MANAGEMENT OF CORNUAL BLOCK WITH DANAZOL

by

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Introduction

Haney and Fortier (1982) found intraluminal endometriosis causing cornual block in one-fifth of their patients with proximal occlusion. In the absence of any inflammatory stigmata and by ruling out cornual spasm by two separately performed procedures it was felt that either intraluminal endometriosis or tubal polyp which may also be endometriotic in origin (Vasquez *et al* 1980), were the cause of the cornual block. Hence a trial with Danazol was attempted for 3 months before resorting to microsurgery (Winston, 1981; Ayers, 1982). This line of therapy was fully vindicated by the subsequent results.

Case Report

Mrs. R. A., a 34 year old woman married for 2 years came with primary sterility. She menstruated for 3 to 4 days every 22 to 24 days. There was no history of any operation, history suggestive of pelvic inflammatory disease, or appendicitis in the past. General examination revealed no abnormality while a pelvic examination showed an anteverted normal sized uterus with no pathology palpable in the fornices.

The semen examination of the husband was within normal limits while an endometrial biopsy performed on the 1st day of her menstrual period showed proliferative endometrium. A laparoscopy performed post-menstrually revealed a normal sized uterus, normal ovaries and tubes which were externally normal but showed proximal tubal block. There was no evidence of endometriosis, pelvic inflammatory disease or any adhesions in the pelvis. The patient was subsequently subjected to a hysterosalpingography which confirmed the laparoscopic findings (Fig. 1).

The patient was put on 400 mg of Danazol per day in two divided doses for 3 months. After her first menstrual period following cessation of Danazol a hysterosalpingography was repeated which revealed bilaterally patent tubes with no evidence of a block (Fig. 2). Patient subsequently conceived and pregnancy is on at the time of submitting this case report.

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See Figs. on Art Paper II