

# Visual Diagnosis in Emergency Medicine



## POSTMENOPAUSAL PATIENT WITH SUPRAPUBIC PAIN

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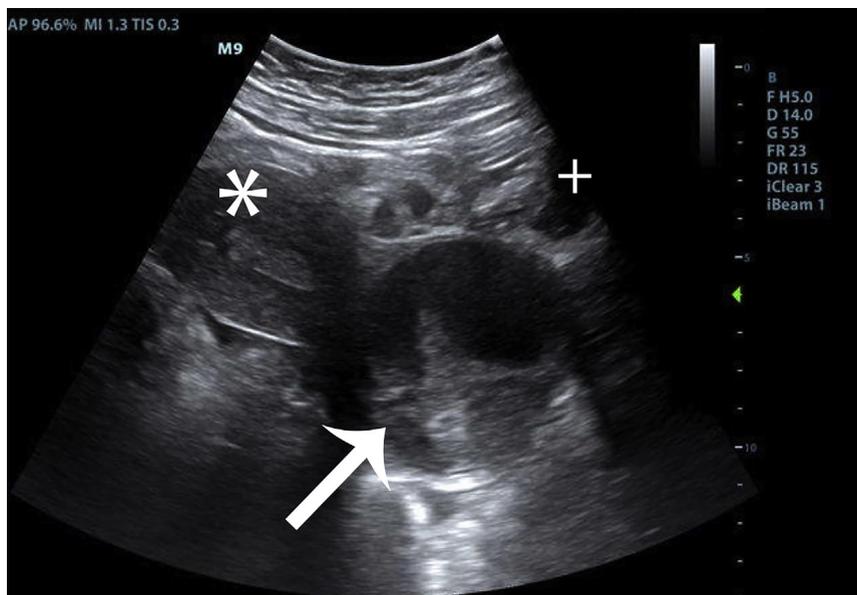
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### CASE REPORT

We present a case of a postmenopausal woman with abdominal pain who ultimately received the diagnosis of hematocervix after emergency physician-performed point

of care ultrasonography, with the images obtained in this manner motivating additional imaging before a surgical procedure that addressed the cause of the problem.

A 52-year-old gravida 1 para 1 postmenopausal woman presented to the emergency department with



**Figure 1.** Point of care transabdominal ultrasonographic image captured with a curvilinear probe placed over the midline suprapubic region in the sagittal plane shows a large, cystic fluid collection with posterior acoustic enhancement and filled with substance of mixed echogenicity (arrow) located between the uterus (asterisk) and the bladder (plus sign).

Reprints are not available from the authors.

RECEIVED: 23 April 2018; FINAL SUBMISSION RECEIVED: 12 August 2018;  
ACCEPTED: 27 September 2018

