CORRESPONDENCE

Genitourinary tuberculosis, CA-125 and tuberculin anergy in disseminated tuberculosis

O. Jolobe

From the Department of Medicine, Manchester Medical Society, Manchester. email: oscarjolobe@yahoo.co.uk

The case report highlights the importance of maintaining a high index of suspicion for treatable causes of tubo-ovarian mass such as genitourinary tuberculosis despite the presence of a high blood level of CA-125, especially in countries with high background prevalence of tuberculosis. In a patient from a country with high background prevalence of both tuberculosis and human immune deficiency virus (HIV) infection genitourinary tuberculosis can, in turn, co-exist with HIV infection, as was the case in a 35-year-old woman with a tubovarian abscess attributable to Mycobacterium tuberculosis, the latter infection validated by polymerase chain reaction. Given the fact that screening tests such as the tuberculin skin test, and the interferon gamma release assay test may be negative in patients co-infected with M.tuberculosis and HIV, there should be a high index of suspicion for HIV co-infection as the underlying cause of those negative test results when the diagnosis of genitourinary tuberculosis is eventually confirmed. The index of suspicion should even be higher when there is concurrent evidence of disseminated tuberculosis (as in the recent case report), given the fact that disseminated forms of tuberculosis are significantly ($P < 0.007$) commoner and M.tuberculosis bacteraemia is also more prevalent in tuberculosis patients co-infected with HIV than in HIV negative counterparts.

References


