RECURRENT ENDOMETRIOSIS: A CASE REPORT

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ABSTRACT

A 38 year old patient who had hysterectomy and bilateral salpingo-ophorectomy for recurrent endometriosis is reported here. She presented with vaginal vault endometriosis that kept on recurring in spite of local surgical excision and extensive medical treatment.

Key words: Recurrent Endometriosis, Vaginal Vault Endometriosis.

INTRODUCTION

Endometriosis is the presence of ectopic endometrial tissue in the extrauterine sites[1]. It is present in 5-10% of patient in reproductive age, 25-35% with infertility and in 15% who are being investigated for pelvic pain[2]. Endometriosis may recur after medical therapy, conservative surgical therapy and even after castration. In long term follow up study, rate of recurrence in women treated with Gonadotropin Releasing Hormone (GnRH) agonist was 37% for minimal disease and 74% for severe disease [3]. The recurrence rate 5 year after conservative surgery is close to 40%.[3] Early studies of conservative surgical therapy shows a laparoscopically defined cumulative effect of five years recurrence rate of about 19%.[4,5] The long term benefit of surgical intervention for pain is enhanced by definite surgery, including bilateral oophorectomy, with a 10% cumulative recurrences after 10 year.[6] A case report of recurrent endometriosis in a 38 years old patient is presented here.

CASE REPORT

A 38 year age patient was admitted with the recurrent vaginal vault endometriosis. She was married for 3½ years and gave birth to a healthy male child. Six months after the delivery she started getting pain abdomen. She visited many doctors and took various treatments. Ultrasound as well as C.T. scan revealed 6.2x4.3cm complex cystic mass in left adnexal region. On laparotomy left endometriotic ovarian cyst was removed which was confirmed by histopathology. Ten months after surgery she again developed pain and on ultrasound 11x8cm complex mass was diagnosed. Considering her previous diagnosis, she was put on Danocrine 200mg BD for 3 month by a gynecologist. Midst her medical treatment she developed urinary retention due to pelvic mass. Repeat surgery was planned and one year after previous surgery she had total abdominal hysterectomy with salpingo-opherectomy. Intra-operative findings were suggestive of extensive endometriosis. Biopsy report confirmed the endometriosis. She was never put on any medical treatment after surgery. After one year of radical surgery she started irregular vaginal bleeding. On examination polypoidal fungating benign looking lesion was found in the area of vault. Lesion was excised and biopsy confirmed same. She had persistent vaginal bleeding. On transvaginal ultrasound a complex mass about 5.2x4.8 was seen in the pouch of Douglas. She was put on medical treatment and received 5 courses of injection decapeptide with one month interval. Her problem could not be solved and she had still growth on the vaginal vault which was causing persistent irregular bleeding. Third time surgery was planned after 1½ year of 2nd surgery. On laparotomy there was cord like growth in the pouch of Douglas. There were extensive adhesions between rectum and peritoneum of the bladder which were carefully dissected. There was a polypoidal firm cords like mass in the pouch of Douglas which was infiltrating through the vaginal vault. The growth was excised piece meal and area around the vault was completely excised. Specimen was sent to two different laboratories and both

confirmed endometriosis. Patient was cured from the symptoms and follow up till 8 months after surgery did not reveal any recurring symptoms.

DISCUSSION

The recurrent rate of endometriosis is up to 20% per year with a 40% cumulative rate at five years. The possible reasons for the recurrences are residual microscopic lesions, incomplete treatment, or to be the same mechanism which results in the primary occurrence. Recurrent rate of clinically detectable endometriosis tends to be higher in old women with advanced stage of disease[7]. Surgical completeness may have significant effect.[8,9] Koga K has reported that previous medical treatment or large cyst size was associated with high recurrence of the disease[10]. In this case initial conservative surgery did not reveal extensive endometriosis, more over the size of the cyst was not significantly large still she had recurrence of the disease.

In some of the patients, second conservative surgery especially laparoscopic surgery may have beneficial effect. Medical treatment may have some role in the prevention of recurrence. Hornstein MB (1997)[14] has shown that a three month treatment employing a Gn Rh agonist (buserelin acetate) was safe and effective with minimal loss of bone mineral density, which was almost completely reserved after therapy.[11] Surgical castration is considered the treatment of choice for complete cure. Radiotherapy may have some role in the prevention of recurrence of the symptoms. Thomas WW has suggested that radiotherapy should be considered in selected cases where ovarian castration is not a viable surgical option and hormone therapy has failed[12]. In this patient, second conservative surgery was not considered and radical surgery (hysterectomy with salpingooopharectomy) was done, but this treatment could not prevent her recurrence of endometriosis which resulted in irregular vaginal bleeding. Similar case has been reported by Oliver R where the patient had post hysterectomy menstruation due to endometriotic vault fistula which was treated laparoscopically[13]. This type of presentation may be due to mullerian adenocarcinoma of vagina arising in persistent endometriosis as reported by Liu L[14]. So it is necessary to have close clinical follow up of extrauterine endometriosis. Vaginal vault endometriosis may be associated with hormone replacement therapy[15] or may be considered due to cycling ovarian remnants. In this patient there was no history of hormone replacement therapy the theoretical possibility of cycling ovarian remnants cannot be excluded. Medical therapy was given in the form of five cycles of injection decapeptide with one month interval, in spite of this treatment her symptom could not be controlled and third laparotomy for excision of the growth was done. Though this treatment temporarily improved her symptoms, she needs longer follow up. Recurrent endometriosis remains the dilemma and more research is needed to find out the best treatment for this disease.

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