Imaging Manifestations of Accessory Cavitated Uterine Mass—A Rare Mullerian Anomaly

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Abstract

Context Accessory cavitated uterine mass (ACUM) is an uncommon and under-recognized entity with distinct imaging characteristics and causing significant patient distress. Differentiating it from its other clinical and radiological differentials is therefore extremely important and prevents delay in surgical management which is the treatment of choice.

Aims The aim of the study is to describe the MRI appearance of the surgically and pathologically proven ACUM cases from our institution in the last 2 years.

Settings and Design This is a retrospective study in a tertiary care hospital in South India.

Methods and Material We reviewed the clinical presentations and imaging findings of seven surgically proven cases of ACUM qualifying the proposed diagnostic criteria.

Results All patients presented with chronic pelvic pain, dysmenorrhea, and prolonged post-menstrual pain. MRI in all seven cases showed an intramural, noncommunicating, and cavitating lesion near the uterine cornua with internal contents similar to that of endometrioma. Although the cavity was lined by endometrium in all the cases (proven in pathology), it was well appreciable on MRI in only five cases. The rest of the uterine myometrium and main endometrial cavity were normal with no features of adenomyosis.

Conclusion MRI is a reliable diagnostic tool for accurate diagnosis of ACUM, and more importantly, in distinguishing it from other causes of chronic pelvic pain like adenomyosis and endometriosis and other imaging differentials like adenomyoma, noncommunicating uterine horn, and degenerating leiomyoma.

Introduction

Accessory cavitated uterine mass (ACUM) is a relatively under-recognised entity characterized by the presence of a noncommunicating accessory cavity lined by endometrium and surrounded by uterine smooth muscle.1 It is typically located within the uterus close to the round ligament and has a uterus-like structural arrangement.2 The main endometrial cavity, fallopian tubes, and ovaries are normal. This entity has been previously reported in the literature as juvenile...
cystic adenomyoma, isolated cystic adenomyoma, and cavi-
tated uterus-like mass within the myometrium, which are all
now thought to represent ACUM. Although there are a few
theories regarding the development of ACUM, most authors
consider ACUM as a congenital Mullerian anomaly which is
different from other Mullerian anomalies because of the
otherwise normal endometrial cavity. It is hypothesized
that this entity could be attributed to the duplication and
persistance of a segment of Mullerian duct at the level of
round ligament attachment, possibly due to Gubernaculum
dysfunction.1,4

In this retrospective review, we highlighted the distinct
clinical presentation and imaging findings of ACUM that will
help in differentiating this condition from its other more
common clinical differentials like adenomyosis and endo-
metriosis, and other imaging differentials like true cavitating
adenomyoma, noncommunicating functional uterine horn,
and degenerating leiomyoma.

Subjects and Methods
In our retrospective study, we reviewed seven cases whose
imaging showed isolated noncommunicating cavitated uter-
ine lesion that was eventually proven to be ACUM based on
the diagnostic criteria proposed by Acién et al.1 We also
described the clinical presentation, MRI findings of these
patients in detail, and reviewed the relevant literature.

Diagnostic Criteria for ACUM

1. An isolated accessory cavitated mass.
2. Normal uterus (endometrial cavity), tubes, and ovaries.
3. Surgical case with excised mass and pathological
   examination.
4. Accessory cavity lined by endometrial epithelium with
glands and stroma.
5. Chocolate brown–colored fluid content.
6. No adenomyosis (if the uterus is removed) but there could
   be small foci of adenomyosis in the myometrium adjacent
to the accessory cavity.

Results
Five out of our seven patients were under 30 years of age
and unmarried. The remaining two patients who were over
30 years of age had two children each, one of whom
delivered through caesarean sections both the times during
which the accessory cavity was not recognized. One patient
underwent emergency laparoscopic ovarian cystectomy for
torsion, during which the bulge on uterus (from the ACUM)
was presumed to be a pseudo-broad ligament fibroid and
was left intact; surgical specimen histopathology subse-
quently confirmed ovarian serous cystadenoma. All our
patients presented with chronic pelvic pain and severe
dysmenorrhea starting a few years after menarche and
five of them complained of prolonged post-menstrual
pain lasting for up to 20 days. It is interesting to note
that one of the patients reported a symptom-free interval
during pregnancy and the post-partum period. All the
patients received a combination of pain killers, OCPs and
Dienogest (synthetic oral progestin) for varied clinical
diagnosis (fibroid, endometriosis, rudimentary uterine
horn, and ureteric colic). Six of them had an ultrasound
scan prior to MRI and were told to have a fibroid. Review of
the ultrasound images showed a cavity with endome-
tria-like contents in five of the six patients (►Figs 1
and 2). Five patients underwent pelvic MRI (one of them in
a scan centre elsewhere) and two of them underwent CECT
abdomen and pelvis following which limited pelvic MRI was
done by the radiologist. None of the patients underwent
HSG or hysterosalpingogram (►Table 1).

