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Adenomatoid Tumour of the Uterus: A Rare Case Report

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ABSTRACT
Adenomatoid tumours are rare benign tumours originating in the mesothelium. Uterine adenomatoid tumours are benign tumours of the uterine serosa and myometrium that originate from the mesothelium. They are mostly under diagnosed as they resemble leiomyoma of the uterus. They may resemble pre-existing vessels and lymphatic ducts as well as metastatic adenocarcinomas. We report a case a of adenomatoid tumour of the uterus in a 50 years old lady that was found accidently during the treatment of adenomyosis. Although adenomatoid tumour may cause a diagnostic problem, in our case histological study has confirmed the diagnosis.
Key words: *Adenomatoid tumour, Uterus, Mesothelium*

INTRODUCTION

Adenomatoid tumours are rare benign tumours originating in the mesothelium that are usually found in the myometrium and fallopian tubes in females and epididymis in males [1]. They have been observed in women in the age group between 30-72 years. These tumours are usually incidental findings in 0.1-1% of females, in whom the uteri are

removed for various other indications [2]. Uterine adenomatoid tumours are associated with smooth muscle hypertrophy. Adenomatoid tumours may be accompanied by adenocarcinoma of endometrium or cervix and differential diagnosis must be definitely performed in this condition, because of the typical pseudoglandular structures these tumours possess. We here in report a uterine adenomatoid tumour in a 50 years old woman.

CASE REPORT

A 50 years old lady, para3 living3 was referred to our gynaecology department with complaints of painful menstruation since 2-3 years. Her menstrual cycles were regular and she had normal menstrual bleeding during cycles. On examination, uterus was bulky, retroverted, mobile, firm in consistency and tender. Transvaginal ultrasonography was suggestive of adenomyosis. Pap smear showed no evidence intraepithelial malignant lesion. Endometrial biopsy showed secretory endometrium. She underwent non-descent vaginal hysterectomy with bilateral salphingo-oopherectomy. Intraoperatively, uterus measured about 6-8 weeks in size with a fundal subserosal fibroid measuring about 1.5x1x1cm3. Cut surface of uterus showed a fibroid measuring 1 cm in diameter. Another circumscribed greasy white area measuring 1.5cm in diameter was seen in the uterine fundus. On histological examination, section studied from the endometrium showed secretory endometrial glands with edematous stroma. Section from the myometrium showed a circumscribed tumour composed of tubules and cords lined by cuboidal to flattened cells having abundant vacuolated cytoplasm, eccentrically placed nuclei. The tumour cords and tubules were seen in between the smooth muscle of myometrium as shown in Fig.1.This was suggestive of adenomatoid tumour. Cut section from small intramural fibroid showed features of leiomyoma. Both the ovaries and fallopian tubes showed unremarkable histology.

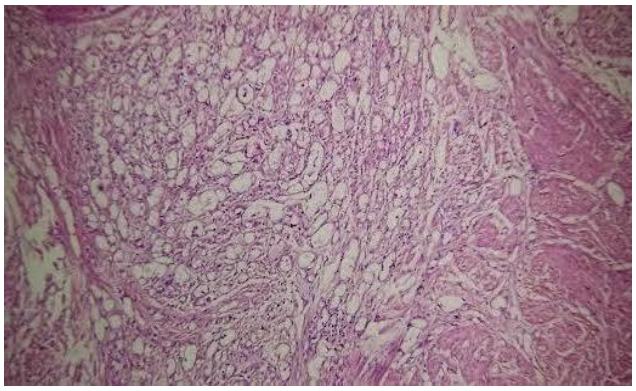

Fig.1: Typical adenomatoid tumour with a mixture of flattened and cuboidal cells enclosing spaces within smooth muscles of myometrium (Hematoxylin and eosin x10)

DISCUSSION

The term adenomatoid tumour was first approved by Golden and Ash in 1945[1]. Adenomatoid tumours are generally considered to be of mesothelial origin and occur in organs close to mesothelium-lined surfaces. In males they are found in the epididymis, spermatic cord, tunica albuginea, prostate and ejaculatory duct. In the female genital tract they occur in order of frequency in the uterus, fallopian tubes and ovarian hilus. They are incidental findings in hysterectomy specimens of adult women, the incidence being approximately 1% [1], [2]. These tumours are typically solitary, subserosal or myometrial masses, often located near the cornu and usually less than 4cm in diameter [3].

They are often accompanied by leiomyomata and adenomyosis [4]. An interesting finding is that relationship between diffuse adenomatoid tumours has been observed with immunosuppressed renal transplant recipient [5].

Histologically, the tumour can have an adenoid, angiomatoid, solid or cystic architecture or a combination of more than one type. Some tumours, as in the present case, can have a prominent smooth muscle component [4]. The histogenesis of adenomatoid tumour was controversial and subject to debate, but ultimately it was proven by electron microscopic and immunohistochemical findings to be of mesothelial origin [2]. The tumour cells are strongly positive for cytokeratin, vimentin, calretinin and HBME-1, but do not express EMA, CEA [1], [2].

The differential diagnosis of adenomatoid tumours is usually not complicated due to its typical morphology [3]. However, they can be mistaken macroscopically for leiomyomas or lymphangiomas if the tumour is cystically enlarged. Adenomatoid tumour with a diffuse infiltrative growth pattern have to be distinguished from malignant lesions such as metastatic signet ring cell adenocarcinoma, epitheloid hemangioendothelioma, germ cell tumour or sex cord stromal tumour [2]. Typical circumscribed gross appearance, the bland cytologic features and lack of mitosis allow distinction from malignant tumour. We would like to report a case of this rare tumour.

CONCLUSION

Adenomatoid tumours of female genital tract have mesothelial origin. The biologic behaviour of adenomatoid tumour is benign and has a good prognosis. If it is not correctly interpreted, it may potentially lead to more aggressive therapy than warranted.

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