"Para-aortic endometriosis in nulliparous woman."

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Abstract

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Para-aortic endometriosis in a nulliparous woman

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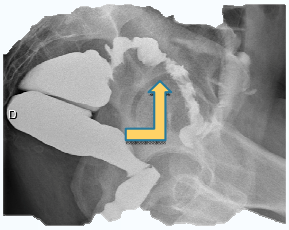
Objectives

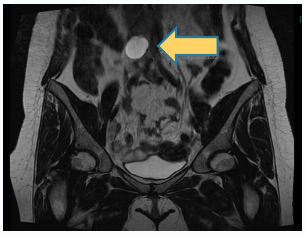
We report an unusual presentation of endometriosis, potentially leading to serious life-threatening complications by late diagnosis.

Case report

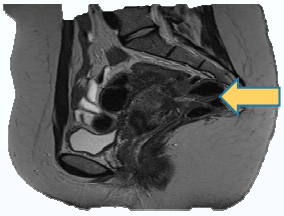
A 31-year-old nulliparous woman with an unremarkable history presented for dysmenorrhea, dyspareunia and dyschezia. Clinical examination revealed an endometriotic nodule of the rectovaginal space. MRI confirmed the presence of a nodule of the rectovaginal space and an endometriotic lesion on the sigmoid, which was covering the entire uterine fundus.
A large cyst was also found at the level of L3,close to the inferior vena cava. It was hyperintense in T2 sequence, and mildly hyperintense in T1 and T1 with fat saturation sequences.



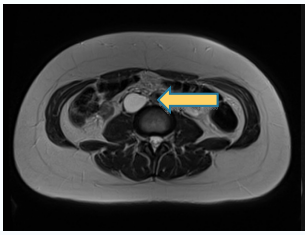
Colon perivisceritis



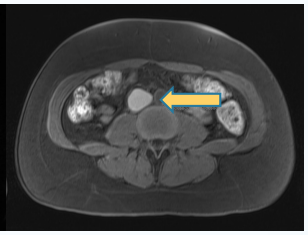
Endometriotic para-aortic cyst at MRI



Rectovaginal nodule and perivisceritis



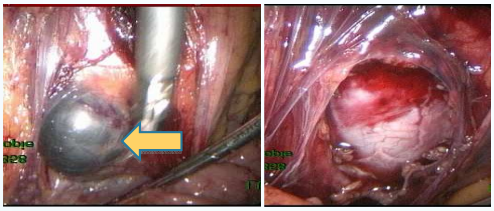
T2-FS cyst with compression of vena cava



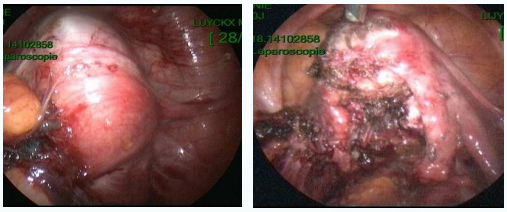
T1-FS hyperintense cyst

Management & outcome

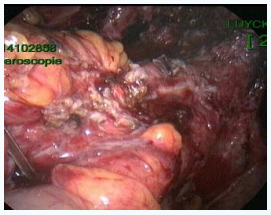
We proposed surgical exploration of the lesion and treatment of the endometriosis. Surgical procedures were performed as scheduled. The patient was discharged from hospital on day 1. Histopathology confirmed endometriosis, with an endometriotic cyst in a para-aortic lymph node. Treatment with LH-RH analogs was initiated postoperatively.



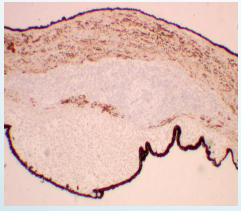
Endometriotic cyst of vena cava before and after resection



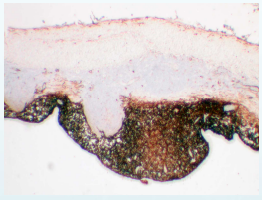
Rectovaginal nodule and uterine perivisceritis before and after resection



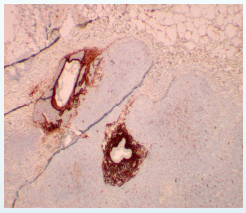
Vaporized rectal perivisceritis



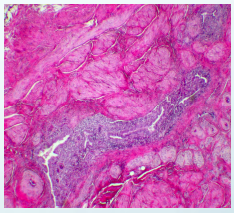
Cytokeratin 7 IHC showing epithelial covering of the cyst



CD10 IHC showing endometriotic stroma in the wall of the cyst



CD10 IHC showing other endometriotic lesions in the lymph node



H&E staining of recto-vaginal endometriosis

Discussion

Differential diagnosis between a cystic of lymphangioma, Müllerian cyst, mucinous cystadenoma and endometriotic cyst of para-aortic location was proposed.
This is the first description of endometriotic lesions in the para-aortic region. Surgical treatment was recommended because of compression of the inferior vena cava.
While the pathogenesis of the lesion remains unclear, colonization of a previous lymphocele could be envisaged.

Conclusion

We report the first case of para-aortic endometriosis in a nulliparous woman treated by laparoscopy with no complications.