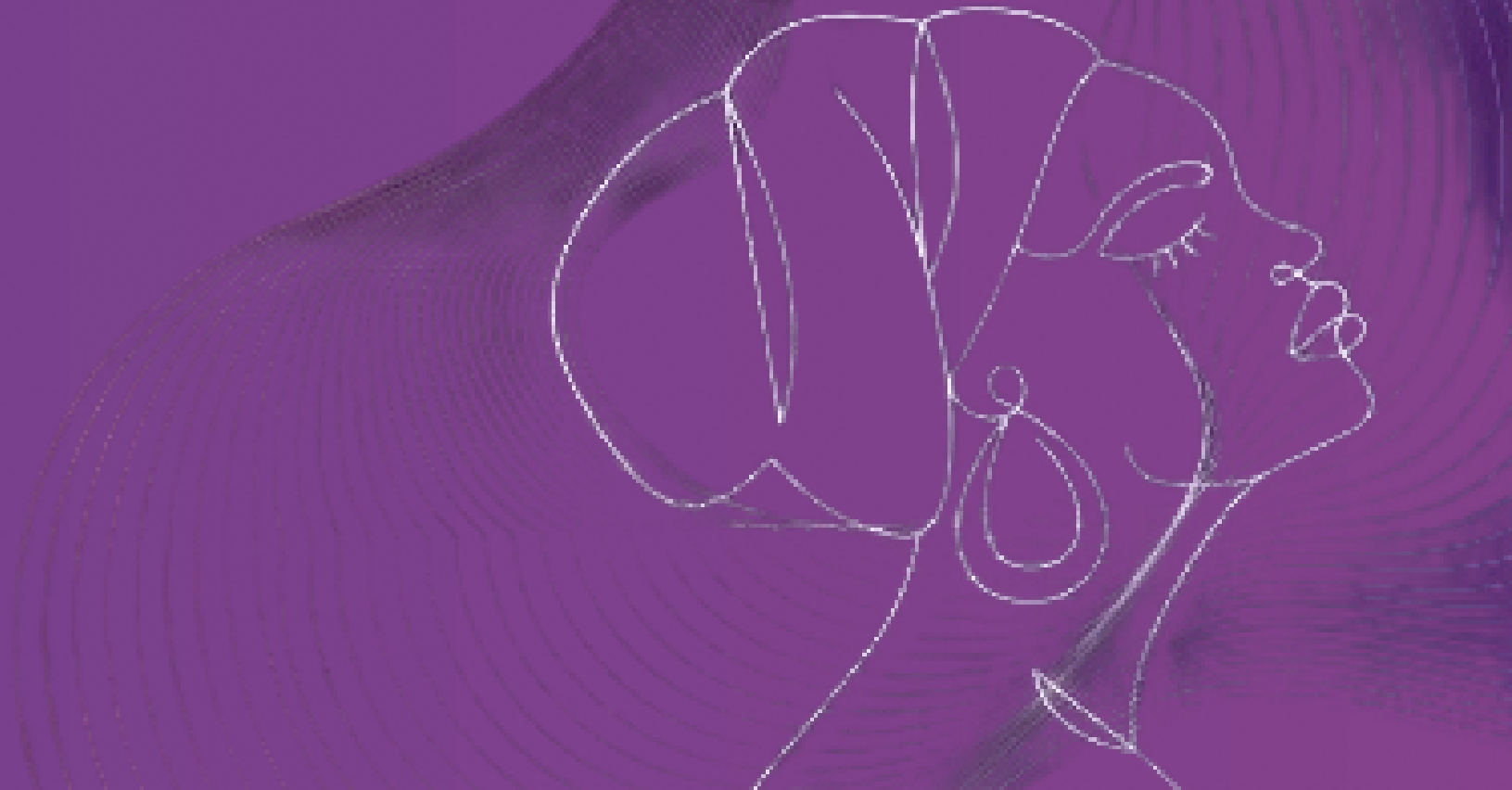


Contrast Presentations of a Benign Disease

Endometriosis Unveiled

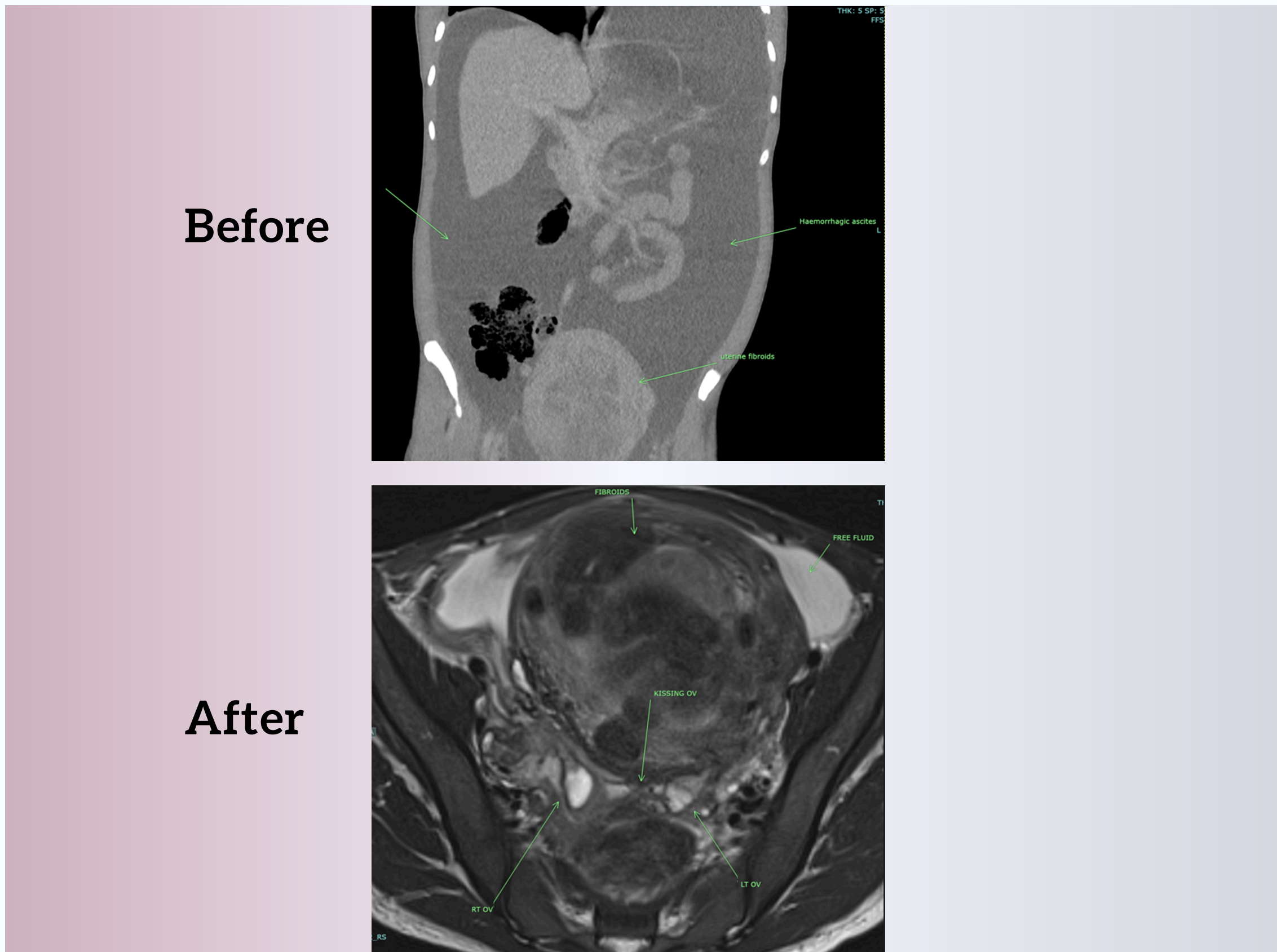
A Tale of Two Extremes – From Acute Sepsis to Silent Suspicion
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Endometriosis is a multifaceted disease with presentations ranging from subtle to life-threatening. This poster presents two contrasting rare cases that highlight the diverse manifestations and diagnostic challenges of severe endometriosis. The first case involves a young woman with stage IV endometriosis presenting as massive haemorrhagic ascites and fibroid-related complications, initially mimicking malignancy. The second features an adolescent diagnosed with a tubo-ovarian abscess, later resolved without surgery, and retrospectively identified as an infected endometrioma. These cases underscore the importance of accurate imaging, multidisciplinary management, and individualized treatment strategies to avoid overtreatment and improve long-term outcomes

