A Unusual Late Complication of Endometrial Ablation

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Background

A 52 year old lady presented to the postmenopausal bleeding clinic with a single episode of postmenopausal bleeding. She had undergone an endometrial ablation 15 years previously outside the UK. She had a history of chronic pelvic pain. She was para two with one previous caesarean section and one vaginal delivery. She was otherwise fit and well and up to date with cervical smears.

On examination she had a normal vagina and vulva, her cervix showed a stenosed external os. A transvaginal ultrasound showed a left sided 7.6cm simple cyst, thought to be either para ovarian or para tubal. She also was noted to have a thickened endometrium of 6.5mm.

It was not possible to perform an endometrial biopsy, so she was listed for an urgent hysteroscopy and laparoscopy +/- proceed to bilateral salpingo-oophrectomy.

Investigations

At hysteroscopy on grasping the cervix a copious amount of clear mucous was released. A hysteroscope was introduced through the external os, into a large mucous filled cervical cavity. The internal os was identified but it was not possible to pass the hysteroscope into the uterine cavity due to the floppy nature of the cervix. Laparoscopy showed a normal sized uterus, with normal tubes and ovaries. It appeared the cystic structure had been the mucous filled cervical canal.

Planning and Definitive Management

Following the attempted hysteroscopy the patient had no further episodes of vaginal bleeding but continue to produce large quantities of cervical mucous. In light of this and not having been able to investigate why there was a thickened endometrium, she was listed for laparoscopic assisted vaginal hysterectomy and bilateral salpingo-oophrectomy. The procedure was straight forward. She made a swift successful recovery.

The histology showed foci of epithelial denudation and chronic inflammation in the cervix. There were some small serosal fibroids within the uterus, but over all no evidence of atypia or malignancy. It concluded the appearance of the cervix confirmed a mucocele of the uterine cervix.

Conclusion

A mucocele of the uterine cervix measuring 7.6cm is a rare finding. It was presumably due to the build up of mucous within the cervical canal, secondary to stenosis of both the internal and external os. Aside from endometrial ablation there was no obvious cause for cervical stenosis. Therefore is this a late complication of endometrial ablation?