ORIGINAL RESEARCH PAPER

Obstetrics & Gynaecology

A RARE CASE OF GAINT UTERINE LEIOMYOSACRCOMA IN PERIMENOPAUSAL WOMEN: CASE REPORT

KEY WORDS:
leiomyosarcoma, malignancy

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ABSTRACT

Background: Malignant changes in a leiomyoma or uterine fibroid are termed leiomyosarcoma. It arises from the smooth muscle of the uterus and is a rare tumour that accounts for 2% to 5% of all uterine malignancies. Very few cases are reported in the literature. Our patient did not have any history of genital bleeding, which is the usual presentation of uterine sarcoma. We report an original case report of an unusual presentation of this rare tumor arising from the uterus. The prognosis for females with uterine sarcoma primarily depends on the extent of disease at the time of diagnosis and the mitotic index

INTRODUCTION

Leiomyosarcomas (LMS) are one of the rarest uterine malignancies accounting for only 1–2% [1]. It is most commonly reported that these women present with a rapidly enlarging abdominal-pelvic mass, or they may be asymptomatic. Histopathological examination of the hysterectomy specimen is diagnostic [1]. LMS incidence is approximately 0.1–0.3% in hysterectomies performed for presumed uterine leiomyomas [2]. The cornerstone of treatment for LMS is by resection of localised disease by total abdominal hysterectomy and bilateral salipngo-oopherectomy ; however, pelvic and para-aortic lymphadenectomy is not routinely indicated because of low incidence of lymphatic spread [3]. Chemotherapy or pelvic radiation may be considered following surgery, but whether any form of adjuvant therapy improves survival rates is unknown.

CASE REPORT

A 45-year-old multiparous woman reported to our outpatient clinic with complaints of a mass in the lower abdomen for 2 years and lower abdominal pain for 4 months. The patient was apparently asymptomatic for 2 years and then noticed a mass in the lower abdomen that gradually increased. She documented rapid growth in the past four months. She also had associated lower abdominal pain, which was dull and aching in type, dragging in nature and continuous with no aggravating or relieving factors. Her menstrual cycles were regular and normal. She had no history of genital bleeding. No history of white discharge per vagina. On examination, pallor was present, and the patient's vital signs were normal. She was thinly built. On abdominal examination, an irregular midline mass arising from the pelvis was present. Uterus size was around 28 to 32 weeks. The upper and lateral borders of the mass could be determined; the lower margin could not be ascertained. The mass was firm to hard in consistency with restricted mobility and nontender with no free fluid. There was no hepatosplenomegaly. On vaginal examination, the patient's uterus was enlarged to 24 weeks' gestational size and nodular, occupying the whole pelvis. No mass could be appreciated separately from the uterus. Computed tomography (CT) scan findings suggested a large, lobulated, and arising from the pelvis, measuring 16x12x18.5cm superior border extending in the supraumbilical region up to lower border L3, adherent to both the uterus and bladder. Fat planes are maintained. Multiple dilated tortuous venous collaterals noted in the pelvis. CA125 was 25ng/mL (0-35 ng/mL). Other results were normal, and the patient was posted for exploratory laparotomy.

The abdomen opened vertically. Intraoperative, the mass was 24 weeks. It was lobulated with solid, cystic, haemorrhagic components. [FiGURE 3] shows the ovaries were normal, and the fallopian tubes were oedematous. A mass anteriorly was adherent to the bladder. Omental adhesion was absent. Before hysterectomy internal iliac artery was ligated at origin bilaterally to decrease the intraoperative blood loss [FIGURE 2]. Total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. The uterus measured 8 cm×5 cm×3 cm with a subserosa bosselated growth from the fundus measuring 18 cm×15 cm×11 cm with variable consistency. A biopsy of an internal iliac lymph node was taken and sent for histopathological analysis. A total of four pints of packed red blood cells, four pints of fresh frozen plasma, and four random platelet donors were transfused. The patient tolerated the procedure well. Histopathologic examination showed a cellular tumour arranged in interlacing bundles of spindle cells with elongated hyperchromatic nuclei. Figure 4]The tumour cells displayed moderate pleomorphism and bizarre nuclei with multinucleate tumour giant cells. There were scattered areas and normal and abnormal mitotic figures (> 4/high-power field) with marked nuclear atypia suggesting uterine leiomyosarcoma. Internal iliac nodes were free of tumour.

