Iatrogenic endometriosis due to isthmic stenosis post-trachelectomy

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DESCRIPTION

A nulliparous 42-year-old woman presented for a prophylactic prepregnancy laparoscopic transabdominal cerclage (suture around the cervicoisthmic junction to prevent pregnancy loss due to cervical insufficiency) after having undergone a trachelectomy for stage IA cervical cancer 10 years ago. The patient had a laparoscopy for investigation of pelvic pain a couple of years before the trachelectomy. Mild superficial endometriosis was reported and treated at the time. She had been having regular menstrual cycles until the trachelectomy and became permanently amenorrhoeic postsurgery. Blood tests done prior to the procedure showed normal ovarian and thyroid functions. She did not undergo chemotherapy or radiotherapy that could have contributed to reduction in ovarian activity and hence cessation of menses. She has recently started In-vitro fertilisation (IVF) treatment for infertility attributed to anatomical factors (stenosed cervix). All hormonal investigations came back within normal range, again confirming adequate ovarian function. There was no transvaginal access to the endometrial cavity due to cervical stenosis.

The laparoscopic transabdominal cerclage was placed successfully; however, significant endometriosis was evident during the laparoscopy, including several lesions over the bowel (see figures 1 and 2). We believe that the more extensive endometriosis seen at the time of the transabdominal cerclage developed some time after the trachelectomy and supports the aetiological theory of retrograde menstruation as a contributor to endometriosis. It is not possible to determine exactly when it happened within the 10 years that passed; however, the retrograde menstruation caused by the blocked cervix seems to have been a major contributor. Acquired isthmic stenosis causing backflow of menstrual blood through the fallopian tubes has been suggested in small studies and demonstrated on magnetic resonance imaging (MRI), theoretically increasing predisposition to endometriosis.[1–5] This case provides a clinical presentation of subsequent endometriosis. We have not found evidence in the literature definitively demonstrating this until now.

At present, there seems to be no evidence as to whether iatrogenic endometriosis behaves or progresses differently from the non-iatrogenic form of the disease. Hence, the management of iatrogenic endometriosis should be as for the non-iatrogenic disease. Indications for treating the condition are based on the clinical presentation and associated symptoms, mainly dysmenorrhoea, dysuria, dyschezia, chronic pain and subfertility. The same medical treatment for control of symptoms and surgical treatment for excision of endometriotic lesions should be considered. The authors are investigating measures such as insertion of a levonorgestrel intrauterine device after trachelectomy to prevent endometriosis.

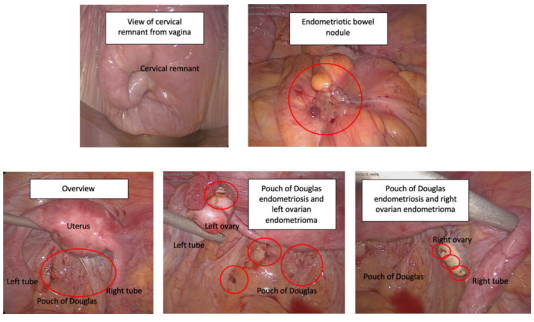

Figure 1 Labelled images.

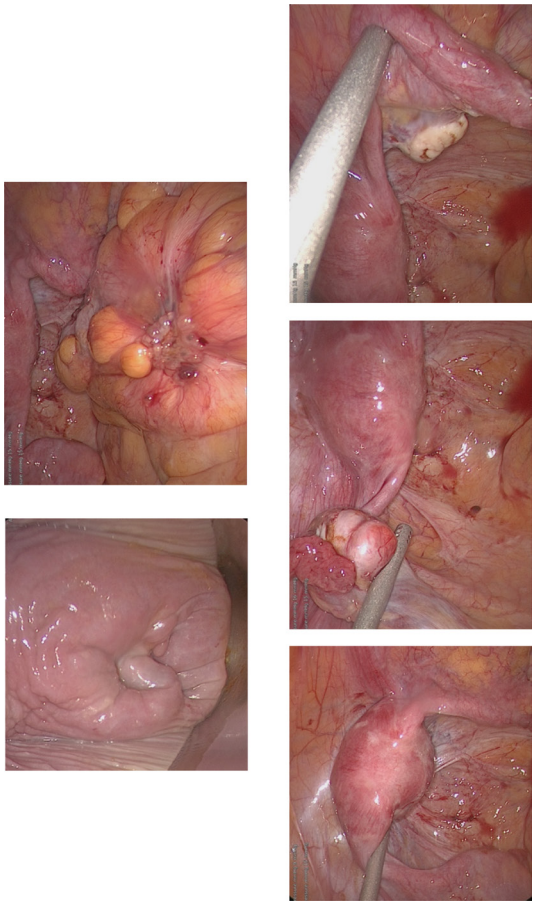

Figure 2 Images without labels.

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Learning points

- Endometriosis can occur as a result of retrograde menstruation secondary to outflow tract obstruction.
- It is important to consider the possibility of endometriosis in women who have undergone procedures that may result in cervical or isthmic stenosis; preoperative counselling of the risk of endometriosis is suggested.

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