

Preschool Girl With Vaginal Bleeding Due to Pinworm Endometritis



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ABSTRACT

Genital tract bleeding in prepubertal girls is a rare clinical condition, which can occur for multiple reasons. It frequently generates anxiety in the family and in health care professionals. A thorough anamnesis and careful genital inspection can give important diagnostic hints; however, there are cases in which the cause remains doubtful and a complete gynecological evaluation (including cultures and vaginoscopy) is necessary. Therefore, the attending physician should always consider less frequent diagnoses in order to perform the necessary studies in a sequential and rational manner. We present the case of a preschool girl with vaginal bleeding due to pinworm endometritis, which, to our knowledge, has never been reported before as a cause of genital bleeding in prepubertal girls.

Key Words: Prepubertal vaginal bleeding, Pinworm, Vaginoscopy, Genital examination, Endometritis

Introduction

Genital bleeding in a girl without signs of pubertal development is cause for alarm and poses a diagnostic and prognostic dilemma, given its great etiological diversity including infections, tumors, foreign bodies in the vagina, genital trauma, and also non-gynecological diseases. In addition, because of the low prevalence of this entity, there are limitations for the gynecological examination of prepubertal girls for many doctors, due to a lack of experience and the limited availability of appropriate instruments.

The basic knowledge of all the potential causes is essential in order to carry out an exhaustive evaluation and/or to be able to consult the appropriate specialist if necessary.

Case

An otherwise healthy girl 3 years 4 months of age attended the Emergency Pediatric Unit because of genital bleeding without other associated symptoms. Physical examination showed breasts and pubic hair at a Tanner I stage. Genital inspection revealed female genitalia without signs of estrogenization and no injuries, annular hymen without notches, and multiple blood clots without bad odor, emerging from the vaginal orifice. The perineal and anal

regions were unremarkable. A vaginoscopy was performed under general anesthesia, which showed multiple blood clots and a large number of white, thin worms about 1 cm long, compatible with pinworms (Figs. 1 and 2). Vaginal mucosa showed no lesions; however, the cervix was found to have inflammatory mucosa and active bleeding coming from external cervical os. Cultures of vaginal secretion and gonococcus were negative; a perianal Scotch Tape test was positive for *Enterobius vermicularis* eggs. The bladder was filled in order to perform transabdominal gynecological ultrasound, which showed ovaries and a uterus of prepubertal characteristics (right ovary, 0.04 cc; left ovary, 0.11 cc; uterus, longitudinal diameter 20 mm). The endometrium was hyperechoic and 1.8 mm thick, with images suggesting occupation of the endometrial cavity with moving elements (Fig. 3). Considering the absence of any pubertal development, the negative cultures, the visualization of pinworms in the upper vagina, and the positive perianal cellophane test, the bleeding and ultrasound findings were attributed to endometritis due to *Enterobius* infestation.

A single dose of albendazole 400 mg was given to the patient and her contacts. The bleeding persisted, with hematocrit and hemoglobin declines from 31.5% to 28.2% and 10.7 g/dL to 9.3 g/dL, respectively, over 4 days. Leukocyte counts and platelets as well as coagulation tests remained within the normal range. A second dose of albendazole 400 mg was administered, and systemic therapy with metronidazole and amikacin was initiated, considering the possibility of secondary bacterial endometritis. The vaginal bleeding stopped after 3 days, and the patient was discharged on oral antibiotic treatment with metronidazole and cefadroxil to complete 14 days.

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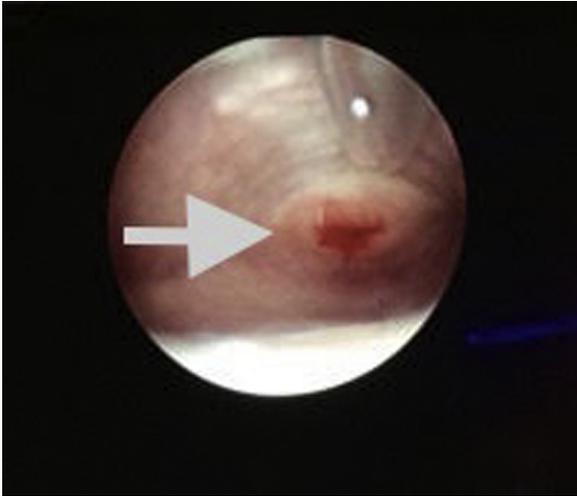


Fig. 1. Vaginoscopy: cervix was found to have inflammatory mucosa and active bleeding coming from external cervical os.

In the following months, she maintained growth according to chronological age, without pubertal signs and without genital bleeding. A subsequent transabdominal gynecological ultrasound showed ovaries and uterus of prepubertal characteristics (right ovary, 0.07 cc; left ovary, 0.10 cc; uterus, longitudinal diameter 32 mm), with no visible endometrium at the uterine fundus. Normal hematocrit and hemoglobin were achieved after 6 weeks of oral iron therapy.

The child's mother authorized the publication of her daughter's case.

