Decidualized Endometrioma: Its Optimal Clinical Management
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INTRODUCTION
Endometriosis is a common gynecologic disorder affecting about 10% of women of reproductive age, and ovarian endometriomas account for 4-5% of ovarian cysts diagnosed in early pregnancy. Decidualization of an endometrioma (DE) may appear sonographically as having ultrasound (US) features similar to an ovarian malignancy, which often prompts a surgical extirpative approach. Encountering this entity may become increasingly frequent since many pregnant women are having routine obstetrical US in the first trimester. An endometrioma is often well-characterized, and it is sometimes altered during pregnancy as a result of this process of decidualization. DE can cause anxiety to women and lead to unnecessary and potentially harmful surgical interventions. The authors wish to contrast a previous encounter with this condition with a more current instance, to offer a possibly improved modern approach to DE.

METHODS
A current Case Report was compared with a previous one that was reported five years ago at CAOG, in order to determine a possibly improved upon manner of treatment of the condition in question. Both cases are presented here for this Case Series.

Case 1 – A 33 y/o G2P010 was diagnosed with a 2.6 x 1.8 x 1.7 cm left ovarian cyst at her routine 20-week gestation US. She had no history of ovarian endometrioma on previous US scans during earlier gestation. The cyst was unilocular with ground-glass echogenicity and vascularized papillary projections suggestive of ovarian malignancy (Fig 1). Gynecologic oncology consultation was obtained, and patient underwent laparoscopy left salpingo-oophorectomy at 23 weeks gestational age without complications. The pathology diagnosis of the removed mass was decidualized endometrioma.

Case 2 – A 30 y/o G2P010 female patient presented for initial US at 11 weeks and 4 days for a Nuchal Translucency Screen. Bilateral ovarian endometriomas were demonstrated with this initial US exam (Fig 2). Bilateral ovarian decidualized endometriomas were suspected during a repeat US at 30 weeks 3 days gestation, due to the presence of rounded vascularized papillary projections with smooth contours within an ovarian cyst and ground-glass low-level echogenicity of the cyst fluid (Fig 3 and 4). The patient was treated conservatively with serial follow-up US studies during her pregnancy. The patient had a NSVD at 36 weeks 6 days of gestation on 8/30/2020. Follow-up US at 2 months post-partum demonstrated persistent bilateral endometriomas without decidualization and (Fig 5 and 6).

CONCLUSIONS
The contrasting management of both of the cases described in this report revealed the resolution of the appearance of malignancy at the end of the pregnancy, demonstrated by each of these cases of decidualized endometrioma. In the first case, surgery was performed, and in the second case, no surgery was performed, yet the results were the same for both cases.

The results of this comparison produced the following lessons:
• When what appears as a Decidualized Endometrioma is sonographically identified during pregnancy in a patient who is otherwise asymptomatic, she can continue to be closely observed with US every 4 weeks during the pregnancy. Such sonographic features of DE can include: Papillary projections with smooth contours within the cyst, Color flow within the papillary projection, Usually unilocular but sometimes can have 2–4 cyst locules, Ground-glass or low-level echogenicity of the cyst fluid.
• After delivery, a repeat sonogram should be performed, and if resolution of the DE is identified, the patient can be reassured.
• Observation of this in DE patients will continue, to observe the likelihood of recurrence, so patients can receive the appropriate counseling for this in the future.

Demonstrations such as what is presented here, have been reported in the literature previously, and there appears to be wide support for watchful waiting when similar sonographic findings in pregnancy are seen.

REFERENCES

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