An interesting case of chronic endometritis

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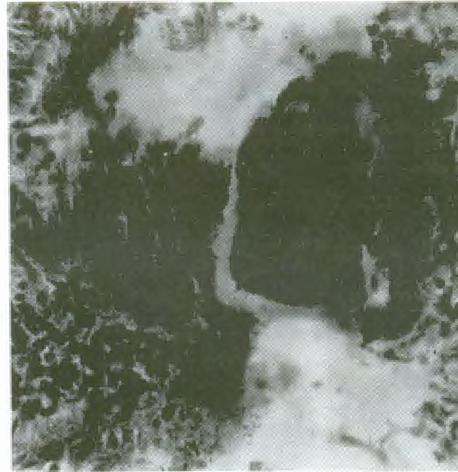
Chronic endometritis is a very rare disease during the reproductive age group, because regrowth of new surface endometrium during each menstrual cycle prevents the persistence of any infection. This case is being reported because of its unusual presentation and interesting histopathological findings.

Patients Mrs. Makani Devi aged 35 years presented on 12/4/97 with chief complaintts of blood stained foul smelling discharge P/V since 2 years and pain in the abdomen since 2 months. Her obstetric status was P_4A_1. She had all full term normal deliveries and her last delivery was 8 years back. Two years back she had a medical termination of pregnancy at 2 months gestation, followed by tubectomy. Her menstrual history was 6-7/30 days with average flow and no dysmenorrhea. Her LMP was on 12/3/97. Her general condition was fair, vitals were stable and mild pallor was present. On Pelvic examination, the cervix was unhealthy, congested and a cervical erosion was present on both cervical lips, the uterus was retroverted, firm and of multiparous size. Both adnexae were clear. Patient gave history of having taken antibiotics, metrogyl and vaginal pessaries many times in the past one year. Her eosinophil count was 35% suggesting eosinophilia but all other routine investigations were within normal range.



Photograph showing trabecular bone and chronic inflammatory cells.

Sonographic examination revealed a uterus of normal size and lot of air was seen in the endometrial cavity. Adenexa were normal. Air in the endometrial cavity could be due to: a) Ca Cervix b) Gas in pyometra c) Secondary to D&C done within past one month. PAP smear was inflammatory. A fractional curettage was done on 16/4/97 and the H.P.E. report showed:

a) Cervical tissue - chronic ectocervicitis
b) Endocervical tissue - Severe chronic inflammatory reaction with prominent eosinophilia. At places there was presence of squamous metaplasia.
c) Endometrial tissue showed proliferative endometrium with severe chronic inflammation and eosinophilia. Areas of necrosis with neutrophilic exudation were also present. There was plenty of calcium deposition. There was no evidence of malignancy, no retained products of conception or no evidence of tuberculosis. Impression was chronic ectocervicitis, endocervicitis, chronic and acute endometritis with calcification.

Patient was given Tab. Doxycycline 100mg BD for 14 days, Hetrazan was given for 21 days and deworming was done. Repeat eosinophil count was 8%. On follow-up, her complaints of foul smelling blood stained discharge and pain in abdomen persisted. Therefore a total abdominal hysterectomy was performed.

The histopathological examination of the specimen revealed that the uterus was containing trabecular bone with bone marrow, hair shafts, fetal parts and showed chronic endomyometritis. Endometrium was replaced by chronic inflammatory tissue containing plasma cells and the inflammation was extending into the adjacent myometrium. The cervix showed mild cervicitis with squamous metaplasia. On routine follow-up, patient was asymptomatic.

The above case report confirms that chronic endometritis most often does not respond to medical treatment and D&C. Secondly, diagnostic curettage alone may not always reveal the basic pathology in a case of chronic endometritis.