

Vaginal Adenosis Successfully Treated with Simple Unipolar Cauterization

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Vaginal adenosis, without a history of diethylstilbestrol (DES) exposure, is a rare condition with an unclear etiology. A 24-year-old female presented with complaints of persistent vaginal discharge and dyspareunia. On examination, there were red, patchy, diffuse lesions on the vaginal wall and cervix. Histopathologic examination of the lesions revealed vaginal adenosis with chronic inflammation. Due to a poor response to metronidazole and tetracycline treatments, unipolar cauterization was performed with successful removal of the lesions.

Key words: obstetrics/gynecology ■ vaginal adenosis ■ chronic inflammation ■ cauterization

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INTRODUCTION

Vaginal adenosis is a rare pathology defined as the presence of Müllerian type epithelium within the vaginal wall, which is presumed to be derived from persistent Müllerian epithelium islets in postembryonic life.^{1,2} Although little is known about the etiology, pathogenesis, symptomatology and medical management of this poorly understood condition, its association with in-utero exposure to diethylstilbestrol (DES) and a subsequent high risk of clear-cell vaginal adenocarcinoma is well known.³ Since the withdrawal of DES from the market, this condition is rarely described in the medical literature. Spontaneous vaginal adenosis appears to be fairly common (present in about 10% of adult women), but it is mostly an insignificant finding on physical examination.¹ However, it should be considered as a possible differential diagnosis in women with persistent vaginal discharge.

A 24-year-old nulliparous woman with vaginal adenosis without DES exposure is presented. Therapeutic and treatment options will also be discussed.

CASE REPORT

A 24-year-old nulliparous woman presented to the obstetrics/gynecology outpatient clinic with complaints of excessive vaginal discharge and dyspareunia. On speculum examination, the mucosa of the vaginal wall, with extension to the ectocervix, displayed extensive bright red, fragile, hyperemic, superficial erosions and ulcerations, which were sharply and irregularly demarcated (Figure 1).

Further diagnostic studies were undertaken. A Pap smear was performed, which yielded a diagnosis of ASCUS (atypical cells of undetermined significance). Also, a wet mount was prepared, and it was determined that the patient had trichomonas. She was treated with metronidazole and tetracycline, but her symptoms did not improve.

Multiple punch biopsies were taken from the lesions. The histopathological examination of the biopsy revealed chronic inflammation with vaginal adenosis (tuboendometrial-type, epithelium-lined glands throughout the lamina propria) (Figure 2). It was confirmed that patient's mother had not been treated with DES during her pregnancy. There was no history of condyloma, 5-fluorouracil, CO₂ laser treatment or any dermatological disorder.

We cauterized the cervical and vaginal lesions under local anesthesia because of incomplete regression, despite adequate treatment. No lesion, except minimal cervical erosion, was seen after three weeks of cauterization.

DISCUSSION

The clinical appearance of vaginal adenosis is varied: it may present as patchy or diffuse red stippling, granularity or nodularity, single or multiple cysts, erosions, ulcers or even warty protuberances. Occasionally, the process may extend into the vulva.⁴ The symptoms most often reported are soreness of the vaginal introitus, vaginal bleeding independent of the menstrual cycle (often precipitated by sexual intercourse) and profuse mucoid vaginal discharge.¹

Trauma and inflammation have been reported as pathogenic factors. Although some studies argue that oral contraceptives play a role in the etiology, this is

Figure 1. Vaginal adenosis clearly visible on posterior wall of vagen



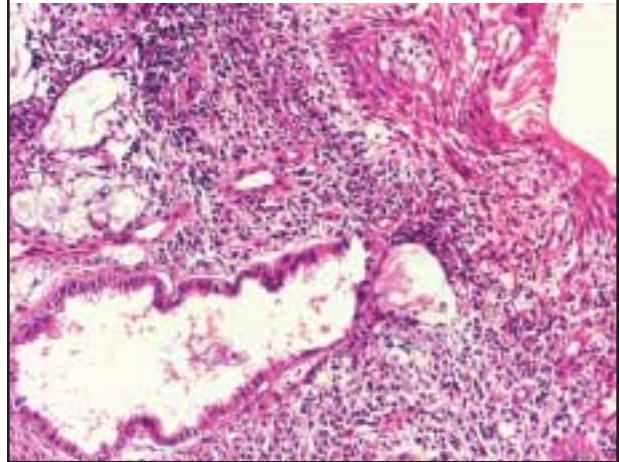
unclear.¹ In our case, history of a long-standing infection with vaginal adenosis on histopathological examination, as well as chronic active inflammation that partially responded to the local and systematic infection treatment protocol, is confusing and may further support the trauma and inflammation theory.

Treatment of vaginal adenosis can be difficult. According to current opinion, spontaneous squamous differentiation is thought to occur in most women with spontaneous vaginal adenosis if left untreated.⁵ Furthermore, the option to wait for spontaneous resolution may not be feasible if subjective symptoms are severe and impair the quality of life, as in the patient presented. CO₂-laser coagulation can be performed in patients to eliminate metaplastic columnar epithelium and to provoke its replacement by physiological squamous epithelium. In resistant cases, vaginal resection may be considered an ultimate therapeutic option.¹ In our case, cauterization with a unipolar cautery was chosen as a therapeutic intervention, which is not only cost effective and simple, but it has completely eliminated the lesions. One of the major advantages of this technique is that the procedure can be easily performed in an outpatient clinic with great success under local anesthesia.

CONCLUSION

Although vaginal adenosis is a rare and generally asymptomatic pathology, it should be part of the differential diagnosis in young patients with persistent vaginal mucoid discharge and resistant to appropriate treatment. Although the etiology of the disease is unclear, it has been suggested that inflammation may have an effect on the pathogenesis of vaginal adenosis without a history of DES exposure. Treatment with unipolar cau-

Figure 2. Tuboendometrial-type dilated glands are seen under the vaginal stratified squamous epithelium (HEX 100)



terization is cheap, safe and effective in patients with resistance to traditional medial therapy.

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