Case Report

TWO CASES OF ENDOCERVICAL GONORRHOEA AND BARTOLIN GLAND DISEASES

Mahwah Dezfulimaneh[1]

ABSTRACT: Gonorrhoea a sexually transmitted disease if left untreated can cause infertility apart from other disorders. We report two cases and feel that all pregnant women should be screened for gonorrhoea.

KEY WORDS: Endocervical Gonorrhoea, Bartolin Gland diseases.

Pak J Med Sci January - March 2007 Vol. 23 No. 1 135-136

INTRODUCTION

Gonorrhoea is a sexually transmitted disease caused by Nisseria Gonorrhoea.[1] Gonorrhoea can infect the cervix, urethra, rectum, anus and throat. Gonorrhoea is a curable STD but if left untreated can cause infertility, meningitis, septicaemia,[2] Endocarditis, pericarditis, chronic pelvic pain in women.[3-5]

These infections are associated with increased risk for human immunodeficiency virus infection.[6,7] In some patients genitourinary infection may result in dysuria and purulent discharge after a one to three week incubation period.[8] Pus may be excreted from the urethra, Skene's ducts, or Bartholin's gland.[9] In some studies, colonized pregnant patients have been reported to have an increased risk of preterm birth, premature rupture of membranes, puerperal infection and Gonococcal neonatal ophthalmia,[9] A gram's stain of the purulent material from the genitourinary tract exudate can provide rapid identification of Nisseria Gonorrhoea.[10]

This study has done in two parts. The first part was to find out the prevalence of Endocervical Gonorrhoea in women and the second part was to follow up the infected cases. Two infected women were followed up for ten months.

Since the screening for Gonorrhoea in pregnant women is not a routine test in Iran, because of the high cost, therefore most women with Gonorrhoea are asymptomatic and widespread appearance of Gonorrhoea strains is resistant to drugs due to reinfection rather than treatment failure. So it is important to report these cases for further evaluation because both patients belonged to a low socioeconomic set up.

CASE REPORT

Case Report-1: Ms ZK age 29 years was admitted to our hospital with complaints of painful large swelling of left labian magus, advanced pregnancy (approximately early first trimester) and excessive vaginal discharge. The patient belonged to low socioeconomic set up and was uneducated. She was Gravida three, Para two and the present pregnancy was from her second marriage. She had been attending antenatal clinics in local health centre and taking anti-anemic medication, and had necessary investigations including ultrasonography.

After hospital admission patient was given antibiotics Cefteriaxon and Gentamycin and underwent abscess drainage. Her husband was also given antibiotic cover. The culture reports of cervical discharge and abscess pus confirmed the presence of Gram Negative diplococci a sign of Gonococcal infection. She recovered well. At completion of full term the patient was readmitted in labour ward and

1. Dr. Mahwash Dezfulimaneh,
Ph.D. Reproductive Health, MS. in Midwifery,
Faculty member of Nursing & Midwifery College,
Kermanshah University of Medical Sciences, IRAN.

Correspondences:

Dr. Mahwash Dezfulimaneh,
E-Mail: mdezfulimanesh@yahoo.com

* Received for Publication: December 6, 2005
* Revision Received: June 16, 2006
* Revision Accepted: June 26, 2006

had normal delivery of a healthy male infant with no signs of gonococcal infection. Culture for the mother's genital tract six weeks after delivery was also negative.

Case Report-2: Ms RS a 35years old housewife with low socio economic background and uneducated was Gravida 3, Para 3 reported with excessive foul smelling vaginal discharge, dyspareunia, pelvic discomfort and labial swelling. Apart from essential blood picture she had smear and culture examination of her vaginal and cervical discharge which came positive for gram negative diplococci–Neisseria Gonorrhoea. She was treated with Ceftriaxone and Doxycycline. Her partner was treated with antibiotics as well. The Bartholin Cyst was surgically drained. A repeat culture of cervical discharge was negative for Gonococci.

DISCUSSION

The highest incidence of gonorrhoea occurs in women aged 20-29 years.[11] Occurrence in those older than 40 years is rare and should raise concerns about malignancy as an alternative cause. The course of the disease may be several hours to several days, with painful unilateral labial edema, dyspareunia, sudden relief of pain followed by discharge (highly suggestive of spontaneous rupture).[12] Diagnosis of Bartholin abscess or cyst is made primarily upon the following physical examination findings:

A labial mass may be present and may be very tender and fluctuant, fever is reported in approximately one third of patients and spontaneous rupture may occur. If spontaneously ruptured, the mass decompresses and may yield few findings other than discharge, which may be purulent if an abscess has formed. In general, risk for Bartholin gland disease is similar to that for sexually transmitted diseases (STDs).

Identified risk factors in a small case control study include patient aged 20-29 years, no health coverage, low or null parity or gravidity.[12] Abscess formation is usually due to one or more pyogenic organisms, although sterile abscesses (negative cultures) have been reported with varying frequency. Nisseria Gonorrhoea is the most commonly cultured organism, reported in up to 80% of abscesses.[13] As such in the age of AIDS, attention has tended to focus on that lethal and feared sexually transmitted disease. But for those caring for adolescents, infection by these two bacterial pathogens (Chlamydia, Gonorrhoea), is still a daily and serious concern. Once they establish a foothold, the way to serious sequelae, including HIV infection, is open.[8] We suggest that all pregnant women should be screened for gonorrhoea.

ACKNOWLEDGEMENT

The author is grateful to Kermanshah University of Medical Sciences for sponsoring this project under Grant No 82042/50.2.2003. Thanks are also due to the reviewers for improving the manuscript and Dr. Mirmoayedi, my husband for linguistic improvement of the original text.

REFERENCES

1. Anonymous, Global prevalence and incidence of selected curable sexually transmitted infections overview and estimates. WHO/CDS/CSR/EDC/ 2001;10:15-9.
2. Jones HB, Noble R. STD statistics worldwide 2001;1-5.
3. Stamm WE. Chlamydia trachomatis infections of the adult. In: Holmes KK, Sparling PF, Mardh PA, et al. Sexually transmitted diseases. 3rd Ed New York: MC Graw-Hill 1999.
4. Amir O, Nguyen VD, Barnett BJ. Acute Human Immunodeficiency Virus presenting as disseminated Gonococcal infection. MedScape. South Med J 2003; 96(3):284-6.
5. Lau KH, Ho HF. Gonorrhoea. Handbook of Dermatology & Venereology. Social Hygiene Handbook -2nd Edition 2005;1-7.
6. Fleming DT, Wasserheit JN. The contribution of other sexually transmitted diseases to sexual transmission of HIV infection. Sex Transm Infect 1999;75:3-17.
7. Royce RA, Sena A, Cates W, Cohen MS. Sexual transmission of HIV. N Eng J Med 1997;336:1072-80.
8. Farb AFG. Chlamydial infection and Gonorrhoea in teenage women NASPAG 2004; 1-15.
9. ibid 5 p-4.
10. Morales WJ. Gonococcal infection in pregnancy. Contemporary OB/GYN ® Archive 2001;1-40.
11. Blumstein H. Bartholin Gland Diseases. E-medicine 2003;1-10.
12. Anonymous. "American Family Physician"; copyright © 2003;68:135-40.
13. Scholes D, Stergachis A, Heidrich FE, Andrilla H, Holmes KK, Stamm WE. Prevention of pelvic inflammatory disease by screening for cervical Chlamydial infection. N EngI J Med 1996;334:1362-6.