Case Report

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Accessory Caveatted Uterine Mass: A Case Report

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ABSTRACT

Accessory caveatted uterine mass (ACUM) represents a new variety of müllerian anomaly that is usually located at the level of insertion of round ligament and is probably related to a dysfunction of female Müllerian duct. ACUM is described in literature as an accessory isolated caveatted uterine mass which is lined by endometrium but with no communication to normal uterine cavity. Usually it protrudes from a normally shaped and functional uterus and mostly is located on lateral uterine wall below the insertion of round ligament. Till now this condition is not included in ESHRE Classification system and because of this it is not so commonly diagnosed, these patients are usually presented with severe dysmenorrhea and chronic pelvic pain and some report showed coincidence of ACUM and endometriosis in 5-6% of patients which are usually less than 30 years old [1].

ACUM needs to be differentiated from other similar conditions such as

1. Rudimentary and caveatted uterine horns
2. Adeno-myosis with cystic or degenerated areas.
3. Essential and primary dysmenorrhea.
4. Degenerated fibroids.

So proper diagnosis and raised awareness of ACUM can lead to earlier access to treatment.

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Received: September 15, 2020; **Accepted:** September 25, 2020; **Published:** October 20, 2020

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Mrs ABC, 30YR old patient married since 11 years para 2 having 2 living children's. Last child birth was 18 months back by cesarian section done for breech presentation, she had complaints of dysmenorrhea on and off since 5 years taking symptomatic treatment. Patient was operated for right ovarian ectopic pregnancy in 2017, exploratory laparotomy done HPR s/o decidual tissue.

For the complaints of severe dysmenorrhea pt underwent ultrasonography on 24.01.2020 which suggested anteverted uterus, bicornuate, with collection in left cornua 3.8 x 2.4 x 3.5 cm with internal echoes and minimal free fluid in pelvis.

As there was no pain relief even after taking symptomatic treatment another USG we repeated suggest 11.06.2020 Bicornuate uterus with hypo echoic collection with thick echoes 4.1 x 3.8 x 3.8 cm in endometrial cavity of left horn.

On Examination

Per abdominal examination suprapubic mass palpable ~12-14 weeks size and deviated to left side.

Per speculum single cervix.

On bimanual examination uterus size was 12-14 weeks/deviated to left / non tender / mobile.

Considering this findings decision to go for diagnostic laparoscopy and SOS surgical management was discussed with patients and relatives.

After routine investigations and pre-operative fitness hysteroscopy done which showed single uterine cavity and single Ostia, 10 mm supra umbilical port placed which showed left large uterine horn look-ing like large fibroid so decision to go for exploratory laparotomy and surgical excision of cavitary mass or myomectomy was taken at intra-operative stage small incision taken on tense part of mass which caused escape of hematometra fluid approximately 100 cc of chocolate coloured fluid,so after confirmation complete enucleation and removal of mass done and sent for histopathology.

Discussion

As we have earlier seen ACUM represents a new verity of mullein anomaly that is usually located at the level of insertion of round ligaments and may it be related to dysfunction of female Gebernacu-lum. This mullerian anomaly is not yet classified by ESHRE [2]. So it is still under diagnosed, if it is more readily diagnosed and identified properly it will help to prevent the constant suffering of the women with dysmenorrhea.

Presently following criteria is being used to diagnose ACUM.

1. An isolated accessory caveatted mass.
2. Normal uterus,fallopian tubes and ovaries.
3. A surgical case with an excised mass and pathological examination.
4. An accessory cavity lined by endometrium, epithelium with glands with storm
5. Chocolate brown coloured fluid content.
6. No Adenomyosis.

Clinically this condition is diagnosed frequently in women less than 30years of age, nulliparous wom-en having severe dysmenorrhea and chronic pelvic pain. This condition can also be found in multipa-rous women and more than 30 yrs of age. This can be diagnosed with strong clinical suspicion in young women with severe dysmenorrhea that is progressive since menarche and chronic pelvic pain that persists during pre and post menstrual period and usually does not respond to common analgesics [3]. These patients usually had a history of repeated visits to emergency departments.

Occasionally the pain and discomfort associated with adolescent dysmenorrhea became more intense and unbearable during adulthood and sometimes after childbirth but severe dysmenorrhea generally occurs before 30 yrs of age. On clinical examination of these patients there is abdominal supra-pubic bulge that is palpable and in married women bimanual examination shows a nodule or mass on right or left side of uterus.

