CASE REPORT

A CASE REPORT OF 2 SYNCHRONOUS TUMORS OF FEMALE GENITAL TRACT – RARE FINDING

Rajul Desai[1], Dimple Darad[2], Ashima Chugh[3], Harsh Patel[3]

[1]Professor, [2]Associate Professor, [3]Resident, Dept of pathology, SBKS MI & RC, Pipariya

Correspondence:
Dr Ashima Chugh,
Room no 85, NRI Hostel,
Sumandeep vidyapeeth, Pipariya, waghodia, Vadodara - 391760
Email: chughashima@yahoo.com

ABSTRACT

Synchronous gynecological tumors are rare. It is even rarer to find the rarest of gynecological tumors that of the fallopian tube, together with a histological sub-type as rare as adenocarcinoma cervix. In the field of Gynecological Oncology, this type of lesion is infrequent, representing no less than 6% of cases. We present a case of a 45 year patient with a primary adenocarcinoma of the fallopian tube synchronous with a papillary endocervical adenocarcinoma of cervix. A Radical Wertheim Hysterectomy With Bilateral Pelvic Lymph Node Dissection was done. We reported papillary endocervical adenocarcinoma of cervix in association with fallopian tube adenocarcinoma [A Synchronized Origin]. All the lymph nodes were negative. FIGO staging was done, for cervix it was 1B1 and for fallopian tube it was 1A.

Keywords: Synchronous gynecological tumors, adenocarcinoma of the fallopian tube, Papillary endocervical adenocarcinoma of cervix, FIGO staging.

INTRODUCTION

The majority of synchronous multiple primary neoplasm of female reproductive tract are of endometrial and ovarian origin. Cancer of the cervix is frequent neoplasm. The most frequently identified histologies are Squamous, adenocarcarcinoma, and adenosquamous, this representing > 95% of cases. Primary adenocarcinoma of the fallopian tube with papillary features is the most common histological type .While the etiology of this phenomenon remains unclear, it has been postulated that embriologically similar tissues of the female genital tract, when simultaneously subjected to carcinogen may develop synchronous neoplasm. Others suggest that these neoplasm represent metaplasia occurring in similar histological epithelium of genital tract.

CASE REPORT

A 45 year old lady was admitted with menstrual history suggested an irregular pattern of cycles. Local examination revealed an irregular non tender mass involving the cervix and the upper vagina projecting into the vaginal cavity. CT scan showed a heterogeneously enhancing soft tissue mass of 94.9mm x 89.2 mm in the region of cervix. An exploratory laparotomy and A Radical Wertheim Hysterectomy with Bilateral Pelvic Lymph Node Dissection was done. We received Uterus with cervix with right sided adnexa. Right & left Pelvic nodes were also dissected & sent to us.

GROSS FINDINGS

We received a specimen of uterus, cervix with vaginal cuff & Right sided adnexa. A separate Left tubo-ovarian mass was received measuring 14X8X6 cm weight 380 Gms. Cervix was markedly enlarged & multi nodular on left side measuring 8.5X7.5X5 cm. Right fallopian tube measure 3.5cms. There was pink homogeneous mass coming out of the cervix. The mass involved left half circumference of cervix and left half vaginal cuff. On cut surface endometrial cavity was hemorrhagic. Also received left tubo-ovarian mass measuring 8x6x3cms,on opening the left tube half of the lumen contain whitish mass attached to inner wall of tube measuring 5x3x2cms. Rest of fallopian tube was dilated which measuring 3.5cm. Also received soft tissue bit measuring 4x3.5 cm. 10 lymph nodes dissected largest measuring 2x1cms, smallest measuring 0.3cm. They also sent soft tissue bit measuring 6x3cms grayish white in colour. Total 9 lymph nodes dissected largest measuring 3.5x1.2cms.

MICROSCOPIC EXAMINATION

Multiple sections from the cervical mass had shown histology of papillary adenocarcinoma. Tumour involves left half of cervix with superficial involvement of lower left half of isthmus.

