Journal Homepage: - www.journalijar.com

INTERNATIONAL JOURNAL OF ADVANCED RESEARCH (IJAR)

Article DOI: 10.21474/IJAR01/16370
DOI URL: http://dx.doi.org/10.21474/IJAR01/16370

RESEARCH ARTICLE

ATYPICAL PRESENTATION OF GENITAL CHLAMYDIA

Ebtessam Saad Hassanin[1] and Dr. Khaled Kouteich[2]

1. MBBCH - Tanta University, Egypt MD - Ain Shams University Egypt Gyne Specialist Prime Hospital, Dubai.
2. MD, DES, FCOG, ESGO Consultant Gyne Oncologist. Prime Hospital Dubai.

Manuscript Info

Manuscript History
Received: 31 December 2022
Final Accepted: 31 January 2023
Published: February 2023

Abstract

Chlamydia is one of the most common sexually transmitted infections all over the world. It is passed on through unprotected sex (sex without a condom) and is particularly common in sexually active teenagers and young adults. Most people with chlamydia do not notice any symptoms and do not know they have it. Although chlamydia does not usually cause any symptoms and can normally be treated with a short course of antibiotics, it can be serious if it's not treated early if left untreated, the infection can spread to other parts of your body and lead to long-term health problems, such as pelvic inflammatory disease (PID). And infertility. It can also sometimes cause arthritis. Rare complication is perihepatitis (Fitz Hugh Curtis syndrome).our rare case, presented with abdominal discomfort, ascites and elevated CA125, no genitourinary symptoms.

Copy Right, IJAR, 2023,. All rights reserved.

Introduction:-

Chlamydia trachomatis infections may occur in multiple organs including lungs, lymph nodes, peritoneal cavity, and genitourinary systems.

Intra-abdominal inflammatory disease resulting in ascetic peritonitis may also become a more common manifestation of **Chlamydia trachomatis**.

Severe PID due to **Chlamydia trachomatis** may result in significant ascites, pelvic masses, and cul-de-sac nodularity on exam as well as an elevated Ca-125 tumor marker and imaging findings that mimic an ovarian malignancy.

Case presentation:

25 years old sexually active woman, presented to the clinic referred from gastroenterology clinic with generalized intermittent abdominal pain, mild to moderate, since 20 days with moderate ascites, and simple ovarian cyst?

History:

She’s smoker since 10 years, her father has cancer kidney, and her period is regular, menarche at 13 years old.

She is denying any dyspareunia, dysuria, no genital complain at all, Pap smear done once few months ago, it was normal.

Corresponding Author:- Ebtessam Saad Hassanin
Address**:-** MBBCH - Tanta University, Egypt MD - Ain Shams University Egypt Gyne Specialist Prime Hospital, Dubai.

Examination:
Abdominal exam:
Abdomen soft, mild tender right hypochondria, dullness on both flanks

Speculum examination's looks healthy, with excess cervical mucus, no tenderness, Pap smear collected.

Transvaginal USS:
Average size AVF uterus, both adnexa floating in free pelvic fluid

CT abdomen:
Moderate Pelviabdominal ascites, scattered iliac,mesentric and para aortic lymph nodes?

