Florid cystic endosalpingiosis of the uterus

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Abstract
A 73 year old woman presented with a right sided adnexal cystic mass. At laparotomy, this proved to be a benign serous ovarian cyst and an aggregation of thin walled sub-serosal and soft tissue cysts and spongy nodules up to 16 mm in diameter involving the side wall of the uterus and adjacent parametrium. These were removed by total abdominal hysterectomy and bilateral salpingo-oophorectomy. Histologically, the cystic spaces and smaller acini were lined by benign tubo-endometrioid epithelium, with smaller areas typical of serous differentiation and rare microfoci of endocervical-type mucinous epithelium. These features indicated multidirectional Mullerian differentiation in a process that, overall, was consistent with so called florid cystic endosalpingiosis. This lesion is to be distinguished from other benign conditions including multicystic mesothelioma, endometriosis, endocervicosis, florid deep glands of the uterine cervix, and deep Nabothian cysts of the uterine cervix.

Keywords: uterus; endosalpingiosis; cysts

Pathology
The pathological specimen consisted of an atrophic (73 g) uterus measuring 75 × 45 × 30 mm with attached Fallopian tubes and ovaries, including a unilocular right ovarian cyst and unremarkable left adnexae. The cystic spaces and the nodules, measuring up to 16 mm in diameter, were beneath the uterine serosa (within the superficial myometrium) and extended from the mid corpus to the cervix. The cut surfaces of the nodules revealed a honeycomb pattern of microcysts. Several similar nodules were present in the adjacent right parametrium. An incidental finding was a 12 mm long endometrial polyp.

Histologically, the subserosal, intramyometrial, and parametrical nodules consisted of variably sized and shaped cystic spaces and gland-like structures, lined mainly by tubo-endometrioid epithelium (fig 1). Some cysts were lined by serous (tubal) epithelium, whereas others exhibited attenuated serous epithelium or, rarely, endocervical-type mucinous epithelial cells (fig 2). There was no

Figure 1 Florid cystic endosalpingiosis. Variably sized cystic spaces are lined by tubo-endometrioid and flattened more serous epithelium. Haematoxylin and eosin stained; original magnification, ×40.

Figure 2 Florid cystic endosalpingiosis. Variable differentiation is demonstrated with spaces lined partly by mucinous and tubal type epithelium. Original magnification, ×40.
evidence of epithelial atypia. The lining epithelium demonstrated intense positivity for cytokeratins (CAM 5.2, MNF 116) and for oestrogen and progesterone receptors. The tubo-endometrioid epithelium also stained strongly for vimentin and CA-125, whereas cytokeratin 5/6 was preferentially demonstrated in the more attenuated serous epithelium. The stroma between the cystic/glandular spaces were fibromuscular without evidence of either endometrial stromal differentiation or recent/old haemorrhage.

There was no evidence of epithelial proliferation in either the endometrial polyp or the right ovarian cyst.

**Discussion**

Epithelial structures that occur in women, on or beneath the visceral or parietal peritoneum, in the retroperitoneal lymph nodes, or in the soft tissues of the pelvis and lower abdomen, and with differentiation typical of the lining of the female genital tract, have generically been termed Mullerianosis.\(^1\) They include lesions with tubal/serous differentiation (endosalpingiosis) and the homologous lesions of endometriosis and endocervicosis. Each of these lesions, in its pure form, has a more or less structured anatomical distribution as well as clinical correlates. Mixed forms also occur.\(^2\) The morphological features of our case most closely resemble those recently described by Clement and Young and designated as florid endosalpingiosis.\(^3\) They include lesions of either endometrial stromal differentiation or tubo-endometrioid differentiation determined by the uniform presence of attenuated mesothelial cells lining the cystic spaces, the distribution of the lesions on the surface only of the pelvic structures, and the frequent presence of a mild inflammatory infiltrate in the cyst walls.

The importance of our case, and those few reported in the literature, is that they represent yet another piece in the global “jigsaw” of pathological lesions arising in situ from the secondary Mullerian system.