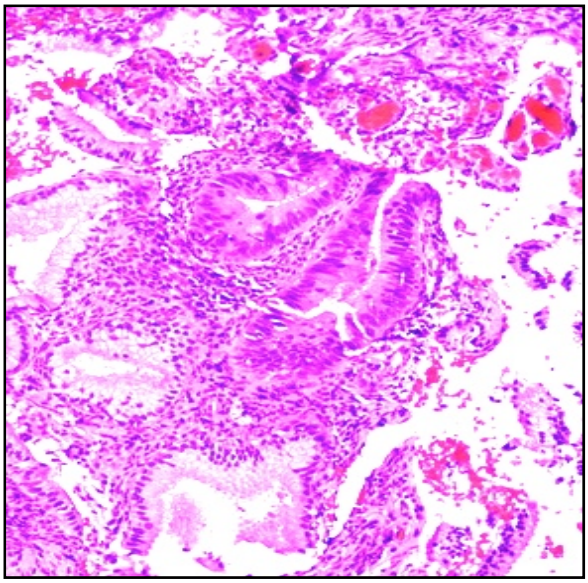

Fig 1: The section endocervical glands lined by malignant cells. Also seen few normal looking endocervical glands along with stromal tissue in the section studied

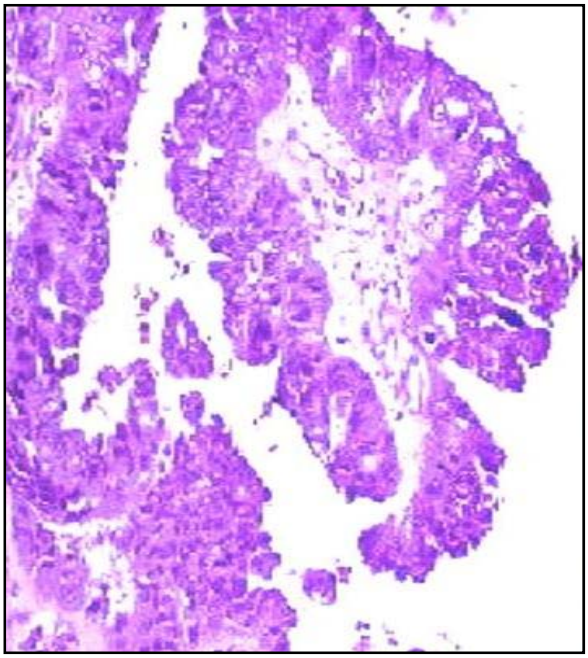

Fig 2: The section shows histomorphology of adenocarcinoma of fallopian tube. The malignant cells lining the tubal mucosa show loss of polarity, high nucleocytoplasmic ratio & prominent nucleoli.

The tumour also involves left side of vaginal cuff. Squamous epithelium is free from tumor cells. Section from left and right parametrium show no tumour cell infiltration. Section from left tubovarian mass had shown papillary adenocarcinoma of similar morphology as that of cervix involving distal half of tubal lumen. A synchronized origin of tumor in cervix and left fallopian tube was seen. Left ovary had showed simple cyst with hyalinised corpus luteum. No evidence of metastasis. Section from left and right pelvic node tissue show total nineteen nodes, all are free from metastasis. No lymphatic or vascular permeation seen. No lymphatic or vascular permeation seen. Section from uterus shows endometrial gland in proliferative phase. Myometrium show normal histology. Section from right ovary and tube show no remarkable pathology.

DIAGNOSIS

Papillary endocervical adenocarcinoma of cervix in association with fallopian tube adenocarcinoma.(a synchronized origin). The tumor involves left half of cervix with vaginal cuff. Squamous epithelium is free from tumour. Tumour infiltrates superficially into left side of isthmus. Left and right parametrium is free from tumour cells infiltration, no vascular or lymphatic permeation seen.

All nineteen nodes from right and left pelvic area negative.
The section from left ovary show normal histology with simple cyst.
The section from endometrium shows endometrial glands in proliferative phase
The section from myometrium shows normal histology.
The section from right ovary and tube shows no remarkable pathology.

Cervix-
TNM-T1b1: FIGO-IBI: T1b1- IB1
Clinically visible lesion or greater than A2, < 4 cm in greatest dimension

Left fallopian tube-
TNM-T1a: FIGO-IA: T1a – 1A
Cancer is only in the inner lining of one tube.