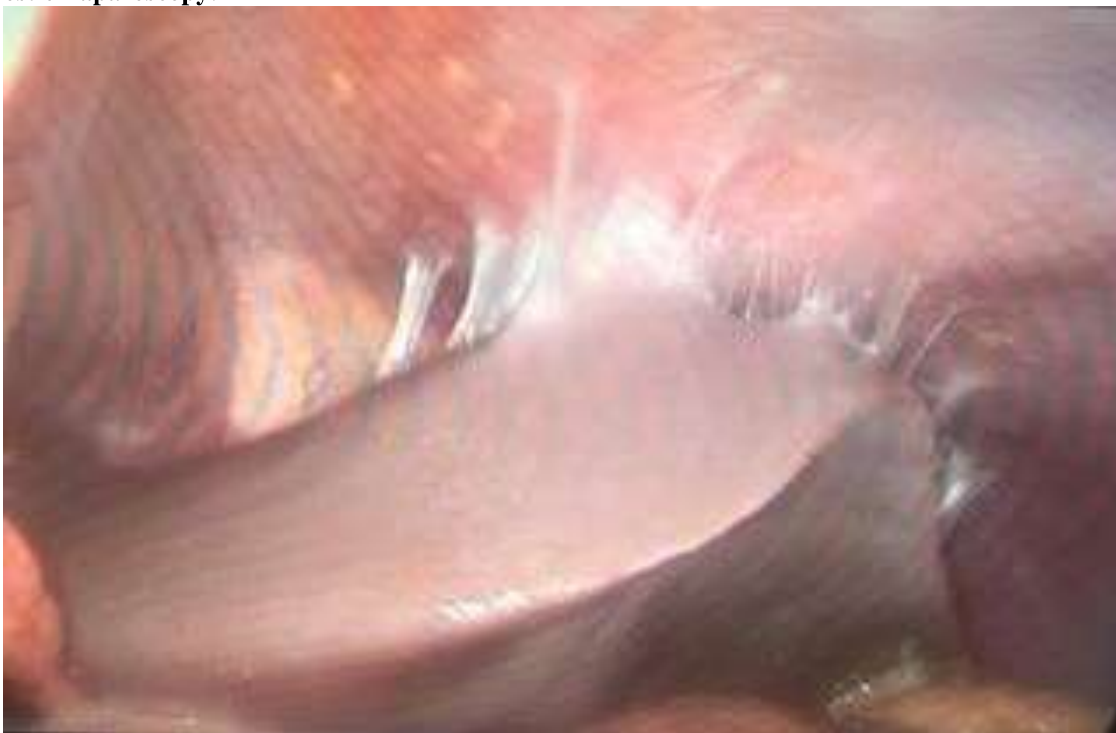
Investigations done:
Tumor markers:
CA125 came: 239.3 elevated
Alpha-fetoprotein:2.39 N
CEA: 0.79 N
B HCG: 0.100 N
LHD: 332 N
LFT,RFT:NORMAL

HIV, Hepatitismarkers:
negative

Patient Councelled about the findings, possibility of ovarian cancer, PID, Tuberculous peritonitis
MRI pelvis with contrast: moderate pelvi abdominal ascites, simple ovarian cyst.

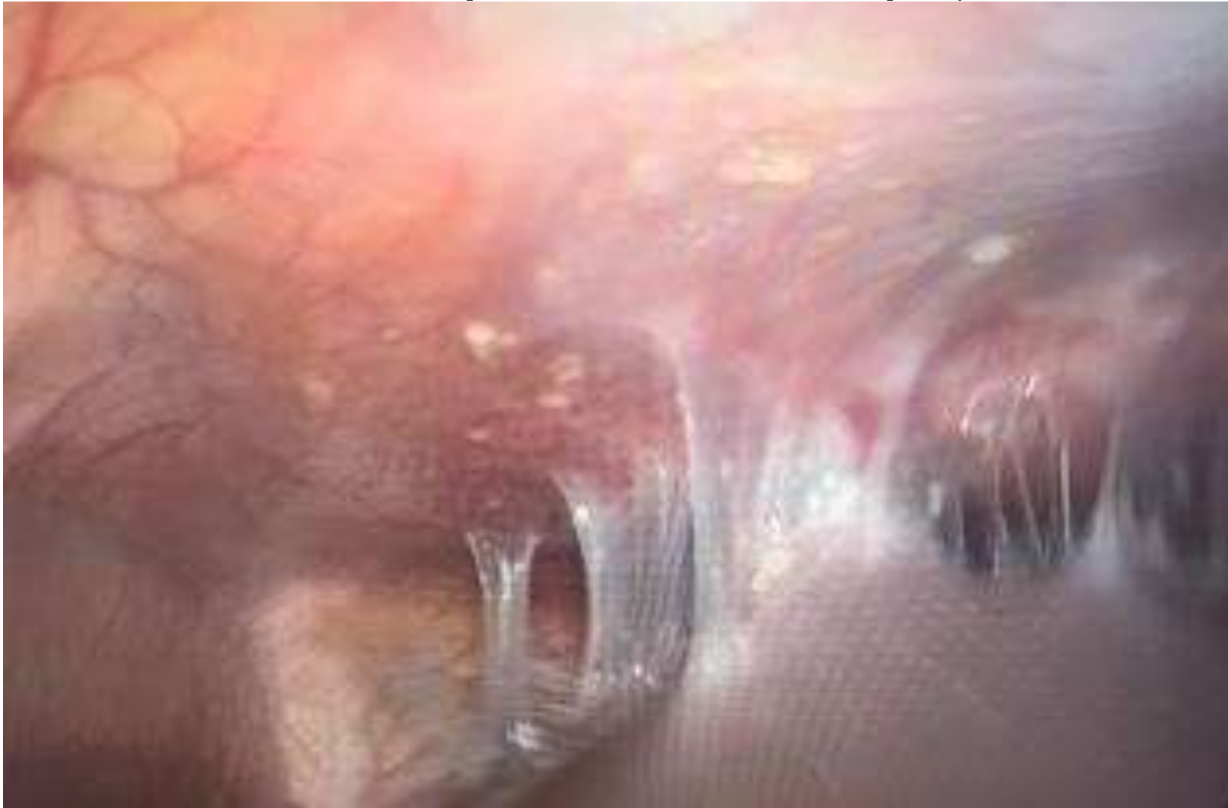
She agreed for diagnostic laparoscopy for further evaluation and diagnosis.

