

Introduction

This case describes the first reported instance of Fibro-Adipose Vascular Anomaly (FAVA) presenting as severe menorrhagia. The patient’s symptoms were initially attributed to common gynecologic causes, delaying diagnosis. Imaging and pathology later confirmed pelvic FAVA, an atypical site for the condition. This case highlights the diagnostic difficulty of rare vascular anomalies with non-specific symptoms and underscores the importance of a multidisciplinary approach in managing complex menstrual disorders.

Case presentation

FAVA is a rare, recently characterized vascular anomaly, most often affecting young females, and typically presents with painful soft tissue masses in the limbs. Its association with gynaecological symptoms has not previously been documented. This case sheds light on the potential for FAVA to influence menstrual function, either directly or indirectly, possibly through shared vascular or hormonal pathways. The mainstay treatment for menorrhagia often involves hormonal modulation, yet in the context of vascular anomalies such as FAVA, systemic hormones carry theoretical risks of promoting vascular growth or exacerbating thrombotic potential. The Mirena IUS, by contrast, offers localized progestogenic effects on the endometrium, making it a particularly appealing option when systemic treatment is contraindicated or undesirable. This case illustrates the importance of individualized care and emphasizes the need for multidisciplinary collaboration when managing rare and complex presentations. It also raises the possibility of an unrecognized link between vascular anomalies and menstrual irregularities, which could have broader implications for clinical understanding and future research.

Case report

A 21-year-old nulligravida woman with a known diagnosis of FAVA, involving a vascular malformation of the left forearm, presented with a longstanding history of debilitating menorrhagia and irregular menstrual cycles since menarche. Her menstrual bleeding was profound and unmanageable, requiring up to 50–80 sanitary pads per day, leading to significant physical discomfort, social withdrawal, and emotional distress. In addition, the patient experienced unpredictable menstrual patterns, with alternating periods of prolonged bleeding and episodes of secondary amenorrhea lasting several months. Transabdominal ultrasound demonstrated a polycystic ovarian morphology in one ovary; however, the patient did not meet the full Rotterdam criteria for polycystic ovary syndrome (PCOS), as there were no signs of hyperandrogenism or metabolic disturbance. Prior attempts at symptom control with Noriday, a progestogen-only pill, provided modest and temporary relief but were eventually discontinued due to concerns about the pro-thrombotic potential of hormonal therapies in patients with vascular anomalies. Non-hormonal management options, including the use of Mefenamic Acid and Tranexamic Acid, were trailed but failed to provide adequate control. Given the limited efficacy of conservative treatment and the patient’s impaired quality of life, she was referred for outpatient hysteroscopy to exclude intrauterine pathology, such as endometrial polyps or structural abnormalities, that might be exacerbating the bleeding. Given the complexity of her condition and the potential risks of systemic hormone exposure in the context of FAVA, ongoing discussions with a multidisciplinary team—including gynaecology, haematology, vascular surgery, and interventional radiology—are evaluating the safety and feasibility of inserting a Mirena intrauterine system (IUS). This levonorgestrel-releasing device offers a targeted approach to endometrial suppression while minimizing systemic hormonal exposure, representing a promising potential strategy in such complex clinical scenarios.

Conclusion

This is the first documented case of Fibro-Adipose Vascular Anomaly presenting with severe menorrhagia, highlighting a previously unrecognized clinical challenge. Management required a personalized and cautious approach, balancing symptom control with vascular safety. This case supports the need for increased awareness, further investigation into the gynaecological manifestations of FAVA, and development of evidence-based guidelines for managing menstrual dysfunction in this rare patient population.

References

- Alomari et al., 2014** – This seminal paper first described FAVA as a distinct vascular anomaly characterized by fibrofatty infiltration of muscle and dilated veins. [PubMed+2PMC+2PubMed+2](#)
- Parmar et al., 2022** – A case report detailing the clinical, radiological, and histopathological features of FAVA, emphasizing the challenges in diagnosis and management.
- Singh et al., 2024** – This article reviews the diagnosis and treatment options for FAVA, including imaging modalities and therapeutic approaches.
- Mohan et al., 2021** – A comprehensive review discussing the clinical presentation, diagnostic challenges, and management strategies for FAVA.
- International Society for the Study of Vascular Anomalies (ISSVA), 2018** – The revised classification of vascular anomalies, which includes FAVA as a distinct entity.

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