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Disseminated Endometriosis and Leiomyomatosis Following Power Morcellation

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Introduction

A 45-year-old, gravida two, para two, presented to the emergency department with acute right sided pelvic pain. A CT scan demonstrated an 11 cm left adnexal solid and cystic pelvic mass, concerning for ovarian torsion. Her past surgical history was notable for a laparoscopic supracervical hysterectomy four years ago for benign indications with uncontained power morcellation.

On exploratory laparoscopy, “chocolate fluid” was noted throughout the pelvis, concerning for recent rupture of an ovarian endometrioma. There were also approximately seven smooth, round, pink lesions present in the pelvis, which appeared to be parasitic leiomyoma leiomyomata, adherent to multiple structures (Figure 1). Histopathologic examination confirmed the presence of a hemorrhagic luteinized cyst and benign leiomyomas.

Surgeons considering a minimally invasive surgical approach without en bloc tissue removal should be aware of the potential complications associated with iatrogenic dissemination of benign viable endometrial and/or myometrial tissue associated with uncontained tissue morcellation [1-3].

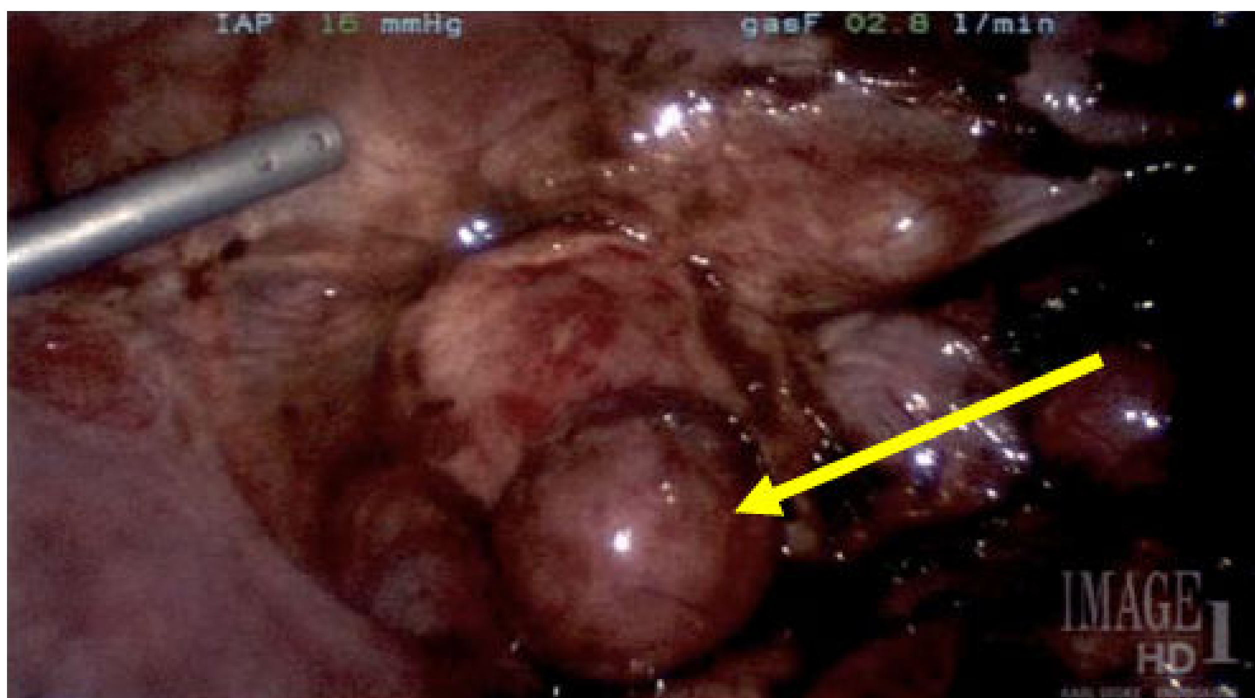

Figure 1: Intraoperative image of parasitic fibroid (yellow arrow) during emergent diagnostic laparoscopy.

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