Accessory and Cavitated Uterine Mass (ACUM)

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ABSTRACT

Case Report: A 19-year-old virgo intacta student from Sandakan, Sabah presented with severe pelvic pain and dysmenorrhea since menarche at the age of 13. Symptoms were not alleviated with COC or NSAID and she needed frequent visits the ED for NSAID or opioid injections. Ultrasound findings were not conclusive hence MRI was performed which showed a bulky uterus with a well-defined rounded non-communicating cavitated mass measuring 3.6 x 3.7 x 4 cm within the left myometrium which is hypointense on T1 and T2. It has central hyperintense cavity on T1 and T2 which may represent haemorrhagic content or proteinaceous fluid. The main uterine cavity has a normal trigone shape with normal fundus and bilateral cornua visualised. Both tubes and ovaries are normal. Impression given by the radiologist was possible accessory and cavitated uterine mass (ACUM). Diagnostic hysteroscopy and laparoscopy was performed which showed a normal endo-cervical canal and normal uterine cavity with both ostia seen. There was no endometrial abnormality. The uterus had a vague globular mass located near the insertion of the left round ligament. Both Fallopian tubes and ovaries appeared normal. Vasopressin was injected into the myometrium to reduce the bleeding. A transverse incision was made on the anterior uterine surface over the swelling with the Harmonic Scalpel (Ethicon©). Approximately 5ml of a thick, chocolate coloured material spilled out during the dissection. Excision, however, was not technically easy as the limits of the mass was ambiguous. The uterine cavity was spared during dissection. The uterine and broad ligament defects were reconstructed with the coated Vicryl 1 (Ethicin®) and V-Loc™ 1 Barbed sutures. The specimen was placed in an endo-bag and retrieved from the peritoneal cavity through a 10 mm trocar. The patient was discharged 2 days after surgery. She did not experience dysmenorrhea in her next cycle when she came for follow-up. A repeat hysteroscopy was performed 8 weeks later which showed the uterine cavity to be normal, no defects with bilateral ostia seen. Macroscopic examination of the lesion showed a 3 cm irregular greyish white nodular mass with a blood filled cyst of 2 cm diameter. The HPE showed a cystic cavity lined by endometrial glands and stroma which confirmed the diagnosis of ACUM. There were no adenomyotic foci surrounding the myometrial tissue in the excised specimen. **Conclusion:** ACUM is a rare Mullerian anomaly. Early diagnosis and surgical intervention removing the mass can shorten the suffering of the patient.

Xanthogranulomatous Oophoritis (XO): A Management Dilemma in a Pregnant Woman

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ABSTRACT

Xanthogranulomatous inflammation is a rare but serious form of chronic granulomatous disorder that causes destruction to the affected organ such as kidney and bladder. Pathologically, it is characterised by lipid-laden foamy macrophages and cellular infiltrates such as neutrophils, lymphocytes and plasma cells. Xanthogranulomatous oophoritis (XO) involves the ovary and although it has previously been reported, this is the first case that coexists in pregnancy. A 30-year-old female, Para 1 was referred to our centre for further management of suspected ovarian malignancy. She presented with one-year history of gradual abdominal distension associated with non-cyclical right-sided abdominal pain and significant weight loss. She has regular menses with no urinary or bowel symptoms. Prior to coming to us, patient underwent ozone therapy, which she claimed improved her symptoms temporarily. Abdominal examination revealed a firm pelvic mass of 20 weeks size with restricted mobility. Ultrasound and CT scan showed a right-sided multiloculated cystic ovarian mass measuring 10x8 cm with no ascites, with normal tumour markers. Patient was advised for surgery; however, she conceived spontaneously and wished to keep her pregnancy. MRI revealed a complex right ovarian cyst with suspicion of malignancy. Throughout the pregnancy, she remained well but had moderate iron deficiency that required treatment with parental iron. The mass continued to increase in size with large vascularity seen on Colour Doppler. She had a planned elective repeat lower segment Caesarean section, right salpingo-oophorectomy and appendicectomy at 37 weeks of gestation. Intraoperatively, uterus was 36 weeks size being pushed to the left by the ovarian mass. There was no ascites however peritoneal washing was sent for cytology. There was a right-sided ovarian mass measuring 12x12 cm mimicking tubo-ovarian abscess, which was adhered to the recto-sigmoid colon and fixed to the Pouch of Douglas. Adhesiolysis was done and the cyst ruptured, extruding pus discharge. Incidental finding of hepatomegaly and subserosal fibroid measuring 4x4 cm which myomectomy was done. Histopathological examination revealed a diagnosis of right Xanthogranulomatous oophoritis and leiomyoma with negative cytology. Xanthogranulomatous oophoritis is a rare disorder which to date only 20 cases reported in literature and none reported to occur during pregnancy. Zhang et al reported in 2012 that clinical manifestations, imaging and macroscopic observation of XO are subject to be confused with ovarian malignancy. In pregnancy the window for surgical treatment is narrow. Despite knowing the risk of malignancy, patient wished to continue her pregnancy and refused any surgical intervention. Therefore, she was treated conservatively and allowed to carry the pregnancy till term.