Delayed Diagnosis of Non-Sexually Acquired Pelvic Inflammatory Disease in a Patient with Severe Endometriosis and Multidisciplinary Approach to Management

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BACKGROUND

Similarities in the symptoms of endometriosis, pelvic inflammatory disease (PID) and irritable bowel syndrome (IBS) may delay the correct diagnosis in young women presenting with pelvic pain.

CASE PRESENTATION

A nulliparous 36-year-old female presented to the Emergency Department with pelvic pain on a background of Stage 4 endometriosis. Pelvic ultrasound reported bilateral 6cm ovarian endometriomas with a correctly sited Mirena IUCD. She was managed conservatively.

She represented the following week with worsening symptoms. On examination she had abdominal fullness, lower quadrant peritonism and purulent discharge from the cervical os. Inflammatory markers were grossly elevated and CT identified bilateral 8cm adnexal masses (see Figure 1).

She was transferred to a tertiary centre where laparoscopy demonstrated free pus, a frozen pelvis, bilateral tubo-ovarian abscesses, bowel adhesions and Fitz-Hugh-Curtis Syndrome (see Figures 2-4).

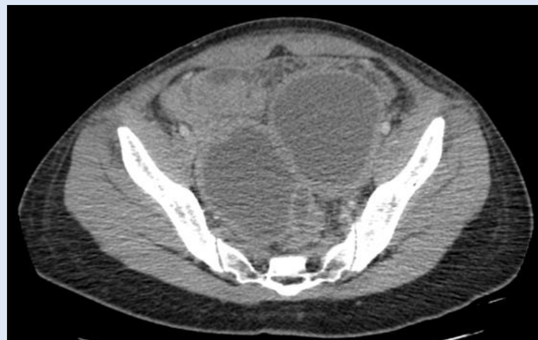

Figure 1: CT pelvis: large cystic lesions are noted in the pelvis arising from the adnexa, the left one measuring approximately 7.5cm and the right one measuring approximately 7.4cm. With the history of endometriosis, these could represent very large endometriomata.

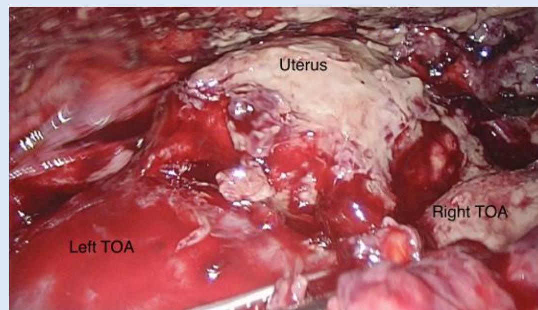

Figure 2: Intraoperative photo of frozen pelvis, bilateral tubo-ovarian abscesses and free pus

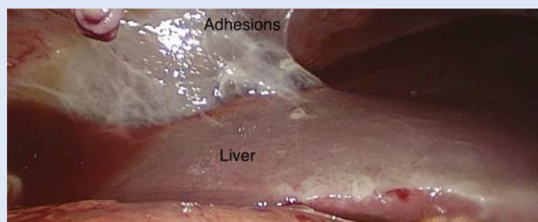

Figure 3: Intraoperative photo of Fitz-Hugh-Curtis syndrome

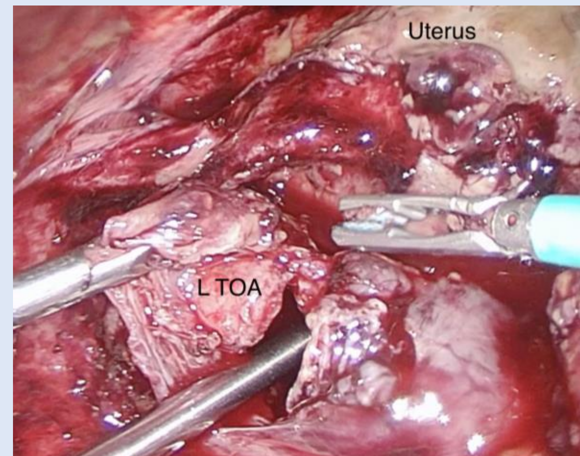

Figure 4: Intraoperative photo of excised left tubo-ovarian abscess

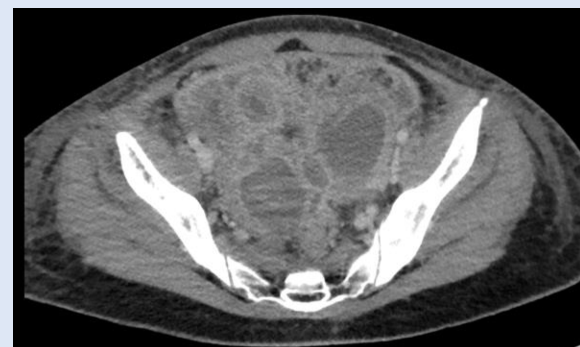

Figure 5: There are multiloculated rim enhancing collections, primarily interposed between the uterus and the sigmoid colon/rectum, that span 11.5 x 11.2cm. Given the history of recent abscess drainage, these presumably represent residual/recurrent phlegmon and abscesses. There is associated peritoneal thickening and enhancement indicating peritonitis.

CASE PRESENTATION (ctd.)

The Mirena was removed, surgical drainage performed in association with colorectal surgeons and drains left in-situ. She was admitted to the Intensive Care Unit for vasopressors and intravenous antibiotics. All cultures grew pan-sensitive *Escherichia Coli.*

An observed clinical and biochemical improvement reversed 5 days later with progress CT demonstrating abscess reaccumulation (see Figure 5). These were drained percutaneously under radiological guidance.

Thereafter she made slow but steady improvement. Her 2-week admission involved specialists in gynaecology, intensive care, colorectal surgery, interventional radiology, infectious diseases and nutrition.

DISCUSSION

The history of endometriosis likely influenced timing of the diagnosis of non-sexually acquired PID. The need for a multidisciplinary team approach to management including alternatives to laparoscopy is demonstrated.