

Case Report

A case of endometrial stromal sarcoma

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Introduction

Uterine sarcomas are relatively rare tumors of mesodermal origin. They constitute 2 to 6% of uterine malignancies¹. Of these, endometrial stromal sarcoma is a rare neoplasm². It constitutes 15% of uterine sarcomas¹. Huang et al² reported that endometrial stromal sarcoma comprised 4.3% of corpus cancers in their study².

Case report

A 42 years old P₂+0 coming from a low socio-economic family and married for 22 years was admitted on 24th January, 2005 with complaints of menometrorrhagia of 5 years duration and mild intermittent lower abdominal pain of 4 months duration. Both her deliveries were normal. She was treated outside with hormones without much improvement. Her last menstruation was on 10th January, 2005. She had no hypertension, diabetes mellitus, and exposure to radiation. General examination and examination of the abdomen revealed nothing significant. Pelvic examination showed a 8 weeks size retroverted uterus with restricted mobility. Cervix and the fornices were normal. Baseline investigations were

normal. Chest x-ray was normal. Ultrasonography done on 2nd December, 2004 showed bulky uterus with a small fibroid. Both ovaries were enlarged with heterogeneous echotexture and right ovary had a small cyst with hemorrhage. Provisional diagnosis was endometriosis with uterine fibroid. Endometrial biopsy done on 26th December, 2004 showed proliferative endometrium. Laparotomy done under spinal anesthesia on 27th January, 2005 showed that the uterus was enlarged to 8 weeks size with intact surface. There was a yellowish rubbery mass of 3 x 2 cm in the right adnexa. Right ovary was not seen separately. There was another irregular



Figure 1. Hematoxyline and Eosin stained slide showing left side muscle tissue which has been infiltrated by endometrial stromal sarcoma from the right side. The tumor cells are small, dark and forming whorls.

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firm friable mass of 3 x 4 cm on the left of the uterus. Left tube and ovary were apparently normal. There was a firm nodule of 2 x 1 cm in the omentum. There was no free fluid in the peritoneal cavity and no lymphadenopathy. Liver, spleen, kidney, stomach and intestine were normal. Total abdominal hysterectomy with bilateral salpingo-oophorectomy and partial omentectomy were done. Postoperative period was uneventful and the patient was discharged after suture removal on the 7th postoperative day.

The histopathology report was endometrial stromal sarcoma of the uterine myometrium with secondary deposits in the right ovary and the omentum. Thus it was a stage III disease. Unfortunately, facilities for progesterone receptor studies are not available with us. She was referred to radiotherapy department for further management. She was given external pelvic beam radiation by telecobalt and received 1000cgy in five fractions per week for 5 weeks from 21st April, 2005 to 25th May 2005. Both anterior and posterior fields were treated daily. She had no problems during radiotherapy. At follow up on 16th August, 2005 neither clinical examination nor sonography revealed any growth.

Discussion

Mesenchymal tumors of uterus with histologic features reminiscent of endometrial stromal cells are classified as endometrial stromal tumor. WHO recognizes three such lesions – 1) endometrial stromal nodule 2) low grade endometrial stromal sarcoma (LGESS), and 3) high grade endometrial stromal sarcoma (HGESS)³. Our case belongs to category 2 (LGESS). Stromal tumors primarily occur in perimenopausal women between 45 and 50 years of age and often present with vaginal bleeding⁴. Yilmaz et al⁵ reported a mean age of 51 years in their study. Stromal sarcoma is characterized by slow clinical progression, repeated local recurrence, and occasional metastasis⁴.

Secondary involvement of cervix by the tumor has also been described³. The diagnosis may be determined by endometrial biopsy, but the usual preoperative diagnosis is uterine leiomyoma¹. Optimal initial therapy in LGESS consists of surgical excision of all grossly detectable tumors along with total abdominal hysterectomy with bilateral salpingo-oophorectomy. Pelvic irradiation is recommended for inadequately excised or locally recurrent pelvic disease. In HGESS treatment should consist of total abdominal hysterectomy with bilateral salpingo-oophorectomy. The dismal therapeutic results obtained to date suggest that radiotherapy or chemotherapy or both should be used in combination with surgery¹. The surgical stage is the most significant prognostic factor regarding the recurrence and survival in LGESS. They tend to grow slowly and commonly recur many years after initial diagnosis. LGESS with significant level of progesterone receptors respond more favorably to progestin therapy³. HGESS have more aggressive clinical course. They tend to recur within 2 years of initial treatment. Hormone therapy does not seem to be effective. Five year disease free survival is 25%¹.

Reference

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