**Infected endometriomas – acute and long-term management**

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**Introduction/Background**

Infected endometrioma is a special subgroup of pelvic infections, having a different epidemiology and pathophysiology1,2,3, and yet may be difficult to distinguish from routine pelvic inflammatory disease (PID)4. Optimal management remains unknown3. We present a series of 10 cases of infected endometrioma including clinical progress and eventual outcomes.

**Materials and Methods**

10 cases of infected endometriomas were prospectively recruited at a tertiary university hospital over 10 months (January to October 2023). Blood cultures and vaginal swabs - for cultures and sexually transmitted infection (STI) testing – were collected prior to intravenous antibiotics. Cases that failed antibiotic therapy underwent drainage and the endometriotic fluid sent for cultures. All cases were offered hormonal suppression immediately after acute episode paired with definitive surgery at >2 months interval.

**Results**

All cases presented via emergency department with fever, pelvi-abdominal pain. Ultrasound imaging demonstrated endometriomas. Following a trial of intravenous broad spectrum antibiotics; 2 failed to respond and underwent drainage (1 transvaginal, 1 transabdominal). Blood and vaginal cultures were negative in all cases while STI testing yielded only 1 positive for Trichomonas vaginalis. Drainage cultures returned positive for Hemophilus influenzae and Peptoniphilus. The median age was 40 years. Half were nulliparous. None had prior STIs, recent pelvic instrumentation, obesity or immunocompromise. Only 6/10 cases had preceding diagnoses of endometriosis, Subsequently, 9/10 agreed for hormonal suppression and 8/10 cases underwent definitive surgery with visual and histopathological confirmation of endometriosis; 2 declined surgery. No recurrence of infection or endometriosis was present at 1 year post-operatively.

**Conclusion**

Infected endometriomas may affect older, nulliparous women lacking traditional risk factors for PID e.g. STIs or prior instrumentation1,2. Careful history, examination and targeted ultrasound5 is required. Antibiotics should cover gut flora and anaerobes, with early drainage considered for culture-directed therapy. Hormonal suppression and definitive surgery are essential in preventing relapse.

**Key words:** Tubo-ovarian abscess, endometrioma, pelvic inflammatory disease

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