ACCESSORY AND CAVITATED UTERINE MASS (ACUM): A RARE TYPE OF MULLERIAN ANOMALY

Clinical details: A 21 year old, unmarried female presented with history of dysmenorrhea and chronic pelvic pain since more than 3 years, aggravating each passing year. MRI pelvis was performed.

Imaging findings:

- Thick walled lesion (ACUM) contiguous with the left lateral uterine wall. Its wall shows signal intensity similar to the myometrium on all sequences (Fig 2). Central cystic component is noted which shows signal intensity changes consistent with blood degradation products(Fig 4).

- There is no communication of this lesion with endometrial cavity of main uterus(Fig 1&3).Junctional zone, endo-myometrial interface, and myometrial signal intensity of the main uterine cavity appear normal. Both uterine cornua visualized. Both ovaries are normal. No pelvic endometriotic deposits are seen and there is no evidence of hematosalpinx.

Diagnosis: Accessory and Cavitated Uterine Mass.
Discussion:

Uterus develops from the embryonic fusion of the two Mullerian ducts. Seven classes of uterine anomalies are described in literature including septate uterus, arcuate uterus and unicornuate uterus to name a few.

Uterus like masses (ULM's) are rare lesions that resemble to uterus both macroscopically as well as microscopically. Accessory and Cavitated Uterine Masses (ACUM) are non communicating ULM's that occur contiguously along the wall of uterus. ACUM is a developmental anomaly, as postulated by majority of authors. It is considered to be due to duplication of the Mullerian duct at the level of attachment of the round ligament.

ACUM's generally present in young females, less than 30 years. Repeated bleeding within the ACUM, during menstrual cycle causes distension of its cavity and chronic pelvic pain. ACUM may be larger in size when the woman is older in age.

To characterize a lesion to be an ACUM on imaging, the following criteria need to be met:

1. An accessory cavitated mass with habitual orientation of the lesion around the round ligament
2. Normal uterus, endometrial cavity, fallopian tubes and the ovaries.
3. Cystic component within the lesion showing chocolate content and signal intensity of blood degradation products.
4. No signs of adenomyosis in the uterus, however tiny foci of adenomyosis may be seen in the myometrium of ACUM due to increase intracystic pressure.
5. No pelvic endometriotic deposits.

ACUM may coexist with other Mullerian anomalies as reported in literature and may further complicate the diagnosis. MRI remains the modality of choice as it clearly distinguishes a contiguous, non communicating ULM with cystic component within.

Clinical suspicion of this entity based on the occurrence of symptoms, recurrence of symptoms, patient age and knowledge and awareness of this entity will help to consider preoperative diagnose of ACUM more accurately.

Regards,

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N.B: This case is authentic and from the archives of Radiance Diagnostics. For any queries/suggestions/feedback write to us at radiance@radiancediagnostics.in. Case of the month can also be accessed anytime online at VIEW BOX at www.radiancediagnostics.in