A 34-year-old black woman was being evaluated for vaginal bleeding as an outpatient when abnormal findings on chest roentgenogram were noted (Fig 1). She complained only of vague abdominal discomfort and had no respiratory complaint. Her past medical history was significant for menometrorrhagia in 1981 which resulted in an abdominal hysterectomy. The ovaries were left intact. She was receiving no medication, had no allergies or history of illicit drug, alcohol or tobacco use.

Positive physical findings were limited to obesity and mild, ill-defined abdominal pain on palpation. There was no guarding, rigidity, rebound, masses or organomegaly.

A second roentgenogram (Fig 2) nine days later showed an obvious decrease in nodule size although no treatment had been instituted. A transbronchial biopsy was performed (Fig 3).

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Diagnosis: Endolymphatic stromal myosis

Endolymphatic stromal myosis (ESM) is rare. It has been reported under numerous synonyms including uterine stromal endometriosis, uterine stromatosis, proliferative stromatosis and endometrial stromal sarcoma.1 Although it has been well described histologically, there remains controversy as to its classification as a benign or malignant tumor.8 Histologically, ESM is characterized by its infiltrative growth of endometrial stromal-like tissue within the myometrium.3 It may extend to the serosal surface of the uterus involving surrounding structures such as the perimetrium and pelvic side walls.4 The tumor also has a tendency to extend into blood vessels and lymphatics and may be expressed as worm-like masses. Distant metastasis have been described to the peritoneum, liver, lung, brain and bone.4,5

The mean age at presentation is in the fourth decade, but ESM can effect both pre- and postmenopausal women and has been reported from ages 17 to 75 years.2,8

In most reviews and case reports, clinical symptomatology is limited to the pelvis and abdomen.1-7 Norris and Taylor4 reviewed 35 cases of ESM and reported that the most common presenting symptom was abnormal vaginal bleeding. Accompanying symptoms included abdominal or pelvic pain (frequently ill-defined), abdominal cramping, backache, fatigue, urinary frequency and urgency and a palpable abdominal mass.4,5 The most frequent sign is a pelvic mass.5

Pulmonary metastases are usually asymptomatic, although complaints of dyspnea and cough have been described.1 The roentgenographic appearance of ESM metastatic to the lung is that of multiple nodules.1,6

The treatment of ESM has included surgery, chemotherapy, radiotherapy and hormonal therapy. Total abdominal hysterectomy with or without bilateral salpingoophorectomy has routinely been performed.1-7 Controversy exists as to whether radiation therapy is beneficial.8,9 The use of progestational agents has been reported by several investigators,1,6,7,10,11 who have described either complete or partial response, while Kirby12 noted progression of ESM in his patient given progestogens.

REFERENCES

1 Pellillo D. Proliferative stromatosis of the uterus with pulmonary metastasis. Obstet Gynecol 1968; 31:33-9
4 Kreiger PD, Gusberg SB. Endolymphatic stromal myosis. Gynecol Oncol 1973; 1:299-313

Figure 4 shows the chest roentgenogram ten months after bilateral salpingoophorectomy and therapy with megestrol acetate (Megace-Bristol Myers).