DISCUSSION

Primary malignancies of the genital tract seem to occur synchronously more often than one would expect by chance. The association of early stage and low histological grade indicates that they may have arisen separate multifocal primary lesions rather than metastases. The prognoses in these patients was found to be more favorable when compared to metastatic lesions of individual tumors [1,2]. The International Federation of Gynecology and Obstetrics FIGO staging system assign nearly two-thirds of patients to stage I or II and is based on surgical staging criteria similar to ovarian cancer. In cervical adenocarcinoma radical surgery, radiation therapy, or a combined approach offered equal survival. The most significant

factor influencing prognosis is likely to be the lymph node status[4]. Tumor grade significantly influences prognosis and these results are consistent with other reports showing well-differentiated adenocarcinoma had the best survival [5]. There are some case reports of cervical and tubal carcinomas, one of them[7] was associated with two other tumors of the genital tract (endometrial and ovarian), the characteristic feature was that both tubal and cervical carcinoma were from glandular origin[6]. Similar case was reported by Ayas[8] who reported coexistence of an epidermoid carcinoma in situ of cervix with a stage Ic serous papillary adenocarcinoma of the left fallopian tube, this case is interesting since is similar to ours in relation to the tubal neoplasm. One more case of a 84 year female having synchronic fallopian tube adenocarcinoma and a verrucous cervical cancer was reported[5]. We can conclude that synchronous gynecological tumors are rare, most frequent association of fallopian tube tumors is with endometrium . Several reports show relation between abnormalities on cervical smears and tubal carcinoma, these abnormalities are characteristically glandular rather than squamous. There was no association found with human papilloma virus [8]. The important reasons for our presentation of this case are:

1. These type of synchronous tumors are rare.
2. It will be useful to present a case report to help in the treatment of these patients[6].

REFERENCES

1. Matloch DL, Salem FA, Charles EH, Save EW. Synchronousmultiple primary neoplasms of the upper female genital tract. Gynecol Oncol 1982;13:271.
2. Eifel P, Henricksen M, Ross W, Ballon S, Martines A,Kempson R. Simultaneous presentation of carcinoma involving the ovary and the uterine corpus. Cancer 1982;50:163.
3. Michael p. Hopkins, m.d., patrick sutton, m.d.,and james a, roberts, m.d. Department of Obstetrics and Gynecology University of Michigan, Ann Arbor, Michigan 48109 Received January 27, 1986 Prognostic Features and Treatment of Endocervical Adenocarcinoma of the cervix GYNECOLOGIC ONCOLOGY 27, 69-75 (1987)
4. Berek. J. S., Hacker, W. F., Fu, Y. S., et al. Adenocarcinoma of the uterine cervix: Histologic variables associated with lymph node metastases and survival, Obstet. Gynecol. 65, 46 (1985)
5. David Cantu de Leon , Delia Perez Montiel , Adan Tabarez , Rocio Mendez Martinez and Lucely Cetina Department of Pathology, Instituto Nacional de Cancerologia, Delegación Tlalpan, Mexico City, Mexico, Serous adenocarcinoma of the fallopian tube, associated with verrocous carcinoma of the uterine cervix: a case report of synchronic rare gynecological tumors *World Journal of Surgical Oncology* 2009, 7:20doi:10.1186/1477-7819-7-20
6. Saglam A, Bozdag G, Kuzey GM, Kuçukali T, Ayhan A: Four synchronous female genital malignancies: the ovary, cervix, endometrium and fallopian tube. *Arch Gynecol Obstet* 2008 , 277:557-62
7. Ayas S, Karateke A, Aköz I, Kir G, Yenidede I: Primary serous carcinoma of the fallopian tube with synchronous cervical epidermoid carcinoma in situ: a case report. *Eur J Gynaecol Oncol* 2007 , 28:501-2
8. Riska A, Finne P, Koskela P, Alfthan H, Jalkanen J, Lehtinen M, Sorvari T, Stenman UH, Paavonen J, Leminen A: Human papillomavirus infection and primary fallopian tube carcinoma: a seroepidemiological study.*BJOG* 2007 , 114:425-429