Journal of Cardiovascular Disease Research

ISSN:0975 -3583,0976-2833 VOL 15, ISSUE 07, 2024

Case Report

Accessory and cavitated uterine mass and left ovarian endometriotic cyst in young infertile women: A case report

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Abstract

Background: Accessory and Cavitated uterine mass (ACUM) is an uncommon form of uterine anomaly seen in young nulliparous women, which presents with chronic pelvic pain and severe dysmenorrhoea. It is often underdiagnosed due to broad differential diagnosis, including rudimentary uterine horn, true cavitated adenomyosis and degenerating fibroids.

Case summary: A 29 year women presented with severe dysmenorrhoea and was initially diagnosed with Rudimentary uterine horn with left ovarian endometriotic cyst 8x7x6cm on ultrasonography. The patient underwent laparoscopic excision of rudimentary horn with left ovarian endometriotic cystectomy with hysteroscopy and chromopertubation and histopathological examination confirmed the diagnosis as ACUM with endometriotic cyst. Postoperatively, the patient did well and no further dysmenorrhoea.

Conclusion: ACUM is difficult to diagnosed. A correct diagnosis can be made only after excion and histopathological evaluation. Surgical excision is necessary and can be done by laparoscopy.

Keywords: Accessory and cavitated uterine mass, Mullerian anomaly, diagnosis, laparoscopic excision, case report

Introduction

An Accessory cavitated uterine mass (ACUM) Was first reported in 1998 by potter and schenken [1], and is a uncomman variety of uterine lesions, found in young women, which is a non-communicating, accessory cavity with normal endometrium located in the uterus of normal shape and function. This uterine anomaly is categorised as U6 (still unclassified) in ESHRE/ESGE classification, which is related to female gubernaculum dysfunction [2, 3]. A recent study revealed that most cases of non-communicating accessory uterine cavities and juvenile, or isolated, cystic adenomyomas, practically respond to the same pathology: An ACUM with functional endometrial lining [4]. ACUM is a rare entity, more frequently observed in young, nulliparous women, and is charecterized by severe dysmenorrhoea and recurrent pelvic pain. Some women are infertile. Pain usually occurs on the ipsilateral side of the mass and persists or even aggravates after menstruation [5]. The criteria used to diagnose an ACUM are as follows: isolated cyst-like mass; normal uterine cavity, tubes and ovaries; exereses of the mass with a pathology assessment; accessory cavity bordered by endometrial epithelium with glands and stroma; chocolate brown coloured liquid content; and no adenomyosis (if hysterectomy has been performed) but there may be small foci in myometrium near the mass [4].

ACUM'S are commonly underdiagnosed because of the extensive differential diagnosis, including other uterine malformations, cavitated adenomyosis and primary dysmenorrhoea. Ultrsonography, magnetic resonance imaging (MRI) and hysterosalpingography are conducive to the diagnosis so as to quickly choose the best management strategy [6-8].

Here, we present a patient with ACUM and endometrotic cyst diagnosed using recommended diagnostic criteria [4-5]. This patient was a 29 year woman who suffered from severe dysmenorrhoea and pelvic pain after menstruation and was initially misdiagnosed as rudimentary horn with left adnexal mass. Laparoscopic excision of the ACUM and endometriotic cyst was performed.

Case presentation

A 29 yr woman presented with dysmenorrhoea and was diagnosed with rudimentary horn and left endometriotic cyst in ultrasonography report.

Chief complaints-severe dysmenorrhoea and recurrent pelvic pain since 4-5 yrs.

Menstrual history-regular 4-5days/30 days, normal flow, associated with dysmenorrhoea.

Married life 2 yrs, Nulligravida.

No significant medical, surgical and family history. Patient is not allergic to any medications.

