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A case report of Carcinosarcoma – Rare type of uterine sarcoma

KEYWORDS: carcinosarcomas, uterine tumours, mixed mullerian tumor.

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ABSTRACT

INTRODUCTION: *Carcinosarcoma also known as malignant mixed mullerian tumor. It is uncommon and its incidence is< 5% of all uterine malignancies. It is associated with more than 15 % cancer related deaths. Almost all these cancers occur after menopause with median age of 62 years. The survival of women with advanced uterine carcinosarcoma is poor with a pattern of failure indicating greater likelihood of upper abdominal and distant metastatic recurrence.*

CASE SUMMARY: *A 60 year old female came with complaints of bleeding per vagina associated with history of weight loss. She attained menopause 6 years back. On examination umbilicus was central,inverted. A 2cm infraumbilical scar was noted, no dilated veins or sinuses were seen. On speculum examination-cervix and vaginal mucosa were healthy, minimal blood tinged discharge was seen . Per vaginal examination revealed-uterus was around 8 to 10wks size, anteverted , mobile, no fornicial mass or tenderness.PV findings was correlated with per rectal examination and rectal mucosa was free. MRI was done,which showed a 8*6 cm growth within the uterine cavity with evidence of infiltration of the myometrium extending upto serosal surface in the right anterior wall .However no evidence of serosal involvement was seen. B/L fallopian tubes were dilated with multiple enlarged paraaortic lymph nodes. Fractional curettage with cervical biopsy was done and provisional diagnosis of carcinosarcoma was made based on histopathology report. Total abdominal hysterectomy with bilateral pelvic lymphadenectomy done .Final histopatholgy report revealed carcinosarcoma.*

CONCLUSION: *Total abdominal hysterectomy with bilateral salpingo-oophorectomy along with pelvic node dissection is the mainstay if the treatment of carcinosarcoma. Stage1A1 –surgery+tumour directed RT or CT .Stage1A2 to stage 4 with adequate debulking- CT with tumour directed RT or whole abdomen RT.*

Introduction: Uterine sarcomas are rare mesodermal tumours that account for approximately 3% of uterine cancers[1].The main lesions are carcinosarcomas, leiomyosarcomas and endometrial stromal sarcomas[2]. Most common is endometrial stromal sarcoma(Leiomyosarcoma).It is seen in perimenopausal women (45 to 50yrs) and about 1/3rd is seen in post menopausal women. Uterine sarcomas can be divided basically into two types- 1)Pure-only malignant mesodermal elements are present(eg. leiomyosarcomas and endometrial stromal sarcomas). 2) Mixed-malignant mesodermal and malignant epithelial elements are present (eg.carcinosarcomas).

Carcinosarcoma also known as malignant mixed mullerian tumor. Its incidence is <5% of all uterine malignancies and associated with more than 15% cancer related deaths. Almost all these cancers occurs after menopause with median age of 62years .60% of the patients present with advanced disease and 80-90% of patient present with postmenopausal bleeding. They can also be present with bloody or watery vaginal discharge, pain abdomen or mass per abdomen and passage of tissues from the vagina.

Treatment – Because of the rarity of the carcinosarcomas , most studies have evaluated the entire range of uterine sarcomas as a group with regards to various treatment modalities.[4-5]or analyzed all surgical stages of carcinosarcoma as one group [6]. The survival of patients with advanced-stage uterine carcinosarcoma is quite poor and the patterns of failure indicate a higher likelihood of upper abdominal and distant metastatic recurrence [7]. Total abdominal hysterectomy with bilateral salpingoophorectomy with pelvic lymphnode + Para aortic dissection+omentectomy is the mainstay of the treatment. . Multimodel therapy(i.e adjuvant chemotherapy plus radiotherapy) has shown to be effective. 5year survival rate - stage1- 47%, stage2-36% , stage 3- 22%, stage4-10%.

Case report: A 60 year old female came with complaints of bleeding per vagina associated with history of weight loss. She attained menopause 6 years back.

On examination umbilicus was central, inverted. A 2cm infraumbilical scar was noted,no dilated veins or sinuses were seen.On speculum examination-cervix and vaginal mucosa were healthy, minimal blood tinged discharge was seen . Per vaginal examination revealed-uterus was around 8 to 10wks size, anteverted , mobile ,no fornicial mass or tenderness . PV findings was correlated with per rectal examination and rectal mucosa was free.

MRI was done, which showed a 8*6 cm growth within the uterine cavity with evidence of infiltration of the myometrium extending upto serosal surface in the right anterior wall. However no evidence of serosal involvement was seen. B/L fallopian tubes were dilated with multiple enlarged paraaortic lymph nodes.

