

Shri Balaji Institute of Medical Science College, Mowa Raipur (C.G.)

DEPARTMENT OF OBSTETRIC & GYNAECOLOGY





UTERINE CARCINOMA: RACE AGAINST TIME

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INTRODUCTION

- Uterine carcinosarcoma are highly aggressive tumors, accounts only 1-3% of uterine tumors with incidence less than 2 per 1,00,000 women per year. They carry very poor prognosis irrespective to the stage of diagnosis as survival is 50% or less even in early stage.
- Uterine carcinosarcoma earlier termed as malignant mixed müllerian tumors were classified initially as uterine sarcoma. Recent literature classifies it as carcinosarcoma as they are derived from monoclonal cancer cell exhibiting carcinosarcoma metaplasia based on IHC, in vitro and molecular studies [1]. Also behavior of these tumors are determined by the epithelial component as they invade lymphatic and vascular spaces and metastasize, whereas the spindle component has a very limited metastatic potential [2].
- The management strategies of carcinosarcoma has also changed from the old high grade sarcoma to that of high grade endometrial carcinoma. The aim of the study was to analyze the management and outcome of patients with uterine carcinosarcoma [3].

CASE STUDY

A 51 year P1L3 diabetic woman with lower abdominal pain for 1 month and postmenopausal bleeding since 2 days had an anorexia or weight loss. The pain was not relieved with analgesics.

On P/A, both tender and uterus not palpable. On bimanual examination uterus was 12 weeks, firm and regular with 6/3 firmness free.

INVESTIGATION

- Ultrasonography investigations were within normal limit. CA-125 was raised (100) and liver investigations were within normal limit. CA-125 was raised.
- Utg reported thickened endometrium (1.41 cm).
- Endometrial biopsy suggested adenocarcinoma of endometrium.
- MRI reported thickened endometrium with 4.3 cm mass, with no transaxial evidence of any sign of metastasis. She was subjected to radical surgery.
- Paritoneal fluid reported carcinosarcoma of endometrium with 10% of specimen constituted carcinosarcoma of endometrium with abundant mitotic activity. Post operatively she is under close follow up.

DISCUSSION

Uterine carcinosarcoma has propensity for early metastasis. Approximately 30-40% of cases have an extensive involvement and poor prognosis of this rare disease at the time of presentation, contributing to poor prognosis of this rare disease. Total hysterectomy and bilateral salpingo-oophorectomy along with surgical adjuvant chemotherapy is the first line of treatment in completely resected tumor and recommended as standard adjuvant treatment. However, there is local control after debulking, an metastatic disease. Radiation therapy provides better local control without survival advantage [4].

- These patients should be closely followed up regardless of the disease stage, because there is a high risk of local recurrence (60%) and distant metastasis (60%).
- Clinical follow-up with a physical exam and vaginal cytology is recommended every 4 months for 2 years, then every 6 months for 5 years.
- The 5-year survival is 60-75% for uterine carcinosarcoma, 40-60% for early stage disease (I and II), and 15-30% for late stage disease, with overall median survival of less than 2 years [5].

CONCLUSION

Considering the highly invasive nature of uterine carcinosarcoma, timely diagnosis of this cancer using characteristic imaging and pathological finding with prompt treatment is of extreme importance to improve the patient's survival. Correct staging, should be done by surgery with pelvic and para aortic lymphadenectomy and postoperative chemotherapy.

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DIAGNOSING THE DECEIVER: UNDERSTANDING PELVIC ACTINOMYCOSIS MIMICKING PELVIC TUMOR

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INTRODUCTION

Actinomycosis is chronic suppurative infection caused by gram positive anaerobic bacilli actinomyces. They cause abscess formation in mouth, lung, gastrointestinal or genital tract when breaks in mucosal barrier occur. Although benign, it mimics malignancy when it erodes epithelium allowing invasion of adjacent structures.

Genital tract involvement is second most frequent site for actinomycosis infection, primarily related to foreign body. The clinical manifestation of ovarian actinomycosis is mostly a solid or cystic ovarian mass. Although benign and rare, can cause serious complications.

CASE STUDY

- A 44y/f, P2L2, presented with amenorrhoea, pain abdomen, weight loss and altered bowel habits for 4 months. There was no history of fever or IUCD insertion. Ligation was done 20 years back.
- On P/A: hard irregular mass up to 18 weeks was felt.
- Hb-11 gm%, TLC-15,600/mm³, ESR-120 mm/hr, CA125-61, CEA and CA19.9 were normal.
- USG and CECT abdomen - reported neoplastic ovarian mass (9.8x9x11.4cm), abutting bowel, bladder with loss of fat planes, involving mesentery and B/L moderate hydroureteronephrosis. B/L small inguinal lymph nodes noted. Trucut biopsy revealed actinomycosis.
- Exploratory laparotomy was done with suboptimal debulking as it was involving colon and rectum. Uterus along with solid cystic mass was removed. Tissues were fragile. However, no abscess formation seen. B/L Hydroureters present. Omentectomy was done. IPE confirmed actinomycosis.
- Postoperatively, patient started on antibiotics, and planned to be continued for 6 months.

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FIG 3: Intraop finding - Frozen pelvis, FIG 4: Specimen removed

DISCUSSION

- Usually, Ovarian actinomycosis is closely related to long term IUD implantation. Non-specific clinical and imaging findings, benign radiographic as ovarian cancer. Fever is also rare unless of high grade.
- CA-125 may also be raised.
- Most appropriate specimen is tissue biopsy of infected site. Histological culture and pathology are the conventional ways of diagnosis. require particular attention to prevent misdiagnosis. Pathology examination show purulent inflammation and sulfur granules.
- Most of the cases can be resolved with antibiotics, surgery, adjuvant. Duration of therapy is usually 6-12 months, shortened if surgical resection has been performed. Type of response depends upon site and extent of the disease. With antibiotic advanced surgical techniques, outcome and mortality has improved.

