PRIMARY BILATERAL ENDOMETROID OVARIAN TUMOUR WITH PRIMARY ADENOCARCINOMA OF UTERUS

(A Case Report)

by

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SUMMARY

An uncommon association of primary endometroid carcinoma of ovary bilateral Grade-I with primal endometrial adenocarcinoma of body of the uterus Grade-I has been found in this case. The prognosis was very good in not recurring malignancy 7 years after operation without any chemotherapy.

Introduction

Though endometroid carcinoma of ovary has been described in the past, its association with primary endometrial carcinoma has rarely been found. Such a rare case is reported here.

Case Report

Mrs. B.T. 51 years old was admitted on for Pain and Lump in abdomen with intermittant vaginal bleeding for 3 months. Her past M/H—3-4/22-25 regular 2 years ago, i.e. in 1973. Her present menstruation was occassional spotting. She had no issue as her husband died 6 months after the marriage.

On admission her general condition was good. Breasts were normal. Respiratory and cardiovascular systems revealed no abnormalities. On abdominal examination, nodular masses were felt all over lower abdomen which were mobile, could be pushed upwards. There was no evidence of ascitis or tenderness. . Liver, spleen were not enlarged.

On per vaginal examination Uterus was felt separately from lumps. The lumps were felt in both Fornices. Posterior Fornix was clear.

On operation uterus was found bulky. Both ovaries were enlarged to a size of small coconut nodular, mobile but capsules were well preserved. There was no evidence of metastasis or haemorrhagic fluid in the peritoneal cavity. Panhysterectomy with removal of cuff of vagina was done. Post-operative period was uneventful.

Folow ups—Patient has been followed for last 7 years. She is in good condition without evidence of any metastasis.

Histopathological Report

Gross: The specimen consists of uterus with cervix, tubes and ovaries. The cervix and tubes unremarkable. The uterus was bulky. Endometrium shows slight generalised hyperplasia (0.5 to 0.7 mm) and localised hyperplasia (1 cm.) at one place. Both ovaries are replaced

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by encapsulated yellowish gray ovoid masses which are partly cystic and partly solid. The right has greatest diameter 12 cm. and left 15 cm. The cut surface is similar in both masses containing multiple cysts of varying sizes (0.5 to 4 cm) containing translucent coagulum of mucus, some with haemorrhagic material. In addition to the cysts there are solid yellowish-gray areas. There is no evidence of breach of capsule with exteriorisation of the growth.

Microscopic: Endometrium shows extreme atypical hyperplasia going into well differentiated papillary and glandular adenocarcinoma without invasion of myometrium. Cervix, myometrium and fallopian tubes are histologically unremarkable.

Ovarian masses show tumour to be composed of cuboidal and columnar cells arranged in glandular and papillary formation resembling endometrial glands. The stroma of the tumour is of ovarian type. The mitotic figures are 0-3 p.h.f.

Diagnosis: Primary endometroid carcinoma of the ovary, bilateral Grade I, with primary endometrial adenocarcinoma Grade I.

See Fig. on Art Paper VII