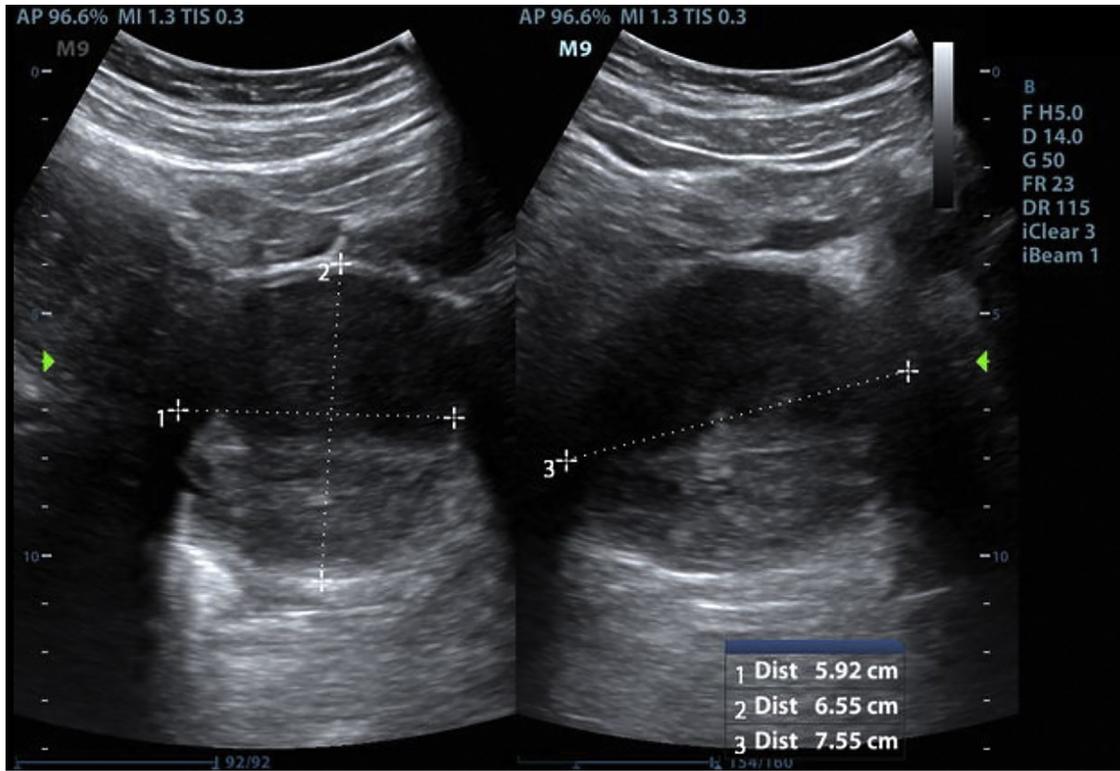


Figure 2. Transverse and sagittal measurements taken by the emergency physician of the cystic structure, found to be 5.9 × 6.6 × 7.5 cm.

2 days of worsening, 8 out of 10, sharp, and constant suprapubic pain that was not associated with urinary symptoms, vaginal bleeding, or discharge. Her last menstrual period was >2 years earlier according to patient report, although she reported having had similar epi-

sodes of abdominal pain in the past that had self-resolved. The physical examination revealed mild suprapubic tenderness, normal external female genitalia, and a bulging cervix protruding into the vaginal canal on speculum examination. Point of care

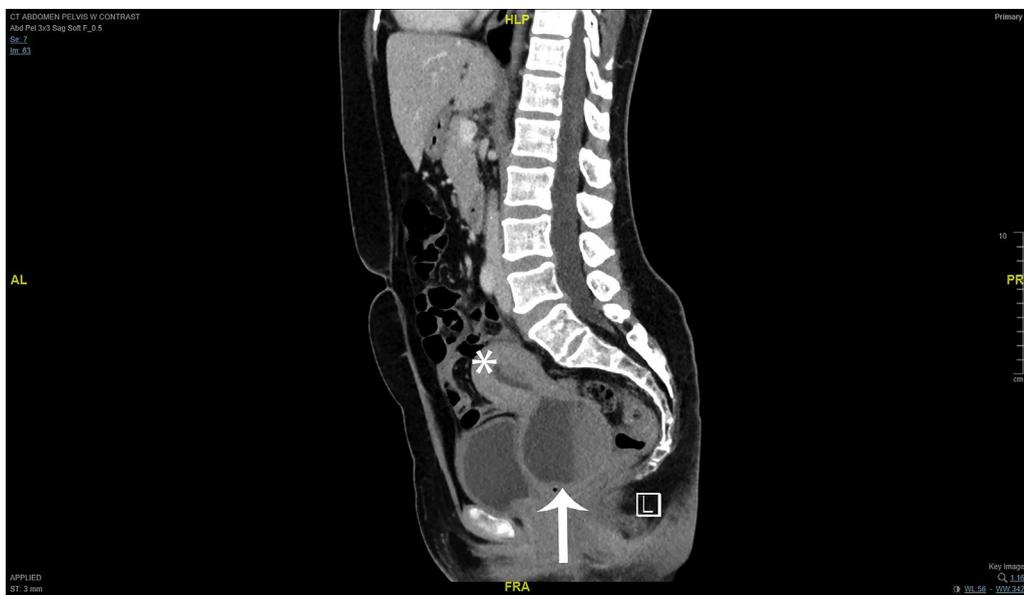
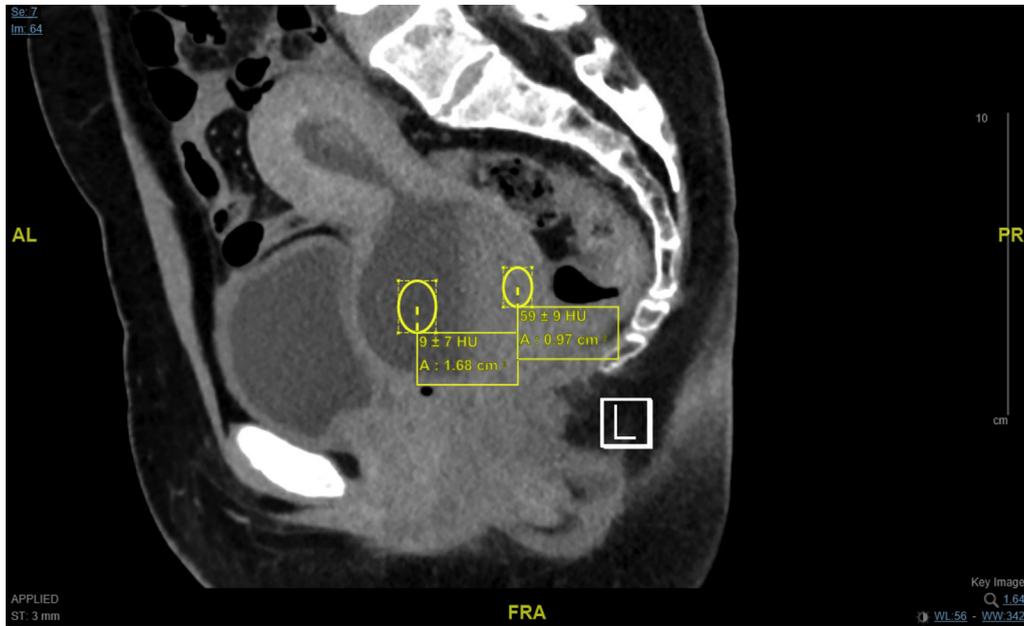


