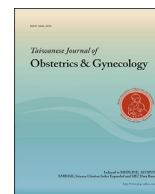




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## Case Report

## A case of rapidly-growing atypical polypoid adenomyoma which was histologically diagnosed before operation and removed by a laparoscopic resection

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## ABSTRACT

**Objective:** Atypical polypoid adenomyoma (APAM) is an epithelial-mesenchymal mixed tumor which often develops in the uterine cavity of reproductive age women, requiring preservation of the reproductive functions. Preoperative endometrial biopsy may not yield histological diagnosis as the tumor is a solid smooth muscle tumor. The standard treatment option is a hysteroscopic resection for the diagnosis and the treatment at the same time.

**Case report:** We report a case of rapidly-growing APAM successfully diagnosed preoperatively via transcervical punch biopsy followed by a laparoscopic resection. The mass was relatively large, had been located in the lower segment of the uterus, and the area of contact with the muscular layers was large. It was a complete removal and no recurrence had been observed 9 months after the operation.

**Conclusion:** This is the first report of APAM treated by laparoscopic resection. The method may be a useful alternative when hysteroscopic surgery is inappropriate.

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## Introduction

Atypical polypoid adenomyoma (APAM) is a benign disease of epithelial-mesenchymal mixed tumor which develops in the uterine cavity. The first report was made in 1981 by Mazur MT [1]. Hysteroscopic resection is the main stay for the diagnosis and treatment. However, the secondary resection may have to be performed in case if the primary resection had been incomplete [2,3]. This is a case report of a rapidly-growing APAM which was histological diagnosed preoperatively followed by a laparoscopic resection.

## Case report

The patient was a 37-year old nulliparous woman with height of 158 cm and body weight of 63.8 kg. There was no remarkable past

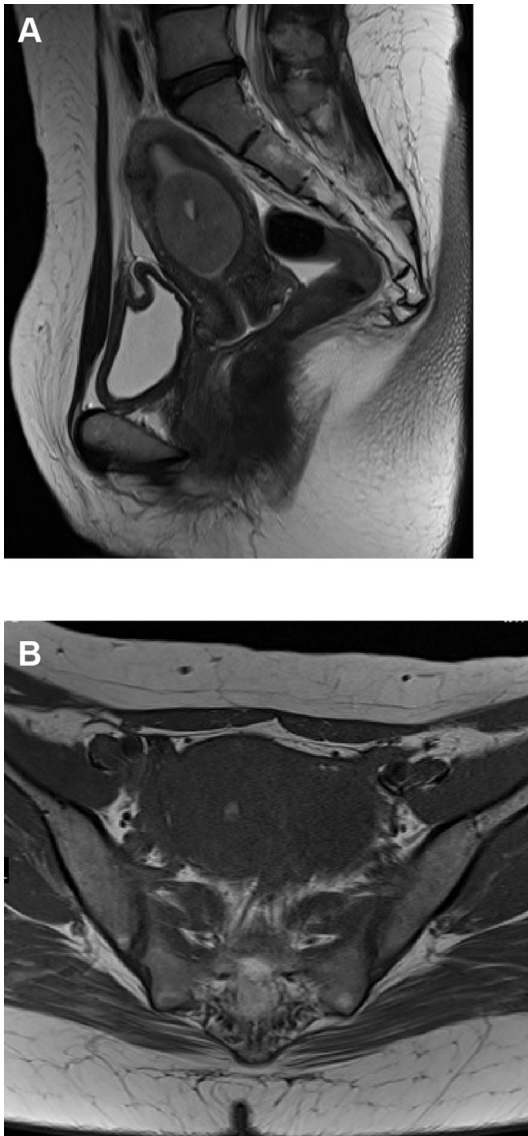
medical history. She had been under regular check-up for fibroid at a nearby clinic for the past 4 years. She visited our clinic for the first time with a chief complaint of irregular vaginal bleeding. Internal examination showed uterine body mass. Transvaginal ultrasonography revealed the mass size of 50 mm at low intensity of subserosal location and another mass of 20 mm with high intensity in the submucosal location. MRI confirmed a subserosal myoma of 52 × 38 mm and a sub-mucosal myoma of 20 × 20 mm. We recommended hysteroscopic resection but she declined. After 3 months of observation, the subserosal mass showed no significant growth but the diameter of the submucosal mass had been increased to 40 mm (Fig. 1). The patient therefore had another MRI. A mass of 41 × 34 × 31 mm was detected inside the uterine cavity at slightly high intensity in a T2-weighted image and at high intensity in a T1-weighted image with some blood components (Fig. 2 A, B). The result of endometrial cytology was negative. The level of CA125 was 13 U/ml and CA19-9 was 13 U/ml and was both within a normal range. In order to obtain adequate specimen to establish diagnosis, the cervix was dilated and the punch biopsy of the submucosal mass was performed. The material showed irregular growth of the glandular tissue in the interstitial tissue consisting of spindle cells.

