

# Archives of Clinical Case Reports

## Case Report

### A Huge Subserous Adenomyoma Presenting as Ovarian Cancer

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#### Abstract

Uterine adenomyosis is a common benign gynecologic lesion which can have clinical presentation of diffuse lesions in the myometrium causing myometrial thickening giving a trabeculated gross features especially in the posterior uterine wall. The other less common finding is a discrete mass with a trabeculated with tiny hemorrhagic foci instead of a whorl-like feature found in leiomyoma which is much more common. Sometimes, this adenomyotic mass is called adenomyoma. Most of the adenomyoma are found locating within the myometrium. However, the adenomyoma can be found in various locations, such as, submucosal [1], subserous [2,3], endocervical [4], or even outside the uterus at broad [5], or round ligaments [5,6]. We presented a patient with subserous adenomyoma presenting with a huge pelvic mass mimicking ovarian cancer.

#### Case Report

A 42-year old woman, parity 2, was referred from a general gynecologist in a primary hospital to our hospital which is a tertiary center for cancer care for a large abdominal mass which had been palpable by herself for 2 months. Aside from an associated symptom of an increased urinary frequency, other medical history was unremarkable. After a menarche at 13years old, her menstruation had been regular with modest volume and without any problems of dysmenorrhea. She had family history of breast cancer of mother at the age of 55 and colon cancer of her (maternal) aunt at the age of 40.

Physical examination revealed a large firm midline pelvic mass fixed to uterus approximately 20-week gestational size. The com-

plexed mass was fixed to the uterus without tenderness. Pelvic ultrasonography was performed revealing an antevert uterus measured 8.3 x 5.2 x 5.4 cm. The endometrium was well delineated measured 10.4 mm in thickness. A left adnexal mass with heterogenic features of hyper- and low-echoic areas, sized 16.6 x 13.4 x 13.9 cm, was identified. The right ovary was not visualized. With the clinical findings and the ultrasonographic features of solid-cystic component, differential diagnoses may include subserous myoma with degenerative change, endometrioma which may have various stages of hemorrhage/ blood clots, mature cystic teratoma with various components, ovarian cancer, and etc. Adenomyoma with large cystic component was rarely reported, so was not included in our differential diagnosis (Figure 1). With

the rapid growth of the tumor reported by the patient, the solid cystic appearance of the assumed ovarian origin including with the strong family history of cancer as previously described, ovarian cancer was the most likely diagnosis and a plan of surgical treatment, pre-operative laboratory tests were done. Tests for tumor markers showed elevation of CA 125 (386.50 U/ml) and CA 19-9 (1448.80 U/ml), with normal value of CEA were supported our diagnosis. Computerized tomography (CT scan) or magnetic resonance imaging (MRI) could show more details of the mass, this patient did not undergo such imaging study due to administrative and reimbursement problems. Furthermore, any operations of pelvic mass in our institution were generally performed by the gynecologic oncologists. NIG

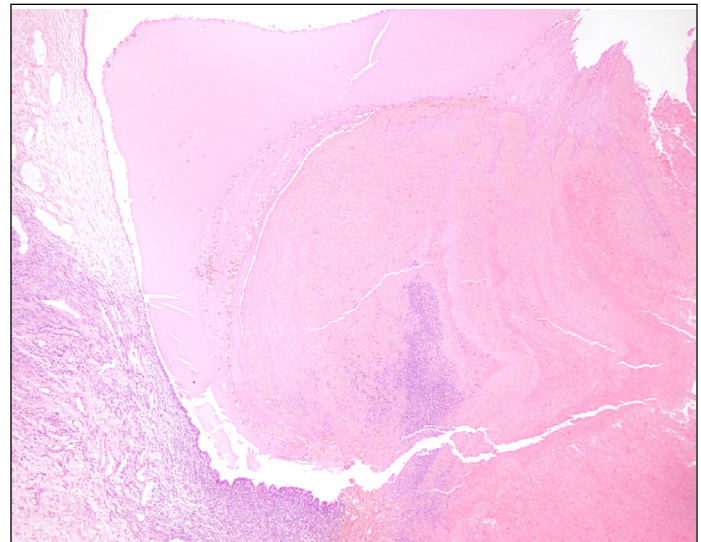
High-grade squamous intraepithelial lesion (HSIL) was found from cervical cytology. With a colposcopic impression of low-grade lesion with only moderate dysplasia of ectocervix and unremarkable endocervix from endocervical curettage and without evidence of invasive cancer, an exploratory laparotomy was proceeded as planned without cervical conization.

