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Pelvic Lipomatosis in Female – A Case Report

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Introduction

Pelvic lipomatosis is a rare benign disease. It is characterized by the non-malignant proliferation of mature fatty tissue in the pelvis encasing the bladder & rectum, producing characteristic radiological findings. Surgical treatment is observed to be often incomplete and associated with substantial post-operative morbidity like thrombosis and recurrence & hence is only recommended in patients presenting with ureteric obstruction. CT scan is effective in the evaluation of patients with known/ suspected pelvic masses and is diagnostic of pelvic lipomatosis and obviates the need for surgical exploration. Till 2000, to our knowledge, only 148 cases have been reported in the literature out of which only 8 were in females. The cause of pelvic lipomatosis remains uncertain. We wish to report on unusual presentation of pelvis lipomatosis in a female diagnosed on CT scan and managed conservatively.

Case Summary

32 years old Mrs. K. resident of Delhi, presented on 12-10-95 with complaints of secondary amenorrhoea of 8 years duration and progressive dyspareunia since 5 years. There was history of perineal abscess during adolescence. She had a full term vaginal delivery at home 8 yrs ago. This was not followed by PPH, sepsis, or failure of lactation. On examination, she was of average weight and had no lymphadenopathy. The cardiovascular and respiratory systems were normal. On local examination, the vulva was healthy, though there were multiple small raw areas (Fig. 1). There was a rectovaginal fistula 5 mm diameter, 2 cm away from the introitus with fibrosis around the edges. The cervix was not seen. On vaginal examination neither the cervix nor the uterus could be made out. Rectal examination also could not clearly define the uterus or cervix. There was an ill-defined, fixed, firm, non-tender mass, extending from the mid line to the left lateral pelvic wall. On transvaginal sonography, uterus was anteflexed, normal sized but without any endometrial echoes and an ill-defined hypoechoic mass was seen extending from the posterior wall of the uterus to sigmoid colon indenting it. Her hemoglobin was 9.4 gm%, ESR-80 mm/1st hr. Chest x-ray was normal. Montoux test, and ELISA for Koch's were negative. Thyroid function tests, FSH and LH were normal and the complement fixation test for LGV was negative. On examination under anesthesia, uterus was appreciated anteriorly and there was a suspicion of a growth felt high up in sigmoid on rectal examination. Vaginal biopsy from raw areas revealed epitheloid cell granuloma (non tubercular), foreign body giant cell and melanin deposition in mid-dermis. Sigmoidoscopy revealed a polypoidal growth (4x3cms), firm in consistency with normal rectal mucosa stretching over it at the rectosigmoid junction (Fig. 2). Biopsy from this showed stratified squamous epithelium and fibrosis with inflammatory cells in the subepithelial zone. Noncontrast computerized tomographic scan of whole abdomen was done with pelvic scans taken after rectal air insufflation through an indwelling rectal tube (Fig 3). The rectal wall showed irregular thickening involving the right half of the circumference approximately 10 cms from the anal verge. An irregular mildly enhancing space occupying lesion was seen in relation to the thickened wall obliterating the pouch of Douglas and displacing the uterus anteriorly, indenting the urinary bladder. The fat planes between the mass and the uterus were not clearly demarcated. The pararectal fat was increased, increasing the presacral space (1.9 cms). No infiltration of the rectal lesion into the pelvic sidewall was seen. The fat planes between the mass and the uterus were not clearly demarcated. The pararectal fat was increased, increasing the presacral

space (1.9cms). No infiltration of the rectal lesion into the pelvic side wall was seen. The other abdominal organs were normal. There was no evidence of fluid or lymphadenopathy. Diagnosis of a rectal growth (possibly malignant) or pelvic lipomatosis was made on CT scan. Signoidoscopic appearance and a negative biopsy report did not support the diagnosis of a rectal growth. Non visualization of the uterine cervix however was a confusing dilemma. On reviewing CT scan, it appeared that the polypoidal mass indenting the rectum could be the cervix being pushed backwards and the uterus pushed anteriorly indenting the bladder.

