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A rare case of cervical endometriosis presenting with profuse vaginal bleeding during an embryo transfer cycle: A case report.

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Abstract

Cervical endometriosis is seen very rarely, much lesser than even the extra pelvic sites like an abdominal wall or vaginal wall. Limited awareness of the condition may account for its rarity. This report aims to remind gynaecologists of the possibility of cervical endometriosis by reviewing the case of a woman who presented with profuse vaginal bleeding during embryo transfer in an assisted conception cycle.

Case presentation

A 40-year-old woman was referred for assisted conception. During embryo transfer, the procedure had to be abandoned due to excessive bleeding from the cervix. Her cervix appeared abnormal, and she was referred urgently to colposcopy. Her previous cervical smears were up to date and normal. Colposcopy revealed a slightly inflamed cervix with an ectropion. Within this area, was a raised nodular growth that appeared suspicious and bled profusely on contact. Biopsy confirmed histological features of cervical endometriosis with no features suggestive of dysplasia or malignancy. She was referred back to the gynaecology for further investigation in light of this new diagnosis and to review her in the context of any potential consequences for her fertility treatment.

A detailed history revealed a chronic symptom of prolonged bleeding throughout the month with the variable flow for which she was on combined oral pills for 18 years. She had been experiencing chronic pelvic pain and dyschezia.

Diagnostic laparoscopy was undertaken and was suggestive of endometriotic spots on the right ovary and the utero-vesical fold which were treated by diathermy. Hysteroscopic view of the endometrial cavity was normal.

Discussion

Endometriosis is a very common condition affecting women of reproductive age. Although endometriosis is most commonly noted in the pelvis, extra-pelvic locations are also demonstrated in some cases. The presentation of cervical endometriosis is variable. It is usually asymptomatic and diagnosed retrospectively in histopathological reports but can also present as post-coital bleeding or abnormal smears. Almost all the previous documented cases were misdiagnosed with cervical myoma, cysts, polyps, melanoma, or cervical cancer; only to receive the diagnosis of endometriosis once the tissue had been biopsied.

Some authors consider cervical endometriosis as a leading cause of recurrent minimal metrorrhagia **[1]**. In one of a large series only 12.5 % of cases of cervical endometriosis, complained of irregular bleeding **[2]**. In another case series, 20 % of women presented with metrorrhagia **[3]**. One of the cited cases in literature was presented with severe vaginal haemorrhage, who ultimately required uterine artery embolization to control the haemorrhage. A considerable number of patients reported in the literature only had abnormal smear results and were diagnosed after histopathological evaluation. Other findings are glandular abnormalities like cervicitis, endocervical gland dysplasia, adenocarcinoma in situ, squamous carcinoma in situ, atypical squamous metaplasia involving glands and tubal metaplasia, especially in the superficial cervical endometriosis. Cervical endometriosis being a source of atypical glandular cells should be kept in mind **[4-7]**. In our case, there was no abnormality noted in the cervical smears.

Various theories had been proposed to explain the origin of endometriosis. Theories such as Sampson's menstrual reflex and implantation theory can be used to explain cervical endometriosis in cases with previous cervical trauma caused by the procedures such as LLETZ or curettage or biopsy **[8]**. In our patient, there was no history of the aforementioned procedures ruling out any cervical trauma and hence the most likely theory for her developing

cervical endometriosis could be explained by the abnormal intrinsic properties of eutopic endometrium, embryonic remnants and metaplastic origination **[9]**.

Asymptomatic cases may not always require treatment but symptomatic cases presenting with post-coital bleeding and inter-menstrual bleeding can be treated with the LLETZ procedure, electrocoagulation, cryosurgery or CO2 laser vaporization **[10]**. Also, treatment can be necessary as many will present with associated pathologies like adenomyosis, fibroid, ovarian cyst or pelvic endometriosis. In our case, a diagnostic laparoscopy was performed to evaluate the extent of the disease before proceeding with fertility treatment. In order to prevent a further recurrence, patients can be prescribed hormonal management in order to delay menstrual bleeding for several weeks, to allow the cervix to heal. Our patient was keen on her fertility treatment and therefore refused to wait for her next IVF cycle.

Learning points

· Cervical endometriosis can be encountered in different clinical presentations and should be considered in the differential diagnosis of abnormal vaginal bleeding.

· Colposcopy, cervical biopsy and fine-needle aspiration cytology (FNAC) are important investigations for superficial cervical endometriosis.

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