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Cervical Endometriosis: A Case Report.

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ABSTRACT

Endometriosis is when cells similar to the cells of the uterus lining develop elsewhere in the body. Most women with cervical endometriosis are asymptomatic and are diagnosed only after a pelvic examination. It is for the same reason its important to improve awareness on this condition to increase incidence of diagnosis so the patient get appropriate treatment at the earliest. This report aims to emphasize the importance of diagnosis of cervical endometriosis by presenting the case of a patient with intermenstrual bleeding, heavy menstrual bleeding, dysmenorrhea, dyspareunia. We concluded that endometriosis of the cervix is very rare and always misjudged as a cervical polyp/fibroid hence causing delay in diagnosis. However a women complaining of dysmenorrhoea, infertility, heavy menstrual bleeding should always raise a suspicion of cervical endometriosis.

Keywords: Endometriosis, cervix, infertility, dysmenorrhoea, dyspareunia

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INTRODUCTION

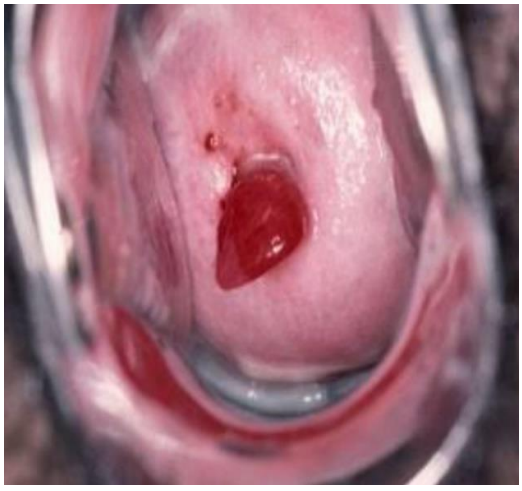
Endometriosis affects an estimated 6 to 10 percent of women, and is especially prevalent in those of reproductive age. In a 2011 study that included more than 13,500 women with endometriosis, only 33 had growths on their cervix [1]. It is predominant in women with a previous history of cervical trauma, such as biopsy, conization, or laser vaporization. Most published reports on Cervical Endometriosis deal with the usage of fine-needle aspiration for diagnosis and with how the atypia in cases with this condition poses differential diagnosis for other premalignant and malignant endocervical lesions.

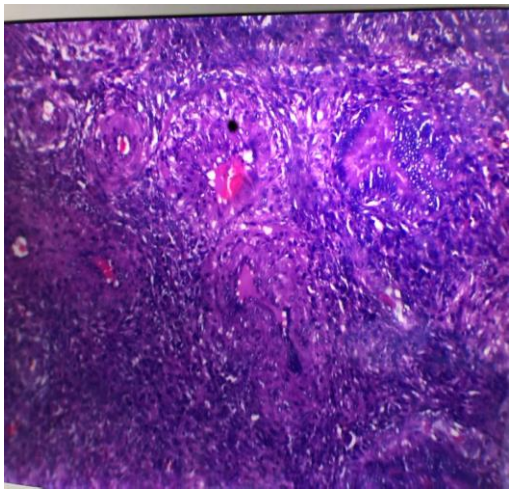
This report presents the case of a 39-year-old woman with intermenstrual spotting diagnosed as endometriosis of the cervix. The purpose of this article is to report a case of endometriosis of the cervix in histopathology which is a rare diagnosis .

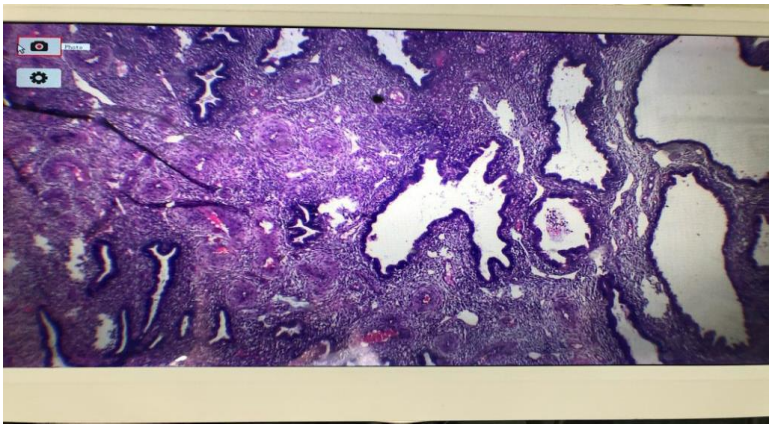
The importance of considering cervical endometriosis in the differential diagnosis when dealing with mass arising from the cervix is emphasised.

