دوره تخفیف نوروزی ویژه کارگاه‌ها و فیلم‌های آموزشی

اصول تنظیم قراردادها

پروپوزال نویسی

آموزش مهارت‌های کاربردی در ندوین و چاب مقاوم
Leiomyoma of the Adrenal Gland Presenting as An Incidentaloma

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Abstract
This was an unusual case of a primary leiomyoma tumor of the adrenal gland in a 26-year-old woman incidentally found during workup for mild, dull abdominal pain.

Keywords: adrenal gland, adrenal incidentaloma, leiomyoma, pathology

Introduction
Adrenal incidentalomas are clinically unapparent adrenal masses discovered inadvertently in the course of diagnostic testing or treatment for other clinical conditions that are not related to adrenal disease.1 Their incidence has risen recently due to improved imaging studies and their increased use.2,3 The differential diagnosis of incidentaloma consists of a long list of rare, miscellaneous tumors, including leiomyoma.4

In this paper, we report a case of adrenal leiomyoma suspicious for either hepatic or hydatid cyst pre-operatively. A literature review of previously reported adrenal gland leiomyomas is also presented.

Case Report
A 26-year-old woman presented with a history of dull, mild abdominal pain in the right upper abdominal quadrant since six months previous, with aggravation during the last month. The pain worsened with eating and lasted for about 2 hours. She also had a history of weight loss and anorexia but not early satiety or nausea and vomiting. She was known case of hypothyroidism who was treated with levothyroxin therapy (100 /g orally per day). Liver function tests, hematologic workup and 24 hour urine for Vanillyl mandelic acid (VMA) and catecholamines measurements were within normal limits. HIV antibody assay via the ELISA technique was negative.

Physical exam revealed a normotensive non-icteric woman with no palpable abdominal mass.

Abdominal sonography revealed a hetero-echo 9 cm diameter mass with a calcified peripheral wall on the right adrenal gland. Computed tomography (CT) scan was also performed which showed a heterogeneous right adrenal mass (9×7 cm) with multiple hypo-attenuated foci (Figure 1). Radiological differential diagnosis included adrenal cortical adenoma, carcinoma, and pheochromocytoma.

Chest X-ray was performed and according to normal findings of this evaluation, no more radiological studies (i.e., chest CT scan) were ordered.

Surgery was successful with no adhesion of the mass to neighboring tissues. The mass, in its entirety, plus the partially adhered right adrenal tissue were removed. The patient had an uncomplicated recovery and was discharged from the hospital three days after admission. There was no long-term follow up of the patient.

In this paper, we report a case of adrenal leiomyoma suspicious for either hepatic or hydatid cyst pre-operatively. A literature review of previously reported adrenal gland leiomyomas is also presented.

Discussion
Primary leiomyoma of the adrenal gland is a rare tumor associated with the adrenal vein or its tributaries.5 Only 14 cases have been previously reported in the literature (Table 1) with an age range from 2 to 72 years (average: 36 years).6–18 Adrenal leiomyoma predominates in females (10 cases out of 15; 66.6%). Only two cases had bilateral masses and seven, as with our case, were right sided. Tumor sizes ranged from 0.7 to 11 cm (average: 6.2 cm). Adrenal leiomyomas are regarded as one diagnosis in the long list of differential diagnoses for incidentalomas. They occur most frequently in the uterus and gastrointestinal tract but can be identified in different places, including the adrenal glands.16
Figure 1. Abdominal computed tomography (CT) scan showed a heterogeneous right adrenal mass with multiple hypo-attenuated foci (arrow-heads).

Table 1. Reported cases of adrenal leiomyoma.

