Xanthogranulomatous (pseudoxanthomatous) salpingitis masquerading malignancy

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ABSTRACT

Introduction: Xanthogranulomatous inflammation (XI) is a rare form of chronic inflammation that can affect various organs. XI of the female genital tract is uncommon. We report a case of xanthogranulomatous(pseudoxanthomatous) salpingitis (XGS) masquerading as malignancy. **Case Description:** A 50-year-old woman presented with abnormal vaginal discharge. Pelvic examination showed Pouch of Doughlas (POD) fullness with mass without vaginal or cervical pathology, and per-rectal examination done with external compression. USG revealed a cystic-like complex mass of bilateral adnexae, with adenomyoma of the posterior uterus. CT TAP showed features of benign ovarian and tubal pathology, however, was unable to rule out malignancy in view of the high level of CA-125. Pre-operative cervical smear consistent with bacterial vaginosis infection. TAHBSO, omentectomy, and bilateral PLND? was performed. During the exploratory laparotomy, we observed foul-smelling, greenish pus and severe adhesion to the posterior uterine wall, lateral pelvic wall, and rectum. The final pathology showed xanthogranulomatous (pseudoxanthomatous) salpingitis. However, no organism was isolated from the pus culture. Our patient received a two-week course of antibiotic treatment and was discharged thereafter. **Discussion:** Xanthogranulomatous inflammation (XI) has been described in several organs, including those of the genital tract. Pelvic endometriosis, pelvic inflammatory disease (PID), chronic endometritis, and a history of intrauterine device (IUD) use have all been suggested among benign causes of this uncommon tubal pathology. Xanthogranulomatous salpingitis (XGS) can further differentiate into pseudoxanthomatous salpingitis or granulomatous salpingitis. Pseudoxanthoma portrays acute and chronic inflammatory infiltrates with brown cytoplasmic lipofuscin pigment, as in this case. Meanwhile, in granulomatous salpingitis, a well-developed granulomas should be seen histopathologically.

From snow storm to thyroid storm: A challenge in management

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ABSTRACT

Introduction: Gestational trophoblastic disease causes exaggerated elevation of beta-human chorionic gonadotropin level. In molar pregnancy, it can lead to thyrotoxicosis. It is difficult to differentiate thyroid storm from primary hyperthyroidism as no specific laboratory parameter is available. Early diagnosis is important and immediate initiation of anti-thyroid medications, intensive care monitoring, and prevention of multi-organ failure is paramount. Medical management of thyroid storm prior to surgical intervention is crucial to prevent adverse maternal outcomes. Here, we report a rare case of thyroid storm induced by molar pregnancy. **Case Description:** A 28-year-old Myanmarese in her fourth pregnancy was diagnosed with molar pregnancy. Due to financial constraints, she presented 3 months later with hyperthyroid symptoms associated with fever and vaginal bleeding with 20 weeks' size uterus that demonstrated a snowstorm appearance on the transabdominal scan. Beta-human chorionic gonadotropin hormone (βhCG) was 1.25 million IU/ml, TSH was<0.01 IU/mL, and thyroxine level was 51.8 pmol/L. Burch-Wartofsky point scale was 55. Propranolol, Dexamethasone, Propylthiouracil, and Lugol's iodine were started immediately to control her thyroid function. Repeat thyroid function test after 2 weeks showed significant improvement. Following the surgical evacuation, she had plateauing of BhCG level and was diagnosed with an invasive mole. She made a good recovery after a total of 8 cycles of Methotrexate, Etoposide, and Actinomycin-D. **Conclusion:** Gestational trophoblastic neoplasia is not only associated with hyperthyroidism but can induce thyroid storms. A high index of suspicion and prompt recognition is important to prevent catastrophic events from thyroid storms.