FIG 5: HISTOPATHOLOGICAL FINDINGS factors with surrounding sarcoma

CONCLUSION

- Correct diagnosis in unoperated patient can be managed with antibiotics. Ovarian actinomycosis is differential whenever the suspicion is raised. If managed properly, prognosis is excellent.



UNVEILING THE MIMICRY: ABDOMINAL TUBERCULOSIS MASQUERADING AS ADVANCED OVARIAN CARCINOMA

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INTRODUCTION

- Abdominal tuberculosis is the most common form of extrapulmonary tuberculosis. Tuberculosis peritonitis, the commonest cause of abdominal TB, accounts for 1-2% of all TB cases.
- It presents with abdominal-pelvic mass, ascites, and elevated CA-125, thus mimics ovarian malignancy.
- Serum CA-125 can be raised in both ovarian carcinoma and abdominal TB, thereby making diagnosis difficult.
- Hence a high index of suspicion with good clinical acumen can aid in making correct diagnosis. Pre-operative investigations may not give a definitive diagnosis. Thorough investigations, including laparoscopy, may be possible to rule out ovarian malignancy or confirm abdominal TB without exploratory laparotomy.

CASE STUDY

A 45-year-old female presented with 4 months of abdominal pain and ascites.

On P/A, abdomen moderately ascitic, otherwise unremarkable.

Ultrasonography investigations showed moderate ascites, otherwise unremarkable.

CT abdomen revealed a 29x21x11 cm right ovarian mass, with central necrotic area, moderate ascites, and nodular peritoneal thickening.

Biopsy showed granulomatous inflammation with caseation, consistent with tuberculous aetiology. Histology was inconclusive.

She was treated with anti-tubercular therapy and has been asymptomatic for 6 months.

DISCUSSION

- Abdominal tuberculosis can occur at any age but its mostly affects young adults with mean age of 30-40 years.
- Abdominal tuberculosis with ascites may mimic advanced ovarian cancer, with elevated CA-125 and pelvic masses found in 90% and 77% of patients respectively [1]. A high index of suspicion can help reach the diagnosis earlier [1].
- Diagnostic laparoscopy with intraoperative frozen section is diagnostic in most cases and prevents unnecessary surgery.
- PCR for Mycobacterium and Adenoine deaminase activity in ascitic fluid can be done to detect abdominal TB. These tests however may not provide a conclusive diagnosis.

CONCLUSION

Abdominal tuberculosis should be considered a differential diagnosis in patients presenting with ascites and abdominal pain especially in those of reproductive age.

Minimally invasive tests to establish the diagnosis of abdominal tuberculosis should be attempted to prevent unnecessary laparotomy.

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STUMP - A DIAGNOSTIC DILEMMA AND CHALLENGE TO CLINICIAN

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INTRODUCTION

SMOOTH MUSCLE TUMOR OF UTERINE MALIGNANT POTENTIAL (STUMP) was first described by Langley in 1973. Defined as uterine smooth muscle tumor that does not meet current diagnostic histologic criteria of either benign or a malignant tumor. STUMPs follows IHC classification of leiomyosarcoma. Typical histopathological features were first reported from Stanford in 1994, including cytologic atypia, mitotic count, and necrosis [1].

Prevalence of p16, p53, and Ki67 protein levels to be higher in leiomyosarcoma than leiomyoma [2] and hence are most useful immunomarkers for identifying clinically aggressive smooth muscle tumors.

STUMPs presents with heavy menstrual bleeding and abdominal swelling with minimal pain for 3-6 months with no associated loss of appetite or weight loss. In married since 23 years and never conceived but didn't seek any treatment.

Biopsy revealed a firm, irregular mass arising from pelvic wall involving posterior wall with necrotic center. Histomorph examination confirmed 14 weeks size fibroid mass.

Large myxoid area (19.0*10.5*11.5 cm) with large intratumoral fibroid.

Immunohistochemistry and high hydroxydeoxythymidine phosphorylation to primary leiomyosarcoma and not sign of malignancy were seen.

Final diagnosis performed by Papanicolaou stain revealed a neoplasm of smooth muscle with histological features of leiomyosarcoma.

STUMP, as tumor had significant necrosis atypia and mitotic figures but not necrosis.

Postoperative management with anti-tubercular therapy and antibiotics.

Postoperative management with anti-tubercular therapy and antibiotics.

DISCUSSION

Pertaining to the rarity of the disease and inconsistency in diagnostic criteria, only limited data available on its standard treatment and follow up. Total hysterectomy with or without bilateral salpingo-oophorectomy is suggested when fertility desire is satisfied. Myomectomy alone can be considered for young patients for fertility preservation.

Post-hysterectomy, 6 monthly follow-up for 3 years. If yearly for further 5 years with imaging by MRI or ultrasound.

Recurrence or metastasis is recommended. Post-hysterectomy, pre-conceptional evaluation and frequent monitoring for recurrence with consideration of hysterectomy potentially is suggested.

CONCLUSION

Fertility preservation strategy in a case of STUMP is safe and feasible. Although larger study is required to draw a conclusion about outcome in terms of fertility, malignant potential and recurrence.

These cases should be followed up closely for any recurrence and conversion, to identify explained.

Post-hysterectomy potentially is suggested.

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FIG 1: STUMP with cytologic atypia & elevated mitotic activity



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