Transvaginal ultrasound and Transrectal ultrasound in unmarried women is used to diagnose this con-dition with certainty, it may detect a myopia or a Nodule and sometimes there can be cavitation seen in the centre of this mass resembling endometrio-ma and this fluid has "Ground Glass echogenicity" and is surrounded by myometrium.

3-D USG identifies uterine cavity with normal shape with normal ovaries and fallopian tubes.

hematometra in horn

HSG needs to be performed to rule out possibility of non communicated caveatted rudimentary uter-ine horn.

In some cases MRI pelvis will show an accessory endometrial cavitation in endometrium and this cavi-tation does not communicate with uterine cavity and appear super-intense on T1 as hematometra [4].

Diagnostic hysterolaparoscopy is considered after the diagnosis and it will confirm and treat at the same time.

Hystroscopy single ostia

Best therapeutic approach is to do tumorectomy. This can be done either by exploration, laparoscopi-cally or laparoscopic with

robotic assistance [5]. Laparotomy gives an advantage to assist in complete enucleation of tumour and perfect closure and also helpful when the tumour mass is located inside the myometrium at lateral side or in a broad ligament.

HISTOPATHOLOGY	
SLIDE NO	: ASV 178/20
SPECIMEN	: Excised accessory horn of Uterus
GROSS EXAMINATION	: Received in formalin single oval greyish white mass measuring 6.0*3.5*3.0 cms.
	: Cut section shows greyish white appearance with central elongated cavity (mimics endometrial canal).
MICROSCOPIC EXAMINATION	: H/E sections show mass lined by columnar epithelial cells of endometrial tissue with stroma and surrounded by smooth muscle.
	: Few areas of calcification also seen.
	: There is no evidence of dysplasia or malignancy seen in the sections examined.
IMPRESSION	: Above histopathological features are suggestive of Accessory Uterine horn.
NOTE	: Above histopathological features are correlated with Gross appearance, USG appearance, Intraoperative pictures of specimen and clinical history Hence, labelled as Accessory Uterine horn.
REMARK	: Kindly correlate with clinical findings

Histo-Pathology Report:

Conclusion

ACUM is uncommon Mullerian uterine anomaly not yet classified by ESHRE, but from various recent publications it appears that this pathology is not very rare as thought previously [6]. With strong clinical suspicion, history taking, examination and guided investigations such as 3-D USG, or MRI, and hysterolaparoscopy will help to promote an earlier access to treatment.

Early surgical treatment will help in alleviating troublesome symptoms and includes adequate removal of cavitary mass using laparoscopy or by doing laparotomy and as far as possible it is safe to recommend the mass removal from anterior aspect of uterus as it appears to be safe [7].

References

1. Grimbizis GF, Gordts S, Di Spezio Sardo A, Brucker S, De Angelis C, et al. (2013) The ESHRE/ESGE consensus on the classification of female genital tract congenital anomalies. Hum Reprod (Oxford England) 28: 2032-2044.
2. Acien P, Acien M, Fernandes F, Jose Mayol M, (2010) The cavitated accessory uterine mass. a Mullerian anomaly in anomaly in women with an otherwise normal uterus. Obstet Gynecol 116: 1101-1109.
3. Garofalo A, Alemanno MG, Sochirca O, Pilloni E, Garofalo G, et al. (2017). Accessory and caveated uterine mass in an adolescent with severe dysmenorrhea. From ultrasound diagnosis to surgical treatment. J Obstet Gynecol 37: 259-261.
4. Jain and Verma R (2014) Imaging Diagnosis of accessory and caveated uterine mass, a rare mullerian anomaly, Indian J Radiol Imaging 24: 178-181.
5. Persson J, Bossmer T, Teleman P (2010) Robot-assisted laparoscopic surgery for a rudimentary uterine horn with two non communicating cavities. J Robot Surg 4: 137-140.
6. Bedaiwy MA, Henry DN, Elguero S, Pickett S, Greenfield M (2013). Accessory and caveated uterine mass with functional endometrium in an adolescent; diagnosis and laparoscopic excision technique. J Pediatr Adolesc Gynecol 26: e89-e91.
7. Peters A, Rindos NB, Guido RS, Donnelley NM, (2018). Uterine sparing laparoscopic resection of accessory caveated uterine masses. J Minim Invasive Gynecol 25: 24-25.

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