Case Report

Adenomatoid tumor of uterus - A rare Leiomyoma mimicker

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Introduction

We report a case of adenomatoid tumor of the uterus in a patient with bad obstetric history who underwent myomectomy with a diagnosis of fibroid. Adenomatoid tumor is an uncommon slow growing tumor of mesothelial origin which is cured by surgical excision. Macroscopically and rarely microscopically it can pose diagnostic difficulty and can even be mistakenly labeled as malignant. We are presenting this case to remind clinicians about this entity and also to stress the importance of frozen sections for evaluation during surgery.

Case Report

A 33 year old women who presented with bad obstetric history of two abortions was admitted on 26th Sept. 2006. Ultrasound scan revealed a 4 X 4 cm circumscribed echogenic mass in the myometrium, consistent with a fibroid. (Fig.1) Pre operative investigation were normal. Patient was operated on 27th Sept 2006. At laparotomy, a probable degenerated fibroid grey white, friable with

variable consistency, measuring 5X4X2 cm was removed. The postoperative period was uneventful. Patient was discharged on the 1st Oct, 2006.

Histology

Sections show a lesion composed of variably sized tubules and fenestrated channels arranged in a variably fibrous stroma with congested vascular spaces. Tubular structures are lined by either plump epithelioid cells with abundant eosinophilic cytoplasm to flattened cell resembling endothelial cells. Signet-ring like cells with apparent intracytoplasmic lumina are seen. Few inflammatory cells are seen in between. On immunohistochemical staining cells were reactive for cytokeratin and vimentin showing its mesothelial origin. Ki-67 index was very low.

Discussion

Adenomatoid tumor is a relatively uncommon benign neoplasm of mesothelial origin, usually occurring in the male and female genital tracts. It has been reported to occur in a variety of extragenital sites including the heart, intestinal mesentery, pleura, peritoneum and adrenal gland¹. The tumors may be present in upto 1% of hysterectomy specimens². CT and MR findings of these tumors simulate the findings of uterine leiomyoma and preoperative diagnosis is difficult³. Macroscopically they are usually nodular resembling a leiomyoma. Rarely diffuse tumors which can mimic malignancy, have also

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Fig 1. Ultrasonography Pictures

Fig 2. Tubules and channels lined by cuboidal and flattened cells, smooth muscle cells seen towards the left. H & E -100x

Fig 3. Tumor cells showing cytokeratin positivity –400x

Fig 4 Tumor cells showing vimentin positivity – 400x

been reported. Microscopically four types are distinguished, solid, angiomatoid, macrotubular, and mixed types. The tumor has a distinct morphology and is characterized by anatomizing and variably sized tubules lined by flattened and epithelioid cells¹. Infarcted adenomatoid tumors causing diagnostic dilemma have, been reported in other sites⁴. Immunohistochemical co-expression of cytokeratin and vimentin confirms a mesothelial histogenesis. They are slow growing tumors with low ki-67 staining as in our case. During surgery section examination is of help in differentiating some giant or diffuse adenomatoid tumors for carcinomatosis or vascular proliferations. Surgery is the treatment, but recurrence has been reported, especially in cases of incomplete excision. At present, three months after surgery patients is still asymptomatic and there is no evidence of recurrence in our patient.

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