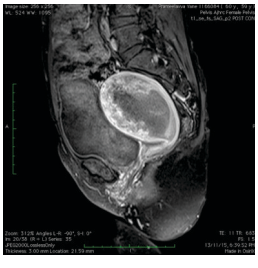

Figure 1:MRI picture showing the lesion.

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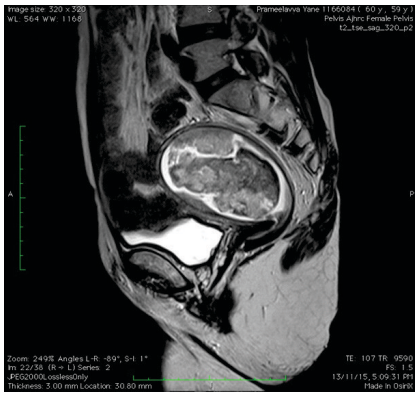

Fig2:

Fractional curettage with cervical biopsy was done and provisional diagnosis of carcinosarcoma was made based on histopathology report.

She was taken for total abdominal hysterectomy with bilateral pelvic lymphadenectomy. Intra operative findings–uterus 10wks size, Right tube hydrosalphinx noted bilateral ovaries and left tube normal, obturator and internal ilac lymph nodes of 1.5 * 1cm noted in Right side and 3 paraaortic lymph nodes were seen which were enlarged. Cut surface showed fleshy red growth with pultaceous material inside.

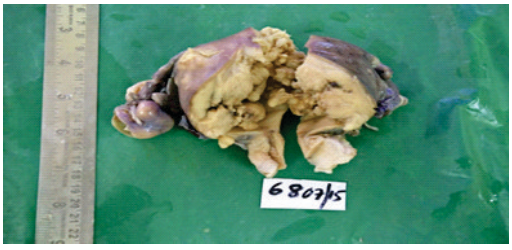

Figure 3:Gross appearance

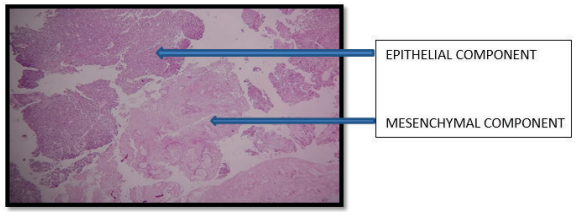

Fig:4 low power field

Final histopathology report revealed carcinosarcoma.

Discussion: Based on studies performed so far, carcinosarcoma are very rare,highly aggressive,biphasic tumours composed of epithelial amd mesenchymal elements believed to be arised from monoclonal origin. These tumors can arise in any organ of the female genital tract such as vulva, vagina, cervix, endometrium and fallopian tube. Endometrium is the common site. A recent gene expression profile study found carcinosarcomas were more similar to uterine sarcoma than endometrial sarcoma. The main treatment is surgery i.e hysterectomy with bilateral salphingo-oophorectomy, however, because of the high rates of both local and distant recurrence after surgery, lymphadenectomy and post-operative effective adjuvant therapies are needed. There are only a few series that compare the outcome of surgery alone versus surgery and WPI(whole pelvic irradiation) in relation to patterns of recurrence and survival for early-stage uterine carcinosarcomas. While a recent Gynecologic Oncology Group (GOG) study [6] demonstrated only a small improvement in pelvic control associated with the addition of WPI, a review by Olah *et al.*[5] reported that patients who were given adjunctive pelvic radiotherapy actually had a worse prognosis than those who had surgery alone .[5] Cochrane review has shown that women with high stage disease(stage III-IV persistant or recurrent disease) who received combination chemotherapy including ifosfamide had a lower risk of death and disease progression than who received ifosamide alone ,after adjustment for performance status. In addition ,radiotherapy to the abdomen may reduce locoregional recurrences but not improve overall survival, as it was found in one trial that there was no difference in the risk of death and disease progression than women who received whole abdominal irradiation and chemotherapy, after adjustment for age and stage of disease. Multimodel therapy(i.e adjuvant chemotherapy plus radiotherapy)has shown to be effective.

Conclusion:

Total abdominal hysterectomy with bilateral salpingo-oophorectomy long with pelvic node dissection is the mainstay if the treatment of carcinosarcoma. In cases of Stage1A, surgery plus tumour directed radiotherapy or chemotherapy should be given but in cases of stage1A2 to stage 4 with adequate debulking, chemotherapy with tumour directed radiotherapy or whole abdomen radiotherapy is needed. In cases of inadequate debulking, only chemotherapy is required.

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