WHEN TO BLAME?
STUMP the PROFESSOR
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Presentation
45 yo healthy G2P2 presenting to her PCP with 1 week history of Lower Abdominal Pressure, Dysuria, Urgency, Cramping

Suspected urinary tract infection
- treated with Macrobid for 3 days

No significant relief → POC Urinalysis with SG 1.025; 2+ blood, neg Nitrites and LE
- switched to Ciprofloxacin for 7 days, Urine culture obtained

No significant relief → urine culture – no growth

Referral to General Gynecologist

Physical exam unremarkable

CBC:
- WBC 10.2 x 1000/uL, Neutrophils 81%
- Plt 427 x 1000/uL

Transvaginal ultrasound:
Uterus: 12.5 cm x 7.7 cm x 7.5 cm
- Fibroids: #1 - 5 cm, intramural
  #2 - 3 cm, intramural
  #3 - 2.5 cm, intramural

Right Ovary: 3.9 cm x 4.1 cm x 3.3 cm
- Cyst #1: 2.2 cm x 2.5 cm x 2.1 cm - complex

Left Ovary: 5.8 cm x 2.3 cm x 3.4 cm
- Cyst #1: 3.2 cm x 5.2 cm x 1.4 cm - complex

Ascites in Cul de Sac, middle and upper abdomen
Referral to Gynecologic Oncology

Symptoms:
- Persistent lower abdominal pressure
- Dysuria, urinary frequency
- Shortness of breath

Past gynecologic history:
- Abnormal uterine bleeding → ablation in 2007 → amenorrheic since
- Known fibroid uterus
- No h/o abnormal Pap smears
- No h/o sexually transmitted diseases
- In monogamous relations with her husband for many years

Obstetrical history: full term vaginal delivery x 2

Past medical history: none

Past surgical history: hysteroscopic myomectomy, 2002; endometrial ablation, 2007

Family history: no h/o ovarian, uterine, colon, breast cancer

Medications: Motrin PRN

Allergies: none

Social: denies smoking/alcohol/recreational drugs

Physical exam:
HR 119 bpm; BP 108/72 mmHg; Temp 36.8 °C; Wt 78.4 kg; SpO2 97%

Pertinent exam findings:
Chest: decreased breath sounds on the right, dullness to percussion in the right lung base
Abdomen: nontender, flank bulging on the left
Pelvic exam:
- no vaginal discharge;
- cervix deviated to the right
- uterus anteflexed ~10 wk gestational size
- fullness in the right parametria
- no tenderness with pelvic exam

Pertinent Labs:

WBC 14.6 x 10^9/L; Hct 40.8% 
Platelets 516 x 10^9/L; PTT 32.3 sec
AST 37 U/L; ALT 33 U/L; Hgb 13.4 g/dL
Cr 0.6 mg/dL; PT 13.3 sec

CA125 – 376 U/mL
CA 19.9 – 25.8 U/mL
CEA – 0.37 ng/mL
Chest:
- large right pleural effusion with almost complete atelectasis of the right lung
- minimal smooth pleural enhancement
- left lung is clear
- small pericardial effusion.

Abdomen and pelvis:
- liver, spleen, pancreas, adrenal glands and kidneys – unremarkable
- a 7 mm mesenteric node is seen
- large amount of ascites with multiple calcifications in the posterior cul-de-sac, which could represent calcified implants
- no adnexal masses are discerned
- uterus is enlarged and heterogeneous likely due to underlying fibroids

Paracentesis
- 500 mL of sanguinous fluid
- Multiple thin septations noted
- Culture – no growth
- Pathology – no evidence of malignancy

Thoracentesis
- 1500 mL of sanguinous fluid
- Protein – 4.1 g/dL
- Glucose 36 mg/dL
- LDH 503 U/L
- Culture – no growth
- Pathology – no evidence of malignancy

DIFFERENTIAL DIAGNOSIS:

Malignant – GYN or Non-GYN

Benign causes

Pseudo – Meigs syndrome

Para pseudo Meigs syndrome

- Ovarian cancer
- Breast cancer
- Stomach cancer
- Colon cancer
- Etc...

To the OR for diagnostic laparoscopy...
Operative Findings:

- EUA: enlarged moderately mobile ~10 wk sized uterus, ovaries not palpated.
- Laparoscopy, unable to place umbilical port → port placed at Palmer’s point
- Severe adhesive disease involving omentum, bowel, liver, pelvis
- Pelvic organs not visualized due to adhesions

Converted to laparotomy via Pfannenstiel incision:

- Dense adhesions throughout pelvis and abdomen
- Inflammatory reactive changes involving bowel and pelvic organs
- Yellow-green ascites with occasional collections of mucinous material between the bowel, in the greater and around liver
- Liver significantly enlarged at the level of umbilicus.
- Appendix with some reactive changes but otherwise unremarkable.

Pelvis:

- ~10 week sized uterus densely adherent to sigmoid colon, tubes and ovaries b/l
- Tubo-ovarian abscess on the right
- Right ovary with a small chocolate cyst.

Deep Wound Culture – 2+ mixed aerobic gram positive flora of 3 varieties

<table>
<thead>
<tr>
<th>Final Diagnosis</th>
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<tbody>
<tr>
<td>UTERUS, RELATIONAL OVARIES AND FALLOPIAN TUBES, TOTAL HYSTERECTOMY, RELATERAL SALPINGO-OOPHORECTOMY (390 GAMS)</td>
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<tr>
<td>UTERUS:</td>
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<td>CERVIX: WITHOUT SIGNIFICANT ABNORMALITY</td>
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<td>ENDOMETRIUM: PROLIFERATIVE PHASE</td>
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<td>MYOMETRIUM:</td>
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<td>SMOOTH MUSCLE TUMOR OF UNCERTAIN MALIGNANT POTENTIAL (4.5 CM), SEE NOTE</td>
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<td>MULTIPLE LEIOMYOMAS</td>
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<tr>
<td>ADENOMYSOSIS</td>
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<td>TUBO-OVARIC ADHESIONS WITH FIBROUSULCENT EXUDATE</td>
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<td>RIGHT Ovary: ENDOMETRIOSIS WITH SURFACE ADHESIONS</td>
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<td>RIGHT Fallopian TUBE: CHRONIC SALPINGITIS</td>
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<td>LEFT Fallopian TUBE: CHRONIC SALPINGITIS</td>
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<td>2) &quot;CYST WALL&quot;, SITE NOT SPECIFIED:</td>
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<td>BENIGN FIBROUS TISSUE WITH ACUTE INFLAMMATION, CONSISTENT WITH ADHESION</td>
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<td>3) &quot;ADHESIONS&quot;, SEGMENTOCOLUMN, BIOPSY:</td>
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Smooth muscle Tumor of Uncertain Malignant Potential – STUMP
Final diagnosis
Meigs' syndrome in the setting of:
- Tubo-ovarian abscess/pelvic inflammatory disease
- Endometriosis
- Adenomyosis
- Fibroid uterus
- Smooth muscle tumor of the uterus of uncertain malignant potential

Thank you!

Questions?