The MRI of all patients showed a cavitated lesion in the
uterus (►Figs. 1–3) just anterior to the uterine cornua and
corresponding to the round ligament attachment, three on
the right side and four on the left with the size ranging from
3 to 4.3 cm. All the lesions showed T1 hyperintense content
with a T2 shading sign. The lesion wall was formed by T2
hypointense myometrium with thickness ranging from 8 to
11 mm. Endometrial lining in the accessory cavity could be
seen in five out of the seven patients and could not be
distinctly seen in two of the patients. Rest of the uterus

![Fig. 1](https://example.com/fig1.png)

Fig. 1 T2 HR axial (a) and coronal (b) MR images show a thick-walled cavity in the left juxta-cornual location of the uterus lined by thin
hyperintense endometrium and showing intermediate signal intensity fluid within. The fallopian tube attachment is seen posterior to the cavity
(arrow in b). Representative transvaginal ultrasound image in the transverse plane (c) shows a cavity with ground-glass contents surrounded by
hyperechoic endometrial lining and a thicker hypoechoic wall around it.
including the endometrial cavity was normal in all patients with two well-seen uterine cornua, with the exception of a small intramural fibroid in one patient. Bilateral ovaries were normal except for one patient with a 4-cm hemorrhagic cyst in one of the ovaries (which spontaneously resolved by the time of surgery) and another patient with a 4-cm corpus luteal cyst. A preoperative diagnosis of ACUM was suggested based on the MRI findings in four of the cases while in the other three cases, the differentials of cystic adenomyoma and functional noncommunicating rudimentary uterine horn were raised at the time of prospective MRI reporting.

All patients underwent laparoscopic excision of the lesions. Intraoperatively, the lesions were beneath the round ligament attachment and ipsilateral fallopian tubes were seen along the posterior aspect of the lesion. The cavities had altered blood within and there was no communication with the main endometrial cavity. One of the patients was found to have intraoperative ipsilateral pelvic endometriosis.

The pathological examination of the excision specimens showed a myometrial wall with endometrial lining. Three of the patients also showed foci of adenomyosis within the wall of the cavity, although MRI did not show any evidence of endometrial tissue within the myometrium around the main cavity or the ACUM.

We were able to follow-up four patients (2 months to 2 years after surgery) who did not have any gynecological complaints. Two patients were lost to follow-up. One of the most recently operated patients had not yet come for first follow-up.

**Discussion**

Although ACUM was named so and clearly defined as a distinct clinical entity in 2010 by Acién et al., awareness about this condition among radiologists and gynecologists is still not widespread. To date, we have found 58 cases described in the literature satisfying the diagnostic criteria for ACUM. Of these, 24 cases were reported prior to the index article under various terminologies, and 34 cases were reported after 2010 (including four cases in the index article). The largest case series constituting 11 cases was published in August 2018.

It is now clear that juvenile or isolated cystic adenomyomas and ACUM represent the same pathology. The typical patient was thought to be nulliparous under the age of 30 years, although it is now fairly clear that some of these women present later in life and some after previous childbirths. These women present with chronic pelvic pain and severe dysmenorrhea lasting for a few weeks after menstruation that is explained by the increased intracystic pressure following menstruation.

Ultrasound shows an intramural lesion which may be mistaken for a degenerating intramural or pseudo-broad ligament fibroid; however, the presence of a central single cavity with a ground-glass appearance of internal contents should raise the suspicion for ACUM.

MRI can help in localizing the lesion which is almost always seen at the uterine horn/cornua, beneath the round ligament and just anterior to the ipsilateral fallopian tube attachment. A few authors have reported the slightly more anterior location of the cavitated mass in the myometrium and more posteriorly in the myometrium close to the broad ligament. The contents of the cavity appear hyperintense on T1W or T1W fat-saturated images and intermediate signal to hypointense on T2W MRI, sometimes with a T2 shading effect. The cavity is lined by a thin T2 mildly high-signal-intensity endometrial lining (similar to that of the endometrial lining in the main endometrial cavity) which may or may not be well seen on T2-weighted MRI. The wall of the cavity appears T2 hypointense and is made up of organized uterine smooth muscle tissue. Although the wall of the accessory cavity can show foci of adenomyosis, there should not be any adenomyotic changes in the myometrium surrounding the main endometrial cavity. There may be an occasional rudimentary accessory fallopian tube attached to the mass, which is not necessarily seen on MRI. Bilateral ovaries and fallopian tubes are otherwise normal. There are no reported cases of associated renal or other congenital/developmental anomalies.

