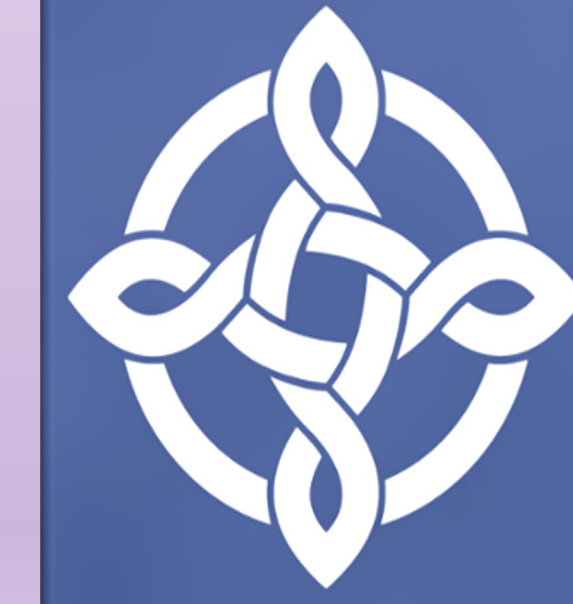


Adnexal mass: a rare diagnosis of gastrointestinal stromal tumour(GIST)



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Objective

Always consider the possibility of the non-gynaecological origin of adnexal masses in women.

Case report

A 52-Year-old woman who presented with postmenopausal bleeding was found to have a complex right adnexal cyst on an ultrasound scan(USS). It was further delineated in computerized tomography(CT) to be likely ovarian in origin measuring 85mm x74mm x53mm. The uterus was normal in size with an endometrial thickness of 3mm. Tumour markers, CA 125 and CEA were within the normal range. Following the MDT discussion, the patient preferred total abdominal hysterectomy and bilateral salpingo-oophorectomy. Due to the uncertainty of diagnosis, during the preoperative discussion, the consultant discussed the small possibility of a bowel-related mass and explained that surgery may involve bowel resection in such cases. Hence the patient was aware and pre-informed of the differential diagnosis. Intraoperatively, a large pedunculated cystic lesion (approximately 8cm) was seen arising from the antimesenteric border of the ileum, 80cm proximal to the ileocecal valve without surrounding invasion. Uterus, Bilateral Ovaries, tubes and upper abdomen appeared to be normal. Resection of the small bowel along with pedunculated cystic lesion was performed by the colorectal surgical team. Histopathology confirmed a GIST with no mucosal invasion. Follow up plan was made to arrange CT scans every six months for the next 5 years.

References

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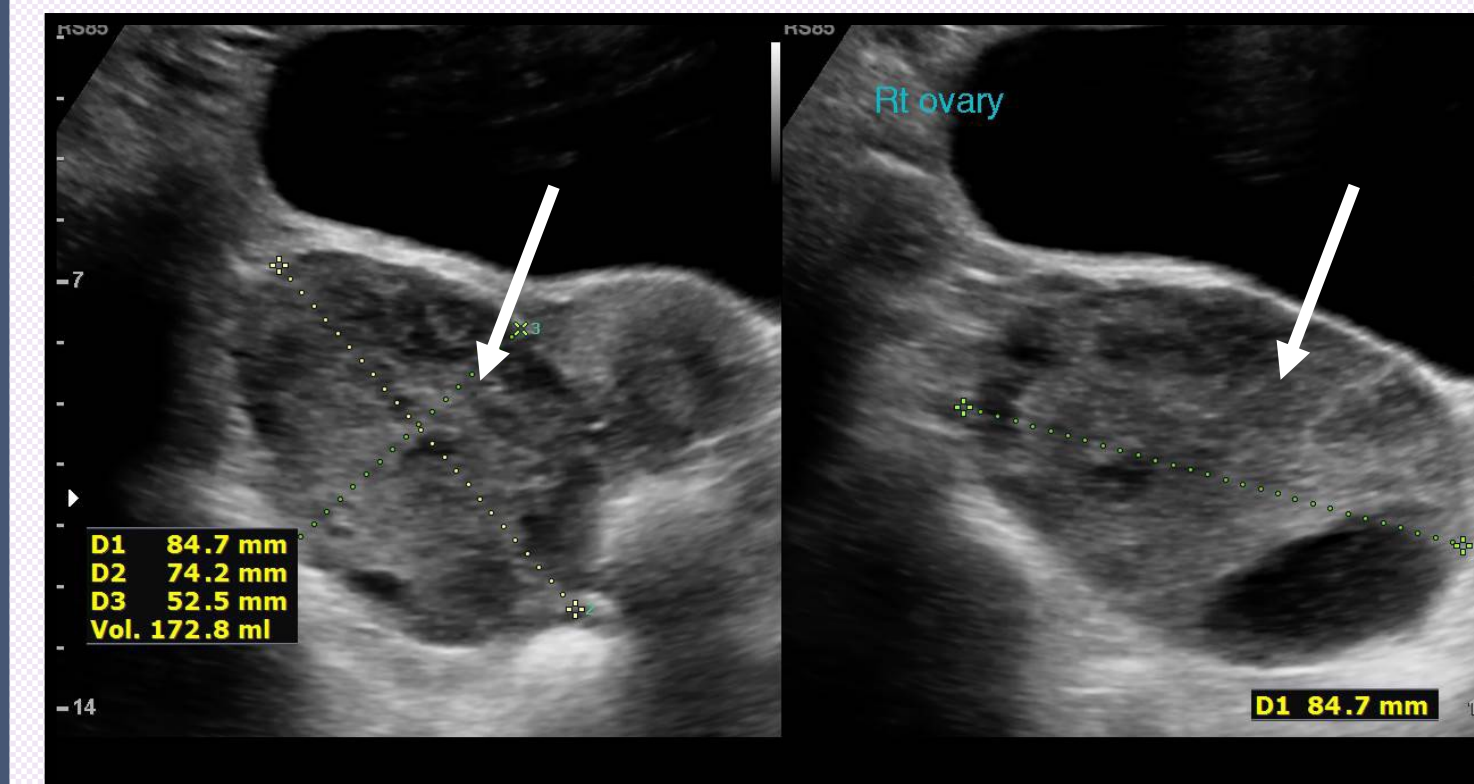