Figure 3. Sagittal cut of the computed tomography scan showing hematometra (asterisk) and hematocervix with layering fluid-fluid level (arrow), likely representing blood products and corresponding to the ultrasonographic images above.



**Figure 4.** Enhanced image of [Figure 3](#). Hematocervix is redemonstrated with Hounsfield units included of the 2 densities. The more anterior density measures to  $9 \pm 7$  Hounsfield units; the more posterior density measures to  $59 \pm 9$  Hounsfield units.

ultrasonography over the site of discomfort demonstrated a well-circumscribed cystic structure with mixed densities located between the uterus and bladder ([Figures 1](#) and [2](#)). Given this unusual finding, a computed tomography scan of the abdomen/pelvis was ordered to further characterize the structure ([Figures 3](#) and [4](#)) and led to the diagnosis of hematocervix. The patient was taken to the operating room by the gynecology service for cervical dilation and evacuation of blood products. Samples of blood and a posterior uterine polyp were sent for anatomic pathology which were negative for malignancy; she was ultimately diagnosed with hematometra and hematocervix resultant from perimenopausal menstrual bleeding in the setting of cervical stenosis. It is possible that cervical stenosis precluded external evidence of menstruation and that the patient was not truly postmenopausal as she had believed. The patient was discharged in stable condition on postoperative day 0 and has yet to attend a follow-up appointment.

## DISCUSSION

Anatomic obstruction of the passage of blood out of the uterus may lead to its buildup within the female repro-

ductive tract. In comparison to hematometra (blood in the obstructed uterus), hematocervix appears to be relatively uncommon (1). Hematocervix or hematometra may be suspected in women with amenorrhea or lower abdominal pain and may be caused by congenital abnormalities or acquired etiologies, such as cervical stenosis or malignancy (2). Definitive management of hematocervix involves cervical dilation and evacuation of blood with treatment of underlying cause as indicated (3). The patient received a gynecologic consultation in the emergency department and definitive management through operative suctioning and evacuation of the intracervical/intrauterine contents and hysteroscopy.

## REFERENCES

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