Intraoperative findings showed a large pedunculated solid mass arising from the anterior uterine wall with two cystic content mass attached to the solid mass bilaterally measured 15.8 x13.5 x 11.4 cm altogether. Cut surface of the mass showed solid trabeculated tan white with a central cystic liquefaction area containing dark brown hemorrhagic content. The uterus was 9.4 x 6.5 x 4.3 cm with a 2-cm endometrial polyp at fundus. The cervix appeared grossly normal. Bilateral ovarian old hemorrhagic cysts of 5 cm and 2cm were identified. Multi-foci of pelvic adhesion and peritoneal endometriotic spots were also found. Frozen section of the solid mass was reported as adenomyosis. Total hysterectomy with right salpingo-oophorectomy with left cystectomy and salpingectomy were performed along with lysis adhesion and electro cauterized of the peritoneal endometriotic spots. Post-operation courses were uneventful.

The final pathologic diagnosis was a subserous adenomyoma and multiple foci of adenomyosis, cervical intraepithelial neoplasia III with glandular involvement of the cervix, bilateral ovarian endometriotic cysts with unremarkable fallopian tubes (Figure 2).

## Discussion

Abnormal vaginal bleeding was the most common presenting



**Figure 1: Dilated endometrial gland lining a large cyst containing hemorrhage (H&E 10x4).**

symptom of adenomyoma [5,7]. However, other clinical presentations may be found depending on the site of the lesions, such as, submucosal [1], subserous [2,3], endocervical [4], or even outside the uterus at broad [5], or round ligaments [5,6]. Among these, subserosal adenomyoma was quite uncommon being reported in 10% to 15% in previous series [5,7]. Most of them were asymptomatic and were incidentally found from the operations of other indications. Our patients had a clinical presentation of pelvic mass causing pressure symptom. With ultrasonographic features and elevation of tumor markers, pre-operative diagnosis of ovarian cancer was given. History of cancers at young age in first degree family members raised a suspicion of hereditary ovarian cancer. Cervical conization for cervical intraepithelial lesion was not done because no invasive lesion was evidenced from colposcopic examination and we did not want to delay the definite operation. Further pre-operative imaging of CT scan or MRI, which would be performed upon discretion of the physician, was not done in this patient. Retrospectively review, the detailed pre-operative imaging may demonstrate a small pedicle of the pedunculated mass originated from the uterus, and other associated pathology of endometrioma might raise a differential diagnosis of adenomyoma in this patient. Previous study reported high signal intensity on T-1 weight of a solid mass with central cystic content in adenomyoma [8].

