Tuberculosis of the female genital tract

Tuberculosis of the genital tract is almost invariably secondary to disease elsewhere—usually in the lung, less frequently in the renal tract, and occasionally in a bone or joint. There may be a long latent period between the initial infection and its discovery in the genital tract; often little or no evidence of the primary lesion remains, or it may be totally inactive. A known pre-existing pulmonary lesion will make the interpretation of pelvic symptoms (which may be quite imprecise) relatively easy, but even direct questioning may fail to elicit a history of tuberculosis and examination may fail to show any trace of an earlier lesion. Clinicians need to remember that tuberculosis is still the most important communicable disease in the world—nearly half of India’s population has at one time been infected. The incidence of reported disease in Britain has declined recently but a reservoir remains, and global population movements ensure that there will be a steady seeding for the foreseeable future.

Earlier surveys showed that the peak ages for genital tuberculosis were in the 20s and 30s. Today the age range of affected individuals with pulmonary disease has two peaks—the lower one representing an immigrant group and the higher one the indigenous population. A wide scatter of ages, with a maximum incidence in the fourth decade, has been reported from New Zealand for genital disease, which is often a chronic infection with abscess formation. The younger members of this group were immigrants from the Pacific Islands.

The Fallopian tube is the most common site of tuberculous pelvic infection, with spread to the uterine endometrium in 60% of cases. Less frequently organisms may be identified in the ovary, cervix, vagina, and vulva, but in virtually all cases the Fallopian tubes are affected as well. Most patients have bilateral lesions. Infection has usually been through the blood stream, but direct spread from other abdominal organs and the peritoneum is possible.

Most patients with genital tuberculosis present with infertility, abdominopelvic pain, or menstrual irregularity. Infertility is by far the most common of the three, and, though figures vary, up to 50% of those attending infertility clinics anywhere in the world will be found to have active disease. One-fifth of these will be entirely normal on clinical examination, and awareness that the disease is still with us is thus particularly important.

Though it may result from advanced active pulmonary disease, amenorrhoea is rarely a presenting symptom of genital tuberculosis. Malkani and Ragani, however, reported an incidence of amenorrhoea as high as 50%, in some parts of India, attributing it to end organ failure from endometrial cseation. Menorrhagia and metrorrhagia are about as common as in other types of pelvic inflammatory disease, and there is a small but constant incidence of postmenopausal bleeding.

Breast lumps in adolescent girls

Public awareness of breast cancer has been heightened recently, largely through popular journalism, and in consequence a steady trickle of frightened young girls are attending surgical outpatients and specialist breast clinics. Many of them have cyclical mastalgia, nodularity, or asymmetry, but a small proportion will indeed present with breast lumps. How should doctors manage these breast lumps in teenage girls, and are they ever any cause for concern?

Cancer of the breast under the age of 30 is extremely rare, accounting for only 1.2% of the 6000 cases in Haagensen’s series, for example; and carcinoma under the age of 20 might be considered a medical curiosity, with only seven cases among the series of over 70,000 patients dying from the disease reported by Pirquet.1 Stone et al, writing from a clinic in New York, recently described 143 adolescent girls presenting with breast lumps over 14 years.2 As might be expected, over 70% proved to be fibroadenomas on biopsy. There was one case of infiltrating duct adenocarcinoma and two cases of cystosarcoma. The remainder were a variety of benign conditions including cysts and inflammatory lesions. On the basis of this experience the New York surgeons recommended careful observation and reassurance for two complete menstrual cycles with surgical excision if the mass persists.

At first sight this seems reasonable advice, given that cancer of the breast under the age of 20 is so rare and that when they do arise such cancers are said to have a comparatively benign course. Nevertheless, a recent report in the Lancet3 described a 15-year-old schoolgirl who presented with a breast lump; it was diagnosed as a fibroadenoma but turned out to be an invasive carcinoma with extensive spread to the axillary nodes. She later died with massive hepatic metastases.

The safer policy, then, is for the surgeon to carry out an immediate biopsy on all breast lumps that appear in the breasts of pubescent girls, if only to give them and their parents
peace of mind. Such a policy must not, however, be adopted in prepubertal girls. Anxious parents commonly bring a girl aged between 8 and 12 to a breast clinic with a 1-2 cm discoid mass beneath one nipple. The mass is due to asymmetrical development of the breast disc of early puberty. Surgical interference in such a case is a catastrophe: removal of the breast disc at this stage will inevitably mean complete failure of development of the breast on that side.

