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Large cavernous hemangioma of the adrenal gland: Laparoscopic treatment. Report of a case

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ABSTRACT

INTRODUCTION: Cavernous hemangioma of the adrenal gland is a rare benign tumor. The diagnosis is often postoperative on histological exam with the presence of blood-filled, dilated vascular spaces.
PRESENTATION OF CASE: We report the clinical case of a 49 years-old woman who came to our observation with aspecific abdominal pain. A computed tomography (CT) abdominal scan revealed a 11 cm right adrenal mass. This lesion was well circumscribed, round, encapsulated. After iodinated-contrast we observed a progressive, inhomogeneous enhancement without evidence of active bleeding and with pre-operative diagnosis of adrenal hemangioma. Laparoscopic adrenalectomy was performed by a transperitoneal flank approach. Pathological examination revealed a 11 cm adrenal mass with extensive central necrotic areas mixed to sinusoidal dilation and fibrotic septa. Postoperative diagnosis was adrenal hemangioma.
DISCUSSION: Adrenal hemangiomas occur infrequently. Generally these adrenal masses are non-functioning and there is no specific symptoms. Recent records demonstrate that laparoscopic adrenalectomy is technically safe and feasible for large adrenal tumors, but controversy exists in cases of suspected malignancy. We choose laparoscopic approach to adrenal gland on the basis of preoperative CT abdominal scan that excludes radiological signs of adrenocortical carcinoma (ACC) such as peri-adrenal infiltration and vascular invasion.
CONCLUSION: Laparoscopic adrenalectomy is considered the standard treatment in case of diagnosis of benign lesions. In this case report we discussed a large adrenal cavernous hemangioma treated with laparoscopic approach. Fundamental is the study of preoperative endocrine disorders and radiologic findings to exclude signs of malignancy.
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1. Introduction

Cavernous hemangioma of the adrenal gland is a rare benign tumor. The diagnosis is often postoperative on histological exam with the presence of blood-filled, dilated vascular spaces. These adrenal masses are usually non-functioning and the clinical presentation is usually incidental with no specific abdominal symptoms. Johnson and Jeppesen published the first report of adrenal hemangioma in 1955 [1] and today there are about 90 cases documented in literature.

2. Presentation of case

We report the clinical case of a 49 years-old woman who came to our observation with aspecific abdominal symptoms like acute epigastric pain, nausea and vomiting. She had never experienced similar pain in the past and the symptoms were progressive. She had hypertension but no other comorbidities [2]. We performed routine blood tests (Hb 13.2 g/dl, WBC 11000). On clinical examination, the patient had significant pain in epigastric and right flank region, but there were no signs of acute cholecystitis or peritonitis. So, we decided to perform a computed tomography (CT) abdominal scan that revealed a 11 cm right adrenal mass. This lesion was well circumscribed, round, encapsulated. After iodinated-contrast we observed a progressive, inhomogeneous enhancement without

