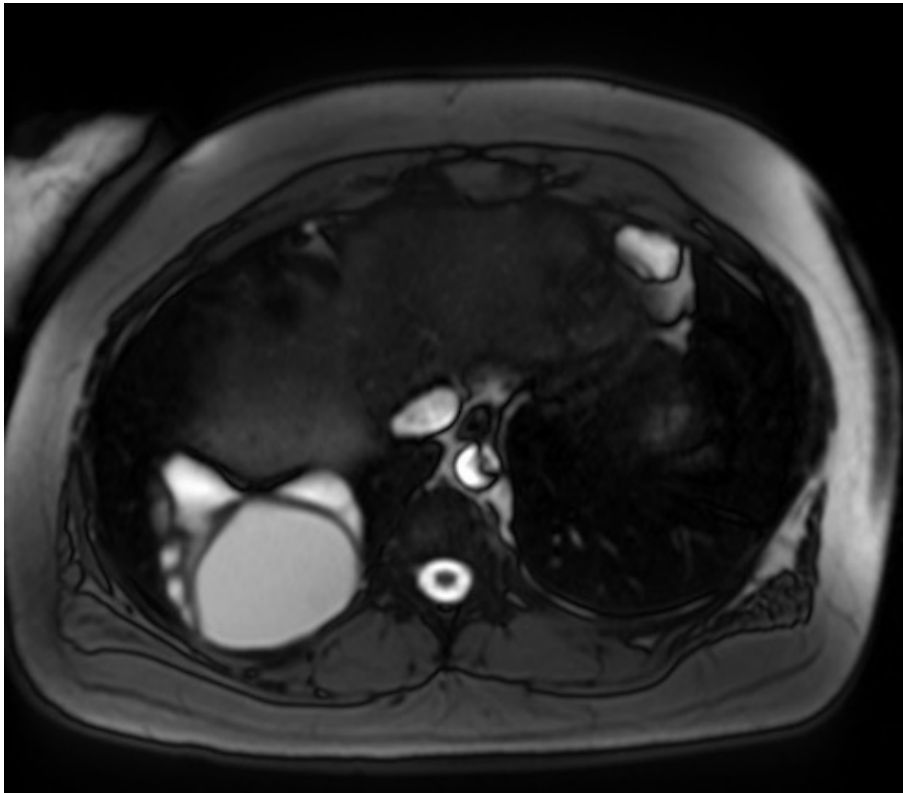


Video Presentation Of Staged Resection Of Bilateral Enlarging Benign Endosalpingiosis Of The Chest A Rare Entity

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Abstract:

BACKGROUND: There is limited information available on pleural/mediastinal endosalpingiosis. Endosalpingiosis primarily involves the presence of tubal-type epithelium outside the fallopian tubes and is predominantlty abdominopelvic in location. Thoracic occurrence specifically within the pleural and mediastinum has not been reported in the literature. We report a unique case of bilateral enlarging cystic endosalpingiosis which were resected robotically in a staged approach for complete resectionMETHODS: 31 year old woman with a history of right salpingo-oophorectomy, left ovarian cystectomy, omentectomy for borderline serous cystadenoma of the right ovary was undergoing exploratory laparotomy for presumed recurrent disease with 25 cm pelvic mass, elevated CA 125 and potential liver metastases. She had a BMI of 35. She was found to have multicystic lesions of the uterus,and a complex left ovarian mass involving surrounding structures. She underwent a total abdominal hysterectomy and left salpingo-oophorectomy and removal of a 3 cm subdiaphragmatic implant, but a larger immobile supradiaphragmatic mass palpated above the liver which corresponded to the imaging findings of metastatic liver lesions. Intraoperative cardiothoracic surgery consultation obtained. The decision was made to obtain thoracic imaging after recovery from surgery. Final pathology was a 25cm serous cystadenoma and endosalpingiosis of the diaphragm implant. Follow up CT chest showed a 3.8cm left cardiophrenic cystic mass near the left ventricle and 7.3cm multiloculated right diaphragmatic cystic mass. MRI chest showed lobulated pleural based 8.9cmx 8.7cmx 5cm multiloculated, multicystic mass from the right hemidiaphragm and 2cm left prepericardial cystic mass. Image in legend. Robotic left anterior mediastinal cystic resection with 3 port technique done. Pathology was 3.2cmx 2.7cm x 1.3cm cystic endosalpingiosis. Follow up CT chest showed right pleural based mass on diaphragm increased in size to 9.2cmx 9cmx12cm and no recurrence on left. She underwent robotic right resection with 4 port technique. The cystic lesion was aspirated to decompress for resection in controlled fashion. broad based pedicle from the diaphragm was found and was transected with the vessel sealer for complete excision. Final pathology was 11.2cmx7.2cmx 4.5cm benign cystic endosalpingiosis.RESULTS: Utilizing staged robotic approach, the left anterior 3.2cm x 2.7cm x 1.3cm mediastinal cystic mass adjacent to the left ventricle was successfully removed and susequently the right 11.2cm x 7.2cm x 4.5cm multiloculated cystic mass was excised from the diaphragm. The left side was done first given proximity to the left ventricle. Patient was discharged home on post op day one for each case and final pathology was benign endosalpingiosis consistent with prior pelvic pathology. CONCLUSIONS: Successful staged robotic resection of bilateral thoracic cystic endosalpingiosis can done safely. This finding or procedure has not been reported in the literature.



legend- mri rt diaphragmatic multiloculated cyst