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Case Report

Gastric wall endometriosis in a postmenopausal woman

Abdallah A.A. Mohamed^{a,*}, Yasser A.R.M. Selim^{a,1}, Mazin A. Arif^{b,2}, Said A. Albroumi^{b,2}^a Radiology Department, Nizwa Hospital, P.O. Box 1222, Nizwa PC 611, Oman^b General Surgery Department, Nizwa Hospital, P.O. Box 1222, Nizwa PC 611, Oman

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ABSTRACT

Endometriosis is the presence of endometrial tissue outside of the uterus. It is common in women of childbearing age, and is frequently located in the pelvic cavity. Approximately 10% of endometriosis cases occur in extrapelvic locations. However there are few reports of gastric wall endometriosis. Here, we report a rare case of endometriosis in postmenopausal woman. The patient presented with epigastric pain. The investigations included ultrasound (US) and contrast enhanced computed tomography (CECT) where she was diagnosed with gastric wall neoplasm. She underwent surgery where the mass was excised. The histopathological examination surprisingly came with the diagnosis of gastric wall endometriosis.

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1. Introduction

Endometriosis is identified as the presence of endometrial tissue in an ectopic location outside of the endometrial cavity. It is a benign chronic gynaecological disorder which may be associated with infertility. The disease is oestrogen-dependent that usually affects women in reproductive age. The prevalence of pelvic endometriosis is approximately 6–10% [1]; however, the presence of extrapelvic endometriosis is seen only in 10% of all diagnosed cases. The prevalence of endometriosis in postmenopausal women can affect 2–5% [2] and usually as a side effect of hormonal therapy and it is rare to present in postmenopausal women without history of hormonal therapy [3].

Extrapelvic endometriosis frequently includes the intestines, kidneys, lungs, skin, and pleura [4]. Gastrointestinal tract (GIT) endometriosis accounts for almost 5% of cases, with the sigmoid colon and rectum being the most commonly affected locations [5].

Here we report a case of gastric endometriosis that presented as a gastric neoplasm in postmenopausal woman with no history of exogenous hormonal therapy.

2. Case report

A 60 year old female patient presented with increasing epigastric pain and left loin pain associated with nausea since long time. She is a known hypertensive on regular medications. She has chronic epigastric pain since long time for which she underwent upper GI endoscopy in February 2014 which revealed diffuse gastritis, and the patient received full regimen proton pump inhibitors with little improvement. No family history of special importance. A physical examination revealed mild epigastric and left loin tenderness, not dyspneic or tachypneic. Chest was clear. BP was 130/80 mm/Hg, temperature was 36.8 °C, and her biochemical and haematological markers

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* Corresponding author. Fax: +968 25211914.

E-mail addresses: abdallahahmed@gmail.com (A.A.A. Mohamed), arazekyasser@gmail.com (Y.A.R.M. Selim), mazararif@hotmail.com (M.A. Arif), broumi2000@gmail.com (S.A. Albroumi).

¹ Fax: +968 25211914.

² Fax: +968 25211909.

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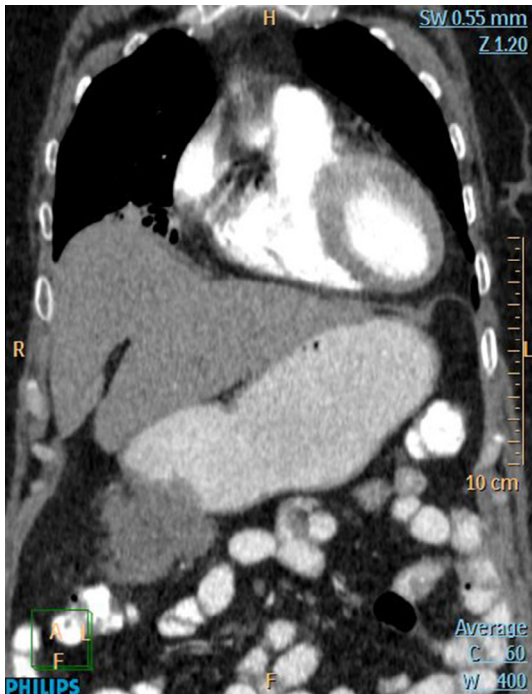


Fig. 1. CECT of the abdomen and pelvis in coronal plan, shows gastric antral wall mass lesion with inhomogeneous enhancement.

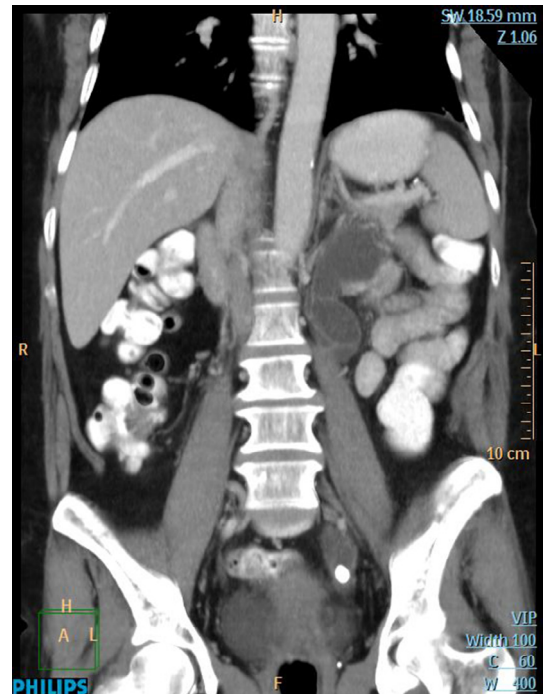


Fig. 3. CECT of the abdomen and pelvis in coronal reformat, shows left lower ureteric stone with subsequent moderate hydroureteronephrosis.



Fig. 2. CECT of the abdomen and pelvis in sagittal plan, shows gastric antral wall mass lesion with inhomogeneous enhancement.

were within normal limits. Abdominal ultrasonography showed gastric antral mass lesion and left ureteric stone associated with moderate hydroureteronephrosis. CECT of the abdomen and pelvis was performed which revealed a

large, irregular, inhomogeneously enhancing soft tissue mass involving the inferior wall of the gastric antrum with large exophytic component and few satellite nodules with possible involvement of transverse colon. The mass measures 4.5 cm × 6.5 cm × 4.5 cm. The impression suggested gastrointestinal stromal tumour (GIST) and Desmoid tumour on top of differential diagnosis [Figs. 1 and 2]. Also, a left lower ureteric stone with subsequent moderate hydroureteronephrosis was noted [Fig. 3].

The patient underwent exploratory laparotomy where excision of the mass with sleeve gastrectomy of the greater curvature together with partial transverse colectomy followed by resection anastomosis of the two colonic ends. The excised surgical specimen was 8 cm × 5 cm. There were also three satellite lesions in the greater omentum which had been removed with the specimen [Fig. 4].

Histopathological examination revealed extensive areas of haemorrhage and haemorrhagic necrosis. These are separated and bordered by proliferation of spindle cells and admixture of foamy macrophages and haemosiderin laden macrophages. Scanty lymphoid cells are also seen [Fig. 5]. The lesion is seen extending up to the serosa of the stomach and the colon with serositis. The spindle cells stain positively with CD 10 and SMA [Fig. 6]. They are negative for CD 117, desmin, S-100 and CD34. The diagnosis based on morphological and immunohistochemical features favours endometriosis.

3. Discussion

Endometriosis is the presence of endometrial tissue in an ectopic location outside of the endometrial cavity. It is

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