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Juvenile pelvic extragenital endometrioma with acute abdomen in a 15 – year – old - girl

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ABSTRACT

We describe a case of a 15-year-old girl with a several month history of chronic pelvic pain, due to a 5 cm pelvic tumour, presenting with acute abdomen. Urgent diagnostic laparoscopy revealed multiple pelvic adhesions and a focal extragenital pelvic tumour. After laparoscopy, ultrasound and magnetic resonance imaging and laboratory procedures (with normal value of oncomarkers) were performed, followed by explorative laparotomy and total tumorectomy. An extragenital pelvic endometrioma was verified on histopathological analysis.

Key words: acute abdomen, pelvic pain, juvenile, endometriosis, extragenital, puberty

INTRODUCTION

Juvenile extragenital endometriosis is extremely rare and mostly accidentally detected due to other associated symptoms (acute abdomen, torsion with pain, chronic pelvic pain, pronounced dysmenorrhea or premenstrual syndrome), usually in association with acute or chronic pelvic pain syndrome. (1,2)
There are only rare, sporadic literature reports of juvenile extragenital endometriosis; therefore, we present this case of juvenile, focal, tumorous endometriosis that was accidentally detected as an atypical pelvic tumor in a 15-year-old girl with symptoms of acute abdomen after several months of intermittent pelvic pain.

CASE REPORT

We present a case of a 15-year-old girl with a normal personal and family history, normal somatic and gynecologic development, menarche at age 12 with normal menstruation and not sexually active. Prior to presentation, she was on conservative treatment prescribed by her family physician for diarrhea and low grade fever. There were no signs of acute abdomen at the time, but gynecologic transabdominal ultrasonography (US) revealed the presence of a retrouterine paraovarian cystic tumor mass, 75x66 mm in size, with detectable flow within the tumor capsule; the ovaries and uterus showed normal morphometry. Laboratory findings were indicative of infection (C-reactive protein 66.1 mg/L; leukocytes 12.3; other findings normal). Urine culture and coproculture were sterile, thus the antibiotic amoxiclav was prescribed for seven days by the family doctor. After one week of therapy, pain in the lower abdomen persisted and the girl, accompanied by her parents, presented to the gynecologist with acute abdomen. Based on the US finding of a paraovarian tumorous cystic mass in the pelvis and persisting pain, nausea and vomiting, we

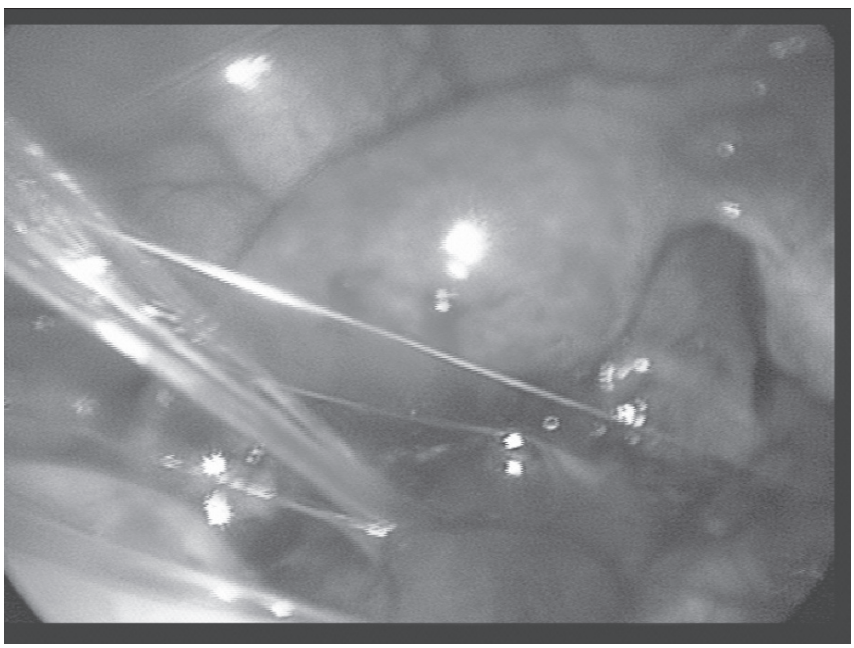

Figure 1. Laparoscopic findings of multiple adhesions with focal pelvic extragenital endometrioma in a 15- year – old –girl.

