

**CYSTIC ENDOSALPINGOSIS OF THE UTERUS PRESENTING AS
PROLAPSE UTERUS-A VERY RARE CASE****Prashant Joshi¹, Raksha Madhu^{2,*}**^{1,2}Department of Obstetrics and Gynecology, Adichunchanagiri
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ABSTRACT

A 40 year old lady P3L3 tubectomised, presented to us in routine gynaec OPD with complaints of mass per vagina since 2 years. Patient is a known case of HTN & DM on treatment. On examination, moderately built and nourished lady, on per speculum examination second degree uterine descent with cystocele, on bimanual examination uterus retroverted, mobile, atrophic, bilateral fornices free, cervical mobility non tender. On ultrasound uterus is retroverted, postmenopausal status, ovaries normal. Impression – prolapsed uterus. Patient underwent Vaginal Hysterectomy with cystocele repair. Intraoperatively, we found a cyst 7X7 cm arising from the uterine fundus, cyst containing serous fluid, no continuity with endometrial cavity with congested blood vessels seen on the inner surface. Uterus, tubes and ovaries was normal. Histological examination showed cyst arising from serosal surface of uterine fundus, uniloculated. One of the cut sections of the cyst showed fallopian tubal epithelium embedded in the cyst wall. Uterine endometrium shows senile cystic atrophy and cervix shows chronic polypoidal endocervicitis. A diagnosis of “Cystic Endosalpingosis of the uterus” was made. The case is reported because of its great rarity and difficult diagnosis.

Keywords: Endosalpingosis, uterine serosa, unilocular cyst.

INTRODUCTION

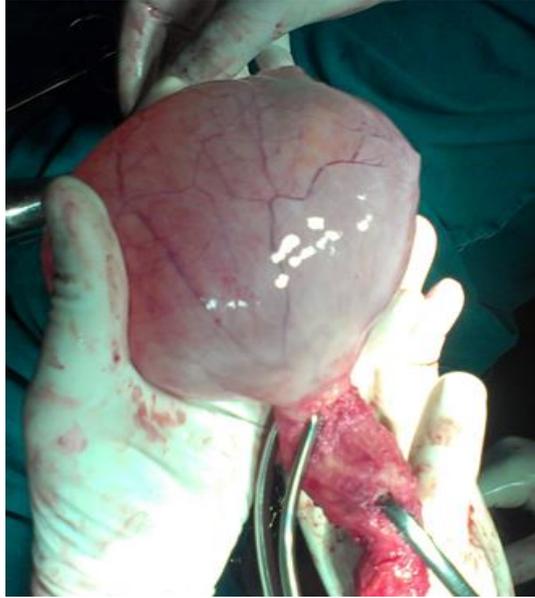
Endosalpingiosis is a non-neoplastic lesion of the mullerian system, similar to but less frequent than the homologous lesions of endometriosis and endocervicosis (1). They have generally been termed mullerianosis, including other epithelial proliferations of normal structures of the female genital tract, involving the peritoneum and subperitoneal tissues (uterus, fallopian tubes, ovaries, bladder, appendix, colon, omentum, pelvic and para aortic lymph nodes, skin) (2-4). The most accepted pathogenesis is metaplastic changes of the pluripotent peritoneal cells. Patients are almost always asymptomatic and it very rarely presents as a large cystic mass known as florid cystic endosalpingiosis(5). Very few cases have been documented till date as per review of literature, 9 cases have been documented.

CASE REPORT

A 40 year old woman P3L3 tubectomised, housewife belonging to lower socio economic status, presented to us in

routine gynaec out- patient department with complaints of mass per vagina since 2 years. Patient is a known case of hypertension and diabetes mellitus on treatment. On clinical examination patient is moderately built and nourished lady, on per speculum examination- Second degree uterine descent with cystocele

Bimanual examination- Uterus retroverted, mobile, atrophic, bilateral fornices free, cervical mobility non tender. On Ultrasound, Uterus was retroverted, postmenopausal status, bilateral ovaries and fallopian tubes was normal. Diagnosed as Second degree Utero-vaginal descent with with grade 2 cystocele. Patient underwent Vaginal Hysterectomy with cystocele repair. Intra-operatively, a cyst 7X5 cm was found attached to the uterine fundus. Bilateral ovaries and fallopian tubes were found to be normal on palpation.(Figure 1) Uterocervix measured 8X3.5X2cm , cyst was attached to the fundus of the uterus, measuring 7.5X5cm. The cyst was seen arising from the serosal surface of fundus of the uterus. (Figure 2)

