SQUAMOUS CELL CARCINOMA IN SITU OF THE ENDOMETRIUM AND FALLOPIAN TUBES AS SUPERFICIAL EXTENSION OF INVASIVE CERVICAL CARCINOMA

by

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Introduction

Involvement of the endometrium by direct spread from a squamous carcinoma of the cervix is rare. Even rarer is the intraepithelial and invasive squamous cell carcinomas of the endometrium and the fallopian tubes. Usually these lesions are associated with intraepithelial or invasive squamous cell carcinoma of the cervix (Baggish and Woodruff, 1967; Hallgrimsson, 1967; Langley and Woodcock, 1954; Qizilbash and Dependrillo, 1975; Salm, 1969) although primary squamous cell carcinoma of the endimetrium and of the fallopian tube also occur.

A case of invasive squamous cell carcinoma of the cervix with involvement of the entire endometrium and fallipian tubes by surface carcinoma is reported in view of its rarity.

CASE REPORT

Patient aged about 60 years came with a complaint of painless abdominal mass postmenopausal vaginal bleeding on and off since 3 months. She attained menopause 18 years back and she is a multiparous woman.

A uniform, mobile swelling moving from side to side, about the size of 24 weeks gravid uterus, extending on to both the iliac fossae and also on to the left lumbar region was felt.

Per speculum: Vulva and vagina were atrophic. Cervix could not be made out. No evidence of any growth.

Per vaginum: Cervix almost flushed with the vault; could not be made out separately except a small depression in the middle of the vault. Fullness present in all the fornices. Not tender. No evidence of any induration. The swelling appeared to be an enlarged, distended uterus. Blood on examining finger.

Laparotomy findings: No free fluid in the peritoneal cavity. Uterine swelling of 24 weeks gravid uterus size, cystic in consistancy, mobile from side to side. Right ovary atrophic, almost attached to the uterine wall with the right tube also atrophic attached to the short infundibulopelvic ligament. Left tube was markedly distended. Left ovary atrophic, of the size of an almond. Total hysterectomy with bilateral salpingo-oophorectomy was done. No evidence of lymph node enlargement.

Gross Pathology: Cervix was atrophic and could not be madeout separately. Uterine cavity was filled with altered blood. Uterine wall was very much thinned out. Endometrial surface was rough with gray-white patches, simulating a condition called "cake icing" or "Zuker-guss" carcinoma in which superficial squamous tumour sweeps over or replaces the

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Accepted for publication on 30-4-82.

normal endometrium (Fig. 1). Right tube and ovary were atrophic and left tube was distended. On sectioning gray white necrotic material was squeezed out from both the tubes.

Histopathology: The section taken from the atrophic cervix revealed invasive squamous cell carcinoma. Endometrium was replaced by squamous cell carcinoma, non-keratinzing large cell type (Fig. 2). The lining epithelium of both the tubes were also replaced by intra-epithelial squamous cell carcinoma (Fig. 3). Both the ovaries showed no significant pathology.

Discussion

Though a rare occurrence, an invasive squamous cell carcinoma of the cervix may display an intrauterine surface spread proliferating through the endometrium (Evans, 1966) and replacing it. Squamous cell carcinoma may arise in one of two ways. It may be a primary or may be a spread of cervical carcinoma directly on to the surface of the endometrium. *Ferenczy* (1971) and associates refer to this mechanism as a horizontal spread whereby the tumour cells mechanically displace and eventually replace the columnar epithelium of the enndometrium.

In our case no invasive disease was seen and no extension of the carcinoma was present outside the tubes or in the ovaries.

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See Figs. on Art Paper VII