Reccurent severe endometriosis
– Case presentation

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Abstract

Introduction and objective: Endometriosis is the presence of normal endometrial mucosa abnormally implanted in locations other than the uterine cavity, characterized by severe pain. In this paper we explore a case of endometriosis with urologic involvement.

Material and methods: A 24 year old girl, already diagnosed with endometriosis 4 years prior, was admitted with dysuria, flank pain, and hematuria at the time of menses, pelvic pain and pelvic tenderness. Ultrasound examination revealed bilateral hydronephrosis and large right ovarian cyst. GnRh antagonist treatment was initiated, right hydronephrosis disappearing after 10 days. MRI detected rectal involvement and multiple pelvic adhesions, and confirmed the ultrasound findings. Left retrograde ureteroscopy and stenting were not possible.

Results: Patient was operated for laparatomy adhesiolysis to restore normal intrapelvic organ mobility. Then right salpingo-oophorectomy and cytoreduction of visible endometriosis was performed, and the left ureteric pelvic obstruction was treated by ureterocystoneostomy.

Conclusions: Any postpubertal patient going to the operating room for acute or chronic pelvic / abdominal pain could have endometriosis, therefore consulting with a physician having the experience to recognize, diagnose, and treat this disease is prudent. Conservation of future fertility may be dependent on the conservative and meticulous surgical approach of an expert reproductive surgeon.

Key words: endometriosis, salpingo-oophorectomy, adhesions

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**Introduction**

Endometriosis is defined as the presence of normal endometrial mucosa (glands and stroma) abnormally implanted in locations other than the uterine cavity. (1) This condition is a common, poorly understood, and extremely debilitating benign gynecologic condition. The psychologic impact of the severe pain experienced by the patient is compounded by the negative impact of the disease on fertility. (2)

The exact cause and pathogenesis of endometriosis is unclear. It is likely a combination of various factors that cause and determine the severity of this disease. (3)

From our experience with 10 operated cases with urologic involvement we present our last case.

**Material and methods**

We present a case of a nulliparity 24 year old girl with recurrent severe endometriosis.

Patient was admitted in hospital with dysuria, flank pain, and hematuria at the time of menses, pelvic pain and pelvic tenderness.

A bluish nodule was identified in the vagina due to infiltration from the posterior vaginal wall.

Ultrasound examination revealed bilateral hydronephrosis and large right ovarian cyst.

She was diagnosed with endometriosis 4 years ago when left salpingo-oophorectomy for large ovarian cyst was performed. Histologic demonstration of both endometrial glands and stroma in biopsy specimens obtained from outside the uterine cavity confirmed the diagnosis of endometriosis.

Dysmenorrhea, heavy or irregular bleeding continued, associated with pelvic pain, lower abdominal or back pain, dyspareunia, dyschezia (pain on defecation) often with cycles of diarrhea and constipation, inguinal pain, pain on micturition and/or urinary frequency and pain during exercise.

In 2011 coaxial retrograde stenting for 12 weeks was performed for treatment of catamenial intermittent left ureterohydronephosis (UHN) (Fig. 1).

Medical therapy with gonadotropin-releasing hormone (GnRH) analogues 3 cycles (3-5 months) every year was prescribed by the gynecologist, but symptoms reappeared after the treatment was stopped.

For rapid onset of medical castration antiandrogen treatment with GnRH antagonist was initiated. Right hydronephrosis disappeared after 10 days.

Transvaginal ultrasonography identified right cyst of the ovary containing low-level homogenous internal echoes consistent with old blood.

MRI was helpful and detected rectal involvement and multiple pelvic adhesions. MRI confirmed the ultrasound findings of the right cyst in the ovary (Fig. 2) and the left ureterohydronephrosis (Fig. 3) due to multiple pelvic adhesions.

Left retrograde ureteroscopy and stenting were not possible.

**Result**

Patient was operated for laparatomy adhesiolysis to restore mobility and normal intrapelvic organ relationships was performed followed by right salpingo-oophorectomy and cytoreduction of visible endometriosis. Left ureteric pelvic obstruction was treated by ureterocystoneostomy.

**Discussion**

Treating patients with endometriosis should be done by an experienced physician in the diagnosis and management of this condition and its complications, such as an obstetrician/gynecologist. If extensive disease is present, specialists in reproductive endocrinology, urology, colorectal surgery, and even gynecologic oncology may be required.
Conclusion

Any postpubertal patient going to the operating room for acute or chronic pelvic/abdominal pain could have endometriosis, therefore consulting with a physician having the experience to recognize, diagnose, and treat this disease is prudent. Conservation of future fertility may be dependent on the conservative and meticulous surgical approach of an expert reproductive surgeon. (4)

References