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Carcinosarcoma in endometrial polyp. Diagnosis and treatment – case report

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Summary

This paper presents a case of carcinosarcoma localized in the endometrial polyp inside the uterus of a 74-year-old patient. This carcinosarcoma was diagnosed in the first clinical disease stage. Postoperative treatment was conducted but was not followed by additional chemo or radiotherapy due to the fact that the illness was in the first clinical stage. Secondary deposits in the abdomen and in the pelvis appeared exactly six months after surgery. Illness progression was sudden causing death three months after the appearance of secondary deposits or nine months after the illness was detected, despite attempts with chemotherapic treatment. Although uterine carcinosarcomas account for three to seven percent of all uterine malignities while malignant polyp degeneration occurs in only 0.36% cases, treatment of this malignant disease is a special challenge to all those involved in oncological gynecological practice with the aim of prolonging the progression-free interval and the overall survival of patients suffering from this rare malignity.

Key words: Uterine carcinosarcoma; Survival; Therapeutic approach.

Introduction

Uterine carcinosarcoma is rare, metaplastic subtype of endometrial cancer comprised of two distinct malignant components – epithelial and mesenchymal, with phenotypic features. Tumor behavior is very aggressive. Local recurrence is frequent as well as distant metastases [1]. Uterine carcinosarcomas are also known as malignant mixed Müllerian tumors. These tumors are generally thought to account for three to seven percent of uterine cancers [2]. Malignant degeneration of an endometrial polyp occurs rarely, i.e. in approximately 0.36% of all cases. Nevertheless, those rare cases of carcinomatous degeneration of an endometrial polyp described in literature have a good prognosis. Data from the literature describes individual cases of carcinosarcoma in the endometrial polyp [3].

Endometrial carcinosarcomas which show polypoidal arising in uterine cavity have aggressive clinical features [4]. According to references, such features cause dilemmas of whether or not systemic chemotherapy should be administered after surgical treatment in patients with first-stage disease, with histopathologically verified endometrial carcinosarcoma, and with polypoid growth inside the uterine cavity. Due to the aggressive nature of these tumors some authors recommend chemotherapy or even combined chemo-radiotherapy after surgical treatment even in early clinical stages of the disease in order to postpone or prevent relapse [5].

Case Report

This paper presents the case of a 74-year old patient treated from endometrial carcinosarcoma localized in an endometrial polyp.

One year prior, this patient underwent a complete gynecological examination, with colposcopy, cytology, explorative curettage, and color Doppler ultrasonography due to one day long postmenopausal bleeding of medium intensity, without results of malignancy. Furthermore a control with ultrasonographic exam performed after exploratory curettage resulted in completely normal findings. One year later, exploratory curettage was performed for new vaginal bleeding; this time it was scarce. It was then visualized by ultrasonographic exam that the endometrium was 32 mm thick honeycomb structure but with no pathological vascularization. Clinical findings were indicative either of endometrial carcinoma or endometrial polyp although scarce vascularization presented a differential diagnosis problem because it corresponded neither to endometrial carcinoma nor to endometrial polyp. Exploratory curettage was performed again. Histopathological finding was sarcoma stromae endometrii. After preoperative examinations with magnetic resonance imaging (MRI) of the abdomen and pelvis, a classic hysterectomy with bilateral adnexectomy, selective lymphadenectomy, and cytological analysis of the peritoneal lavage were performed. Definite histopathological findings verified polypoid carcinosarcoma in the uterine cavity known as mixed Müllerian tumor, comprised of 95% non-differentiated chondrosarcoma tissue and 5% endometrial adenocarcinoma, staged as FIGO Stage Ia. Postoperative period was normal. Patient recovered quickly. Follow-up consisted in regular check-ups, including MRI examination every three months. After six months the patient experienced dull low back pain which lasted for two days. Pain stopped spontaneously but was followed by bowel emptying problem, requiring detailed clinical examinations. The existence of a large abdominal tumor was verified by clinical

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exam. Computed tomography (CT) scan of the abdomen and pelvis was performed, allowing visualization of expansive changes in the entire pelvis and abdomen, spreading from rectum to head of the pancreas, compressing the portal vein, right ureter, and large blood vessels in the pelvis. Patient, however, complained only of bloated abdomen. All laboratory results as well as patient's general state were very good and did not correspond to clinical and CT findings. Systemic chemotherapy by mono-adriablastin in cycles was indicated. Patient completed the first chemotherapy cycle without side effects, but after a few days, clinical symptoms developed due to the expansion of the tumor lesions in the abdomen. The second chemotherapy cycle was prescribed. Patient resisted this treatment with difficulty because of previously described present clinical symptoms. Aside from nausea, complete appetite loss, heartburn, difficult bowel movement, pains, and exhaustion appeared. Although blood analysis showed only slight anemia, lymphostasis appeared especially in lower limbs. Swelling in legs progressively increased day after day despite the symptomatic therapy which was administered daily. Patient died before the third chemotherapy cycle i.e., three months after relapse was diagnosed and six months after radical surgical treatment.

It is interesting to mention that this patient underwent a gastric wall surgery at the age of 55 because of a tumor histopathologically diagnosed as Swanoma benignum which is a rare finding. Besides this, the patient had two sisters diagnosed and treated from malignant breast tumor.

Discussion

Uterine sarcomas are relatively rare mesenchymal malignant neoplasms with poor prognosis, accounting for 8% of all uterine malignant neoplasms. Reference data show that there are only a few moderately active cytotoxic agents for this entity, and therefore, chemotherapy for uterine sarcomas is palliative in most cases [6].

Monoadriablastin was prescribed to the patient without any success. References describe administration of several chemotherapy protocols: paclitaxel and ifosfamide which were the chemotherapy regimen which slightly improved both progression-free and overall survival; combination of ifosfamide and cisplatin which appears to improve progression-free survival but whose therapeutical application is limited by their cytotoxicity, while for leiomyosarcoma and undifferentiated endometrial sarcoma (formerly named high-grade ESS) doxorubicin, ifosfamide, and gemcitabine are used [6].

With regards to the application of radiotherapy to secondary deposits in abdomen, data references show that radiotherapy to the abdomen is not associated with improved survival [7].

The distinct biological behavior and poor overall survival of uterine sarcoma create challenges in the management of these tumors and urge us to perform even more thorough immunohistochemical, biological, genetic, and more extensive multidisciplinary research of this issue in order to prolong the progression-free interval and the overall survival.

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