

moderate flow. Endometrial thickness is 8 mm, with sub mucous myoma 2.67 x 2.63 x 1.44 cm. Right adnexa has irregular mass 8.00 x 3.37 x 7.88 cm or tubo-ovarian abscess.

Treated by a gynecologic-oncologist, given 2 doses of Leupron injection 3.75 mg/IM and treated for PID, readmitted with the same TVS findings. Patient underwent hysteroscopic resection of the endocervical myoma and endometrial curettage. Histopathology result was cervical and endometrial adenocarcinoma. Immunohistochemical stains were negative for P16, ER, PR and positive for CK20, CDX2, CEA and CK 7 (focal). Immunomorphologic findings compatible with colon primary.

In the USA, cervical cone biopsy done, colonoscopy and endoscopy, CT with contrast and PET scan are negative for primary colon. Diagnosed as endocervical cancer stage 2B and is for chemotherapy, radiation and brachytherapy.

Incidence cervical adenocarcinoma is more common than squamous cell carcinoma. Human papillomavirus (HPV) is a primary cause. The average age is 45-55 years old, but can be seen in younger women. The symptom is abnormal vaginal bleeding. Diagnosis is based on cervical biopsy. According to FIGO clinical staging is based on pelvic exam, cystoscopy, and rectoscopy. Pelvic ultrasound with Doppler studies, MRI and PET scan can be used for evaluation of cervical cancer for optimal treatment.

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Diagnosis of Robert's uterus by 3D ultrasound volume contrast imaging: a case report

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A patient, female, 18-year-old, unmarried and had gradually aggravated dysmenorrhea. Ultrasound examination was performed by using transrectal 3D ultrasound, with the imaging mode by using multiplanar volume contrast imaging and TUI mode. The C-plane of the multiplanar pattern clearly shows an intact contour of the uterine fundus with the endometrium offset to the left in a columnar pattern that communicates with the cervix. There was a circular anechoic area in the right myometrium, a thin and dense hypoechoic spot was seen in the myometrium, and the periphery was annular hyperechoic. Several parallel planes of the B-plane of the TUI pattern show that the hyperechoes along the right anechoic zone converge gradually to the right uterine horn, and the linear echoes eventually terminate in the uterine fundus serosa. Based on these findings, ultrasound eventually diagnosed Robert's uterus.

One month later, the patient underwent laparoscopic excision of uterine oblique septum. The thickness of oblique septum was about 3 cm between the left uterine cavity and the right uterine cavity.

3D ultrasound can image more anatomical details due to the obvious improvement in the resolution. In this case, multiple imaging techniques can be used to show the relationship between the blind cavity and the ipsilateral horns, thereby enhancing diagnostic confidence.

Supporting information can be found in the online version of this abstract

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Acquired uterine arteriovenous malformation after obstetric event

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Series of cases describing women with a history of abnormal uterine bleeding after obstetric event. The women underwent transvaginal ultrasound with 3D, colour and power Doppler ultrasonography (DUSG) (GE E10) and were followed clinically. Case 1: A 31 years old, G2A0 was referred for menorrhagia after missed abortion, with β -HCG of 16,7mU/ml. DUSG evidenced a mixed echogenic mass with heavy vascularisation of the myometrium characterising arteriovenous malformation (AVM) (figure a, b). Case 2: A 35 years old, G3A0 was referred with an abnormal bleeding history 24 days after vaginal delivery. β -HCG not performed. DUSG evidenced mixed echogenic mass with discrete vascularisation of the myometrium characterising AVM (figure c). Case 3: A 31 years old, G1A1 referred after history of abnormal bleeding after missed abortion followed by uterine curettage. β -HCG of 52.3mU/ml. DUSG evidenced mixed echogenic mass with heavy vascularisation of the myometrium characterising AVM (figure d). Case 4: A 22 years old, G3A1 referred after history of abnormal bleeding after gestational trophoblastic disease followed by uterine curettage. β -HCG reduced from 133.32 to 60.27mU/ml in 11 days. Ultrasonography evidenced mixed echogenic mass with heavy vascularisation of the myometrium characterising an extensive AVM involving the whole myometrium (figure f-i). Case 5: A 35 years old, G4A2 referred after spontaneous missed abortion. β -HCG reduced from 259.1 to 24.32 um/ml in 15 days. DUSG evidenced mixed echogenic mass with discrete vascularisation of the myometrium characterising AVM. All cases evolved hemodynamically stable with abnormal bleeding stop and spontaneous regression. Embolisation was not necessary.

Supporting information can be found in the online version of this abstract

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Hematometra as a late complication five years after endometrial ablation: diagnostic challenges – a case report

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Hematometra is a recognised complication of endometrial ablation. Reports in the literature are of patients presenting within two years of ablation.

We describe a case of a 45 year-old lady presenting with acute abdominal pain. She had undergone radiofrequency endometrial ablation five years before and was otherwise fit and well. On abdominal and vaginal scan a uterine mass was identified. Ultrasound identified the mass with blood/fluid as most likely hematometra. Hysteroscopy failed due to adhesions. MRI scan confirmed a diagnosis of hematometra with no adnexal masses or evidence of hydrosalpinx. The scan images, including MRI, clearly differentiate hematometra as opposed to an endometrioma. The patient is to be managed with hysterectomy to exclude malignancy.

Our case reports the first reported case of hematometra as late as five years after the initial procedure. We explore differential diagnoses on ultrasound and MRI and treatment options available.

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Modified IETA-based scanning to minimise invasive investigations in postmenopausal bleeding: a service improvement outcome

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