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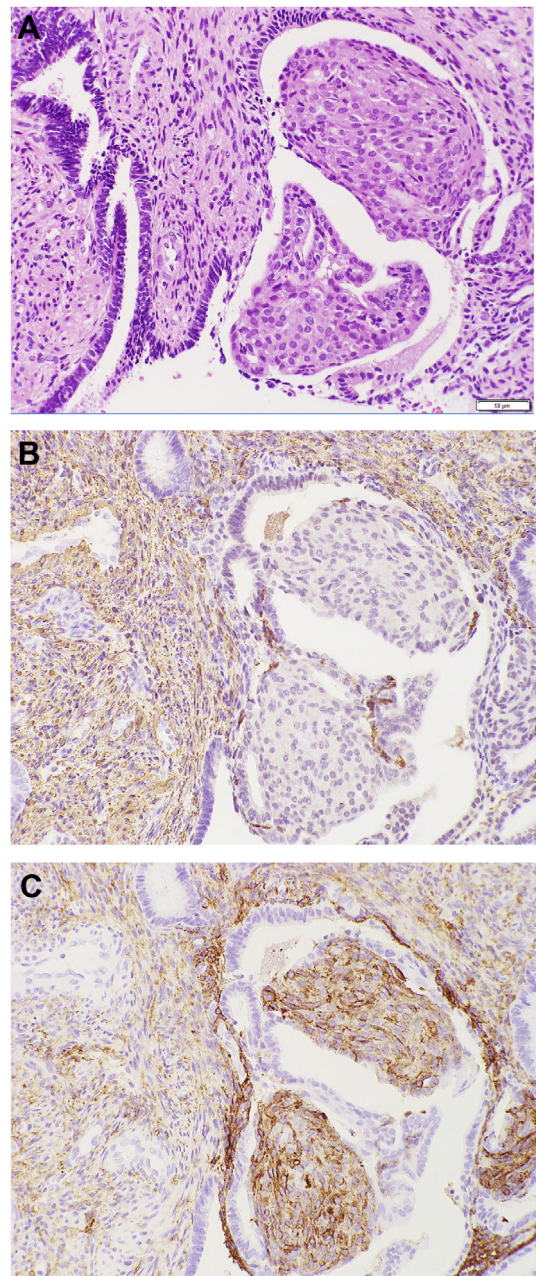
**Fig. 1.** The sagittal section of transvaginal ultrasonography. A mass of 40 × 32 mm was detected at low intensity in the lower segment of the uterus.



**Fig. 2.** Pelvic MRI images (A: T2 weighted image, sagittal section, B: T1 weighted image, horizontal section). The mass was located in the uterine cavity with slightly high intensity on T2 weighted image and low intensity on T1 weighted image. There was a high intensity area inside the mass on T1 weighted image.

Also squamous cell-like morula was observed in some glandular tissues (Fig. 3A). Those spindle cells were immunohistochemically stained with SMA. The endometrial stroma and morula were strongly positive for CD10 (Fig. 3 B, C). These pathological results suggest APAM. In hysteroscopy, a mass protruding in the lower segment of the uterus was observed. The base of the mass was widely in contact with the uterine wall, and no peduncle was found. As it appeared difficult to have a clear visual field and detect the border between the mass and the muscular layers in hysteroscopic approach, we decided the resection by a laparoscopic surgery.

After obtaining consent, laparoscopic surgery was performed with pneumoperitoneum using 4 ports (the parallel method) under general anesthesia. We first resected the subserosal myoma on the posterior wall of the uterus. Then the uterine manipulator



**Fig. 3.** Pathological findings. A: HE stain, ×200. Squamous cell-like morula was observed in the interstitial tissue consisting of spindle cells. B: SMA stain, ×200. SMA, which indicates smooth muscle cells, was positive in the interstitial tissue. C: CD10 stain, ×200. The endometrial stroma and morula were strongly positive for CD10.

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