MIXED MESODERMAL TUMOUR

by

V. PADUBIDRI,* M.D., M.R.C.O.G.

Introduction

Mixed mesodermal tumour is a rare uterine malignancy and comprises only 0.5-2% of all malignancies of the female genital tract. This tumour has raised a considerable discussion regarding its histogenesis and the place of radiotherapy and chemotherapy in its postoperative management.

CASE REPORT

Mrs. R. aged 65 years, was admitted to the hospital on 6th July, 1977. She complained of postmenopausal bleeding for the last 6 months and pain in lower abdomen for a similar duration. She bled continuously for about one and a half months initially and thereafter intermittently. She also had noticed foul smelling discharge per vaginam recently. Her menopause was 2 years back. She had one full term normal delivery 30 years back but the child died at 6 years of age. Past illness was not relevant.

Her blood pressure was 136/90 mm. Hg. The systemic examination was normal.

Abdominal Examination

She was an extremely obese woman. A lump corresponding to a period of 16 weeks pregnancy was felt in the hypogastrium. It was firm and slightly mobile from side to side. There was no evidence of ascites.

Speculum Examination: A fleshy polyp protruding through the cervical os and fresh bleeding through the os was seen. The cervix appeared normal.

Vaginal Examination: The uterus was uniformly enlarged to 16 weeks size and was firm. The fornices were free.

At the time of fractional curettage, fleshy polyp was not seen (? expelled). The cervical biopsy revealed chronic non-specific cervicitis and endometrial currettage showed chronic non-specific endometritis. Other investigations were —Haemoglobin—8 gms%. Total white cell count—8,000/cmm. poly—81%, lymphocytes 22%.

Urine was clear, and culture was sterile.

Blood urea—20 mg%. Blood sugar (fasting) 90 mg%. Blood group—A Rh +ve.

ECG and X-ray chest were normal.

Laparotomy done under general anaesthesia showed a bulky uterus of 16 weeks size. There was a small fibroid 2 x 2 cm on the posterior surface. There were no pelvic adhesions and both adnexae appeared normal. The liver, omentum and pelvic peritoneum did not show any evidence of malignancy and there was no ascitis. Extended hysterectomy with bilateral salpingo-oophorectomy was done. She was given one unit of blood during the operation.

The cut surface of the uterus revealed a small subserous fibroid 2 cm x 2 cm on the posterior surface of the uterine wall. A yellowish fleshy sessile growth, friable in consistency was seen projecting into the uterine cavity at the fundus. The endometrial surface elsewhere appeared smooth, with minimal naked eye infiltration into the uterine wall. The cervix appeared normal.

Histopathology: Report: Mixed mesodermal tumour containing cartilage and embryonic muscle fibres is seen. There is microscopic evidence of intravascular involvement in one of the slides.

Postoperatively, she received Alkoran 2 mg, 3 times daily for 2 weeks. Her recovery was uneventful. She was seen 3 months and 6 months later and there was no clinical evidence of metastases.

Discussion

Mixed mesodermal tumour is a highly malignant, but fortunately a rare tumour of the uterus. Various authors have quoted the incidence as varying from 0.08% (Sternberg 1954; Williams 1972) to 2% of all malignancies of the female genital tract.

*Asst. Prof. Dept. of Obst. & Gynec., L.N. Jayaprakash Hospital & Associated M.A.M. College, New Delhi-2.

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Most authors (Baggish 1974; Novak and Novak 1962 and Williams and Woodruff 1972) agree that there is no need to differentiate between carcinosarcoma and mixed mesodermal tumours, as this separation does not confer any clinical advantage and bears no prognostic significance. The mixed mesodermal tumour is now accepted as an endometrial sarcoma arising from the stromal cells, with foreign elements such as cartilage and bone arising from a simple metaplasia of the stromal tissue.

These tumours bear clinical appearence similar to that of endometrial carcinoma. Although Chuang (1970) reported previous radiation in 17% of his series and Williams and Woodruff (1972) in 33% of their cases, not all authors would agree on their findings. The polyp noted on admission was friable and not seen (expelled) at the time of curettage. Despite the histopathology report on the curettings and on the basis of the age, clinical picture and the enlarged uterus, the surgery was undertaken.

The best results are reported with surgery and extended hysterectomy is the choice if the cervix is not involved. Radiation is futile (Giarratome 1971) and abandoned. The value of cytotoxic drugs and progesterone postoperatively is not clear (Baggish 1974).

Norris (1966) suggests that whereas rhabdomyoblasts and osteoid tissues are indicative of highly malignant tumour, the presence of cartilage points to a better prognosis. He found that cartilage was present in 58% cases, striated muscle in 35% and bone in 15% of his cases.

The earlier reports (Sternberg 1954; Ober 1959) were unfavourable. The recent findings by Chuang (1970) williams (1972) and Hayes (1974) suggest a high mortality in the first 2 years after the diagnosis, but late recurrences and metastasis are unusual. Hayes (1974) quotes 5 year cure rate as 23% and found that the most important prognostic factor was the extent of the tumour at the time of operation.

Summary

(1) A rare malignant tumour of the uterus is described.

(2) A woman with postmenopausal bleeding and a bulky uterus should be subjected to surgery despite the negative histopathology report.

The best treatment is surgery. Radiation and chemotherapy having doubtful benefit.

(4) The prognostic factors have been discussed.

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