<table>
<thead>
<tr>
<th>Report</th>
<th>Size (cm)</th>
<th>Weight (g)</th>
<th>Age (yr)</th>
<th>Sex</th>
<th>Side</th>
<th>Functional</th>
<th>Clinical associations</th>
<th>Reference</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>5.5×4.5×3.5</td>
<td>Un</td>
<td>53</td>
<td>F</td>
<td>Left</td>
<td>No</td>
<td>None</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>3×3.5×3</td>
<td>17.8</td>
<td>49</td>
<td>F</td>
<td>Left</td>
<td>No</td>
<td>AIDS(+), EBV(−)</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>5×3.1×4.2</td>
<td>Un</td>
<td>65</td>
<td>F</td>
<td>Left</td>
<td>No</td>
<td>None</td>
<td>12</td>
</tr>
<tr>
<td>4</td>
<td>3.5</td>
<td>Un</td>
<td>35</td>
<td>F</td>
<td>Left</td>
<td>Un</td>
<td>Un, AIDS(+)</td>
<td>17</td>
</tr>
<tr>
<td>5</td>
<td>7×5×5</td>
<td>Un</td>
<td>2</td>
<td>M</td>
<td>Right</td>
<td>Un</td>
<td>AIDS(+), EBV(+)</td>
<td>13</td>
</tr>
<tr>
<td>6</td>
<td>5.5×5×4.5</td>
<td>84</td>
<td>48</td>
<td>F</td>
<td>Left</td>
<td>No</td>
<td>Hypertension</td>
<td>16</td>
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<tr>
<td>7</td>
<td>9×7×6</td>
<td>Un</td>
<td>72</td>
<td>M</td>
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<td>11</td>
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<tr>
<td>8</td>
<td>3×3×3</td>
<td>Un</td>
<td>32</td>
<td>M</td>
<td>Left</td>
<td>No</td>
<td>AIDS</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>5×4×3</td>
<td>Un</td>
<td>10</td>
<td>F</td>
<td>Left</td>
<td>Un</td>
<td>Ataxia-telangiectasia</td>
<td>15</td>
</tr>
<tr>
<td>10</td>
<td>L: 5; R: 3</td>
<td>Un</td>
<td>11</td>
<td>F</td>
<td>Bilateral</td>
<td>Un</td>
<td>AIDS</td>
<td>18</td>
</tr>
<tr>
<td>11</td>
<td>L: 4×5×3.5, R: 8×5×3</td>
<td>L: 24.5; R: 80.5</td>
<td>15</td>
<td>M</td>
<td>Bilateral</td>
<td>No</td>
<td>Multiple Leiomyomas involving spleen, epicardium, bilateral testicular microlithiasis, and empty sella turcica</td>
<td>9</td>
</tr>
<tr>
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<td>Un</td>
<td>Un</td>
<td>40</td>
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<td>14</td>
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<td>14</td>
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<td>31</td>
<td>F</td>
<td>Right</td>
<td>No</td>
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</tbody>
</table>

Un=unknown; R=right; L=left; AIDS=Acquired immune deficiency syndrome; EBV=Epstein-Barr virus.
The adrenal leiomyomas are usually small tumors, however, as in this case, they can manifest a pressure effect on the neighboring organs. In addition to hematoxylin and eosin (H&E) staining, among IHC assays the tumor was positive for SMA, thus confirming the smooth muscle origin of this tumor. However, other benign tumors of smooth muscle origin, particularly inflammatory myofibroblastic tumors should be ruled out. The latter also has an inflammatory component rich in lymphoplasma cells, which was absent in this case. In addition, other IHC markers such as CD10, CD34, CD117, ALK-1, ER, and PR were assessed, of which all were negative in this case. Inflammatory myofibroblastic tumors are positive in 50% of cases\(^{17,18}\) and are sometimes positive for CD117.\(^{19,20}\) Additional IHC stains have also been used by some authors [i.e., S100, desmin, epithelial membrane antigen (EMA), CD34, Bcl-2, and CD117 (c-kit)].\(^{4}\) This case is 10 years younger than the average age of the reported cases.

As seen in Table 1, many reported cases of adrenal leiomyomas co-exist in patients diagnosed with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and/or latent Epstein-Barr virus (EBV) infection.\(^{21}\) Among the reported cases of adrenal leiomyoma, five are from AIDS patients.\(^{8,16,13,21,22}\) The association of leiomyoma and HIV/AIDS is not restricted to the adrenal gland, as these tumors have been found in various sites in children and adults.\(^{21,24}\) According to ELISA, our case was HIV-negative. EBV infection has been associated with smooth muscle tumors in immunocompromised patients but not in immunocompetent patients.\(^{23}\) The pathologic reason for this association is not clear. The EBV status of our case was not clear.

References

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