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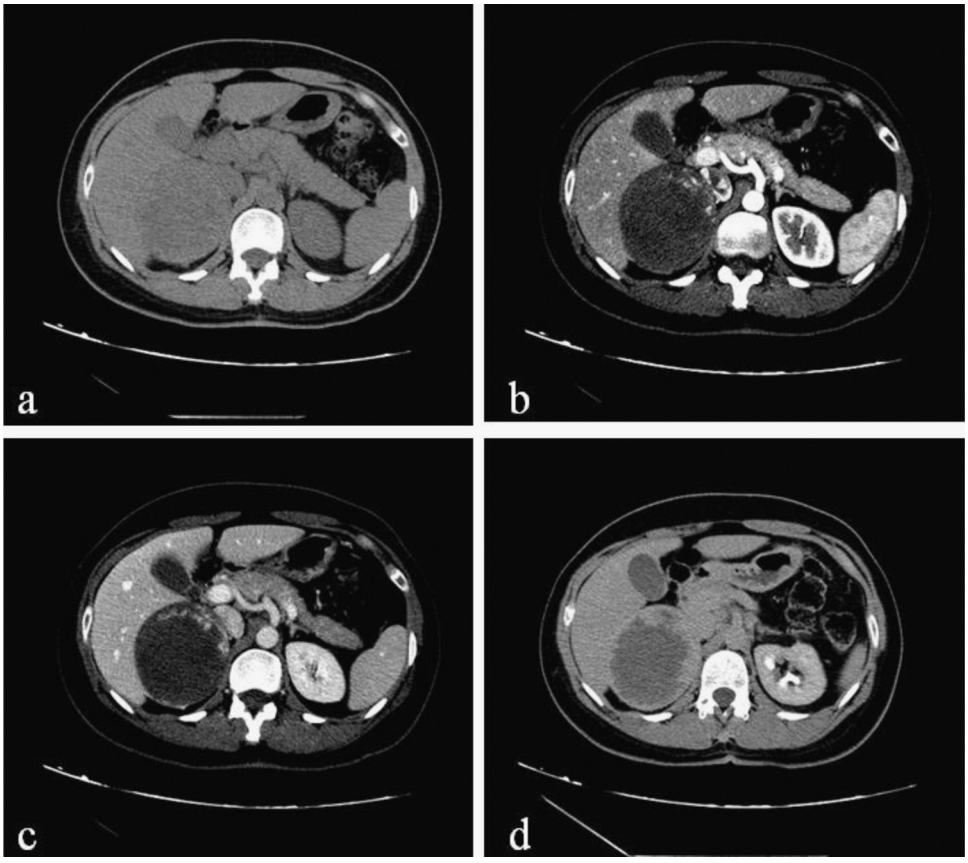

Fig. 1. (a) noncontrast-enhanced CT scan showing encapsulate large right adrenal lesion with regular margins; (b–d) contrast-enhanced CT images obtained in arterial, portal and late phase, 3 min after iodinated contrast administration, showing a hypodense centre with no infiltration of peri-adrenal organs.

evidence of active bleeding and with pre-operative diagnosis of adrenal hemangioma (Fig. 1) [3]. The left adrenal gland was normal and there were no others significant radiologic findings. Abdominal magnetic resonance imaging (MRI) was not performed in this patient. The patient did not have clinical features suggestive of a functioning adrenal tumor, but we however performed complete hormonal tests. The diagnosis of pheochromocytoma was excluded with normal levels of urinary catecholamines on 24 h collection [4]. The only size of lesion was not considered a contraindication to laparoscopic approach, but we considered the possibility of conversion to open surgery in case of peri-adrenal infiltration or vascular invasion. Laparoscopic adrenalectomy (LA) was performed by a transperitoneal flank approach in the left lateral decubitus position with an inclination of 50–60° relative to the operating table which is broken to extend the space between the last rib and the iliac crest [5]. We used Veress needle to induce pneumoperitoneum

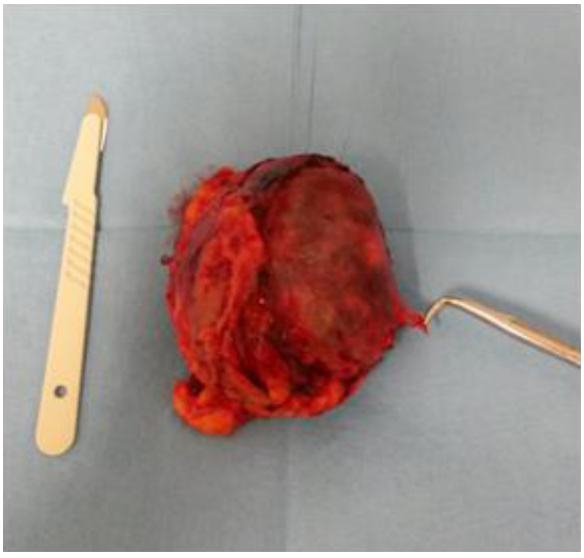

Fig. 2. Resected adrenal gland with a smooth surface and adrenal vein.

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