

Cryptomenorrhea and Hematometra presenting as Acute Abdomen post Dilation and Curettage: A Case Report

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Abstract: Hematometra is a pathologic collection of blood in the uterus secondary to gyneatresia. It is a rare condition that is most commonly associated with congenital anomalies or acquired due to prior surgical procedures causing an obstruction of the genitourinary outflow tract.

Case Patient, 39 years old, para 4, presented to the emergency department with severe acute abdominal pain and amenorrhoea for three months.

We reviewed the literature and to the best of our knowledge there is no case reported to have hematometra post Dilation and curettage in a multiparous woman without prior known risk factors.

Conclusion: This is a rare and important case report due to the complexity of diagnosis and vastness of differential diagnosis when a female presents to the Emergency Department with acute onset of abdominal pain.

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I. Introduction

Today we report a case of hematometra in a multigravida, post dilation and curettage for polyp resection. We reviewed the literature and to the best our knowledge there is no case reported to have Cryptomenorrhoea and Hematometra post D&C in a multiparous woman without the aforementioned risk factors.

II. Case Presentation:

A 39 years-old female presented to the Emergency Department with acute abdominal pain and a three months history of amenorrhea. She has had four normal vaginal deliveries, and were uneventful. Last child birth was 13 years ago. She had regular menstrual cycles until three months ago when she underwent Operative Laparoscopic Ovarian Cystectomy for a haemorrhagic recurrent ovarian cyst and Dilation and Curettage for removal of polyp. Post-operative course was unremarkable. Her Last menstrual period was on 19/8/2018 which was just spotting for 2 days and stopped. On examination, her vital signs were stable. Per abdominal examination revealed tenderness in the hypogastrium and suprapubic quadrant. Pelvic examination was limited by pain. A transvaginal ultrasound scan revealed an enlarged bulky uterus, heterogenous, non-vascular endometrial content measuring about 25 mm in thickness, query hematoma as shown in [Figure 1 and Figure 2]. The quantitative pregnancy test was negative and other investigations were unremarkable. Hemoglobin was 12 g/dl and the white blood cell count 7580 /mm³. High sensitive C- Reactive protein was 17.08 mg/l. She was managed for pain in the ER and she responded well to the intravenous analgesics. She was then referred to the OB Clinic for further management.

Next day, she was seen in the clinic and she was informed about the need for undergoing Dilation and Curettage to relieve her from her symptoms but she was reluctant to undergo another invasive procedure under anaesthesia. Hence, we decided to do an endometrial biopsy to rule out any abnormality in the endometrium or malignancy.

Patient was positioned in a lithotomy position and speculum examination was done using grave's speculum. There was no obvious abnormality seen. Cervix looked normal. Pipelle catheter was inserted in the cervix without applying any force. During the procedure, thick, old, blood was seen coming out of the cervix. Using a 60 cc large syringe, about 30 cc of blood was aspirated under bedside transabdominal ultrasound guidance. Endometrial lining was then clearly visualized. Aspirated Blood was discarded as it was only a collection. The patient tolerated the procedure well and was vitally stable at the end of the procedure. Patient was followed up again after two months and she reported to have had her menses regularly two times, with no dysmenorrhoea, she verbalised normal menstrual blood loss in amount and duration. Bedside transabdominal ultrasound revealed normal uterus with no collection or hematoma inside.



Figure 1.: Showing the Uterine Cavity dimensions with heterogenous collection within the endometrial lining.

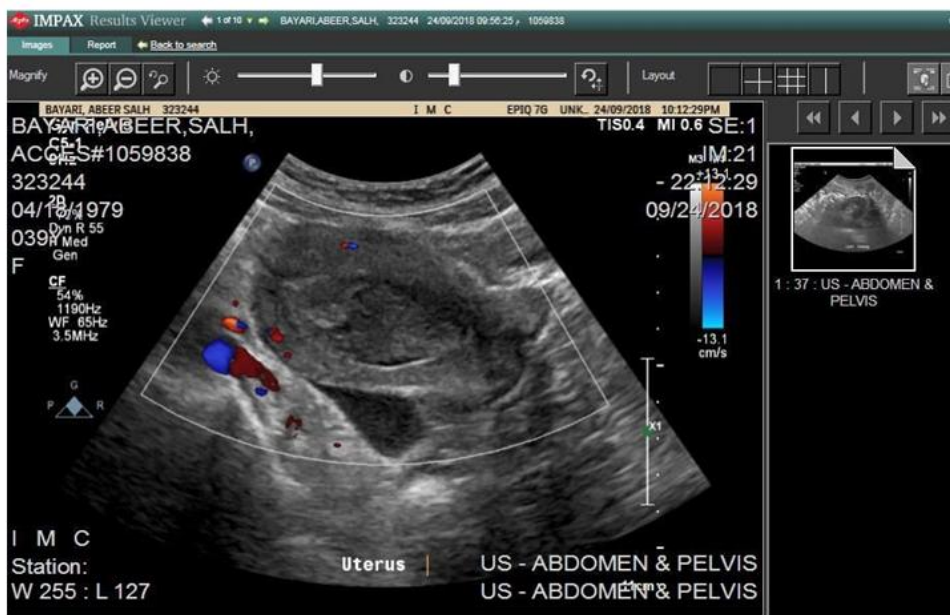


Figure 2: Showing the Uterine Cavity dimensions with heterogenous collection within the endometrial lining with no vascularity seen within on Colour Doppler.

III. Background

Hematometra is a pathologic collection of blood in the uterus secondary to gynecatresia. It is a rare condition that is most commonly associated with congenital anomalies or acquired due to prior surgical procedure causing an obstruction of the genitourinary outflow tract. The two most common congenital causes of hematometra are an imperforate hymen and a transverse vaginal septum. Among the other causes of acquired lower tract stenosis are senile atrophy of the endocervical canal and endometrium, scarring of the isthmus by synechia, cervical stenosis associated with LEEP, radiation therapy, cryocautery or electrocautery, endometrial ablation, and malignant disease of the endocervical canal(1).

IV. Discussion

Hematometra presenting as abdominal pain can be a challenging diagnosis. We reviewed the literature and to the best of our knowledge there is no case reported to have hematometra post Dilation and curettage in a multiparous woman without prior known risk factors. In one case, the rarity of this medical condition resulted in

a delay of intervention and contributed to the patient's prolonged discomfort (2). In another case, multiple diagnostic workups including invasive procedures such as exploratory laparoscopy were conducted prior to the appropriate diagnosis (3). Undiagnosed hematometra increases the disease burden of the patient and adds additional financial cost to their medical care.

Diagnosis of Hematometra should be kept in mind in any female who presents with acute abdomen and amenorrhoea post D&C(4). The complications of anaesthesia and complications of undergoing an invasive procedure were prevented in this patient by undergoing a simple minimally invasive office procedure which relieved her from pain and anxiety and also treated her condition at the same time. The diagnosis of hematometra is generally suspected by the history of amenorrhea and cyclic abdominal pain.

This case could not be considered as Intrauterine adhesions or Ashermann's syndrome as abnormal collection of blood in the uterine cavity resolved without the need of hysteroscopic lysis of adhesions. The patient reported to have had her menses regularly for two cycles, regular in amount and in duration and did not report any discomfort or dysmenorrhoea.

Hence Pipelle aspiration can also be considered as a novel form of management in patients who present with this type of atypical presentation.

This report is expected to create new research questions that may contribute to the acquisition of additional knowledge that will help to improve clinical practice and reduce this complication.

References

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