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Histopathology

A RARE INCIDENTAL FINDING: XANTHOGRANULOMATOUS SALPINGITIS PRESENTED AS AN OVARIAN MASS.

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ABSTRACT Xanthogranulomatous salpingitis is an unusual inflammatory lesion of the fallopian tubes. Only a few cases have been reported in the english medical literature, some under different nomenclature. Pelvic inflammatory disease (PID) and endometriosis have been seen associated. A 47 year old women presented with complaints of Abnormal uterine bleeding since 9 months and have undergone with various laboratory investigations and on ultrasonography she was presented with left ovarian mass but in the histopathological report she was incidentally diagnosed with a rare case of xanthogranulomatous salpingitis.

KEYWORDS : Fallopiantubes, salpingitis, PID.

INTRODUCTION

Xanthogranulomatous salpingitis is a chronic form of granulomatous inflammation which is destructive to the normal tissues of affected organs. It is a rare entity(1). It is characterized by the presence of a large number of lipid-containing vacuolated macrophages admixed with lymphocytes, plasma cells, and neutrophils. Pathogenesis of vacuolated macrophages is unclear, it is believed by many authors to be a secondary degenerative change representing the accumulation of different substances ingested by histiocytes. The proposed causes of vacuolated macrophages are abnormality in lipid metabolism and ineffective clearance of bacteria by phagocytes(2). Multinucleated giant cells may be present. Multiple organs have been reported to be affected by xanthogranulomatous inflammation, most commonly the kidney followed by the gall bladder(3,4). Female genital organs especially fallopian tubes are rarely seen involved, the reason of this entity might be Pelvic Inflammatory Disease (PID) ,most commonly genital tract infection(5).

CASE REPORT

A 47 year old women came to the gynaecology department with complaints of pain in lower abdomen, nonradiating and nonmigratory from last one month, frequent menstruation since 8-9 months. She had two children by full term normal delivery. There was no significant findings in the past or personal history. On her general physical examination there was no significant findings other than mild pallor. On systemic examination cardiovascular system, respiratory system was within normal limits. Abdomen was soft with no organomegaly. Perspeculum examination showed hypertrophied cervix mixed with discharge and there was also second degree cervical descent. Pervaginal examination showed retroverted bulky uterus, firm, tender with restricted mobility and clear bilateral fornices. She was afebrile, Pulse was 78bpm. Her investigations showed: Hb-9.5gm/dl, TLC-16000/cmm. PCV–31%, Platelet count-3.06lacs. MCV-98.6fl, MCHC-31g/l, MCH-30.3pg, RBC-3.14 and RDW-CV-14.5%. Her viral markers (HIV, HBsAg, Anti-HCV) were nonreactive. Tumor marker (CA-125) was not raised. She had mildly raised SGOT-76U/L and SGPT-70U/L. Her urine culture was sterile. She had her previous cytology pap report which showed NILM (Negative for intraepithelial lesion and malignancy). Ultrasonography showed hypoechoic lesion in left adnexa (left ovary) measuring 5.8*6* 4.6cm with well defined regular margin. Right ovary appears to be normal. It gives the impression of left ovarian mass (Figure no.1) CECT abdomen reveals thick walled elongated serpiginous lesion in left adnexal region measuring 10*4.3cm in maximum cross-section. Foci of nodular in the wall with heterodense content showing attenuation from 3 to 25 HU. Right adenexa appears to be normal.

PATHOLOGY

Total abdominal hysterectomy was done with left salphingo-oopherectomy and the specimen was sent to histopathology lab for further evaluation. On Gross examination (Figure2a,b),left fallopian tube measures 7cm in length and dilated at one end measuring 8.5*4.5*2cm. Cut section shows dilated lumina filled with brown coloured material with focal areas of calcification. Specimen was partially embedded.H&E stained section from fallopian tube shows fused tubal plicae and few follicles like dilated structures lined by tubal epithelium. Tubal lumina is filled with both acute and chronic inflammatory cells. Sheets of foamy macrophages also noted. Large areas of tubal mucosa is replaced by fibrosis and inflammation. There is no granuloma or giant cell seen in the section examined.

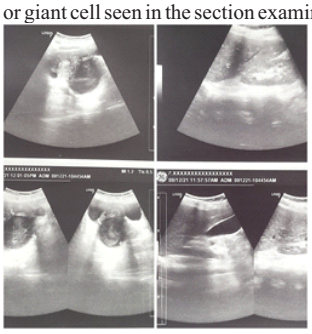

Figure 1: Ultrasonography of whole abdomen, showing hypoechoic lesion in left adenexa

Figure 2:(a)Gross appearance of uterus with left adenexa showing enlarged left fallopian tube.(b)On cut section of left fallopian tube shows dilated lumina.

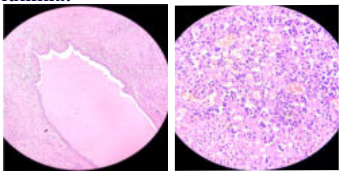

Figure 3: (a)(40x, highpowerview, H&E stain) Lipid containing

macrophages and mixed inflammatory infiltrate.(b)(10x, lowpowerview, H&E stain) Fallopian tube with few follicles like dilated structures lined by tubal epithelium.

DISCUSSION

Multiple etiologies have been involved in xanthogranulomatous inflammation. Kunakemakorn was the first to describe xanthogranulomatous inflammation of serosa of uterus, left fallopian tube and ovary in his report of 7 inflammatory pseudo tumor in the pelvis in 1976(6). Ineffective antibiotic therapy, immunosuppressive patients, endometriosis, chronic inflammatory conditions, the use of an intrauterine contraceptive devices, luminal obstruction, leiomyoma, abnormalities involving lipid metabolism, ineffective clearance of bacteria by phagocytes, radiotherapy, and chronic irritation of the urachal remnants are some causes that implents in the pathogenesis of xanthogranulomatous salpingitis(1). Microorganisms associated include Actinomyces, Staphylococcus aureus, Streptococcus faecalis, E.coli, viridans streptococci, Bfragilis, Candida glabrata and group B streptococci(7). Another rare phenomenon i.e. pseudoxanthomatous salpingiosis needs to be differentiated from xanthogranulomatous salpingitis which occurs in women with along history of endometriosis. The former shows numerous brown lipo fuscin pigmented histiocytes within the lamina propria. We studied in our case report, the presence of acute and chronic inflammatory cells and the lack of lipo fuscin pigments thus supporting the diagnosis of xanthogranulomatous salpingitis(8).

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