

A Rare Case Report: Tubal-derived Endometrioma

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ABSTRACT

Endometriotic lesions affect the fallopian tubes in 6% of patients with endometriosis. According to studies in the literature, patients undergoing laparoscopy for chronic pelvic pain had endometriosis in 70 cases. A 49-year-old patient applied to the polyclinic with pelvic pain and complaint of abnormal uterine bleeding (AUB). Ultrasonographic assessment of the uterus showed the uterus to be of normal size and the largest being 2 cm, and three myomas were observed. The right and left ovaries were of normal size, and a 2.5-cm thick cystic mass was observed next to the left ovarian. Since the patient's hemorrhage was increasingly continuing, surgical intervention decision was made. During the operation, adjacent to the left tubal fimbrial end, 25 mm × 25 mm size cystic lesion was observed. Then, total abdominal hysterectomy and bilateral salpingo-oophorectomy were performed. Pathology report showed that uterine leiomyoma and adenomyosis, in the endometrium irregular proliferation and simple atypical hyperplasia fields, were observed. The ovaries were bilateral normal, and the left tube lesion was reported as an endometrioma composed of hemosiderin-laden macrophages. Diagnosis of endometriosis is difficult, and the differential diagnosis of endometriosis is important. Isolated tubal endometriosis should be considered in the etiology of AUB which cannot be detected by magnetic resonance imaging.

Key words: Abnormal uterine bleeding, endometriosis in fallopian tube, pelvic pain

INTRODUCTION

Endometriosis is classically defined as the presence of endometrial glands and stroma outside the uterine cavity. It affects approximately 4–50% of premenopausal women. The most common symptom is pelvic pain.^[1] Endometriosis is most commonly located in areas such as scar tissue, Douglas pouch, urinary tract, and intestines apart from other organs such as the fallopian tubes, peritoneal surface, vagina, and cervix. It affects the fallopian tubes in 6% of patients with endometriosis.^[2] In this presentation, we aimed to discuss isolated endometrioma holding one tubal.

CASE REPORT

A 49-year-old, gravida 4, parity 4 patient presented to the polyclinic with the complaint of abnormal uterine bleeding (AUB) was selected. Ultrasonographic assessment of the uterus revealed that the uterus size was normal, and three

myomas the largest being 2 cm were observed. The right and left ovaries were normal size, and a 2.5-cm thick cystic mass was observed next to the left ovarian. Endometrial thickness was 17 mm. In the patient's medical history, she did not describe neither dysmenorrhea, irregular menstruation, nor dyspareunia. The vital signs of the patient were stable. There was no known chronic disease in her medical history. Previously she did not undergo any surgical intervention. The patient had no history of smoking and drug use. The physical examination of the patient revealed that the abdomen and other system examinations were normal. Vaginal examination performed with speculum showed that the cervix and vagina were of normal appearance. Active vaginal bleeding was observed. Therapeutic curettage was done to the patient. In the laboratory, complete blood count showed that hemoglobin was 8.5 g/dl, platelet was 265.000 mm³, and complete urine test was normal. CA125 level was 23 U/mL. The patient was summoned to polyclinic for a smear test. Smear result of the patient was

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reported as negative for intraepithelial lesion or malignancy. Diagnostic endometrial curettage result was reported as simple atypical hyperplasia. The patient was administered levonorgestrel-releasing intrauterine system. When the patient's hemorrhage increasingly continued and anemia could not be treated, surgical decision was made. The patient was evaluated during the operation, and uterine was of myomatous appearance, right ovary, and tubal appeared normal. The left ovary appeared normal and adjacent to left tubal fimbrial end, and 25 mm × 25 mm size cystic lesion was observed [Figure 1]. Then, total abdominal hysterectomy and bilateral salpingo-oophorectomy were performed. Since the patient did not have any complications, after the surgery, she was discharged. Pathology report showed that uterine leiomyoma and adenomyosis, in the endometrium irregular proliferation and simple atypical hyperplasia fields, were observed. The ovaries were bilateral normal, and left tube lesion was reported as an endometrioma composed of hemosiderin-laden macrophages [Figure 2].