3 Teasdale, C, and Baum, M, Lancet, 1976, 2, 627.

**American tests of medical competence**

Four years ago pressure from the American public (and from the commercial insurance carriers, who are financially responsible for the greater part of medical care in the United States) led to the introduction of the law on professional services review organisations, the medical audit groups that impose minimum standards of care. At about the same time in professional circles the concept of hiring a medical diploma —rather than having it for life—was gaining credence, at least for postgraduates. In 1973 the American Board of Medical Specialties took a policy decision that all its constituent boards should carry out some kind of regular recertification of accredited specialists.

Some boards have been more active than others in pursuing quality control by recertification, and some are finding that identifying obsolete doctors is not as easy as sticking an expiry date label on a packet of cheese or a roll of film. In a thoughtful article in the *Journal of Allergy and Clinical Immunology* J E Salvaggio has recently set out the problems faced by his board in the absence of fully developed “precise workable examinations for the assessment of clinical competence.” At present the board relies on a multiple-choice test of factual knowledge, which is case orientated and tied closely to its own self-assessment programme. This is the pattern set by the American Board of Internal Medicine. Salvaggio recognises the limitations of a purely cognitive test as a guarantee of competence and his conclusion that it needs to be supplemented somehow with tests of performance recalls the guidelines so ably set out by the Committee on Goals and Priorities of the National Board of Medical Examiners in 1973.3 On the other hand, the bedside clinical test has been viewed with little enthusiasm in the United States for several years—though this disenchantment may be fading, if others follow the trend set by the National Board, which has incorporated an evaluation of a candidate’s ability to perform physical examination into the National Certifying Examination for Primary Care Physicians’ Assistants.3

Other factors need to be taken into account, too: evaluating clinical competence becomes more difficult as a doctor gets older; the educational message of self-assessment programmes will reach only those who are prepared to receive it; the design of continuing medical educational exercises has been seriously criticised; and there is growing recognition that evaluating some current medical practice must take account of the activities of a group rather than that of an individual.

Whatever tests of competence are used, there remains the difficult question of doctors’ “attitudes,” which are valued as highly as technical ability by many patients. Attitudes can be measured by questionnaires, scales, and simulated patients, but more conventional medical audit at present finds more supporters, possibly because it can incorporate some idea of the outcome of a patient’s treatment.

How far do these recertification problems have any importance for Britain, where even a certification procedure has not yet been agreed and the postgraduate examinations are all threshold tests at one level or another and not intended to signify the completion of training in a specialty? It is true, as has been remarked by Forsyth,7 that criticism of the National Health Service comes more from those providing the service than from those using it, but recent parliamentary events have shown more than a stir of lay interest in how we perform. Doctors in Britain should take note of the difficulties being faced by their American colleagues and be ready to grapple with them should a move towards recertification develop here. The crucial point is that evaluation of medical competence must remain a matter to be developed by the profession, and not imposed by the Government.

1 Salvaggio, J E, Journal of Allergy and Clinical Immunology, 1977, 60, 153.

**Cardiac involvement in Friedreich’s ataxia**

Friedreich’s ataxia is a familial neuromuscular disorder characterised by spino cerebellar ataxia, loss of deep tendon reflexes, and skeletal deformities such as kyphoscoliosis, pes cavus, hemivertebrae, and hallux valgus. The association with cardiac disease was already recognised by Friedreich: three of his six original cases described in 1863 showed severe fatty degeneration of the heart at necropsy. Since then cardiovascular lesions have repeatedly been reported. Indeed, it has been suggested that Friedreich’s ataxia is a neurocardiac disease. Symptoms referable to the heart have been found in half of the patients, but the incidence has varied with the diagnostic criteria used by different investigators. Electrocardiographic changes (not necessarily associated with cardiac symptoms) occur in over 90% of patients with the disease. Clinically, cardiac symptoms may on rare occasions precede the neurological manifestations.

Generally the cardiac symptoms are those of progressive heart failure, together with palpitations, retrosternal pain, and angina. Electrocardiographic changes include arrhythmias and changes of repolarisation with Q waves in leads I, II, aVp