LYMPHOSARCOMA OF THE OVARY

(A Case Report)

by

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Lymphosarcoma of the ovary is an extremely rare entity. With few rare exceptions, the lymphoma of the ovary is secondary to a primary in the gastrointestinal tract.

CASE REPORT:

Mrs. A. aged 45 years, Hindu, belonging to poor socio-economic class, was admitted in the medical ward for abdominal pain, swelling in the lower abdomen and fever on and off of 3 months' duration.

The patient gave history of loss of appetite, loss of weight of 3 months and burning micturition of 1 month duration. Her bowel habits were normal.

She attained menarche at the 15th year. Past menstrual cycles were 3/30 regular, moderate and painless. Her last menstrual period was on August 10th. She was married for 25 years,, had 4 normal full term deliveries, all presently alive. Her last childbirth was 12 years age and her husband has had vasectomy.

She was emaciated and anaemic. There was no lymphadenopathy or pedal oedema. The cardiovascular and respiratory systems were found to be normal. The blood pressure was 80/50 mm of Hg. and she had tachycardia.

There was a tender, firm swelling in the abdomen, about 4" x 4" in diameter, occupying the right lumbar and umbilical region, with ill-defined borders and restricted mobility. The swelling was having impaired resonance and there was free fluid in the peritoneal cavity.

On bimanual pelvic examination, cervix was pointing downwards and soft, uterus in mid-position and bulky with restricted mobility. There was an irregular thickening of the right fornix and in the left and posterior fornix, a vague mass, firm in consistency was felt.

A provisional diagnosis of ovarian tumour with secondaries or a tuberculous T.O. mass with mesentric adenitis was made. Preoperatively the patient was on antianaemic and antituberculous treatment.

She was not a diabetic or a hypertensive. Urine examination was normal. X-ray chest and plain X-ray abdomen revealed no abnormality. As the patient had 35 days amenorrhoea, urine for gravindex test was done and was found to be positive. In view of this report, vague mass in the left and posterior fornix and deterioration in her general condition, a colpocentesis was done on 25-9-78 in order to rule out ruptured ectopic pregnancy. At first, clear fluid was drawn and later altered thin blood stained fluid about 10 cc was drawn. The possibility of a twisted ovarian cyst was thought of. She had 350 cc of pre-operative transfusion.

An emergency laparotomy was done on 26-9-78. On opening the abdominal cavity there was about 1 litre of altered blood, partly clotted and partly fluid. Left ovary was replaced by a friable, solid growth, the capsule was ruptured and it had undergone a twist. There was a growth on the right side, near the ascending colon. Uterus was smaller than normal. Macroscopically, the right ovary was normal. A primary in the intestine and a secondary in the ovary was thought of. An attempt to explore the origin of the growth in the lumbar region resulted in brisk haemorrh-

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age from the bed of the tumour which was adherent to the intestines and as the general condition of patient was not fit to proceed for a hysterectomy, a left salpingo-ovariotomy and right salpingo-oophorectomy was done. With the help of a surgeon the mass which was adherent to the intestine was dissected out and it was found to arise from the retroperitoneal region. Same was removed en mass between clamps and haemostasis secured. There was a circumscribed nodule about 2" in diameter in the mesocolon and that was excised. Liver, spleen, kidneys, stomach, large and small intestines were found to be normal. Patient had 1050 cc of 'A' group blood on the table. She had another pint of 'A' group packed cell transfusion on the third postoperative day.

Pathology Report: Retroperitoneal lymphosarcoma and Ovarian lymphosarcoma, probably primary in the retroperitoneal region with secondary in the ovary. (Figures 1A, 1B and 2A, 2B) The other ovary and both tubes were normal.

Postoperative period was uneventful. She was started on Cyclophosphamide 200 mg intravenously on alternate days from 3rd postoperative day. She has received 2000 mg of the drug. She has been advised palliative abdomino-pelvic external irradiation by the radiotherapist. She is doing well till to-day. X-ray chest taken on 24-10-78 shows no secondaries.

The patient was discharged home after the chemotherapy and was readmitted on 29-11-78 for external Irradiation. On examination, she has a fixed right supraclavicular gland palpable now. No other masses are made out. X-ray chest I.V.P. and barium meal taken between 30-11-78 and 2-12-78 show no abnormality. Haemogram did not reveal any pathology except anaemia.

Discussion

Malignant lymphoma of the ovary is always secondary to a primary process in the gastrointestinal tract. Jhonson and Soule (1957) noted that it is for the gynaecological complaint that the patient first seks medical advice. There is no known method of diagnosing ovarian lymphosarcoma except by laparotomy. The finding on palpation of indiscrete, intestinal mases in the upper and mid abdomen along with ovarian masses may perhaps suggest the presence of lymphosarcoma. Pain in abdomen, abdominal swelling, loss of weight and loss of appetite are the usual symptoms. Out of the 35 cases reported by Woodruff and Novak (1963) from the Ovarian Tumour Registry, only 5 had menstrual irregularities in the form of menometrorrhagia.

The therapies that are adopted are surgery followed by radiotherapy and or chemotherapy. Surgery may be either removal of entire internal genitals or unilateral adnexectomy with removal of the other masses in the abdomen or intestinal resection depending upon the involvement.

Lymphomas are highly malignant the mortality having been reported mostly to be 100% within 5 years. Out of 35 cases of lymphomas reported in the Ovarian Tumour Registry only 1 patient lived more than 5 years. Lymphocytic and giant follicular types tend to offer a better prognosis than do the Hodgkin's disease and the reticulum or stem cell varieties. It is believed, inspite of the usual hopelessness of the disease, early and vigorous therapy may produce remissions for long periods.

Summary

This case is presented for its rarity. The retroperitoneal lymphnodes were probably the seat of primary disease and the ovarian tumour, the secondary.

References

1. Jhonson, C. E. and Soule, E. H.: Obstet. Gynec. 9: 149, 1957.
2. Woodruff, J. D., Noti Castillo, R. D. and Novak, E. R.: Am. Obstet. Gynec. 85: 912, 1963.

See Figs. on Art Paper I