ISSN:0975 -3583,0976-2833 VOL 15, ISSUE 07, 2024

On examination-patient is conscious coherent and obeying commands vitals are stable.
Per abdomen examination-soft non tender. Per speculum cervix and vagina healthy.
Bimanual examination-uterus normal size anteverted mobile left forniceal fullness present.

Investigaions
CBP-HB 14.6 g, WBC 15000, Platelet 1.8 lakhs
TSH-2.36
LFT and RFT WNL CA-125 829
AMH 2.06 USG:
Left HUN
Uterus 7.6X4.3X5.1cm, ET 10.5, pelvic endometriosis, uterus pulled to left with retroflexed fundus. Left rudimentary horn 3.5x 2.5x2 cm, left ovary is posteroinferior to uterine body and adherent to left uterosacral ligament, chocolate cyst 84X70X64 mm, likely compressing the left ureter. Right ovary normal.
2D echo normal Lv function, EF 70%, CUE normal. Na/K/cl 138/4.6/102.

Procedure: Laparoscopic Left Endometriotic Cystectomy with Left Acum Excision with Bilateral Posterior Broad Ligament Excision with Left Ureterolysis with Chromopertubation with Hysteroscopy done.

Findings: Uterus normalsize, buried in adhesions, adhesiolysis done. Left endometriotic cyst of 10X8X6cm adherent to posterior uterine wall and lateral pelvic wall noted. Cyst drained, vasopressin instilled into the cyst wall, cystectomy done. CPT positive on both sides, hence both tubes are patent, left ovarian reconstruction done with no 1 vicryl. Left round ligament and left fallopian tube adherent to lateral pelvic wall, adhesiolysis done. Vasopressin instilled into bilateral posterior broad ligament posterior broad ligament excision done. Left ureterolysis done. Specimens retrieved in endobag, thorough peritoneal irrigation and suction done. Haemostasis secured, Surgicele placed *in situ*. Specimen sent for HPE.

Hysteroscopy Findings: Uterus distended well bilateral ostia visualised.
Endometrium apparently normal.

