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Histological examination of sections of the left fallopian tube showed marked chronic salpingitis with numerous granulomas and schistosoma ova in its wall (Figures 1 and 2).

After diagnosis of tubal schistosomiasis, the patient had a Kato-Katz stool examination that revealed *S. mansoni* ova (696 eggs/g faeces) with miracidia. She was then treated with oxamniquine.

**DISCUSSION**

Symptomatic female genital schistosomiasis is a common gynecological finding in areas where *S. haematobium* is prevalent. In contrast, genital manifestations of intestinal schistosomes are not frequent or are neglected and misdiagnosed.

Because schistosomiasis is a highly prevalent poverty-related problem, there are few reports of genital involvement by the worm. Major reports come from developing countries and have been published between 1940 and 1960. Genital involvement by *S. haematobium* is more frequent because adult worms reside in pelvic and vesical venous plexuses, while the others schistosomes live in portal venous system. Nonetheless, there are numerous anastomoses between veins draining genital organs and inferior mesenteric veins. These veins can also have imperfect developed valves, allowing the migration of adult worms of *Schistosoma mansoni* from territory of the portal vein to that of vena cava inferior.

The presence of ova in female genital organs can lead to symptoms, such as lower abdominal pain, dyspareunia, bloody cervical discharge, dysmenorrhea, or pelvic tumors. In many cases, it is asymptomatic. Tubal involvement can produce fibrotic scars, tubal occlusion, and infertility.

Genital schistosomiasis can also complicate pregnancy, causing ectopic pregnancy, abortion, preterm labor, intrauterine growth retardation, and stillbirth.

In this case, the patient had symptoms that could be attributed to leymioma and adenomyosis. It was not found evidence of uterine involvement by *S. mansoni*.

Although she also had tubal involvement, she had no evidence of impaired fertility. As her first pregnancy was at age 14, so before she had moved to a non-endemic area, it may be postulated that migration of worms to genital vasculature could have occurred after pregnancy. Physiological adaptations of normal pregnancy enhance the chance of ectopic localization of parasite eggs because pelvic veins are definitely enlarged.
REFERENCES