The most common characteristic of the adenomyoma from pre-

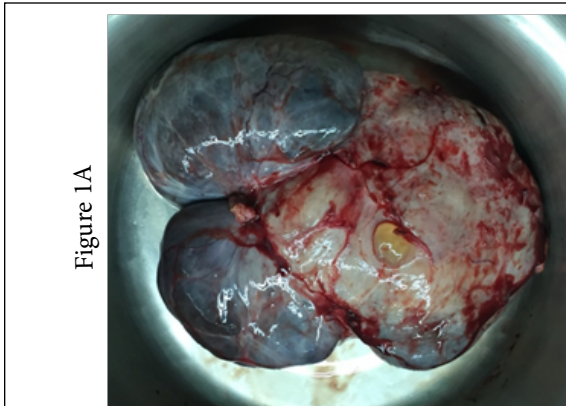


Figure 1A

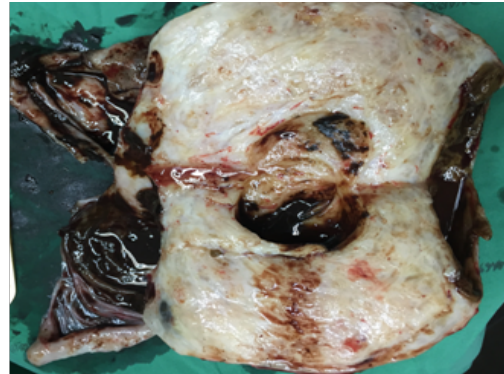
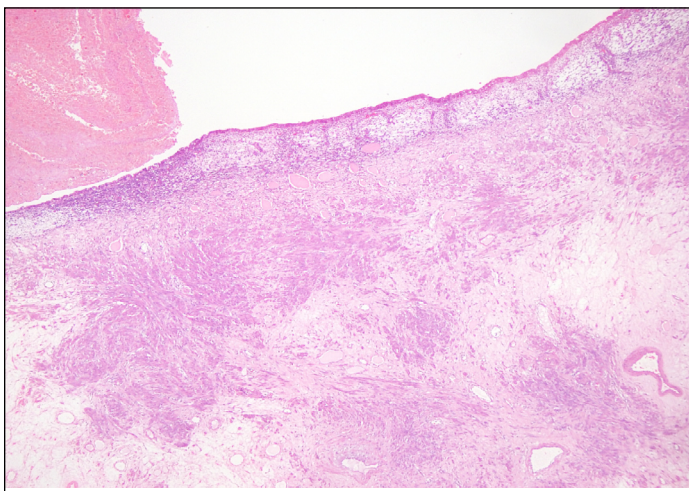
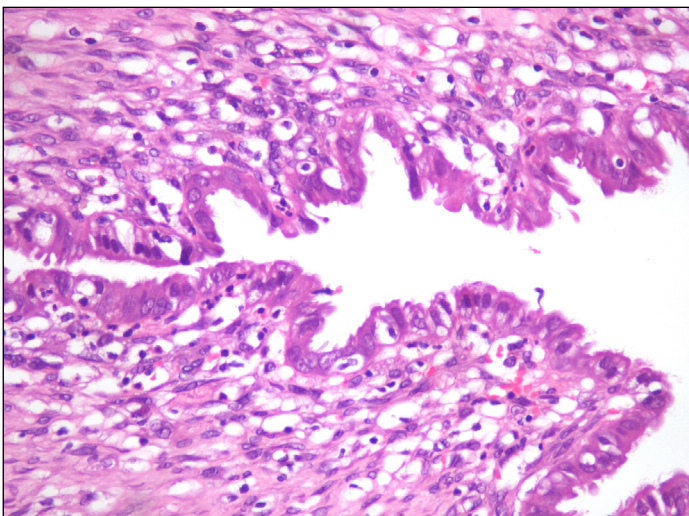


Figure 1B

**Figure 1 A and B:** Gross feature of the mass showed partly solid and partly cystic structure (A). Cut surface showed trabeculated feature of solid mass with central hemorrhagic cystic area; the cystic structure nearby also showed hemorrhagic content of the cyst with some blood clots (B).



**Figure 2:** Smooth muscle fascicles with areas of edema in solid portion of the mass next to cystic area lined by benign endometrial gland. Endometrial stroma and edematous tissue close to dilated cyst were also evidenced (H&E 10x4).



**Figure 3:** Benign endometrial glandular epithelium (H&E 10x40).

vious series was firm solid mass with cystic spaces filled with dark brown content [5,7]. Few may present with cystic lesions. The typical pedunculated subserosal growth with a narrow pedicle connecting to the uterus as found in our patient was rarely reported [5].

The median size of the adenomyoma reported was approximately 4 cm and the largest ever reported was 17 cm locating intramurally [5,7]. To date, our patient had a huge subserous adenomyoma of 15.8 cm which was the largest lesion ever reported locating subserous (Figure 3).

### Conclusion

In conclusion, adenomyoma is a benign lesion. However, it can grow to a large size especially in an extrauterine location. Detailed pre-operative imaging studies such as CT scan or MRI would lead to a correct diagnosis and appropriate management.

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