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Journal of Clinical and Medical Sciences

Short Communication

A Large Postmenopausal Endometrioma: Expect the Unexpected

Ekta Eiran*

Department of Obstetrics & Gynaecology, S.C.B. Medical College, Odisha, India

ABSTRACT

The prevalance of pelvic endometriosis is 6% to 10% of women of reproductive age.

Although endometriosis has been associated with occurrence of menstrual cycles, it can affect between 2 to 5% of postmenopausal women.

We present a case of 62 year old postmenopausal woman with no previous history of menstrual disorder or infertility and no previous or current hormone therapy , with endometrioma , presenting with pressure symptoms.

INTRODUCTION

endometriosis affects 176 million women worldwide.Endometriosis usually causes symptoms of chronic pelvic pain and sub fertility in reproductive age women.The prevalance of postmenopausal endometriosis is 2 % to 5%.Postmenopausal endometriosis is usually associated with hormone replacement therapy which can allow growth of endometriotic deposits in a woman with endometriosis.It may grow silently without the catamenial symptoms leading to serious complications.it infers a risk of malignant transformation; hence a high index of suspicion is warranted.

The following is a case of postmenopausal endometriosis with previous normal menstrual cycles and no history of sub-fertility or hormone replacement therapy presenting with symptoms of bladder outlet obstruction and bowel obstruction.

CASE REPORT

Mrs X 62 year old postmenopausal woman weighing 64kg with height of 154cm presented with two weeks complaint of difficulty in micturition and constipation.There was no history of fever , loss of weight or loss of appetite .She attained menopause 20 years ago and her previous menstrual cycles were normal.She had three living issues; all delivered vaginally.She was diabetic on treatment for 5 years.

On examination there was severe hypotonia of anterior abdominal wall.There was a 20 weeks cystic mass palpable arising from the pelvis.Mass was mobile and non tender with no shifting dullness or fluid thrill

A transabdominal ultrasound revealed a large homogeneous cystic adnexal mass 8*5 inches with internal echoes.Doppler blood flow showed no increase in angiogenesis.CA 125 was normal.With a provisional diagnosis of benign ovarian neoplasm laparotomy was done. Intraoperative there was a 7*5 inches cystic ovarian mass arising from the left ovary; impacted in the pelvis causing severe bladder outlet obstruction.External surface was smooth.The left ovarian mass was excised.As frozen section was reported as benign with a provisional diagnosis of cystadenoma: A Total Hysterectomy with right salpingoophorectomy and appendicectomy was performed.

On opening the cyst revealed yellowish thick fluid.Inner surface revealed adherent yellowish material and haemorrhage.Histopathology showed fragments of cyst wall formed of fibrous tissue.In foci ovarian stroma and smooth muscle bundles seen in outer layers.Inner surface lined by granulation tissue and in parts by ciliated columnar epithelium lining, stroma resembling endometrial stroma.Cyst wall also showed tubular glands with ciliated columnar lining.The granulation tissue was infiltrated by lymphocytes, cells and foamy histiocytes.Few histiocytes contain hemosiderin with final histopathological diagnosis of endometrioma.Also in long standing cases the repeated cycles of hemorrhage efface the endometrial tissue making it difficult to find the endometrial glands and stroma in the cyst wall.

Diagnosis:

- Endometriotic tubo-ovarian cyst left side.
- Uterus and right ovary were atrophic.

Correspondence to: Ekta Eiran, Department of Obstetrics & Gynaecology, S.C.B. Medical College, Odisha, India, Tel: 9986955970; E-mail: ekta.eiran@gmail.com

Received: August 08, 2021; **Accepted:** August 24, 2021; **Published:** September 03, 2021

Citation: Eiran E, (2021) A Large Postmenopausal Endometrioma: Expect the Unexpected. J Clin Med Sci. 05:p469.

DISCUSSION

Endometriosis is a common gynecological disorder associated with chronic pelvic pain and sub-fertility . Endometriosis has traditionally been considered as a disease of premenopausal years.As it is an estrogen dependent condition ;cessation of menses leading to low levels of circulating estrogen causes repression of preexisting endometriosis.However in women with high circulating levels of estrogen in the post menopausal years usually due to phytoestrogens and hormone therapy there can be growth of previous endometriotic deposits.In women with no previous history of endometriosis or hormone therapy the endogenous estrogen may play a role in endometriosis; especially in obese women.

However no single theory has been able the explain the occurrence of premenopausal endometriosis and therefore it is highly unlikely that any single theory could explain post menopausal endometriosis.

In patients with postmenopausal endometriosis differential diagnosis to exclude malignancies is critical as the risk factors are similar.Also the risk of malignant transformation of endometriotic deposits is higher in postmenopausal women.Therefore a careful follow up of such patients on long term basis is necessary for future adverse outcomes.

The treatment of postmenopausal endometriosis is primarily surgical, but medical treatment with aromatase inhibitors could potentially improve symptoms and treat these patients when surgery is contraindicated or for recurrence following surgery.

CONCLUSION

Although rare it is important to be aware of endometriosis in postmenopausal pateints. Post menopausal endometriosis can present in an atypical manner and go undetected leading to serious complications like malignant transformation.Therefore high index of suspicion is necessary along with regular follow up even in postmenopausal period to prevent recurrence.

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