

**BILATERAL FETAL HEAD SIZE ENDOMETRIOMAS WITH DEEP INFILTRATING  
ENDOMETRIOSIS IN AN ADOLESCENT GIRL**

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Submitted on: May 2015

Accepted on: June 2015

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**ABSTRACT**

We describe a rare case of bilateral fetal head size endometriomas with deep infiltrating endometriosis in a 19 years unmarried adolescent girl with sub-acute pain and 16-18 weeks mass lower abdomen. Exploratory laparotomy confirms bilateral fetal head size endometriomas with deep infiltrating endometriosis. Dense areas with periovarian, peritubal adhesions present in pelvis, bladder, bowel and ligaments attaching uterus to pelvis. Bilateral excision of endometriomas and extensive endometriotic implants with done. Only minimal ovarian tissue could be conserved on both sides. In teenage girls' very painful menstrual periods that interfere with daily life may signal an increased risk of developing the most extensive form of endometriosis. Early diagnosis and treatment is promising for Teen Endometriosis.

**Key Words: Endometriomas, Adolescent, Endometriosis, Deep infiltrating Endometriosis, Dysmenorrhea.**

**Introduction**

Endometriosis is tricky to diagnose and many girls and women go years before diagnosis. Myth, that endometriosis is an issue once women reach their 20's, 30's beyond is leading to condition being missed in teenagers. Timely diagnosis of endometriosis remains a challenge for women of all ages and particularly so for adolescents whose symptoms start at young age. In adolescents with chronic pelvic pain,

endometriosis is not rare, 69.6% of teenagers who underwent diagnostic laparoscopy for chronic pelvic pain had endometriotic implants.<sup>[1]</sup>

The chief symptoms leading to diagnosis are Chronic pelvic pain (27%), Acute pelvic pain (21%), a palpable pelvic mass (21%), dysmenorrhea (18%).<sup>[2]</sup> Other reported symptoms include dyschezia, painful bladder, pain with exercise and intestinal cramping along with poor quality

of life. The age of peak diagnosis of endometriosis based on presenting symptoms is pelvic pain, age 15-24 years; infertility, age 25-34 years; and dysfunctional uterine bleeding age 35 to 44 years.<sup>[3]</sup>

We report a 19 years old unmarried adolescent girl, poorly built, malnourished, school dropout in class eight from lower socioeconomic status, rural background with excessive caffeine intake and sedentary lifestyle. She presented with sub acute pain and mass lower abdomen, in Gynae Out Patient Department on 11.04.2012 vides CR No. 13806.

Age of menarche was 12 years with menstrual formula 7-8/22, excessive flow with severe congestive dysmenorrhea. Patient visited seven years back with chief complaints of menorrhagia and dysmonorrhea. Ultrasound pelvis at that time 23/2/2006 showed nulliparous uterus with 2.5 cm cyst in right ovary (Fig. 1). She was put on NSAIDS and cyclic OCPs (MALA-N), but lost to follow up. Now she presented again with sub acute pelvic pain and pelvic mass. Vitals were stable. On Local examination- 16-18 week size firm to solid, non tender midline mass arising out of pelvis. Hb 9.6gm, BT 1'-30", CT 4'-10", urine examination normal, urine for pregnancy-negative. TSH, T<sub>3</sub>, T<sub>4</sub>, ESR, Serum  $\alpha$ FP, B-HCG was within normal. CA125 was 60 U/ml. X-ray chest was normal. CT abdomen and pelvis showed well defined 9 x 7.2 cm smooth walled round to oval right adnexal mass with thickened and diffuse internal echos, displacing adjacent gut loops superiorly and laterally with posterior displacement of right iliac vessels. Another small hypo dense cystic lesion of 2.8x1.7 cm is seen adjacent to the aforementioned right adnexal mass. Another well defined smoothly margined round mass 7.5x5.3cms is seen in left adnexal region. (Figure- 2 and 3). CT guided

FNAC showed benign looking epithelial cells in background of RBCs. Provisional diagnosis of bilateral adnexal masses? Endometriomas? Tubo-ovarian masses? was made.

