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CASE REPORT

Anterior Vaginal Wall Endometrioma: Case Report

Vajen Ön Duvarında Endometrioma: Olgu Sunumu

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ABSTRACT

A 46-year-old woman was referred to gynecology for the assessment and treatment of an anterior vaginal wall cyst. The preoperative physical examination and transvaginal USG of the pelvis were most consistent with the presence of a bladder cyst. Following the excision of the cyst wall, the patient was diagnosed with an endometrioma in the anterior part of the vagina. This case emphasizes difficulties in the identification of endometriosis in the vagina and other uncommon places, potential processes of disease progression, and recommended therapies.

Keywords: Endometrioma, Vagina, Excision

ÖZ

46 yaşında bir kadın vajinal ön duvar kistinin değerlendirilmesi ve tedavisi için jinekolojiye sevk edildi. Preoperatif fizik muayene ve pelvisin transvajinal USG'si en çok mesane kisti varlığı ile uyumluydu. Kist duvarının eksizyonu sonrasında hastaya vajina ön kısmında endometrioma tanısı konuldu. Bu vaka, vajinada ve diğer yaygın olmayan yerlerde endometriozisin tanımlanmasındaki güçlükleri, potansiyel hastalık progresyon süreçlerini ve önerilen tedavileri vurgulamaktadır.

Anahtar Kelimeler: Endometrioma, Vajina, Eksizyon

Introduction

During a woman's menstrual cycle, the endometrial glands and the stroma go through a series of modifications. Endometriosis is defined as the presence of tissue that is similar to the endometrium outside of the uterus (1, 2). Endometriosis affects around 10 percent of women of reproductive age, but the real frequency cannot be ascertained since a conclusive diagnosis requires invasive surgery (1, 2). This illness induces discomfort in the pelvic region and infertility. Patients' well-being and productivity may be negatively impacted by symptoms such as dysmenorrhea, dyspareunia, dysuria, and dyschezia, in addition to exhaustion (1). It is common for patients to have pain in the pelvic region and infertility because of this sickness. Endometriosis has traditionally been diagnosed surgically, particularly before beginning therapies with potentially harmful side effects like gonadotropin-releasing hormone (GnRH) agonists or antagonists. For low-risk and low-cost therapies like hormonal contraceptives or progestins, the presumption of clinical diagnosis based on symptoms, physical examination, and imaging has risen in popularity. Presumptive diagnosis is less invasive, lower risk, and lowers treatment delay (3). Since surgery carries its own hazards, as well as the related recovery time and cost, patients are more inclined, to begin with medicinal treatment. Women who are not responding to medicinal treatment or who experience recurrent pain symptoms may be candidates for surgical removal of endometriosis or nerve transection operations. A histological diagnosis and pain relief are both provided by surgical resection (4, 5).

Endometriosis may have different causes. Sampson was the first researcher to report "chocolate" ovarian cysts and endometrium-like tissue in the myometrium in 1927 (6, 7). As proof, he cited the fact that menstrual dissemination of endometrial tissue was transported to environments that were conducive to its survival (6). Although Sampson's idea, sometimes referred to as "retrograde menstruation," is the most widely accepted interpretation, it is insufficient to account for all of the clinical data. According to new ideas, endometriosis outside the pelvis may be caused by mesothelioma cell metaplasia, in addition to genetic and epigenetic defects that are inherited from birth. These abnormalities are handed down from generation to generation. Koninckx et al. also cited hematologic and lymphatic dispersion of endometrial tissue as possible explanations for their findings (7). Endometriosis implants may be found everywhere in the body; however, the most frequent deposit places are inside the pelvis. Endometriosis implants can also be found in the colon (1). An endometrioma can develop in the anterior abdominal wall, generally around a surgical incision, in a very infrequent basis (8) or the umbilicus, although similar lesions can occur in people who have never had surgery or have no history of endometriosis at all. Endometriosis has been recorded in extremely rare cases in the following locations: breast, pancreas, liver, gallbladder, kidney, urethra; extremities; vertebrae; bone; peripheral nerves; spleen; diaphragm; central

