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## Case Report

# Massive endometrioma presenting with dyspnea and abdominal symptoms

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## ARTICLE INFO

## Article history:

Received 27 February 2017

Received in revised form 18 June 2017

Accepted 18 June 2017

Available online

## Keywords:

Abdominal mass

Endometrioma

Endometriosis

Cystadenoma

## ABSTRACT

An abdominal mass may present with a myriad of symptoms resulting from compression of surrounding organs. A major clinical challenge with practical implications is accurate preoperative identification of the origin of the mass. Here, we present the case of a 29-year-old female patient with abdominal distension and shortness of breath for approximately 6 weeks before presentation. A large abdominal mass compressing the surrounding organs was observed on abdominal x-ray and computed tomography of the abdomen and pelvis. Preoperative imaging was unable to identify the organ of origin; pathologic and histologic analyses of the tumor ultimately identified a rare, massive intra-abdominal endometrioma, freely floating within the peritoneum and fed by an omental blood supply. This case highlights the importance of considering an atypical presentation of endometriosis in women of reproductive age with abdominal complaints.

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## Introduction

Abdominal distension, early satiety, and compression of adjacent organs may indicate the presence of an intra-abdominal mass. The primary objective in diagnosis of an abdominal mass is identifying the organ of origin, which may prove a significant challenge preoperatively [1,2]. Histologic classification has classically divided abdominal masses by their lineage of origin, whereas radiologic studies in the past have focused on the

degree of complexity on imaging, such as simple cystic, complex cystic, and cystic with solid components. These distinctions not only allow for radiologic classification but also suggest certain diagnoses and help guide clinical management [3]. The likelihood of specific etiologies depends on age [4–6], sex of the patient, the organ from which the mass originated, and the imaging characteristics of the mass.

In female patient, both gastrointestinal and gynecologic etiologies must be considered in the differential diagnosis of an abdominal mass [2]. This is an important distinction because

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<http://dx.doi.org/10.1016/j.radcr.2017.06.009>

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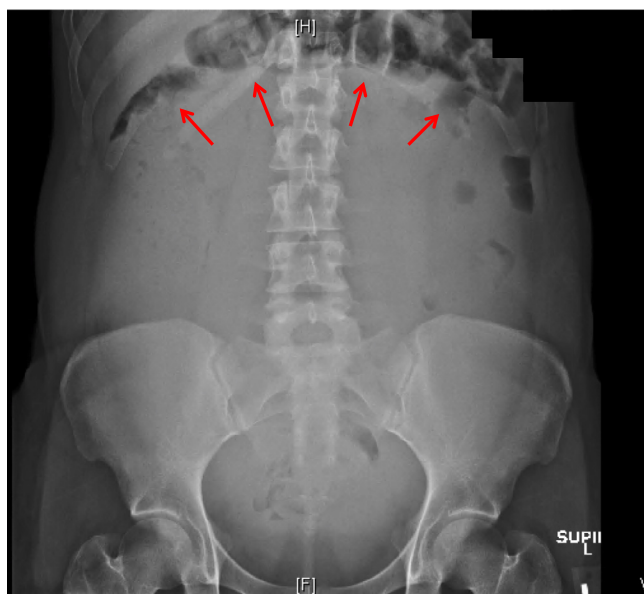
it will dictate the specialists involved in medical and surgical management pre- and post-operatively. Here, we discuss a unique case of a patient presenting with a large, space occupying mass whose site of origin could not be identified radiologically before surgical intervention.

## Case report

A G0P0 29-year-old woman with a medical history significant for a *Helicobacter pylori* negative gastric ulcer 2 years before presentation, chronic gastroesophageal reflux disease, and chronic dysmenorrhea presented to her primary care physician with an approximate 1-month history of increasing abdominal distension, unintentional weight gain, early satiety, postprandial abdominal pain, and increasing shortness of breath. Physical examination demonstrated significant abdominal distension, and she was referred to a gastroenterologist for further evaluation.