Case Presentation 1:

Complex Case of Stage IV Endometriosis with Haemorrhagic Ascites and Multi-Fibroid Uterus:



A 32-year-old woman was admitted with sudden abdominal pain, shortness of breath, nausea, vomiting, and a grossly distended abdomen. CT imaging revealed a fibroid uterus with significant ascites, and 10 liters of ascitic fluid were drained. Cytology was negative for malignancy, but cultures grew Klebsiella. She was treated with IV Tazocin and showed clinical improvement (CRP reduced from 350 to 187). CA-125 was elevated to 440. HIV and AFB tests were negative.

Subsequent MRI imaging identified a bulky, multifibroid uterus and deep infiltrative endometriosis (DIE). Notable features included:

“Kissing ovaries”, suggestive of extensive pelvic adhesion
Hemoperitoneum and an umbilical endometriotic deposit (previously bleeding cyclically)
Endometriotic plaque at the torus Uterius with bowel involvement
Stable uterine size with mixed fibroid response to medical therapy

Clinical Course & Management:

The patient experienced a severe clinical episode in August 2023 requiring ITU admission for haemorrhagic ascites and right ventricular dysfunction. She improved with hormonal therapy (Dienogest and Ryeqo), achieving pain control, cessation of umbilical bleeding, and normalization of haematologic parameters.

Medical management has led to:

Partial reduction in some fibroid sizes, stabilization of the uterine size,no evidence of malignant transformation

Fertility Considerations:

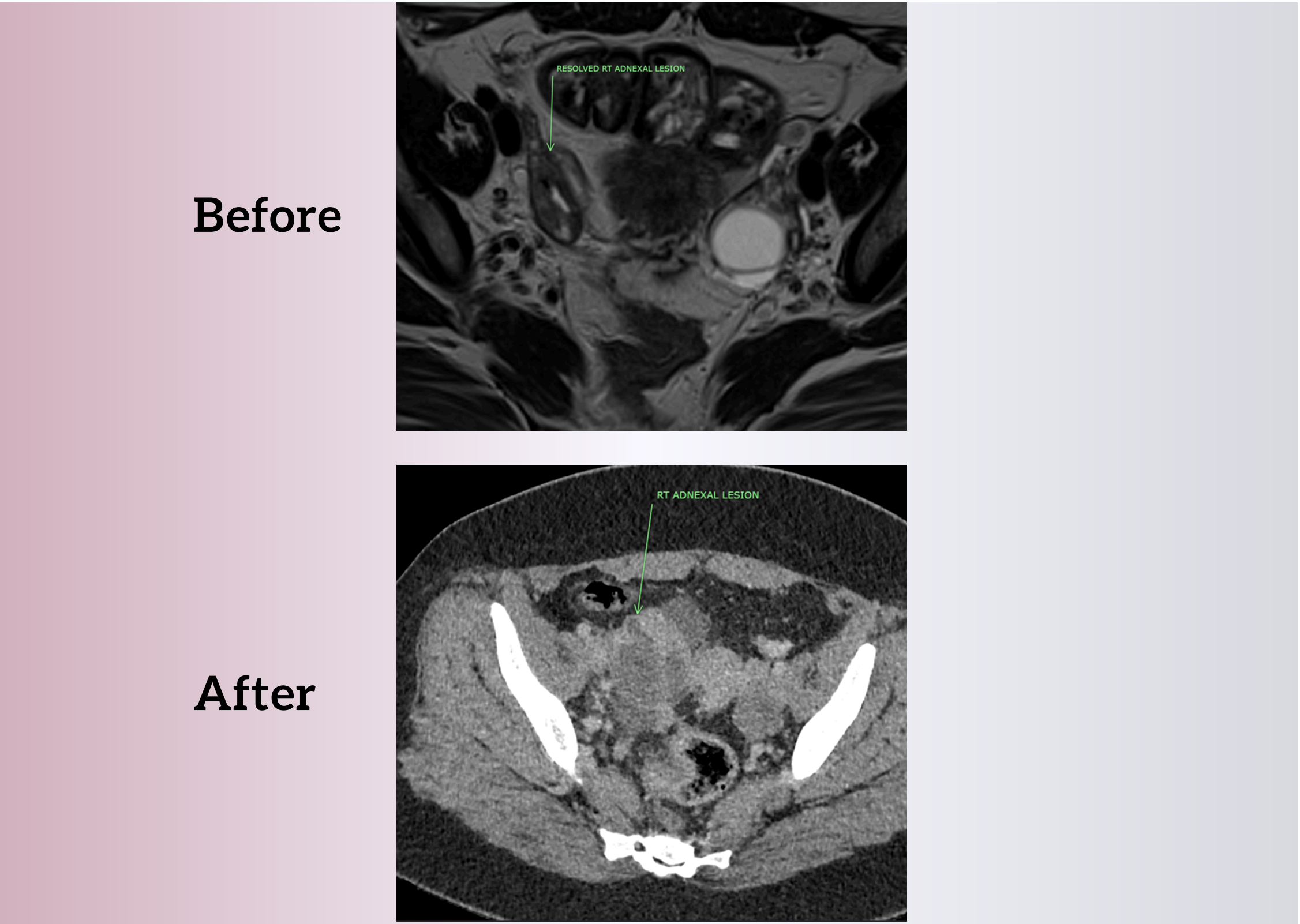
The patient has been trying to conceive for three years without contraception. Given the stage IV endometriosis, distorted pelvic anatomy, and risk of recurrent haemoperitoneum, natural conception poses significant risks. Semen analysis for her partner was normal. She is being considered for urgent IVF referral, ideally before age 35, to minimize complications associated with discontinuing hormonal treatment.