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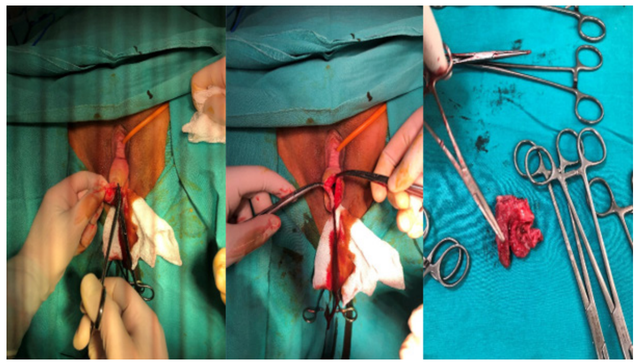
nervous system; hymen (9) and lung (10). Endometriosis and endometriomas that manifest in the vaginal cavity are quite rare. This case demonstrates an unusual presenting symptom and the appearance of an endometrioma. We also discussed the potential causes of endometriosis in this particular setting.

Case Presentation

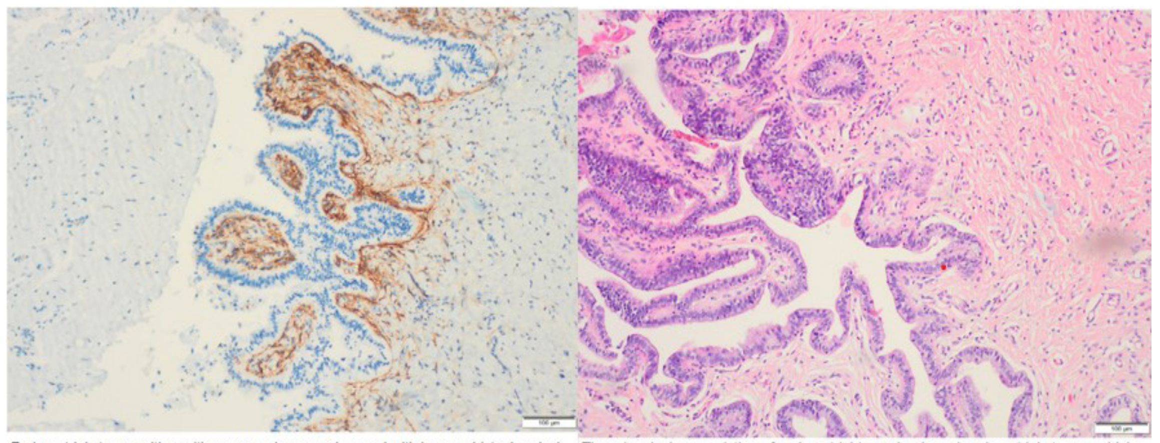
A 46-year-old mother of four was the subject of this case study. She had a natural vaginal birth. Her first period came when she was 12 years old. Neither dysmenorrhea nor dyspareunia plagued this woman. It was found that the smear test taken six months earlier was normal. Over the previous two years, the patient had suffered from monthly irregularities and enlargement in her vagina, which protruded when she bent.