opted for laparoscopic surgery, with the parents' consent. Abundant loose pelvic adhesions were laparoscopically detected and removed (adhesiolysis and salpingo-ovariolysis) (figure 1); then, a distended, sharply delineated mass of about 5 cm in size, with its lower pole tightly coalescing with the presacral peritoneum, was found in Douglas' space behind the uterus. Drainage was placed and antibiosis with meropenem prescribed for a possible subacute pelvic infection (loose adhesions). We decided to perform an additional examination of the pelvic tumor mass: US and magnetic resonance imaging revealed an extragenital cystic solitary tumor in the pelvis, 5.4x4.5x4.5 cm in size, with hyperintense T1 and T2 signals, and differential diagnostic characteristics suggestive of teratoma, without vascular communications with pelvic blood vessels. The appendix was visualized, tumor markers (HCG, β-HCG, AFP, CEA, CA 125, CA 19.9 and CA 15.3), laboratory biochemistry, coagulation and hemogram findings were normal, and so was pelvic swab intraoperative microbiology.

Following preoperative preparation, an exploratory laparotomy, according to Pfannenstiel, and cyst extirpation with cytologic swab sampling was performed under general anesthesia. Histopathology indicated a cystic tumor, 4.4x3.6x3.3 cm in size, with dark-red content, no papillary inclusions, showing histiocytic granulation reaction with old and fresh hemorrhages, but no elements of malignancy, corresponding to the finding of an epithelial cyst with endometriosis (extragenital endometrioma). Cytology pointed to mesotheliocytes. The postoperative course was uneventful, and the patient was discharged from the hospital on postoperative day five.

DISCUSSION

Juvenile endometriosis is underlain by hormonal changes in puberty, therefore being extremely rare. However, rapid development of endometrioid foci, such as adhesions, and focal growths, like extragenital endometrioma, is an example of this clinical rarity, as described above. It is considered that adolescents with chronic pelvic pain have some form of endometriosis, mostly of atypical site seat and clinical picture. (3) There are rare reports of juvenile extragenital endometriosis cases. Gotoh described vesical endometriosis in a 13-year-old girl with a bicornuate uterus and unilateral renal agenesis with dysuria and dysmenorrhea. Resection of the urinary bladder and endometriotic focus was performed, followed by complete patient recovery. (4)

In pubertal (juvenile) and adolescent patients, hormonal estroprogestin inhibitory therapy or use of nonsteroidal analgoantirheumatics is recommended after surgical excision, in order to preserve later fertility. According to some authors, gonadotropin-releasing hormone agonists are not recommended before age 16 (or age 18-20), i.e. before complete pubertal maturation. Adolescents refractory to medicamentous therapy require surgical evaluation and treatment. (5,6) Timely treatment of endometriosis in juvenile and adolescent age can prevent further disease dissemination, alleviate chronic pelvic pain, and preserve patient fertility and quality of life in adult age.

REFERENCES

1. Laufer MR, Sanfilippo J, Rose G. Adolescent endometriosis: diagnosis and treatment approaches. J Pediatr Adolesc Gynecol 2003;16(3 Suppl):S3-11.
2. Habek D, Premužić M, Čerkez Habek J. Sindrom akutnoga abdomena u ginekologiji i opstetriciji. Acta Med Croat 2006;60:227-35.
3. Propst AM, Laufer MR. Endometriosis in adolescents. Incidence, diagnosis and treatment. J Reprod Med 1999;44:751-8.
4. Gotoh M, Yoshikawa Y, Tanaka K, Tsuji Y, Kondo A, Miyake K. A case of juvenile vesical endometriosis with unilateral renal agenesis and bicornate uterus. Hinyokika Kiyo 1991;37:915-8.
5. Bourdel N, Matsusakï S, Roman H. Endometriosis in teenagers. Gynecol Obstet Fertil 2006;34:727-34.
6. Veeraswamy A, Lewis M, Mann A, Kotikela S, Hajhosseini B, Nezhat C. Extragenital endometriosis. Clin Obstet Gynecol 2010;53:449-66.