Conclusion:

This case illustrates a rare but severe presentation of stage IV endometriosis with haemorrhagic ascites and fibroids, requiring coordinated multidisciplinary input, tailored hormonal management, and early fertility planning. Prompt imaging, infection control, and individualized medical therapy were critical in achieving stability and optimizing reproductive outcomes.

Case presentation 2:

A Case of Resolved Tubo-Ovarian Abscess Secondary to Suspected Infected Endometrioma



A young woman, initially presented with a right-sided tubo-ovarian abscess, and was treated with prolonged antibiotics (Doxycycline and Metronidazole). MRI revealed complete resolution of the adnexal mass, which had likely been an infected endometriotic cyst. Her tumor markers (CA-125), initially elevated to 100, normalized to 23, supporting an inflammatory rather than malignant etiology.

CT and MRI imaging identified pelvic lymphadenopathy and peritoneal nodules, which subsequently regressed, further supporting a benign inflammatory process. Planned bilateral salpingo-oophorectomy was cancelled following MDT review due to complete radiological and symptomatic resolution.

She commenced on Dienogest for long-term endometriosis management, later switched to Ryeqo, both of which were discontinued due to side effects. She is currently asymptomatic and off treatment, with ongoing ultrasound surveillance. A Mirena IUS is under consideration for future management.

Imaging Findings:

- Initial CT: Right adnexal mass, para-aortic and pelvic lymphadenopathy.
- MRI: Resolved adnexal mass, features of adenomyosis, suspected endometriotic lesion in broad ligament.
- Follow-up US: Normal.

Outcome:

No current need for surgical intervention.
Patient is pain-free and clinically stable.
Surveillance with periodic ultrasound scans is ongoing.

Discussion:

This case highlights the importance of imaging in differentiating inflammatory vs malignant pathology in the context of endometriosis. It also underlines the value of a multidisciplinary approach and the potential to avoid surgery with appropriate medical therapy and imaging follow-up.

Conclusion:

Not all complex adnexal masses require immediate surgery. Conservative management with close imaging follow-up can be effective in selected cases, especially when the underlying cause is suspected infected endometriosis.