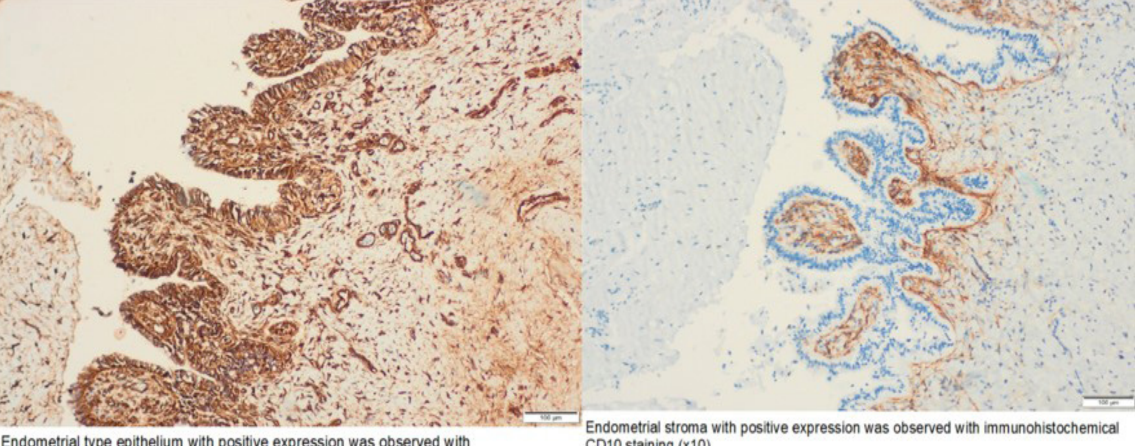
In the pelvic examination, the swelling starting 2–3 cm below the urethral meatus and measuring approximately 10 cm in size gave the impression of a cystocele at first glance. When examined more closely and palpated, it was of soft consistency. A localized cystic formation was observed on the anterior wall of the vagina, adjacent to the bladder, in the transvaginal USG (TVUSG). An additional imaging method was not applied to the patient because the walls of the cystic structure seen in the TVUSG were regular and it could be clearly differentiated from the surrounding tissues.

An unusual mass was palpated near the midline vagina, inferior to the urethra, and it was found to be fluctuant. During the procedure to remove the vaginal cyst, it was discovered that there was an outflow of "chocolate fluid," which was consistent with an endometrioma. Excising the cyst wall was followed by irrigating and reapproximating the cyst cavity using Vicryl suture, which was subsequently removed (Picture 1).



Picture 1: Excision of the endometrioma from the anterior vaginal wall.





Picture 2: Histopathology of the endometrioma.

The final pathology of the patient was reported as endometrioma (Picture 2).

Discussion

This instance demonstrates that endometrioma may be the cause of a vaginal cyst in the absence of any other obvious cause. When endometriosis is discovered outside of the peritoneal cavity, the diagnosis of endometriosis might be difficult to make (2). Endometriosis may “masquerade” as various illnesses, resulting in missing or delayed diagnosis in many instances (11). There have only been a few reports of endometriosis in the vaginal region. Endometriosis was discovered in an episiotomy scar with a painful nodule and cyclic discomfort, according to a review of the literature (12). Another study discovered a vaginal endometrioma in a 43-year-old woman who had no other signs or symptoms of endometriosis, which was similar to the patient reported in this article. Here, the endometrioma in the patient’s vagina was surgically excised (2). Excision of the whole cyst wall is essential for the identification and treatment of endometriomas in this patient and in general. This should be conducted in every instance to avoid the uncommon but potential recurrence and malignant change (12, 13). Endometriosis-related ovarian cancer has been shown in research going back to Dr. Sampson’s study. Endometriosis patients with lengthy histories of endometriosis, early endometriosis diagnoses, histories of infertility and/or infertility treatment, and ovarian endometriomas have a higher chance of malignant transformation (13). The purpose of the hormone therapy used to treat endometriosis is to reduce local estrogen production. Consequently, this may decrease tissue growth and inflammation at endometriotic implants. Oral contraceptive pills are often used in clinical practice because they help alleviate dysmenorrhea and persistent pelvic discomfort in individuals with endometriosis (1).

Conclusion

In cases with perineal scar endometriosis, surgical excision with broad margins was the treatment of choice. Postoperative monitoring is necessary to rule out recurrence (12). Endometriomas in the vagina should be surgically removed with or without medical treatment, based on our experiences with this patient and another case of anterior vaginal wall mass in the medical literature (2).

Conflict of Interest

The authors disclose no conflicts of interest in publishing this case report.

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Patient Consent

Obtained.

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