Diagnostic Laparoscopy:

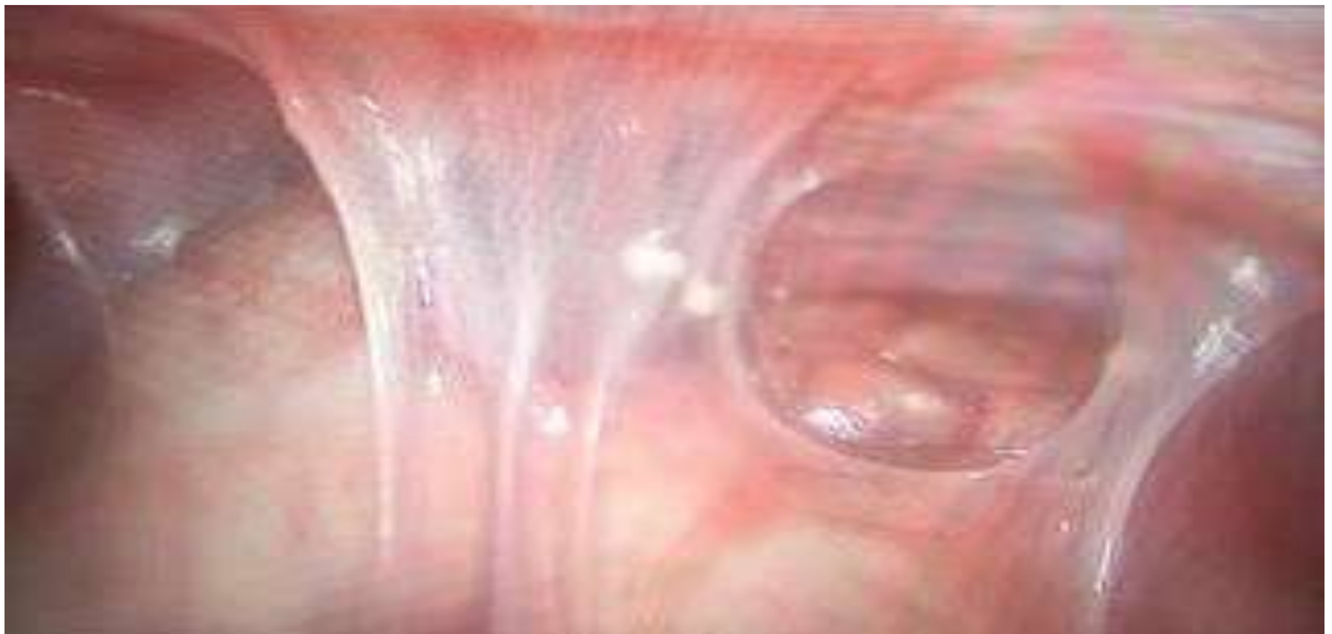


Perihepatic Adhesions

Abdominal and pelvic organs with covering peritoneum were severely inflamed ,tissue were very friable, a lot of fine adhesions spider like were present from pelvis till diaphragm with Perihepatic adhesions, moderate amount of ascites. Scattered mesothelial tissue all over peritoneum? Looks like secondaries or primary mesothelioma?



