



Postmenopausal Uterin Lipoleiomyoma: A Case Report

Özgen Arslan Solmaz¹, Hasan Çılğın²

¹Elazığ Training and Reserach Hospital, Pathology, Elazığ, Turkey
²Tunceli State Hospital, Gynecology and Obstetrics, Tunceli, Turkey

Abstract

Primary uterine lipoleiomyoms are extremely benign tumors. They are usually seen in perimenopausal and postmenopausal obese women. Average tumor size is reported to be 5 to 10 cm. Most are asymptomatic and diagnosed incidentally. The accurate diagnosis of tumors is based on pathological examination. Hysterectomy is the preferred method of treatment. Clinically, they are similar to leiomyomas. Here we present a case with postmenopausal bleeding due to lipoleiomyoma.

Key Words: Lipoleiomyom; Postmenopouse; Pelvic Mass.

Postmenopozal Uterin Lipoleiomyom: Olgu Sunumu

Özet

Uterin primer lipoleiomyomlar oldukça ender görülen benign tümörlerdir. Genellikle perimenopozal ve postmenopozal obez kadınlarda görülürler. Tümör çapının ortalama 5-10 cm olduğu bildirilmiştir. Çoğu asemptomatiktir ve tesadüfen teşhis edilir. Tümörün kesin tanısı patolojik incelemeye dayanmaktadır. Histerektomi tercih edilen tedavi yöntemidir. Klinik olarak leiomyoma benzerler. Postmenopozal kanama nedeniyle başvuran ve histerektomi sonrası lipoleiomyom tanısı alan olguyu sunduk.

Anahtar Kelimeler: Lipoleiomyom; Postmenopoz; Pelvik Kitle.

INTRODUCTION

Uterine primary lipoleiomyoma is an extremely rare benign tumor (1). Its prevalence ranges from 0,2% to 0,03% (2). It is usually seen in perimenopausal and postmenopausal obese women (3). Tumour size varies between 5cm and 10cm. It has a capsule with a thin connective tissue (1). Preoperatively, it is usually diagnosed as leiomyoma or ovarian mature teratoma but final diagnosis can only be made after histopathological findings (4).

Here, we aim to present our uterine lipoleiomyoma case since it is a rare disease that is often confused with other gynaecological diseases.

CASE REPORT

A 59 years old female patient was admitted to our gynaecology and obstetrics clinic with bleeding that had been going on for four months. The patient was in the third year of menopause. The initial gynaecological examination showed a mass 2-3 cm in diameter in the uterine corpus. The ultrasonographic examination revealed a 2,5x2x1 cm solid mass in the front wall of the uterus; the mass was hyperechoic with clear boundaries. The preliminary diagnosis was leiomyoma. The patient underwent a dilation curettage and the histopathological diagnosis was atypical simple hyperplasia. Due to excessive bleeding and atypical simple hyperplasia, we applied vaginal hysterectomy.

The hysterectomy material sent to the pathology laboratory was identified as a 2x2x1,5 cm lesion located in the front wall of the uterus with borders, solid cross-sectional surface, and myomatous look. The histopathological examination of the samples revealed mature adipose tissues that were widespread within myomatous regions with spindle smooth muscle cells and without atypic structures (Figure 1), which was diagnosed with lipoleiomyoma.

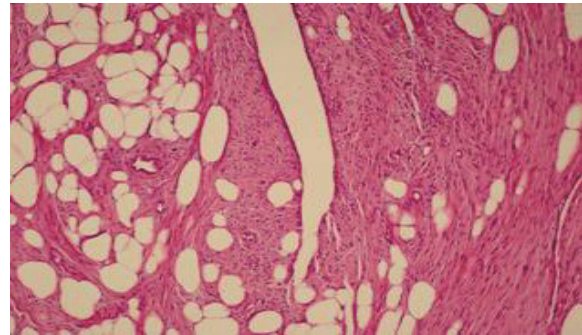


Figure 1. Mature adipose tissues located within smooth muscle cells Hex200

DISCUSSION

First described in soft tissues by Meis and Enzinger in 1991, lipoleiomyomas are seen in hysterectomy materials with a frequency of 0,03%-0,2% (2, 5). In a study 4904-patient study in which patients underwent

hysterectomy or myomectomy due to uterine myomatous tumours, only 17 patient were diagnosed with lipoleiomyoma (6). Lipoleiomyomas are common in postmenopausal women and 90% of cases consists of women over the age of 40 (7). Although it is usually in the uterine body or intramural region, 10% of patients have may lipoleiomyoma in the cervix (8, 9). It has been suggested that lipoleiomyomas originate from the fatty metamorphosis of the smooth muscle tissue of the uterus (5). The origin of lipoleiomyomas is quite speculative. In the past, they were diagnosed as hamartoma or choristoma. Nowadays there are other theories about lipoleiomyomas such as incorrectly located embryonic fat cells, smooth muscle metaplasia, proliferation of perivascular fat cells and planting fat cells into the uterine wall during surgery, and fatty degeneration of connective tissue (10, 11).