HSG may have an indirect role in the diagnosis of ACUM by revealing the morphology of native endometrial cavity. For example, a unicorinate morphology of the endometrial cavity may suggest the possibility of a noncommunicating rudimentary horn and ACUM is more likely to have a normal endometrial cavity with two distinct cornua on an anteroposterior spot image of HSG. But the literature available on this is limited. On the other hand, MRI helps in assessing the uterine wall in its entirety and is by far the gold standard noninvasive diagnostic modality for various myometrial lesions.
### Table 1 Summarizing the results of the study

<table>
<thead>
<tr>
<th></th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
<th>Case 5</th>
<th>Case 6</th>
<th>Case 7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (in years)</strong></td>
<td>17</td>
<td>23</td>
<td>21</td>
<td>33</td>
<td>32</td>
<td>26</td>
<td>19</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>Chronic pelvic pain and dysmenorrhea</td>
<td>Congestive dysmenorrhea + continuous inter/post menstrual pain for 3 y.</td>
<td>Chronic pelvic pain with periodic exacerbations during and after periods for 6 y.</td>
<td>Congestive dysmenorrhea lasting till 20 d after periods; symptom-free interval during pregnancy and lactation.</td>
<td>Dysmenorrhea with pain lasting for 15 days after periods; for 7 y</td>
<td>Dysmenorrhea with pain lasting for 20 d after periods</td>
<td>Dysmenorrhea for 1.5 y.</td>
</tr>
<tr>
<td><strong>Ultrasound findings</strong></td>
<td>Isoechoic cavitating lesion with central ground glass-like content</td>
<td>Hypoechoic cavitating lesion with partly echogenic and partly anechoic content</td>
<td>Isoechoic cavitating lesion with echogenic ground glass-like content</td>
<td>NA</td>
<td>Isoechoic cavitating lesion with ground glass-like content</td>
<td>Isoechoic lesion; cavity could not be clearly made out</td>
<td>Hypoechoic cavitating lesion with ground glass-like content</td>
</tr>
<tr>
<td><strong>MRI/CECT</strong></td>
<td>+/−</td>
<td>+/−</td>
<td>+/+</td>
<td>+/−</td>
<td>+/+</td>
<td>+/−</td>
<td>+/−</td>
</tr>
<tr>
<td><strong>Side and location of ACUM</strong></td>
<td>Right, juxtacornual</td>
<td>Left, juxtacornual</td>
<td>Left, juxtacornual</td>
<td>Right, juxtacornual</td>
<td>Left, juxtacornual</td>
<td>Right, juxtacornual</td>
<td>Left, juxtacornual</td>
</tr>
<tr>
<td><strong>Size of ACUM (in cm)</strong></td>
<td>3 × 2.3</td>
<td>3.3 × 3</td>
<td>4 × 3.5</td>
<td>3.4 × 2.8</td>
<td>4.3 × 3.5</td>
<td>3.3 × 3</td>
<td>4.2 × 4.1</td>
</tr>
<tr>
<td><strong>Internal content signal intensity</strong></td>
<td>T1 hyper, T2 intermediate with shading sign.</td>
<td>T1 hyper, T2 intermediate with shading sign.</td>
<td>T1 hyper, T2 intermediate with shading sign.</td>
<td>T1 hyper, T2 intermediate with shading sign.</td>
<td>T2 intermediate with shading sign, T1 not available.</td>
<td>T1 hyper, T2 intermediate with shading sign.</td>
<td>T1 hyper, T2 intermediate with shading sign.</td>
</tr>
<tr>
<td><strong>ACUM wall thickness (in mm)</strong></td>
<td>10</td>
<td>8</td>
<td>11</td>
<td>9</td>
<td>11</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td><strong>ACUM wall signal intensitya</strong></td>
<td>T2 hypo</td>
<td>T2 hypo</td>
<td>T2 mildly hypo, CT iso</td>
<td>T2 hypo</td>
<td>T2 mildly hypo, CT iso</td>
<td>T2 hypo</td>
<td>T2 hypo</td>
</tr>
<tr>
<td><strong>Endometrial lining in ACUM on MRI</strong></td>
<td>Indistinct</td>
<td>Well seen</td>
<td>Well seen, also seen on CECT</td>
<td>Indistinct</td>
<td>Well seen</td>
<td>Well seen</td>
<td>Well seen</td>
</tr>
<tr>
<td><strong>Rest of the uterus and main endometrial cavity</strong></td>
<td>Small intramural fibroid</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td><strong>Ovaries</strong></td>
<td>4 × 3 cm thin-walled cyst in left ovary</td>
<td>Normal</td>
<td>4 × 2 cm hemorrhagic cyst in left ovary</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td><strong>Definitive treatment</strong></td>
<td>Laparoscopic excision of ACUM</td>
<td>Laparoscopic excision of ACUM</td>
<td>Laparoscopic excision of ACUM</td>
<td>Laparoscopic excision of ACUM</td>
<td>Laparoscopic excision of ACUM</td>
<td>Laparoscopic excision of ACUM</td>
<td>Laparoscopic excision of ACUM</td>
</tr>
<tr>
<td><strong>Intraoperative location and content of ACUM</strong></td>
<td>4 × 4 cm mass embedded in uterine wall beneath round ligament; ACUM cavity with altered blood.</td>
<td>4 × 4 cm mass embedded in uterine wall just inferior to round ligament; ACUM cavity with altered blood; left-sided pelvic endometriosis.</td>
<td>4 × 4 cm mass anterior to left cornua; ACUM cavity with altered blood.</td>
<td>Bulge near right cornua; ACUM cavity with altered blood.</td>
<td>Noncommunicating cavitating lesion seen anterior to the cornua; ACUM cavity with altered blood.</td>
<td>Noncommunicating cavitating lesion; right tubal ostium could not be seen; ACUM cavity with altered blood.</td>
<td>Mass near left cornua; ACUM cavity with altered blood.</td>
</tr>
</tbody>
</table>
Clinical and imaging differentials for cavitated uterine lesion include true cavitated adenomyoma, functional non-communicating rudimentary uterine horn, and cystic degeneration of a fibroid.