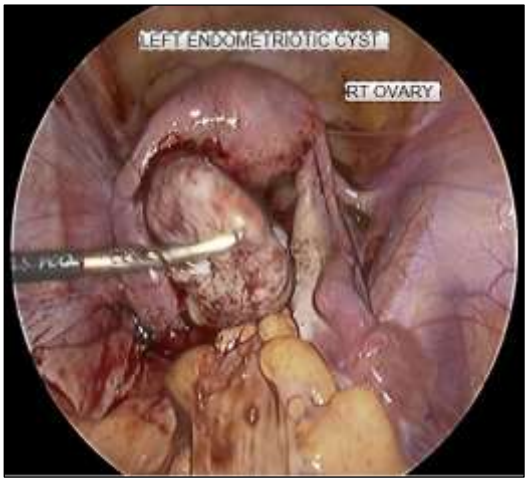

Fig 1: Uterus Round Ligament

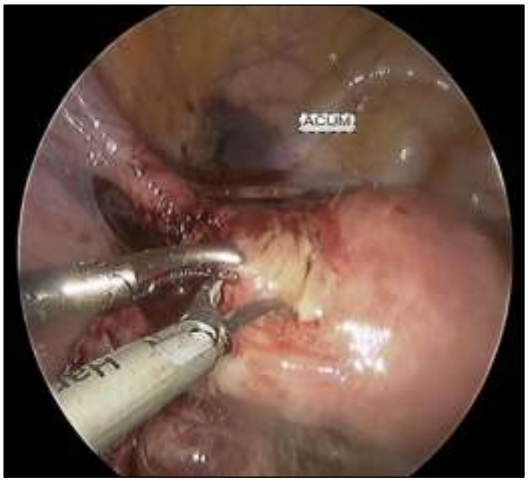

Fig 2: Accessory Cavitated Uterine Malformation on Left Side

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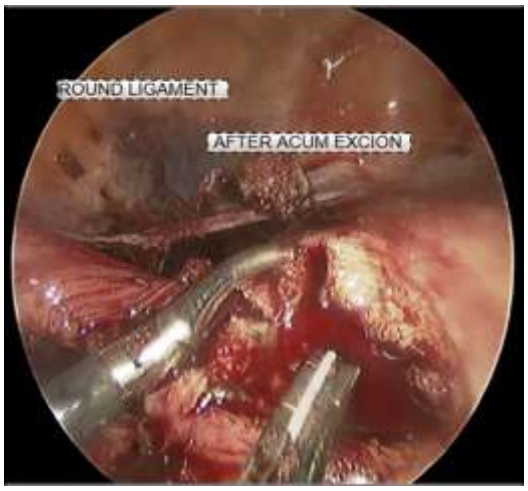

Fig 3: After ACUM Excision

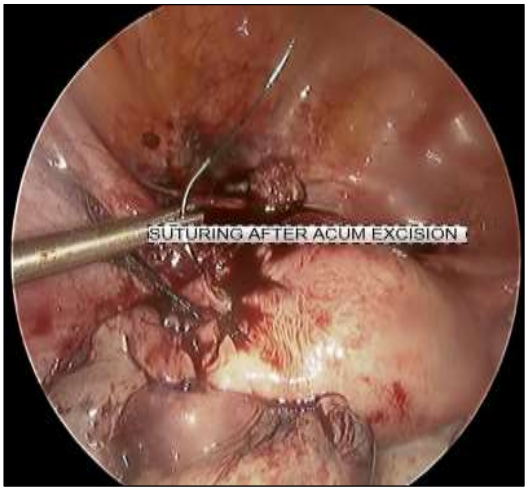

Fig 4: Suturing after ACUM Excision

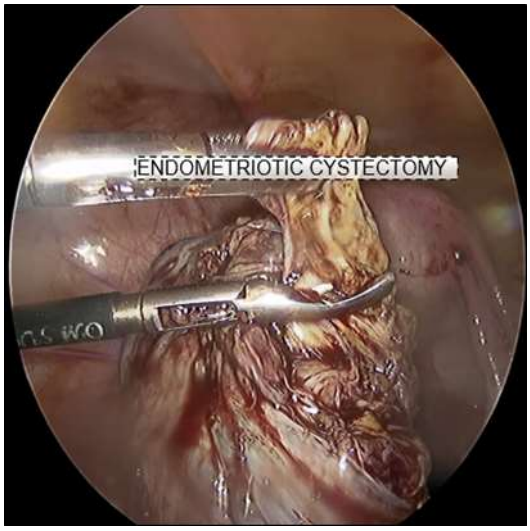

Fig 5: Left Endometriosis Cystectomy

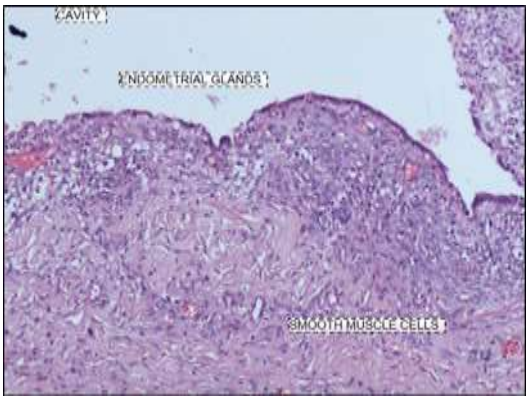

Fig 6: Acum Histopathology

Fig 7. HPE features consistent with accessory and cavitated uterine mass.

ACUM presents as a cavitated lesion, surrounded by myometrial mantle, in continuity with the anterolateral uterine wall and located beneath the insertion of the round ligament and interstitial portion of the fallopian tube. In contrast to other uterine abnormalities, a normal uterine cavity is seen. ACUM'S are not usually associated with endometriosis. So this is unique case of ACUM with endometriosis.

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