Postcoital bleeding in a case of recto-vaginal endometriosis.

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Abstract

Introduction: Rectovaginal Endometriosis (RVE) is a severe form of endometriosis, less frequent than peritoneal or ovarian endometriosis. Recto-vaginal endometriosis has multiple diagnostic and management options with long-term outcomes varying according to the management strategy used.

Case: A 40 years old woman complained of postcoital bleeding. Detailed history revealed that she suffered from persistent dysmenorrhea, dyschasia and constipation. Vaginal speculum examination revealed a large fleshy polypoidal mass in the posterior vaginal fornix, which was excised and biopsied. Histo-pathological examination revealed vaginal endometriosis. Four months later the mass recurred, in spite of, receiving hormonal treatment. Ultrasound and MRI revealed multiple uterine fibroids, with heterogenous lesion located in the rectovaginal area, and CA-125 was 80 u/ml. exploratory laparotomy was done after proper bowel preparation. Total abdominal hysterectomy with excision of the upper vaginal portion and a part of the anterior aspect of the recto-sigmoid was resected due to the invasion of its musculosa, short of the mucosa, with primary repair. Histo-pathological examination showed advanced endometriosis including the vaginal fornix and the rectal wall. The patient received two doses of Leuprolide Acetate 11.25 mg as an adjuvant treatment. Conclusion: All women with postcoital bleeding or pelvic pain should have a detailed history taken from them and thorough examination including speculum examination and visualization of posterior vaginal fornix to detect vaginal endometriosis. The primary line of management for recto-vaginal endometriosis is surgery, as hormonal therapy is less effective in such cases, which might be explained by difference in origin from the peritoneal disease.

Keywords: Postcoital bleeding, Recto-vaginal endometriosis, Surgical treatment.
revealed vaginal endometriosis and endometrial hyperplasia, therefore, she was prescribed oral progesterone (Dienogest 2 mg) continuous daily treatment; however, 4 months later during her treatment she developed dyspareunia, lower back and pelvic pain along with marked post coital bleeding. Combined vaginal and rectal examination showed a newly developed polyp in the posterior vaginal fornix, with left parametrial involvement, and a palpable mass in the rectovaginal area, with intact rectal mucosa, but inseparable from the posterior vaginal wall. Ultrasound and MRI revealed multiple uterine fibroids, with heterogenous lesion located in the rectovaginal area, and CA-125 was 80 u/ml so decision was taken for exploratory laparotomy after proper bowel preparation and the patient was consented for that. Total abdominal hysterectomy was done for multiple fibroids with preservation of both ovaries, in addition to, excision of the upper vaginal portion. A part of the anterior aspect of the recto-sigmoid was resected due to the invasion of its musculosa, short of the mucosa, with primary repair. The postoperative period went uneventful apart from a localized hematoma in the rectovaginal space which was managed conservative & subsided spontaneously. Histo pathological examination showed advanced endometriosis including the vaginal fornix and the rectal wall. The patient received two doses of Leuprolide Acetate 11.25 mg as an adjuvant treatment.

Discussion

The current case is a case of extensive recto-vaginal endometriosis, which is believed to be different in both morphology and microscopy from peritoneal disease, and most probably arise from tracts of embryological remnants of Müllerian tissue inside the uterosacral ligaments, anterior bowel wall and rectovaginal septum [9-11]. There is variation in both estrogen and progesterone receptors when compared to eutopic endometrium, pointing out to differences in both regulatory mechanism and origin compared to peritoneal disease.

Symptoms include lower abdominal pain, severe backache, constipation and dyschezia [9], which were found in the current case. Speculum examination is useful in some cases and should focus on the posterior vaginal fornix, which showed a lesion in the current case. Vaginal endometriosis can present as disruption of the normal vaginal rugae, distortion, epithelial piling, small bluish cysts or a large reddish polypoid lesion as that found in the current case, therefore; excision biopsy was necessary in that lesion in order to confirm diagnosis. Combined rectal and vaginal palpation can confirm bowel involvement and in such cases bowel preparation should be done before surgery to allow for primary repair and avoid a possible colostomy, which was done before laparotomy in the current case.

Adamyan [12] classified recto-vaginal endometriosis into 4 stages which are: “Stage I: Endometriosis lesions are confined to the rectovaginal tissue in the area of the vaginal vault Stage II: Endometriosis tissue invades the cervix and penetrates the vaginal wall, causing fibrosis and small cyst formation. Stage III: Lesions spread into sacro-uterine ligaments and the rectal serosa. Stage IV: The rectal wall, recto-sigmoid zone and rectouterine peritoneum are completely involved, and the rectouterine pouch is totally obliterated”. 

Hormone manipulation is not effective in most cases, despite the presence of estrogen and progesterone receptors and symptoms usually recur after its stoppage [10,11]. Vercellini et al. [13] in their study concluded that medications achieved temporary quiescence of active lesions and can be used in selected cases, but surgery represented the definitive solution of such cases.

Surgical routes include traditional laparotomy, laparoscopy and recently, robotic surgery. Garry et al. [9] published the early analysis of the first 57 cases included in their study and concluded that surgery improves clinical symptoms and quality of life with acceptable operative morbidities. Chapron et al. [14] did a study to assess the efficacy of laparoscopic treatment of deep endometriosis involving 110 cases and concluded that in the hands of a skilled laparoscopic surgeon operative laparoscopy is efficient in treating pain related to deep endometriosis. Carvalho et al. [15] did a systemic review to evaluate the role of robotic surgery in the surgical treatment of deep endometriosis and concluded that this type of surgery is feasible without conversion; however, randomized controlled trials and studies assessing the long-term effects of robotic surgery are needed.
Laparoscopic surgery performed by a skilled surgeon is considered the gold standard. The extent of resection is individualized. Most authors agree on superficial resection of the nodule or full disk resection of the rectal wall in case of a single nodule less than 3 cm in diameter, if bowel involvement is less than half its circumference. Bowel resection is indicated if it is not possible to resect the nodule or in cases with Adamyan stage IV, between 60 and 100% of such patients show symptom improvement [16]. Therefore, surgical en-bloc resection is the most efficient technique for treatment of obliteration of the cul-de-sac regardless of the route as the technique used during laparotomy in the current case (Figures 2a and 2b) [17].

Conclusion

All women with postcoital bleeding or pelvic pain should have a detailed history taken from them and thorough examination including speculum examination and visualization of posterior vaginal fornix to detect vaginal endometriosis.

The primary line of management for recto-vaginal endometriosis is surgery, as hormonal therapy is less effective in such cases, which might be explained by difference in origin from the peritoneal disease.

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