Lipomatous uterine tumours are categorized in three groups. The first group is that of pure lipoma and consists of mature fat cells only. The second group is that of lipoleiomyomas and it consists of smooth muscle and fat cells. The third group is the liposarcoma group and it is a malignant adipose tissue tumour. Lipoleiomyoma is the most common of these three groups (1, 11).

Clinical findings are similar to those of leiomyomas. As seen in the case presented here, there are symptoms associated with the size of the mass like palpability, increased menstrual bleeding, and pelvic pain. The increase in the diameter of the mass makes symptoms such as frequent urination, constipation, pelvic pain, and uterine bleeding more evident (7). Masses can be single or multiple. The diameter of the masses usually vary from 5cm to 10cm but lesions up to 32cm have also been reported (1). Histopathologically, lipoleiomyomas, which consist of smooth muscle cells, fat cells, and fibrous tissues, do not contain mitosis (3).

Radiological view of lipoleiomyomas vary depending on the components of adipose tumour tissues, smooth muscles, and fibrous tissues. The differential diagnosis can be made histopathologically as well (7).

Mature cystic teratoma, cystic teratoma showing malignant degeneration, non-teratoma lipomatous

ovarian tumours, benign pelvic lipomas, liposarcoma, and lipoplastic lymphadenopathy should be considered in differential diagnosis (12).

Uterine lipoleiomyomas are benign lesions. However, two studies report that uterine lipoleiomyomas accompany uterus, cervical and ovary related gynaecological cancers with a frequency rate of 18,8% (6, 13). Therefore, lipoleiomyomas should undergo detailed clinical and pathological evaluation in order to see their relation to potentially coexisting gynaecological malignancies.

REFERENCES

1. Kitajima K, Kaji Y, Imanaka K, Sugihara R, Sugimura K. MRI findings of uterine lipoleiomyoma correlated with pathological findings. *AJR Am J Roentgenol* 2007;189:100-4.
2. Kumar S, Garg S, Rana P, Hasija S, Kataria SP, Sen J. Lipoleiomyoma of Uterus: Uncommon Incidental Finding. *Gynecol Obstet* 2013;3(2):145.
3. Ding DC, Chu TY, Hsu YH. Lipoleiomyoma of the uterus. *Taiwan Obstet Gynecol* 2010;49(1):94-6.
4. Sudhamani S, Agrawal D, Pandit A, Kiri VM. Lipoleiomyoma of uterus: a case report with review of literature. *Indian J Pathol Microbiol* 2010;53(4):840-1.
5. Manjunatha HK, Ramaswamy AS, Kumar BS, Kumar SPA, Krishna S. Lipoleiomyoma of uterus in a postmenopausal woman. *J Midlife Health*. 2010;1(2):86-8.
6. Aung T, Goto M, Nomoto M, Kitajima S, Douchi T, Yoshinaga M et al. Uterine lipoleiomyoma: a histopathological review of 17 cases. *Pathol Int* 2004;54(10):751-8.
7. Ghosh B, Mckeown B, Gumma A. Lipoleiomyoma. *BMJ Case Reports* 2011;
8. Aizenstein R, Wilbur AC, Aizenstein S. CT and MRI of uterine lipoleiomyoma. *Gynecol Oncol* 1991;40:274-6.
9. Çendek BD, Avşar AF, Yazgan A. Uterusun nadir görülen mezenkimal tümörü. *Türkiye klinikleri J Gynecol Obst* 2014;24(1):52-7.
10. Pounder DJ. Fatty tumours of the uterus. *J Clin Pathol* 1982;35:1380-3.
11. Lau LU, Thoeni RF. Uterine lipoma: Advantage of MRI over ultrasound. *Br J Radiol* 2005;78:72-4.
12. Lin M, Hanai J. Atypical lipoleiomyoma of the uterus. *Acta Pathol Jpn*. 1991;41:164-9.
13. Wang X, Kumar D, Seidman JD. Uterine lipoleiomyomas: A clinicopathologic study of 50 cases. *Int J Gynecol Pathol* 2006;25(3):239-42.

Received/Başvuru: : 15.07.2014, Accepted/Kabul: 24.09.2014

Correspondence/İletişim

Özgen ARSLAN SOLMAZ
Elazığ Eğitim ve Araştırma Hastanesi, Patoloji, ELAZIĞ,
TÜRKİYE
E-mail: ozgensolmaz@mynet.com

For citing/Atıf için

Solmaz OA, Cilgin H. Postmenopausal uterin lipoleiomyoma: a case report. *J Turgut Ozal Med Cent* 2015;22:123-4 DOI: 10.7247/jtomc.2014.2177