**ACUM versus True Adenomyoma**

- True adenomyomas can present in a similar manner clinically but in older women with severe adenomyosis; these lesions have ill-defined margins and do not have a topographic preference within the uterus, except for being close to the junctional zone. In adenomyoma, the junctional zone around the main uterine cavity is also thickened (>12 mm) with or without small T1 hyperintense hemorrhagic foci within.

- Cystic changes in adenomyoma are more often seen as multiple small cystic foci, although rarely a single cavity may be seen. In such cases, the lack of true endometrial lining and uterus-like structural and histological organization help differentiate it from ACUM.

- Myometrium around the ACUM can show adenomyosis (as seen in the histopathology of three of our cases) due to the increased intracystic pressure, while the rest of the uterus does not show evidence of adenomyosis.

**ACUM versus Functional Noncommunicating Rudimentary Uterine Horn**

- ACUM can be differentiated from functional noncommunicating rudimentary uterine horn by demonstrating the normal native endometrial cavity with two normal cornua on MRI, although technically ACUM can rarely co-
exist with other Mullerian anomalies. In the case of functional noncommunicating uterine horn, MRI shows the unicorunate morphology of the uterus on the side opposite to the rudimentary horn.

- MRI obviates the need for HSG or hysteroscopy which is recommended by a few authors.
- Rudimentary functional uterine horn and ACUM have similar structural and histological organizations, and therefore, a pathologist cannot distinguish between these two entities when examining the surgical specimen, unless provided with the imaging findings of normal background uterine cavity or alternatively, a hysterectomy specimen is available.

**ACUM versus Leiomyoma with Cystic Degeneration**

- Uncommonly, leiomyomas may demonstrate a single, central cystic degeneration but the contents are rarely hemorrhagic. The lack of topographic preference within the uterus, lack of cyclical pain, and possible presence of multiple lesions help in differentiating this uncommon manifestation of leiomyoma from ACUM.

Definitive management is complete surgical excision of the mass, preferably using laparoscopy. ACUM has well-defined margins and complete enucleation is possible without much myometrial damage. Whenever possible, anterior incision over the uterine mass is preferred over other surgical approaches.

One of our patients was diagnosed to have superficial pelvic endometriosis intraoperatively. Although this finding was not initially described with reference to ACUM, there are at least two other ACUM cases described in the literature showing superficial pelvic endometriosis without evidence of adenomyosis.

Uncommon manifestations of ACUM reported in the literature include:

- More than one accessory cavity in the same patient, which is an exception for the first diagnostic criterion; ACUM can co-exist with other Mullerian anomalies, which is an exception for the second diagnostic criterion; One published case of twin pregnancy in the ACUM cavity.

- Similar extra-uterine uterus-like masses (ULMs) have been reported in the literature in vagina, ovaries, broad ligament, uterosacral ligament, pelvic sidewall, small bowel mesentery, sigmoid mesocolon, along the caecum and colonic wall, inguinal region, and conus medullaris.

**Conclusion**

ACUM is now widely accepted as an uncommon Mullerian abnormality causing significant patient distress. Although an uncommon condition, its characteristic MRI findings allow accurate diagnosis to be made by radiologists. Early surgical excision is the treatment of choice and provides complete symptomatic relief.

**Funding**

None.

**Conflict of Interest**

None declared.

**References**