

Case Report

Laparoscopic Repair of a Post-Myomectomy Spontaneous Uterine Perforation Accompanied by a Bizarre Tumor Resembling Polypoid Endometriosis

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ABSTRACT Among various long-term complications after previous myomectomy, increasing risk of uterine rupture or dehiscence during pregnancy, and in particular during labor, has been widely recognized. In contrast, the world literature includes no case report of spontaneous uterine perforation or rupture after myomectomy in a nonpregnant woman, and only 1 case of iatrogenic uterine perforation after uterine artery embolization has been reported. Recently, we encountered an extremely rare case of spontaneous uterine perforation after previous myomectomy accompanied by a bizarre tumor resembling polypoid endometriosis, which was successfully treated via laparoscopic surgery. The patient reported genital bleeding and lower abdominal pain. Preoperative magnetic resonance imaging and intraoperative findings clearly demonstrated the presence of a uterine wall defect and a multicystic tumor that had developed from the perforated portion of the uterus. The patient underwent successful laparoscopic surgery for repair of the perforated uterus and resection of the tumor. The clinicopathologic diagnosis of the tumor was tentatively confirmed as an endometriosis-like lesion resembling polypoid endometriosis. We speculate that the cause of the tumor was retrograde menstruation, as in the pathogenesis of endometriosis. *Journal of Minimally Invasive Gynecology* (2013) 20, 912–916 © 2013 AAGL. All rights reserved.

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Uterine leiomyomas are the most common tumors of the uterus and the female pelvis [1]. Abdominal, laparoscopic, or hysteroscopic myomectomy is primarily performed in patients with symptomatic uterine leiomyomas who desire future fertility [2]. Long-term major concerns after myomectomy include serious complications such as postoperative pelvic adhesions, which may cause infertility; chronic pelvic

pain; intestinal obstruction; increased risk of uterine rupture during a subsequent pregnancy; and recurrence of uterine leiomyomas, requiring repeat operation [1]. Uterine scar rupture or dehiscence is an established complication after myomectomy [3]; however, almost all previously reported cases have been related to pregnancy. Recently, we encountered an extremely rare case of spontaneous uterine perforation after previous myomectomy in a nonpregnant woman. Furthermore, the uterine perforation was accompanied by a relatively large multicystic tumor resembling polypoid endometriosis, which was successfully treated via laparoscopic surgery. To our knowledge, there has been no previous case report of spontaneous uterine perforation after myomectomy in a nonpregnant woman, and only 1 reported case of iatrogenic uterine perforation with extensive uterine necrosis at the location of a previous myomectomy after uterine artery

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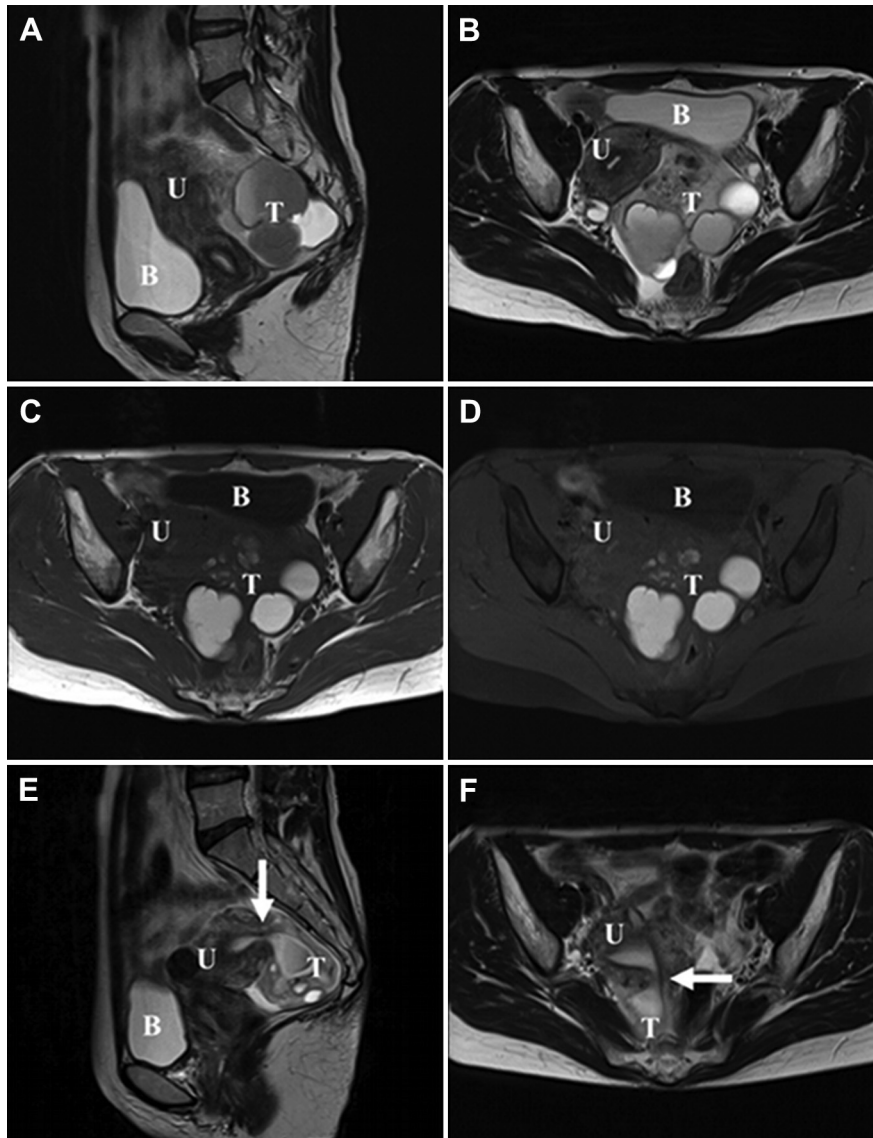
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Fig. 1

Findings at preoperative magnetic resonance imaging. Sagittal T2-weighted images (A and E), transverse T2-weighted images (B and F), transverse T1-weighted image (C), and transverse fat-saturated T1-weighted image (D). (A–D) Magnetic resonance images reveal a 10-cm multicystic tumor located immediately left-dorsal to the normal-sized uterus. The cystic tumor demonstrates high signal intensity on a T2-weighted image (A), a T1-weighted image (C), and a fat-saturated T1-weighted image (D). These findings are like those of endometriotic cysts. (E and F) Magnetic resonance images clearly reveal the presence of a uterine wall defect at the location of a previous myomectomy (arrow), and the tumor arises from the perforated part of the uterus. B = bladder; T = tumor; U = uterus.



embolization in a nonpregnant woman [4]. Herein, we present the clinical course in our patient and review the literature on this condition.

Case Report

A 38-year-old unmarried woman came to our hospital because of atypical genital bleeding after every menstrual period and dull lower abdominal pain for >6 months. She had previously undergone an abdominal myomectomy. Three

years previously, she underwent an operation for removal of 2 dumbbell-shaped uterine leiomyomas, a 3-cm intramural lesion and a 3-cm submucosal lesion located at the fundus of the uterus. During this operation, the uterine myometrium was incised into the uterine cavity at the fundus of the uterus and was repaired using 2-layered interrupted closure with absorbable sutures. At the initial visit, vaginal examination revealed a fist-sized elastic mass located immediately left-dorsal to the normal-sized uterus, and transvaginal ultrasonography demonstrated a large multicystic tumor with a solid

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