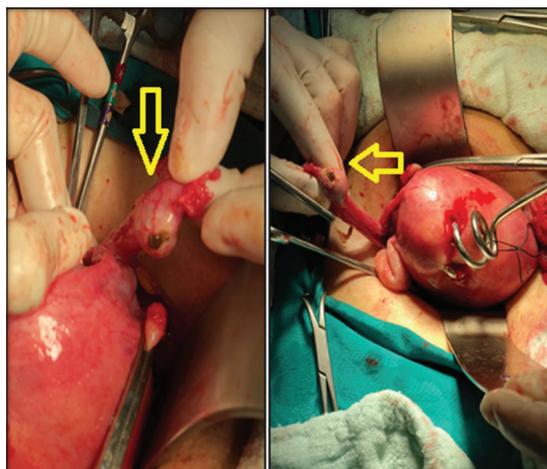


Figure 1: Focal endometriosis detected in the left fallopian tube during surgery

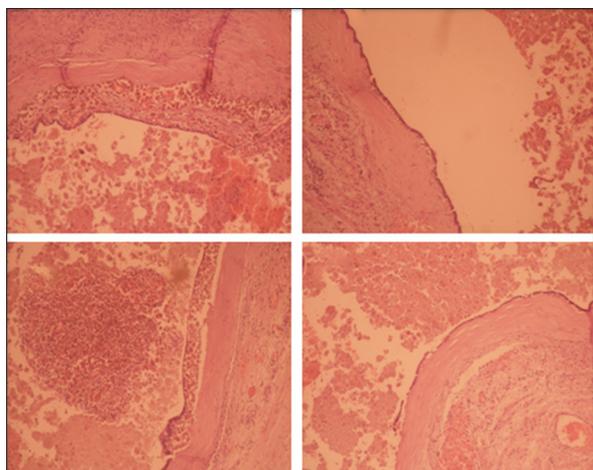


Figure 2: Histopathological appearance of endometriosis in the left fallopian tube

DISCUSSION

Tubal endometriosis masses are very rare, and thus far only a few cases have been described in detail in the literature.^[3-11] In most of these cases, patients presented with pelvic pain. In the present case, the patient also presented to our clinic with pelvic pain. When we check the literature, we see that, in most of the cases, lesions are reported to be on the right, but in the present case, endometriosis was located on the left tubal.^[3,4] During the differential diagnosis of endometriosis, pyelonephritis, and ectopic pregnancy, pelvic inflammatory disease and diseases such as hydrosalpinx should be taken into account.^[5,6,7,10,11] Identifying the location of endometriotic lesions with a complete preoperative obstetric assessment is important for subsequent surgical intervention. However, to decide for a surgery, an accurate pre-operative study is required. For the bladder endometriosis and the diagnosis of endometriosis, transvaginal ultrasound scan is recommended.^[12] Besides, magnetic resonance imaging may be helpful in ovarian foci, superficial peritoneal lesions, and deep pelvic endometriosis.^[13] In some cases, when pelvic pain or AUB cannot be detected radiologically, surgical exploration is important. Furthermore, in this case, during surgical exploration, isolated left tubal endometriosis could be histopathologically diagnosed.

Consequently, in the diagnosis of chronic pelvic pain and AUB which cannot be detected radiologically, isolated tubal endometriosis must be taken into consideration.

REFERENCES

1. Cramer DW, Missmer SA. The epidemiology of endometriosis. *Ann N Y Acad Sci* 2002;955:11-22.
2. Jenkins S, Olive DL, Haney AF. Endometriosis: Pathogenetic implications of the anatomic distribution. *Obstet Gynecol* 1986;67:335-8.
3. James JJ, Powell MC. A case of torsion of a fallopian tube endometrioma. *Gynecol Endosc* 1996;5:301.
4. Peng T, Parmley TH, Genadry R. Endometriosis and perimenarchal tubal torsion. A case report. *J Reprod Med* 1989;34:934-6.
5. Harmanli OH, Chatwani A, Caya JG. Massive hemoperitoneum from endometriosis of the fallopian tube. A case report. *J Reprod Med* 1998;43:716-8.
6. Yamamoto K, Mitsuhashi Y, Takaike T, Takase K, Hoshiai H, Noda K, *et al.* Tubal endometriosis diagnosed within one month after menarche: A case report. *Tohoku J Exp Med* 1997;181:385-7.
7. Datta S, Priddy A. Tubal endometriosis mimicking an ectopic pregnancy. *J Obstet Gynaecol* 2004;24:838-9.
8. Honoré LH, Scott JZ. Postsalpingostomy intercornual bridging with hematosalpinx, chronic salpingitis and perisalpingeal endometriosis. A case report. *J Reprod Med* 1992;37:221-2.
9. Ohara N, Narita F, Murao S. Isolated torsion of haematosalpinx associated with tubal endometriosis. *J Obstet Gynaecol* 2003;23:453-4.

10. Ozturk E, Ugur MG, Aydın A, Kalaycı's H. Intraluminal tubal endometriosis mimicking hydrosalpinx: Report of an unusual case. *Int Med J* 2010;9:43.
11. Chakrabarti I, Ghosh N. Post-salpingectomy endometriosis: An under-recognized entity. *J Midlife Health* 2010;1:91-2.
12. Fedele L, Bianchi S, Raffaelli R, Portuese A. Pre-operative assessment of bladder endometriosis. *Hum Reprod* 1997;12:2519-22.
13. Zawin M, McCarthy S, Scoutt L, Comite F. Endometriosis: Appearance and detection at MR imaging. *Radiology* 1989;171:693-6.

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