After evaluation by the gastroenterologist, the patient was sent for an obstructive series consisting of 2 abdominal x-rays, taken supine and erect, secondary to concern for obstipation (Fig. 1). The images demonstrated a large pelvoabdominal soft tissue mass with cranial displacement of the transverse colon draping over the large mass.

Based on these results, a computed tomography (CT) was obtained. It demonstrated a large, cystic, space occupying mass that extended from the substernal to suprapubic regions, measuring 22.9 cm craniocaudally, 12 cm anterior-posterior, and 22.3 cm transversely (Figs. 2 and 3). No discrete solid components or septations were observed in the mass. These images demonstrated posteriorly displaced intestines and hydronephrosis of the right kidney (Fig. 2).



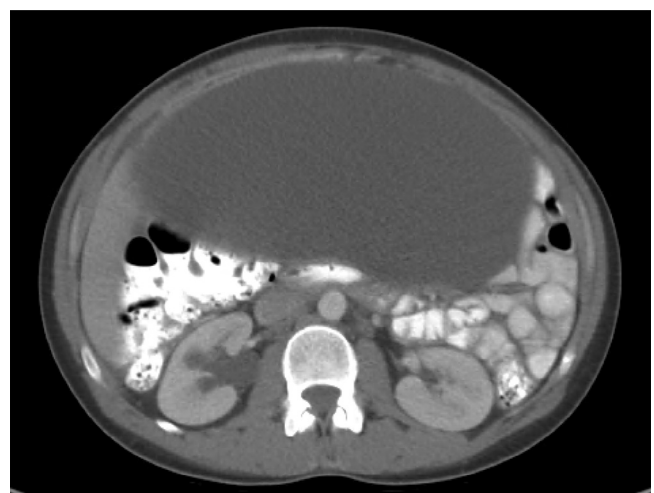
**Fig. 1** – Obstructive series abdominal x-ray. Supine abdomen shows pelvoabdominal soft tissue mass displacing transverse colon superiority (arrows).

A 6.4 cm × 6.0 cm × 7.0 cm mass of unclear origin abutting the uterus was also found, which was thought to represent either a pedunculated fibroid or an ovary (Fig. 3A-C). There was also heterogeneous enhancement of the uterus with multiple masses and some cystic areas, consistent with multiple uterine fibroids (Fig. 3A, C). Additional incidental findings included a 2.0 mm lung nodule in the right lower lobe, multiple low-attenuation cysts within the liver, a 1.1 cm renal cyst in the right kidney, and mild fullness in the left renal collecting system.

Based on these radiologic findings, the decision was made to remove the mass by open laparotomy with a presumptive preoperative diagnosis of benign serous or mucinous cystadenoma of the ovary. Of note, preoperative blood work demonstrated an elevated CA-125 of 108.4, normal CA-19-9 of 17.4, and carcinoembryonic antigen (CEA) of <0.5. Because of the patient's age and desire to retain childbearing ability, the patient was not consented for hysterectomy. Preoperative discussion included the possibility of performing a second surgery including unilateral or bilateral oophorectomy and/or salpingohysterectomy if needed based on findings during the initial surgery.

On laparotomy, the mass was found to have a blood supply originating in the greater omentum. It was removed without incident along with part of the greater omentum. Based on this finding, the larger mass was labeled an omental cyst.

The mass abutting the uterus appeared consistent with a pedunculated fibroid intraoperatively, and it was attached by a pedicle to the uterus. It was also removed without incident, and a leiomyoma was subsequently confirmed by pathologic analysis. Both ovaries were identified and were normal. The operation was completed, and the patient was discharged on hospital day 3. She recovered without any significant complications and with total resolution of her preoperative symptoms.



**Fig. 2** – Computed tomography (CT) of the abdomen and pelvis demonstrating large cystic intra-abdominal tumor causing mass effect. Axial oral and intravenous contrast-enhanced CT image through the middle renal level shows the fluid-filled mass extending into the upper abdomen. The mass is displacing bowel loops. There is right-sided hydronephrosis.

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