Peritoneal scattered masses with adhesions



Pelvic adhesions

Ascetic fluid collected, and peritoneal wash send for cytology examination, also biopsy collected from both ovaries, tubes, peritoneal masses, momentum, appendix, all send for histopathological examination.

Result for histopathology came negative for malignancy with extensive inflammatory reaction of all tissue biopsy collected, negative cytology for ascetic fluid, but positive neoplastic cells at peritoneal wash? Requesting more histoimmunochemical tests for diagnosing the nature of neoplastic cells in peritoneal wash.

Patient was already discharged from hospital third post-operative day on oral antibiotic and analgesic, her pain was improved.

Ten days later, patient start same abdominal pain, by uss, ascetic fluid start to be collected again, final cytology report came that neoplastic cells was epithelial in origin and recommending Pet scan test to identify the malignant focus?

Waiting for official process of PET scan
I offer the patient doxycycline for 2 weeks as she gave history of chlamydia screening +ve.few months ago in her home country.
Pet scan done: no malignant focus can be identified
Patient symptoms improved completely after completion of doxycycline 2 weeks. Still malignancy not ruled out.
Reassessment:M RI pelvis: no ascites
CA125 coming down 64 then 36after one week more.
Second opinion for histopathology and cytology on same slides taken: it came negative for malignancy and only extensive inflammatory reaction
Patient went also for colonoscopy, which came negative.
Final diagnosis was Fitz Hugh Curtis syndrome of sever chlamydia complicated by ascites and peritoneal deposits.

Discussion:-

As the incidence of **C. trachomatis** genitourinary infections is on the rise, clinicians may encounter more cases of **Chlamydia trachomatis** peritonitis, ascites, and adhesion formation. Therefore, **C. trachomatis** and other infectious etiologies should be in the differential diagnosis for a sexually active young patient with abdominal pain, ascites, and pelvic cystic masses and appropriate testing should be pursued early in the workup of these patients. The main difficulty in cases as this one is to balance the consideration of a patient having more than one etiology for their clinical picture with the risk of over investigation.

The managing team in this case had the aim of not missing a potential cancer diagnosis given the imaging findings.(1-7).

Conclusion:-

1) **C. trachomatis** infections may occur in multiple organs including lungs, lymph nodes, peritoneal cavity, and genitourinary systems.
(2) Severe adhesive disease may lead to the formation of inclusion cysts in the pelvis that may mimic an ovarian neoplasm.
(3) Patients with PID complicated by tub ovarian abscess formation, ascites, or nodularity due to post inflammatory scarring may mimic an ovarian neoplasm.
(4) **C. trachomatis** and other infectious etiologies should be in the differential diagnosis in a young sexually active patient with abdominal pain, ascites, and pelvic cystic masses.

References:-

1. Yanagisawa N., Tomiyasu H., Hada T., et al. Chlamydia trachomatis peritonitis: report of a patient presenting spontaneous regression of ascites. Internal Medicine. 1992;31(6):835–839. doi: 10.2169/internalmedicine.31.835.
2. Mueller-Schoop J. W., Wang S. P., Munzinger J. Chlamydia trachomatis as possible cause of peritonitis and perihepatitis in young women. British Medical Journal. 1978;1(6119):1022–1024. doi: 10.1136/bmj.1.6119.1022.
3. Ugianskiene A. Chlamydial infection with marked ascites that simulated ovarian cancer. Ugeskrift for Laeger. 2013;175(14):963–965.
4. Haight J. B., Ockner S. A. Chlamydia trachomatis perihepatitis with ascites. The American Journal of Gastroenterology. 1988;83(3):323–325.

5. Guagenti R. C., Berman A. L., Cohen N. N. Chlamydial ascites. Digestive Diseases and Sciences. 1989;34(1):139–141. doi: 10.1007/bf01536170.
6. Votte-Lambert A., Joly J. P., Becuwe C., Eb F., Capron J. P., Dupas J. L. Chlamydia trachomatisperitonitis: another cause of protein-rich lymphocytic ascites. Journal of Clinical Gastroenterology. 1990;12(3):341–343. doi: 10.1097/00004836-199006000-00024.
7. Mori K., Tomizawa Y., Arai R., et al. Fitz-Hugh-Curtis syndrome presenting spontaneous regression of ascites. Nihon Medicine. 2003;92(12):2417–2419. doi: 10.2169/naika.92.2417.