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Case Report

Parasitic leiomyoma presenting as an inguinal hernia in a postmenopausal woman

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ABSTRACT

Uterine leiomyomas are one of the most common tumors affecting reproductive-age women. Leiomyomas can present as an intrauterine mass or rarely as an extrauterine tumor. Depending on its location, the diagnosis of extrauterine leiomyoma can be challenging, and multiple imaging modalities may be needed for correct identification and differentiation from malignant entities. We report the case of a 48-year-old-postmenopausal female who presented with a painful left inguinal mass, which was clinically diagnosed as inguinal hernia. Ultrasound, computed tomography, magnetic resonance imaging, and percutaneous biopsy were used to characterize the mass. Surgical resection and histopathological analysis revealed the mass to be a parasitic leiomyoma, a very rare cause of inguinal hernia, especially in a postmenopausal woman.

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1. Introduction

Leiomyomas are common tumors which arise from the smooth muscle cells of the myometrium. They usually present as an intrauterine tumor, but may occasionally be extrauterine. The leiomyomas which evolve to lose their attachment from the uterus and become adherent to other organs (such as the broad ligament, omentum, or retroperitoneal connective tissue) and acquire blood supply from them are called

parasitic leiomyomas [1-3]. Laparoscopic hysterectomy or myomectomy has been reported to increase the risk of development of parasitic leiomyomas, due to unintentional seeding of the fragments during the procedure [3]. Parasitic leiomyomas may cause pain or symptoms from compression of adjacent structures. We present this unique case of a postmenopausal woman who presented with an inguinal swelling at an academic institution, and was diagnosed with parasitic leiomyoma. We discuss the imaging findings and the final diagnosis.

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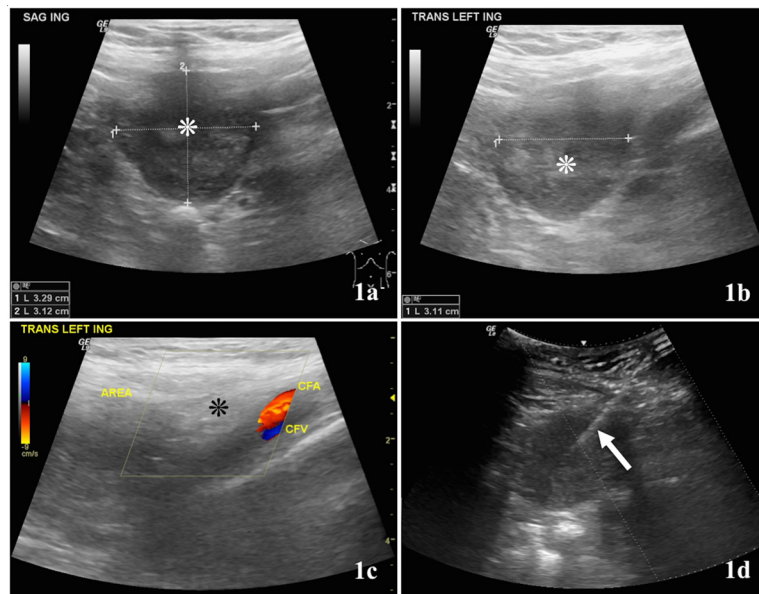


Fig. 1 – Ultrasound of the left lower quadrant of the abdomen. (a) and (b) are sagittal and transaxial US images showing the heterogenous hypoechoic left inguinal mass (asterisk). (c) shows that the mass (asterisk) is superficial to common femoral vessels (red and blue in the color Doppler box). (d) is from the US-guided fine needle aspiration showing the needle (white arrow) inside the mass. (For interpretation of the references to color in this figure legend, the reader is referred to the web version of this article)

2. Materials and methods

2.1. Patient information and clinical findings

A 48-year-old female, G2(gravida)P2(parity), was seen at the primary care clinic with complaint of a 1-year history of left lower quadrant abdominal pain. She reported having her last menstrual period about 18 months ago. Past medical history was significant for left-sided laparoscopic oophorectomy for an ovarian cyst more than 5 years before this presentation. Patient denied prior hormonal therapy. Initially, patient felt a mass in the inguinal region, only during standing and coughing, and it reduced spontaneously upon lying down. More recently, the mass was constantly present and was associated with deep pain. The pain was worse with coughing and walking. Physical examination showed a firm palpable mass, about 4 cm in size, in the left inguinal region, which was tender and irreducible. The overlying skin was normal and no inguinal adenopathy was present.

2.2. Diagnostic assessment

A left lower quadrant ultrasound (US) was performed which demonstrated a well demarcated, hypoechoic, solid mass in the left inguinal region, superficial to the common femoral vessels (Fig. 1). Pelvic ultrasound was also performed which showed a normal uterus with an endometrial stripe of 6 mm, and a normal right ovary. Lymphadenopathy, inguinal hernia, and a soft tissue tumor were considered as possibilities and further evaluation with computed tomography (CT) or Mag-

netic resonance imaging (MRI) was recommended. CT of the abdomen and pelvis (performed with intravenous and oral contrast) showed a solid soft tissue density mass in the left side of pelvis, measuring 4.4×3.3 cm. The mass extends into the left inguinal canal, lateral to the inferior epigastric vessels, and with blood supply from the left broad ligament vessels (Fig. 2). MRI was performed for better intralesional characterization, and demonstrated the well-defined, solid left pelvic mass, hypointense to the uterus on T1-weighted images, no signal drop on fat-saturated images and out of phase images (ruling out macroscopic and microscopic fat respectively), low signal on fat-saturated T2-weighted images with scattered foci of high T2 signal inside the tumor, and with avid contrast enhancement (Fig. 3). Patient was referred to interventional radiology for image-guided biopsy. An US-guided biopsy was performed (Fig. 1) and multiple fine needle and core biopsy samples were obtained. Cytology showed fibrous connective tissue, fibroadipose tissue, and disorganized bundles of smooth muscle. The lesion was reported as possibly leiomyoma, and complete excision was recommended for definitive diagnosis.

2.3. Therapeutic intervention and follow-up

Under general anesthesia, and using a midline laparotomy incision from below the umbilicus to the pubic symphysis, the left inguinal region was accessed. The mass was palpated in the left inguinal canal and then reduced back to the abdominal cavity by manual palpation. There were a few abnormal-appearing lymph nodes near the area of the mass in the left pelvic region and these were dissected out. Other

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