Exploratory laparotomy was done and a bilateral endometriomas 10x10 cm in size filled with chocolate material, densely adherent with uterus, large gut and omentum. Both the fallopian tubes were dilated with chocolate sauce pouting from fimbrial ends. There were dense adhesions with induration and nodularity in multiple areas of pelvis including bladder, bowel and ligaments attaching uterus to pelvis, peritubal and periovarian adhesions with complete obliteration of pouch of douglas. Catastrophic picture of bilateral fetal head size endometriomas with deep infiltrating endometriosis was never seen before. Conservative surgery was not feasible. Bilateral excision of extensive endometriotic implants/ endometriomas with deep infiltrating adhesions was done. Only minimal ovarian tissue could be conserved on both sides. Uterus was conserved for ART. Histopathology confirmed extensive endometriosis. Patient discharged on 9<sup>th</sup> post operative day. Long term combination oral contraceptive pills started after three weeks. On follow up, patient is comfortable with regular menstrual cycles till date.

### Discussion

Endometriosis is traditionally diagnosed after the second or third decade, approximately one third of patient with confirmed endometriosis experience their first symptom before 15 years of age.<sup>[4]</sup> Pelvic pain can interfere with school attendance, involvement in sports and participation in social activities. Adolescents with pelvic pain should be fully assessed for the evaluation and treatment of adolescent pelvic pain and endometriosis.<sup>[5]</sup> It could be a case of premenarchal endometriosis as average time for diagnosis of endometriosis

is about seven years but longer in adolescents. If diagnosis is delayed, disease may continue leading to endometriotic cysts in ovaries and affect fertility. Ovarian endometriomas are significantly associated with severe dysmenorrhea and pelvic pain. Early diagnosis of endometriosis and aggressive treatment with complete excision are the best prevention for teen endometriosis. Conservative surgical treatment with resection of all endometriotic lesions is often the first line treatment of endometriosis. Conservative resection of disease by laparotomy is valuable in cases of extensive dense pelvic adhesions or endometriomas greater than 5cms in diameter. A complete bowel preparation is mandatory in all suspected cases of deep endometriosis. Pre-operative rectoscopy-sigmoidoscopy and intravenous pyelography are recommended in patients with symptoms suggestive of Deep infiltrating endometriosis of cul-de-sac and rectovaginal septum. Laparotomy by maylard incision provides adequate exposure for reconstructive surgery of ovarian endometriomas of almost any size. Principal of microsurgery should be followed in an attempt to avoid trauma, inflammation, tissue ischemia and adhesion formation<sup>[6]</sup>

Surgical procedure during the first part of the menstrual cycle along with long term medical treatment after first line surgery appear useful for prevention of recurrent endometriosis.<sup>[7]</sup>

### Conclusion

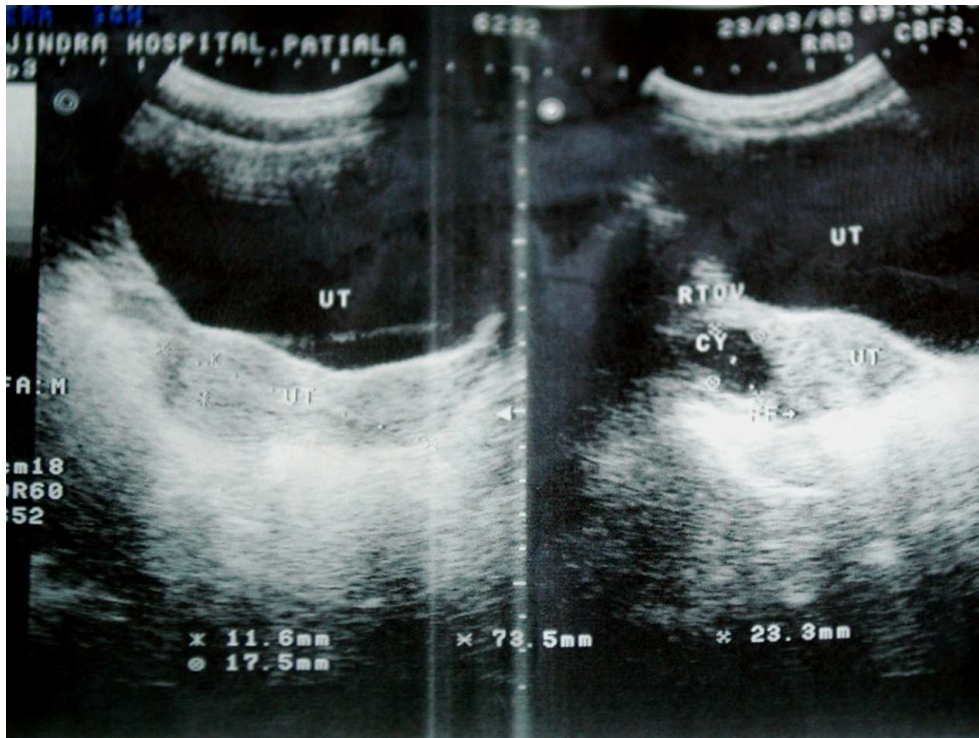
Severe period pain in adolescents is not normal and endometriosis should be considered as possible diagnosis. Early diagnosis and treatment during adolescence may decrease disease progression, prevent subsequent infertility and such catastrophic sequelae. Symptoms in teen years may foretell severe endometriosis and adolescent