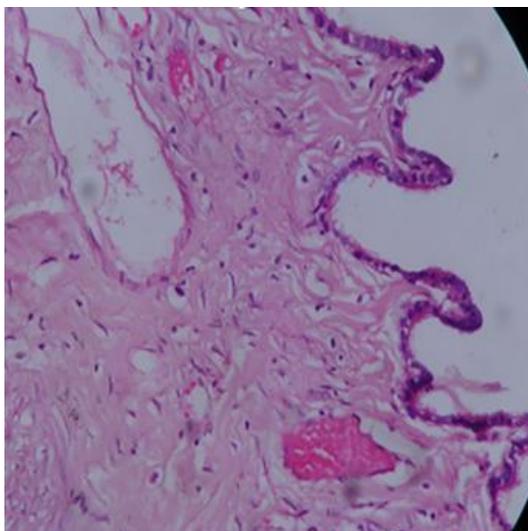


(Figure-1: Cyst wall lined by low cuboidal epithelium)



(Figure 2: Cut surface of uterocervix and cyst)

Cut –Section: Uterus was atrophic, the cyst was uniloculated, contained serous fluid. There was no continuity with the endometrial cavity, Congested blood vessels were seen on the inner surface (Figure 3) .Microscopic evaluation revealed, senile cystic atrophy of the endometrium and cervical changes of chronic polypoidal endocervicitis.The Cyst was lined by flattened, low cuboidal epithelium.(Figure-3) Cyst wall was continuous with the serosal surface of uterine fundus.One of the sections showed fallopian tubal epithelium embedded in the cyst wall (Figure4)



(Figure 3: Cyst wall lined by low cuboidal epithelium)

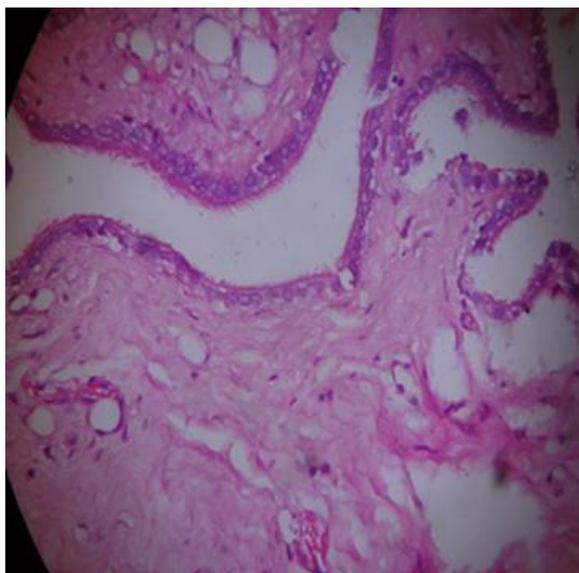


Figure 4: fallopian tube epithelium embedded within parametrium)

Final diagnosis - Cystic Endosalpingiosis of the uterus.

DISCUSSION

The proliferation of epithelial structures that occur in women on or beneath the visceral or parietal peritoneum, in the retroperitoneal lymph nodes, or in the soft tissue of the pelvis and lower abdomen, with differentiation of the female genital tract have generally termed as mullerianosis. They include lesions with tubal/serosal differentiation, (endosalpingiosis), and the homologous lesions of endometriosis and endocervicosis(6).

The term “endosalpingiosis” was introduced by Sampson in 1930 (1) the symptomatology is not specific. The most common symptoms are pelvic pain, hyper or dysmenorrhea, and infertility but sometimes they are asymptomatic. [8,9]. In some studies, they seem to be accidental findings. They are found in association with ovarian tumors [10, 11], endometriosis [12], and myomatous uterus [13]. The morphological appearance in our case is that of Cystic endosalpingiosis. Clement and Young described four cases of florid cystic endosalpingiosis presenting as a tumor-like mass [7].

CONCLUSION

Florid tubal metaplasia & cystification involving the wall of the uterus closely mimics adenocarcinoma. The diagnosis of cystic salpingiosis may be a

crucial challenge that can be solved only by microscopy. In routine practice, cystic endosalpingiosis may be easily missed owing to paucity of reported cases in literature, lack of awareness and rarity of this entity.

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