collapsed uterine cavity with a complexed right adnexal mass measuring 8.2cm X 6.8cm.

Laparotomy was planned; on opening the abdomen a growth was present which was arising from the pelvis and was adherent to the abdominal wall, omentum and intestine. Grossly it was malignant looking and the histology report showed actinomycosis.

She was put on inj. Benzyl Pencillin 10 lac units I/M 6 hourly along with inj Gentamycin 80 mg I/M 8 hourly. She had burst abdomen on the 10th day. Abdomen was resutured. On the 20th day she developed burst abdomen for the second time with discharge of thick pus, which was sent for the confirmation of presence of sulphur granules. Abdomen was resutured. Sulphur granules were present and this confirmed the diagnosis of actinomycosis.

Benzyl Pencillin therapy was

continued. She was discharged on 40th day on inj Benzyl Penicillin 20 lac units I/M B.D for 6 weeks. Her follow up visit at 6 weeks revealed improved general health as well as regression of pelvic mass, which was later confirmed by pelvic ultrasound.

DISCUSSION

Actinomycosis was considered extremely rare previously but now it has been regarded as not an infrequent disease. The first suggestion of an ascending route of infection for actinomycosis of female genital tract was made in 1926 in a woman who was using an intrauterine pessary.² Actinomyces Israelii is not a commensal in the vagina and endometrial involvement is infrequent unless it is introduced directly with intrauterine contraceptive devices (IUCD).³ All common types of IUCD have been implicated. Deguid et al showed a higher incidence in women using plastic devices and Hermet showed an incidence of 25% of actinomycosis in association with copper devices.⁴

Diagnosis is not easy and it is still diagnosed first at laparotomy for suspected malignant tumour.⁵ Biopsy remains an important investigation. Other investigations are pus examination for sulphur granules and use of specific fluorescent-antibody stain for screening purpose.⁵ Response to the chemotherapy is excellent. The drug of choice is Penicillin preparation.⁶ Pelvic

inflammatory disease without an abscess should be treated with one month course of antibiotics following removal of IUCD.⁷ With combined chemotherapy and surgery cure rate is now about 90%.⁸ These organism are also sensitive to other antibiotics like tetracyclin, chloramphenical, streptomycin, ampicillin and kenamycin.

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