Endometrial Stromal Sarcoma - Case Report

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Mrs. B. 45 years P5 L3, was admitted in the month of Oct. 97 with c/o a gradually increasing abdominal mass for 1 year 2 months before admission. She noticed the mass was increasing rapidly. There was no H/o any loss in appetite/weight. Her M/H revealed that for the last 2 months, she was having excessive irregular menstrual periods. Her cycles were now 4-5 days / 10-15 days. Her previous menstrual cycles were normal.

O/E Her general condition was fair. She was mildly anemic, normotensive. Systemic examination was normal. P.A. Exam. - There was an uniformly enlared, nontender, soft suprapubic mass of about 20x20 cm in size and mobile from side to side; lower pole of the mass was not felt. Vulva, vagina and Cx showed no apparent abnormality. Bimanual examination revealed an uniformly enlarged abdomino-pelvic mass continuous with the cervix. Uterus was not felt separately. On vaginal and rectal examinations parametrium felt normal. Rectal mucosa was free. A provisional diagnosis of fibroid uterus with degenerative change was made.

She had an ultrasonogram report of Feb. 97 from a private clinic which showed a large complex predominantly multicystic pelvic mass about 14x13x13cm predominantly on the right side but seemed to cross the midline and was inseparable from right tuboovarian axis. There was no fluid in cul-de-sac. Impression was of a complicated tuboovarian mass. Repeat ultrasonography after admission showed a large, well defined right adnexal mass of 18x14x17 cms size mainly cystic with multiple septae and irregular solid areas. Uterus was displaced to the left by the large mass and was separate from the mass. It was normal in size and echo pattern. The fundo-cervical length was 9.7 cm, left ovary was normal & measured 40 mm x 17 mm. Right ovary was not separately identified. There was no fluid in Donglas's pouch. The diagnosis was malignant ovarian mass. CT scan suggested a solid cystic abdominal mass arising from the pelvis with the uterus separate from the mass. Adnexae could not be visualised. There was no evidence of retroperitoneal lymph adenopathy or ascites and other organs were normal. Diagnosis of ovarian malignancy, most probably primary, was made.

Haemogram, ESR, Urine, LFT, KFT, Blood sugar, Xray Chest and abdomen, and ECG were all within normal limits, Hb being 10.2 gm. D&C showed utero-cervical length of 12 cm. HPE showed mainly blood clots.

On laparotomy uterus was found to be uniformly enlarged to about 20x20 cm was soft and smooth. Both the tubes and the ovaries were normal looking. The peritoneal fluid found was not haemorrhagic or straw coloured. All other organs explored were of normal appearances. Paraaortic lymph nodes were not palpable.

A total hysterectomy with bilateral salpingo-oophrectomy was done. On cut surface, there were multiple cystic masses of varying sizes. Myometrium was very thinned out and appeared to have been invaded by these cysts. These cysts were protruding into the uterine cavity with 3 large soft cysts of about 4 x 4 cm size. One of the cysts ruptured and thick yellowish jelly like fluid came out. Since this picture was of uterine carcinoma/sarcoma, peritoneal fluid sampling and lymphmnode sampling were done. Operation was completed by removal of a vaginal cuff.

HPE report showed a picture consistant with low grade stromal sarcoma, and cervicitis, both adnexae were unremarkable, lymphnodes free and cytology was negative for any malignant cells. Vaginal cuff was free of any tumor cells. She was registered with Radio Therapy Dept. and is regularly coming for a follow up C.T. scan report of whole abdomen including pelvis done in March '98 was within normal limit.