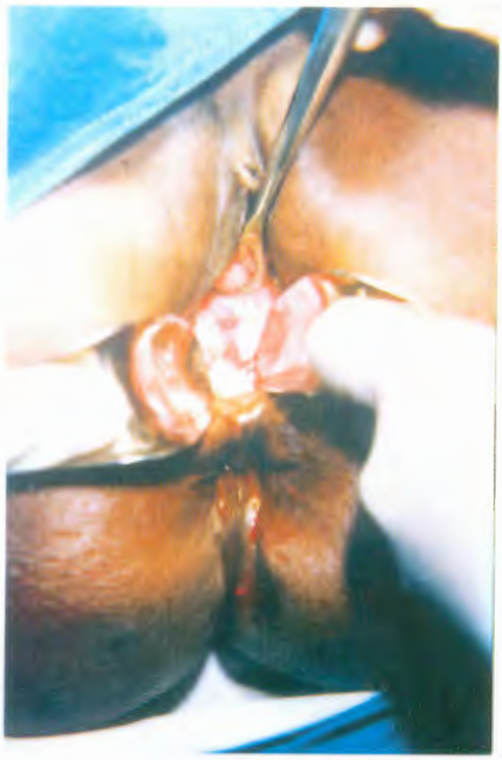

Fig. 1: Blind Vagina with Multiple Raw Areas

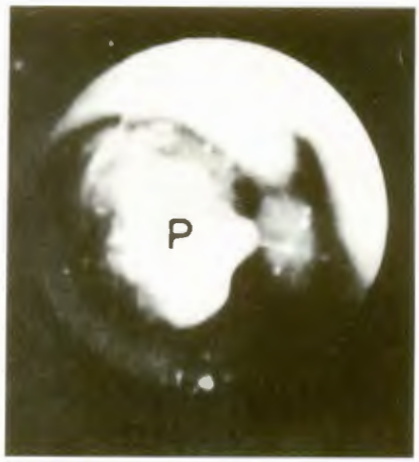

Fig. 2: Polypoidal Growth on Sigmoidoscopy

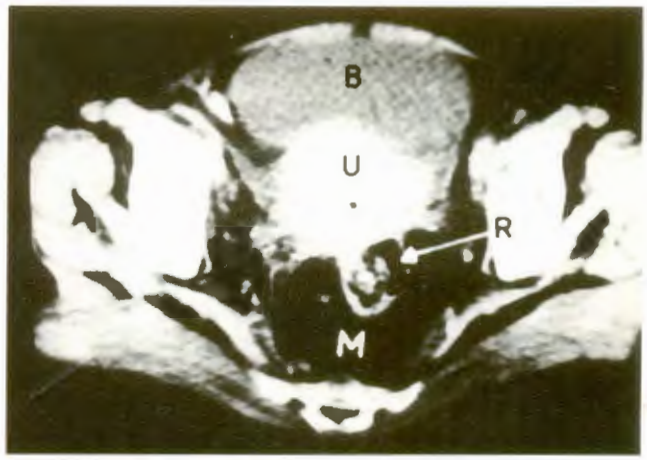

Fig. 3: CT-Scan Pelvis Showing Space Occupying Lesion

A trial of anti-tubercular therapy was given with no response. Hence, the diagnosis of pelvic lipomatosis was made and the patient was kept under observation. She came for follow up for 3 years with no progression of the disease.

Erratum

In the article entitled : 'LEUKEMIA PRESENTING AS MENORRHAGIA'
By A. C. Viswanatha Swamy published on page 108 in the July / August 2002 issue, the names of the co-authors are missing.

It should now read as follows :
'LEUKEMIA PRESENTING AS MENORRHAGIA'
by A. C. Viswanatha Swamy, Jyoti G.S., Sujani B. K. and Rekha G.