Discussion

Prepubertal Vaginal Bleeding

The large number of diagnostic possibilities makes it essential to perform a thorough evaluation of the patient. It is also important to have a rational approach to the child,

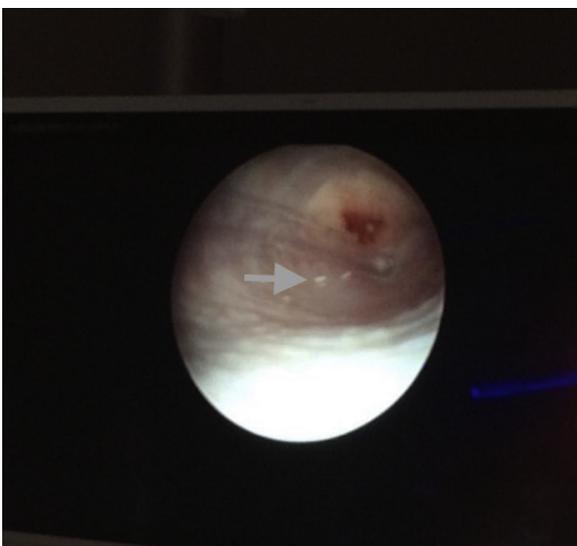


Fig. 2. Vaginoscopy showed thin worms about 1 cm long, compatible with pinworms.



Fig. 3. Transabdominal gynecological ultrasound: Endometrium was hyperechoic, with images suggesting occupation of the endometrial cavity with moving elements.

both to first rule out the most frequent causes and to avoid unnecessary invasive procedures.¹

The general physical examination must evaluate the clinical impact of bleeding and the pubertal stage, and search for any sign of systemic disease. It is also necessary to rule out extra-gynecological causes such as anal or rectal fissures, urethral prolapse, and hemangiomas or other vascular malformations.^{1,2}

If the vaginal origin of the bleeding is confirmed, all possible causes should be kept in mind in order to guide the diagnostic approach. Most etiologies are benign; the most frequent is nonspecific vulvovaginitis (inflammation of vulvar and vaginal mucosa due to environmental factors), followed by vulvovaginitis by specific pathogens. Local lesions such as trauma, irritation due to foreign body, or tumors can also be found. If sexual abuse is suspected (either by anamnestic information, an identified sexually transmitted infection, or the type of lesion), the patient must be referred for a specialized evaluation, consisting of interviews by trained personnel and additional tests for sexually transmitted diseases (STDs). In accordance with local laws, the authorities must be informed.² Uterine causes have less frequently been reported, such as prepubertal menarche (transient endometrial development and desquamation, prior to thelarche), the first manifestation of McCune-Albright syndrome (functional ovarian cyst with endometrial development prior to breast development), and endometritis.³

Genital inspection, including visualization of the distal vagina, frequently allows the identification of the cause of bleeding. Vaginoscopy should be performed in all patients in whom the cause of bleeding is not identified by the initial examination. This enables the observation of lesions at a high vaginal level (or in the uterine cervix) as well as the identification and removal of foreign bodies, and allows the certainty of uterine bleeding as the symptoms source if bleeding through the cervix is seen. It is fundamental to choose the instruments that expose the small and non-estrogenized hymen and vagina to the least possible damage and to consider the patient's ability to cooperate; in case, this is not achieved, examination under anesthesia was suggested.

“Prepubertal menarche” is an entity defined as an isolated bleeding without signs of puberty and with no identifiable cause after a complete evaluation. The diagnosis is made by exclusion and following the evolution in time, as studies are generally unrevealing. It is a benign and self-limiting condition that has no effect on subsequent pubertal development, future fertility, or final height.³

Pinworms in the Pediatric Gynecological Setting

Oxiuriasis or pinworm infestation is an infectious disease caused by *Enterobius vermicularis*, the most common nematode (roundworm) infection in children.⁴ The worms, which parasitize only humans, are white and tapered; males measure between 2 and 5 mm, and females between 8 and 13 mm. *E. vermicularis* is transmitted by the ingestion of eggs, which are deposited by the female at the anal margin, by the fecal-oral route, self-infestation, contact with fomites, or inhalation. Most frequent clinical manifestations are anal, perineal, and vulvar pruritus exacerbated during the night-time. Diagnosis is made by direct visualization of eggs or adult pinworms through perianal Scotch Tape test (also known as the “cellophane test”), which has a sensitivity of 90%.⁴ Antiparasitic treatment should include the patient's close contacts because of the high contagiousity of the parasite.⁴

After the deposition of eggs, female pinworms may erroneously invade the urinary tract, genital region, or other organs; within the scope of gynecological disease, enterobius have been found in every site of the genital tract including the vagina, uterine cervix, uterine body, and fallopian tubes.⁵ It has also been described as a cause of postmenopausal uterine bleeding.⁶ Despite being a very common pathogen in childhood and frequently mentioned as a cause of perianal and vulvar itching, enterobiasis is scarcely described as a cause of high gynecological infections in the field of pediatric and adolescent gynecology, with the sole exception of pelvic inflammatory disease in postmenarcheal adolescents. In those cases, co-infection with bacteriae was identified (specifically, staphylococci

and *Escherichia coli*), and therefore antibiotics were added to the antiparasitic therapy.^{7,8} As mentioned before, we found no reports of pinworms as a cause of uterine pathology in premenarchal girls.

Summary and Conclusions

Enterobiasis, given its frequency and the diversity of its manifestations, should be included in the differential diagnosis of gynecological diseases at any age, whether the cardinal symptom is genital itching, vaginal discharge, or abnormal genital bleeding.

As our report shows, pinworms can invade the uterine cavity of girls. Therefore, in prepubertal girls with abnormal genital bleeding, this infection should be included into the differential diagnosis. If pinworm infestation is confirmed (by the cellophane test), antiparasitic treatment with albendazol or mebendazol should be started, and, because of possible bacterial co-infection, concomitant antibiotic therapy covering bacteria usually found on the perineal and genital area should be initiated.

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