Fig 01: USS of abdomen and pelvis showing Right complex adnexal cyst (white arrow)

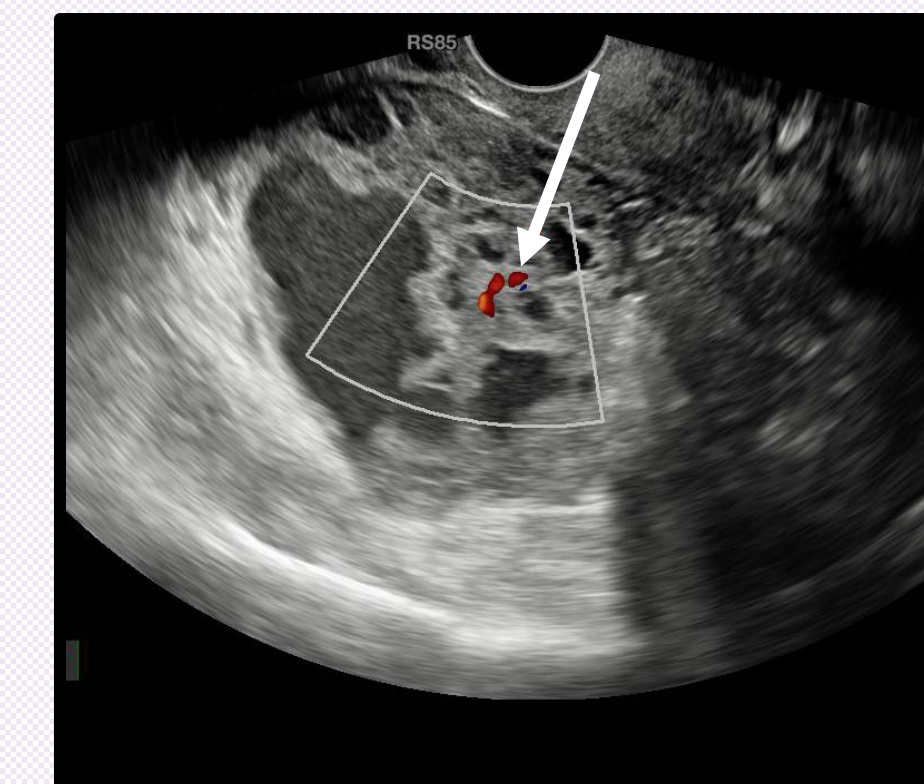


Fig 02: USS showing the complex mass with some vascularity



Fig 03: Axial view of CT Scan showing the mass (M) in relation to pelvic organs



Fig 04: Coronal view of CT Scan showing the mass (M) in the pelvis

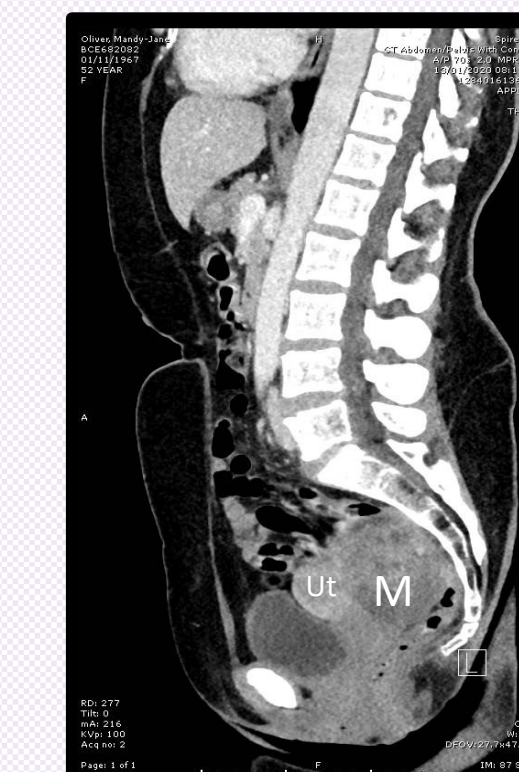


Fig 05: Sagittal view of CT Scan showing the mass (M) posterior to the uterus (Ut)

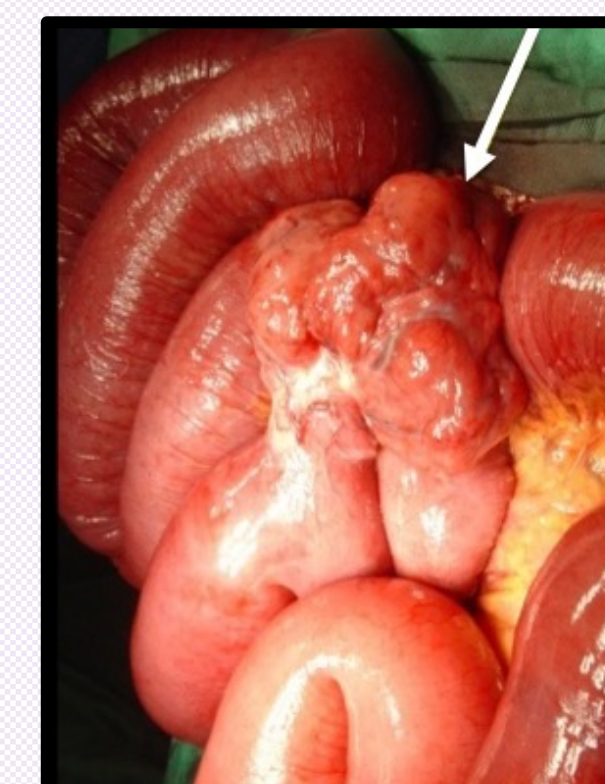


Fig 04: Intraoperative finding of the large pedunculated lesion, arising from the antimesenteric border of the ileum.

Discussion

Adnexal masses in women are usually gynaecological in origin. however, they can rarely be non-gynaecological too. An Adnexal mass in a postmenopausal woman raises the commonest suspicion of ovarian tumour. Tubo-ovarian abscess, Paratubal cysts, pedunculated fibroids and metastatic tumours are also possible lesions. Non-gynaecological causes include appendiceal mass, mesothelioma and peritoneal tumours. GISTs are the predominant mesenchymal tumours of the Gastrointestinal tract. Radiological imaging is of utmost importance in diagnosing GIST. It typically appears in USS as a homogeneous hypoechoic cyst or mass close approximate to the Gastrointestinal tract. Large tumours appear heterogenic due to haemorrhage, cystic changes and necrosis easily mimicking complex ovarian cysts both in ultrasound and CT scans. In this case, the woman was correctly counselled on the possibility of bowel pathology, therefore preoperative informed discussion followed appropriate management.

Conclusions

Non-gynaecological lesions are a rare cause of adnexal lesions in a woman with postmenopausal bleeding. Imaging plays an important role in diagnosing GIST. However, imaging characteristics can lead to a misdiagnosis of an ovarian cyst emphasising the importance of careful interpretation and knowledge of rare possibilities. Surgical resection of the primary tumour is the mainstay of treatment in GIST, followed by risk stratification for recurrence. It is good practice to counsel regarding possible alternative differential diagnoses when the origin of adnexal mass is uncertain.