The right ovary was normal. The left ovary was not identified separate from the mass. Serum tumor markers were negative. Axial CT scan showed a well circumscribed mass lesion of semi-solid density (HU = 31) in the left posterior wall of the uterus (Figure 1b). T1-weighted axial MR images demonstrated a nodular lesion with heterogeneous intensity in the left posterior part of the uterine body (Figure 1c). The patient underwent laparotomy and a subserous uterine fibroid was extirpated. Microscopically, the pelvic mass was proved to be lipoleiomyoma, consisting of smooth muscle cells and mature adipose tissue.

Discussion

Uterine lipoleiomyoma is a rare benign tumor. The reported incidence varies from 0.03% to 0.2% (Prieto et al. 2000). Their management is identical to leiomyomas. They usually present a diagnostic difficulty in differentiation from the much more common benign cystic ovarian teratoma. To date, only ten cases have been published in the imaging literature. MRI findings were described in only five cases (Chawla et al. 2004). A uterine lipoleiomyoma usually appears as a well-defined hyperechoic mass, encased by a hypoechoic ring on ultrasound, which is consistent with our case. In general, a CT shows more specific findings, revealing a predominantly fatty mass with areas of non-fat soft-tissue density arising from the uterus (Tsushima et al. 1997). MRI is highly specific, delineating fat tissue as hyperintense on T1- and T2-weighted images, with chemical shift artifact (Tsushima et al. 1997). But in our case, neither CT nor MRI was able to demonstrate the fat content of the lesion. After the microscopic diagnosis, re-evaluation of MRI revealed a few hyperintense millimetric foci on T1-weighted coronal images, which might be interpreted as a suspicion of fat content (Figure 1d). The authors believe that when the relative quantity of the fat tissue is small, it may not yield a definitive fat tissue image.

References


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Bilateral tubal ectopic pregnancy after clomiphene induction

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Case report

Mrs A.E., a 29-year-old para 1, was receiving clomiphene for secondary infertility of 2 years’ duration. She was admitted with severe lower abdominal pain at 7 weeks’ gestation. She felt faint and had lost consciousness for 5 min. No history of vaginal bleeding or shoulder tip pain was reported. Her first pregnancy had been a normal vaginal delivery when she was only 11 years old as a result of a sexual assault.

She presented with hypovolaemic shock and a positive urine pregnancy test. Abdominal tenderness with guarding and rebound tenderness indicated haemoperitoneum. Intravenous fluids were initiated and 2 units blood were crossmatched. Preoperative haemoglobin was 10.7 g/dl.

Laparotomy confirmed a haemoperitoneum and a left ampullary pregnancy. The right tube appeared normal. The uterus had a 3 cm posterior wall fibroid and the ovaries were polycystic. A left salpingectomy was performed. Blood loss was 1,000 ml and 2 units of blood were transfused. Postoperative recovery was uneventful and the patient was discharged 4 days later. Histology confirmed a left tubal ectopic pregnancy.

Mrs A.E. was re-admitted 1 month later with right iliac fossa pain and brown vaginal loss. A pregnancy test was positive. Lower abdominal and right adnexal tenderness were elicited. Pelvic infection was suspected. Transvaginal scan revealed an antverted empty uterus. A 6 cm right adnexal mass of mixed echogenicity with free fluid was seen in the pelvis. Serial β-human chorionic gonadotrophin (β-hCG) over the next 10 days dropped from 64 IU/L to 12 IU/L. Abdominal pain persisted. Laparoscopy showed right fimbrial ectopic pregnancy. Laparoscopic adhesiolysis and right salpingectomy were performed. Histology confirmed a right tubal ectopic pregnancy.

Discussion

Clomiphene is commonly used for ovulation induction in the treatment of infertility. Although previous studies have suggested that clomiphene increased the rate of ectopic pregnancies, these studies have not been controlled for tubal disease or endometriosis. Interestingly, Dickey et al. (1989) have found no difference in the incidence of ectopic pregnancy associated with clomiphene use in patients who did not have pelvic disease or endometriosis. However, cases of bilateral tubal ectopic pregnancies (Kaupp-Saha et al. 1990; Falk and Lackritz 1977) as well as simultaneous intra- and extrauterine pregnancies (Paldi et al. 1975) have been reported to be associated with clomiphene use. Our patient conceived on clomiphene and this may have resulted in multiple ovulation and therefore, bilateral tubal ectopic pregnancy. This highlights the importance of inspecting the contralateral tube at the time of surgery to remove any ectopic pregnancy. We should also be alert to the possibility of an ectopic pregnancy presenting in a patient who presents with abdominal pain or vaginal loss, even