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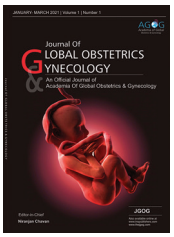
Case Report



Cervical Endometriotic Cyst in a Multiparous Woman – A Rare Case Report

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ABSTRACT

Endometriosis is typically confined to the ovaries, peritoneum, and pelvic organs; involvement of the cervix is rare.[1] We report a case of a 35-year-old para 2, living 2, abortion 1 woman with a previous lower segment cesarean section presenting with a cervical mass exuding chocolate-colored fluid. The lesion was identified as a cervical endometriotic cyst, a rare entity. This case highlights the importance of recognizing atypical presentations of endometriosis, especially in patients with complex medical histories.

Key words: Endometriosis, Rare presentation, Cervical cystic lesion

INTRODUCTION

Endometriosis is defined as the presence of endometrial glands and stroma outside the uterine cavity.[2] The most common sites are the ovaries and pelvic peritoneum, while cervical involvement is extremely rare.[1] Cervical endometriosis typically manifests as a cystic lesion containing altered blood and can easily be mistaken for a nabothian cyst or cervical malignancy.[3] Reported prevalence is very low, with most cases linked to prior cervical trauma, surgery, or instrumentation. Clinical recognition is crucial, as timely diagnosis prevents misinterpretation and unnecessary interventions.

Cervical endometriosis is an uncommon presentation of endometriosis, typically manifesting as a cystic lesion on the cervix containing altered blood. Its prevalence is low compared to ovarian and pelvic endometriosis.[2] Common causes include prior cervical trauma, instrumentation, or surgery.[1] Often asymptomatic, it may rarely present with discharge, post-coital bleeding, or a protruding mass. Clinical recognition is crucial to avoid misdiagnosis as cervical malignancy or a nabothian cyst.

CASE REPORT

A 35-year-old woman, P2L2A1, with a previous lower segment cesarean section (LSCS), presented to the gynecology outpatient department with a complaint of a protruding mass per vaginum for the past 2.5 years. She also reported occasional brownish discharge but denied pain, menstrual irregularities, dysmenorrhea, or dyspareunia.

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Past medical history

Pulmonary tuberculosis, treated 5 years ago with completion of anti-tubercular therapy. Renal calculi, managed conservatively 2 years ago. No history of intrauterine device use.

Obstetric history

Two full-term pregnancies were delivered by cesarean section. One first-trimester spontaneous abortion.

Examination

General condition: Stable.

Per abdominal: Soft, non-tender, no guarding, or rigidity; LSCS scar present.

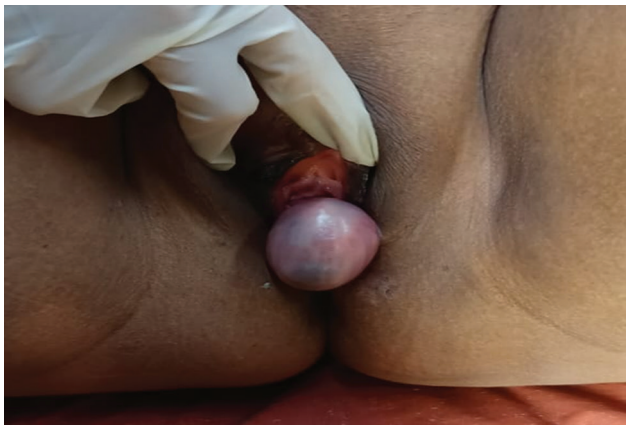
Per speculum: A 3 × 4 cm bluish-brown cystic mass was noted arising from the anterior lip of the cervix, bulging into the vaginal canal. On puncture, it exuded chocolate-colored fluid, suggestive of altered blood.

Investigations

Hematological and biochemical parameters: Within normal limits.

Pap smear: Negative for intraepithelial lesion or malignancy.

Transvaginal ultrasound: A 3 × 3 cm hypoechoic cystic lesion arising from the anterior cervix and protruding into the lower vagina; uterus and adnexa normal.



Management

The cyst was excised under regional anesthesia. Histopathological examination revealed endometrial glands and stroma with hemosiderin-laden macrophages, confirming the diagnosis of a cervical endometriotic cyst. The post-operative course was uneventful, and the patient was advised to undergo regular follow-up.

DISCUSSION

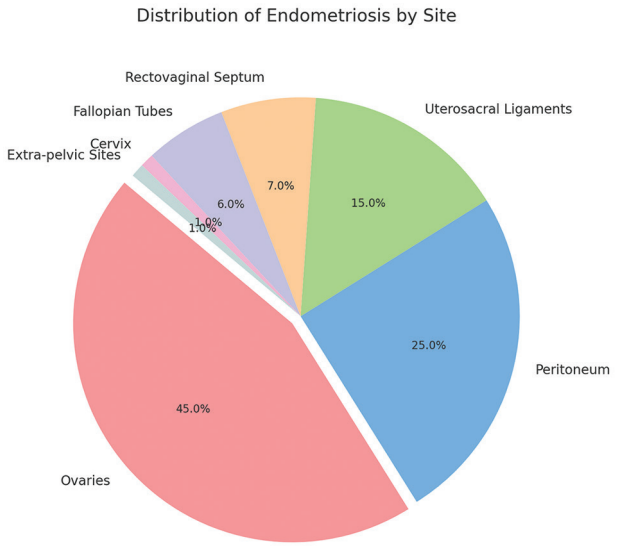
Cervical endometriosis is an uncommon entity, accounting for <1% of all endometriosis cases.[1] It is often associated with previous cervical trauma such as cesarean section, dilatation and curettage, or cervical instrumentation, which may facilitate implantation of endometrial cells into cervical tissue.[2] Clinically, these lesions may mimic nabothian cysts or even cervical carcinoma, particularly when they present with an atypical appearance.[1]

Histopathology remains the gold standard for diagnosis, demonstrating endometrial glands and stroma with hemosiderin-laden macrophages.[3] Management depends on symptoms; surgical excision is both diagnostic and therapeutic. Hormonal therapy may be considered in selected cases to reduce recurrence. In the present case, the patient's history of cesarean section and cervical trauma may have contributed to the pathogenesis of the lesion. Her unrelated history of pulmonary tuberculosis highlights the importance of a thorough evaluation of comorbidities during assessment.

Review of literature shows only a limited number of reported cases, underscoring the rarity of cervical endometriotic cysts and the need for clinical vigilance in differentiating them from other cervical pathologies.[4]

CONCLUSION

Cervical endometriotic cysts are rare but should always be considered in the differential diagnosis of cervical lesions, particularly in women with a history of prior uterine surgery or instrumentation.[3] Accurate diagnosis through histopathology is essential, and surgical excision provides definitive management and symptomatic relief. Awareness of this entity among clinicians can help avoid misdiagnosis and ensure appropriate treatment.



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