clinics for greater awareness of endometriosis for early diagnosis.

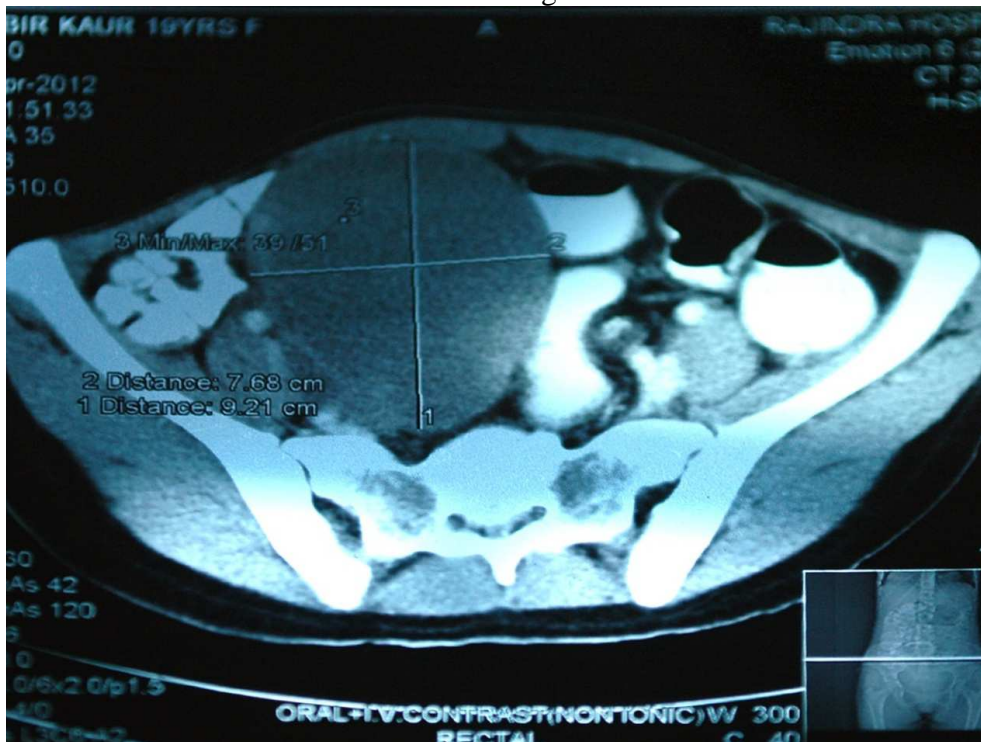
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(Figure – 1)-Both the longitudinal and transverse ultrasound section of uterus showing cystic lesion 2.5cm size in the right adnexal lesion.



(Figure – 2) - Shows thin walled well defined cystic mass seen in right adnexal region measuring 9.21×7.68cm in size.



“Bilateral fetal head size endometriomas with deep infiltrating endometriosis in an adolescent girl.”



(Figure – 3) – Show well defined thin walled cystic mass measuring 8.18×5.10cm in size left adnexal region.