

BILATERAL PRIMARY OVARIAN CARCINOMA WITH TRANSTUBAL METASTASIS IN UTERUS AND CERVIX

by

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Papillary serous cystadenocarcinoma is a common malignant neoplasm of ovary of germinal epithelium origin, constituting approximately 25-30% of ovarian neoplasms (Scully, 1973).

The metastatic pattern and clinical behaviour of these ovarian tumours form a fascinating study on account of great diversity in historical types and their relation to therapy and prognosis, as the extent of spread will be a major determinant in the choice of therapy. The most common sites for local extension of ovarian carcinoma is uterus, endometrium, contralateral ovary and fallopian tubes and see the common secondary involvement is of the parietal peritoneum, lymphatic glands and distant organs like liver gut, lungs and pleura (Novak, 1967).

The present case showed a bilateral papillary serous cystadenocarcinoma of ovary with metastases to fallopian tubes,

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(both in wall in lymphatic channels and lumen of tube-transluminal), subserosal implants in myometrium, endometrium and cervix is reported.

CASE REPORT

Patient S. K., 50 years old female was admitted to Umaid Hospital on 12-7-79 for lump in abdomen of 3 years duration and pain in abdomen of 20 days duration. Since last 2 days patient developed retention of urine.

Patient experienced menopause one year back, her menstrual history was unremarkable. Obstetric history—patient had 7 full term normal deliveries and the last delivery was 12 years back.

General Examination: Patient was fairly built showed evidence of anaemia and free fluid in abdomen. Blood pressure was 140/80 mm of Hg. X-Ray chest was normal, without any lymphadenopathy.

Speculum Examination: Showed chronic cervicitis, vagina was healthy without bleeding.

Vaginal Examination: Cervix was firm, uterus appeared normal but could not be separately defined from a firm irregular mass of about 14-16 weeks pregnant uterus. In both the fornices firm masses were felt, and both the masses were fixed to the pelvic wall. A few firm nodules were also felt in the pouch of douglas. A total hysterectomy with bilateral salpingo-oophorectomy was performed.

Gross Appearance: The specimen of uterus with adnexa showed complete replacement of both ovary by grayish lobulated tumours of

10 x 6 x 6 and 7 x 6 x 4 cm. respectively. Both growths appeared encapsulated and cut section revealed a white, firm friable, granular tumour mass with haemorrhages polar cyst showed papillary concretions on the wall. Both sided fallopian tubes were dilated with thickened walls, lumen was occupied by grayish friable tumour casts.

Uterus showed a small pedunculated tissue fragment in relation to fundus. Similar tissue fragment was seen in cervical canal.

Microscopic Appearance: Tumour revealed characteristic adenocarcinoma with intricate papillary and acinar arrangement, cells showed features of malignancy. Concentric calcified psammoma bodies were seen in the tumour stroma.

Fallopian tubes: Walls showed subserosal dilated lymphatic channels studded with tumour tissue. Lumen was occluded by circumscribed tumour mass, psammoma bodies were seen in tumour stroma.

Myometrium: Subserosal lymphatics contained tumour emboli. Endometrium showed super imposed on normal endometrial and stromal tissue the similar tumour structure. Cervix showed similar tumour deposits in cervical stromal lymphatic channels.

Discussion

Metastatic lesions are more common than primary growths in fallopian tubes, these arise by direct spread and seeding or by the lymph and the blood streams. The parent tumour is more often in the ovary, uterus and large intestine. It can be extremely difficult, some times impossible, which is primary and which is secondary, especially when cancer of the tube is associated with endometrial carcinoma or with certain ovarian tumours.

In the present case also there was involvement of fallopian tubes, both in wall and lumen by carcinomatous deposits and similar tumour implants in subserosal and stromal lymphatics of myometrium and cervix.

The co-existence of ovarian and uterine carcinoma is also common. Scully, 1970 suggested that when both organs are involved, the carcinoma are usually separate primaries, particularly when they are very small. He suggested that if the tumour in endometrium is less than 2 cms., is well differentiated and has involved myometrium either not at all or only a limited extent, then the concomitant carcinoma in the ovary is probably primary there. In present case also endometrium was secondarily involved as tumour tissue was superimposed on normal endometrial tissue and grossly the mass was less than 0.5 cm in size. The infiltrating ovarian tumours having endometrial extensions have prognosis of range of 40-66% in comparison to endometroid carcinoma of ovary (72%) five year survival.

References

1. Novak, E. R. and Woodruff, J. D.: Novak's Gynaecologic and Obstetric Pathology. 6th Edn, W. B. Saunders Company, Philadelphia and London, 1967. p. 276-277.
2. Scully, R. E.: In Sturgis, S. H. and Taymor, M. L. (eds.) progress in Gynaecology Vol. V Grune and Stratton, New York, 1970. p. 329.

See Figs. on Art Paper III-IV