Endometrial carcinoma missed by several curettages, diagnosed by transvaginal ultrasound.

Sir,

Postmenopausal bleeding generally warrants histological examination in order to exclude endometrial cancer. The standard procedure has for many years been dilation and curettage (D&C) although the true sensitivity and specificity of D&C is not known. Occasionally the histopathological answer at D&C is "insufficient material." Routine procedure is to classify these answers as normal, despite the risk of overlooking an endometrial cancer. If symptoms persist despite the results of negative sampling, hysteroscopy directed biopsy usually will be performed. However, transvaginal ultrasound is a non-invasive and more simple and less expensive procedure for examining the pelvic anatomy and is increasingly used to exclude malignancy of the endometrium. Our main purpose in this letter is to draw attention to transvaginal ultrasound examination of the female reproductive organs as one of the first steps in excluding uterine malignancy.

A 68-year old woman para four, was referred because of vaginal bleeding over a period of 6 months. She had never used hormonal replacement therapy. The gynecological examination revealed a slightly enlarged retroverted uterus. A D&C was performed under general anesthesia. There were difficulties dilating the internal os, and a senior gynecologist completed the procedure. The cavity was 6 cm deep, but the sample was small and insufficient for histopathological diagnosis. Due to continuing bleeding a second D&C was performed under general anesthesia three months later. The dilatation was easy and the cavity was 6 cm deep. During this procedure the cavity was felt to be slightly irregular. The amount of material was abundant. The histopathological diagnosis showed an atrophic endometrium. Because of continuous spotting (approximately daily), a transvaginal ultrasound was carried out on the third visit. It revealed a slightly increased retroverted uterus with a distended uterine cavity with a possible hematometra measuring 14 x 40 mm and a wide irregular endometrium. A new attempt was made to obtain a histopathological diagnosis. No endometrial tissue was obtained. Because of the discrepancy between the findings and the symptoms, the patient was offered a total abdominal hysterectomy and bilateral salpingo-oophorectomy. At laparotomy the uterus was found to be double in size, soft and spongy, with several small fibromyomas in the corpus and the cervix.

Macroscopical examination of the uterine specimen showed the whole endometrium occupied by papillary tumor masses. The histopathological examination showed a papillary adenocarcinoma grade 2 with 1 mm invasion into the myometrium. Because of the discrepancy between the final diagnosis and the histopathological findings in the former curettings, the uterine specimen was re-examined. A via falsa was found in the cervical wall at the level of the internal os. The via falsa was about 3 cm long and ended in the parametrium above the level of the internal os. Histopathological examination of the tissue surrounding the canal revealed fresh bleeding and signs of older bleeding with macrophages and inflammation. A fibromyoma 1 cm in diameter was found in the cervical stroma closely related to the via falsa.

In about 20% of women having curettage performed because of postmenopausal bleeding the answer will be "insufficient tissue for diagnosis." This result is mostly classified as benign. The inaccuracy of curettage to exclude malignancy of the endometrium has been stated earlier. In women with uterine fibromyoma the endometrial sampling may fail to identify endometrial cancer. This is not surprising as routine curettage has been found to be incomplete in at least 60% of the cases and has a false negative rate up to 10%. In this case, a perforation was possibly made during the first D&C, making a via falsa in the anterior wall of the uterus, supported by the finding of an old false passage in the myometrium by the histopathological examination. This via falsa unfortunately persisted and led to consecutive misleading histopathological results, except where an atrophic endometrium was found in the second D&C. Transvaginal ultrasound leads to the correct diagnosis and treatment. However, it is judicious to re-evaluate women with an initial negative histopathological result from the endometrium if the bleeding continues. Since repeat D&C does not always lead to the final diagnosis, the use of transvaginal ultrasound in women with persistent postmenopausal bleeding, despite a benign histopathology or insufficient material, might give important information regarding subsequent therapeutic strategy.

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Fournier gangrene

Sir,

Fournier gangrene is an uncommon but fearful condition that carries a definite mortality. It is nearly always associated with diabetes mellitus.\(^1\)\(^2\) It is caused by hemolytic streptococci and less commonly by hemolytic staphylococci. Other organisms have been identified including bacteroides, diphtheroids and pseudomonas. This necrotizing soft tissue infection is characterized by rapid progression and manifesting as erythema and necrosis of genitalia skin.\(^1\) The aim of this report is to increase the awareness of the existence of this fulminating condition and to highlight the importance of early antibiotic therapy with surgical debridement of the affected area.

A 54-year old man presented with scrotal swelling and agonizing pain of 6 days duration. He was a known diabetic and heavy smoker. He had a swollen, red, tender necrotic right scrotal region with a 7 cm gangrenous patch involving the inguino-scrotal junction on the right side together with a foul smelling discharge (Fig. 1). He had leucocytosis of 14.2 with polymorphs of 76 sedimentation rate 100. The patient was started on triple antibiotics on admission including ampicillin, gentamycin and metronidazole. Immediate surgical debridement included wide excision of all necrotic, gangrenous tissue leaving the cord and testis bare.\(^3\)\(^4\)

The microbiology report of swabs taken during surgery confirmed the presence of bacterioids fragilis and pseudomonas Aeruginosa. The pathological examination of resected specimen was reported as ischemic necrosis with gangrene. Postoperatively daily dressing of the area was carried out using 1/2 strength Dakins. Three weeks after the initial debridement, secondary closure of the scrotal wound by approximating the scrotal skin edges was successful with no additional skin flaps needed to cover the bare area. Subsequently, the patient was discharged in a satisfactory condition.

The need for early aggressive intervention is emphasized. The exact mechanism of this fulminating gangrenous disease of the male genitalia is unknown. The necrosis does not involve the muscle layer, and skin involvement is secondary to thrombosis of the arteriolar supplying the overlying skin. There are predisposing conditions present in most patients including systemic diseases, particularly diabetes, geniourinary tract infections and abscess associated with urethral strictures.\(^2\) Aerobic and anaerobic cultures usually isolate a mixture of organisms which include aerobic gram negative rods, aerobic gram positive cocci and strict anaerobes, particularly bacteroides.\(^4\)

In spite of modern antibiotic regimens and surgical debridement, the literature reports a high mortality rate up to 45% in recent series.\(^1\)\(^3\) Broad spectrum antibiotic coverage with early radical debridement of devitalized tissues are recommended. The use of hyperbaric oxygen therapy has also been recommended if such facilities are available.

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