CASE REPORT

A 39 year old sexually active woman, P2L2A1 who had undergone LSCS for placenta previa visited our hospital in October. She came with complaints of intermenstrual bleeding, heavy menstrual bleeding, dysmenorrhea, dyspareunia. On examination per speculum a 2x1cm red inflamed globular mass arising from the ectocervix, mass was free from vagina. Per Rectum no nodularity/RV septum thickening. The mass was held with a sponge holding forceps and the same was removed and sent for histopathological examination.







DISCUSSION

Endometriosis is a benign disease that is commonly observed by gynecologists among women in their reproductive age. It is believed to have been first described by Rokitansky in 1860.This condition is generally detected in the ovaries. However, there are instances of its occurrence on the uterus and its ligaments, in the abdominal cavity, on the cervix, pleura, and very rarely in the nervous system, gastrointestinal tract, thorax, urinary tract, lungs, brain, and eyes. Patients commonly report symptoms such as dysmenorrhea (60% to 80%), infertility (30% to 40%), Menstrual irregularity (10% to 20%) and pelvic pain (30% to 50%) [2]. Other symptoms include perimenstrual spotting, contact bleeding, painful sexual intercourse. It is rare for patients to present with menorrhagia or vaginal discharge.

Cervical Endometriosis is asymptomatic, which makes it difficult to be diagnosed. It can be misinterpreted as tumors, sebaceous cysts, incisional hernia, granuloma or as incisional hernia especially when it is present in extra pelvic sites. This is the main reason for the delay in diagnosis of this condition as patients consult other specialities like dermatologists, surgeons or general physicians due to the atypical presentation. It was identified in most patients by identifying abnormal smear results or by pathologic examinations of their hysterectomy or biopsy specimens. However, even cervical smears can be misleading as they can be mistaken as high-grade squamous intraepithelial lesion, atypical glandular cells of undetermined significance or adenocarcinoma in situ [5-8]. In Veiga-Ferreira's series, only 2 of the 16 cases of cervical endometriosis complained of irregular bleeding (12.5%) [3]. This is the reason why it is important to have awareness of cervical endometriosis. Endometriosis typically appears as superficial powder-burn or gun shot lesions on the ovaries, serosal surfaces and peritoneum: black, dark brown or bluish puckered lesions, nodules or small cysts containing old haemorrage surrounded by a variable extent of the fibrosis [9].

Surgical management is in the form of large loop excision of the transformation zone (LLETZ), hysteroscopic resection of the mass and in some severe cases with big sized mass we might have to go ahead with hysterectomy.

In our case, the presenting symptoms were intermenstrual bleeding, heavy bleeding, dysmenorrhea, dyspareunia. Cervical endometriosis can be seen in patients who never underwent procedures traumatizing the cervix, as in our case. Treatment is necessary when cervical endometriosis causes metrorrhagia. As procedures traumatizing the cervix are thought to be etiologic factors for the disease, locally destructive therapies, such as excision of the lesion or fulguration, have the potential to cause recurrences. Successful treatment of cervical endometriosis with superficial electrocauterization has been reported; however, this technique is also reported to be associated with a high rate of recurrence [2]. Some consider cervical endometriosis to be the leading cause of recurrent minimal metrorrhagia, particularly causing perimenstrual spotting and contact bleeding in the form of postcoital hemorrhagia [4].

CONCLUSION

We concluded that endometriosis of the cervix is very rare and always misjudged as a cervical polyp/fibroid hence causing delay in diagnosis. However a women complaining of dysmenorrhoea, infertility, heavy menstrual bleeding should always raise a suspicion of cervical endometriosis.

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