Introduction:
Endometriosis is a common benign gynaecological condition affecting 6-10% of reproductive age women\(^1\). The gold standard for diagnosis is histological analysis of excised lesions. This case outlines the unexpected diagnosis of metastatic neuroendocrine tumour (NET) in presumed endometriotic tissue.

Clinical History:
- 45-year-old with menorrhagia found to have multifibroid uterus on pelvic USS
- Ga68-Dotatate PET/CT revealed abnormally thickened appendix with increased uptake, suggestive of primary appendiceal NET with nodal spread
- During laparoscopic myomectomy, three peritoneal lesions were excised from the uterosacral ligament, broad ligament and pararectal area with a presumptive diagnosis of endometriosis
- Histopathology diagnosed multifocal metastatic grade 1 NET of probable gastrointestinal origin
- Subsequent operative findings during cytoreductive surgery included primary appendiceal tumour and metastasis in the peritoneum, ileocaecal lymph nodes, right ovary, uterine serosa and surface of spleen

Macroscopic Findings:
- Fig 1. Blue powder burn nodule (pararectal)
- Fig 2. Thickened white lesion (uterosacral)

Discussion:
There are several reports of severe endometriosis mimicking advanced cancer\(^2-4\). This is the first report to our knowledge, of an advanced NET mimicking endometriosis and amongst few that describe the incidental finding of NET outside the appendix. The metastatic NET deposits had the appearance of endometriosis and were in locations typical of pelvic endometriosis.

This case highlights the importance of thorough examination of the abdominal cavity and appendix during diagnostic laparoscopy. Furthermore, these findings favour excision over ablation in the management of both typical and atypical suspected endometriotic lesions and suggests consideration of NET whilst rare, as a differential for endometriosis.

Microscopic Findings:
- Fig 3. Positive chromogranin, synaptophysin and CD56 staining suggests neuroendocrine tumour
- Fig 4. Positive CDX2 staining indicates gastrointestinal origin

References:

Contact: shianli.wong@gmail.com