DISCUSSION:

LMS is a fast growing tumour with an incidence of recurrence and death. It is highly difficult to differentiate between benign uterine leiomyomas from leiomyosarcoma by any reliable method pre-operatively. The diagnosis of uterine leiomyosarcoma (LMS) should be suspected when severe pelvic pain accompanies a pelvic tumour in a postmenopausal woman. LMS symptoms may appear rapidly, with a doubling time of four weeks [4,5]. Our patient noticed the growth of her abdomen, which had 15 kg of sarcoma, just 4 months before surgery. Surgical staging includes hysterectomy and salpingo-oophorectomy (BSO) and resection of any metastatic lesion. 60% of women with LMS present with the disease limited to the uterus upon first diagnosis; cure rates range from 20 to 60%, depending on primary resection success [6,7]. Several case series support the role of primary surgery in patients with life-threatening uterine malignancies [8,9]. Complete cytoreduction is significantly associated with disease-free survival ($p = 0.03$) [9]. Ovarian preservation can be considered in early-stage LMS in pre-menopausal patients. A study of 341 women less than 50 years old who were stage I or II LMS at diagnosis found no difference in five-year disease-free survival between those who did and did not undergo a BSO[10]. We performed a BSO in this case as postmenopausal status was present and sarcomas are aggressive tumours with a high risk of local and distant relapse even in completely resected tumours [11]. Patients with International Federation of Gynaecology and Obstetrics (FIGO) stages I and II LMS have a very high risk of

recurrence after surgery; survival after recurrence is poor. In a study of 1988 FIGO stage I LMS patients, the 5-year survival rate was 51% and only 25% of patients with stage LMS were alive at 5 years [12]. Recurrence rates are approximately 70%; however, some patients have been shown to survive for more than 10 years if they are fortunate enough to be treated with chemotherapy. The site of metastasis or recurrence is often distant due to hematogenous spread into the lungs or liver [6]. There are few prospective data on chemotherapy utility for stage I/II LMS. In a prospective study, gemcitabine and doxorubicin or docetaxel were found to offer a survival benefit to uterine leiomyosarcoma patients [13]. Our patient rejected chemotherapy despite our recommendation.

CONCLUSIONS:

Due to the rarity of uterine sarcomas, they are not appropriate for screening. And no routine screenimng is employed .The only treatment for these uterine sarcomas is surgical removal. The prognosis depends on the extent and metastasis at time of diagnosis [4]. Women with tumors larger than 5 cm diameter have a poor prognosis [14]. A study comparing non-randomized studies has shown that survival improved in patients receiving adjuvant chemotherapy with or without radiation therapy. Current studies consist primarily of phase II chemotherapy trials for patients with advanced disease [15].

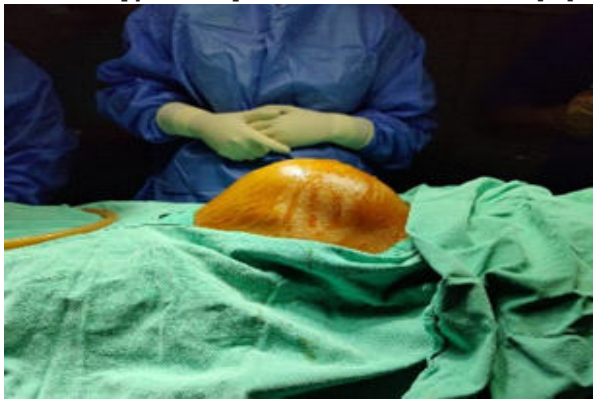

Figure: 1 PRE OP PHOTOGRAPHY SHOWING 28- 30 WEEK UTERUS

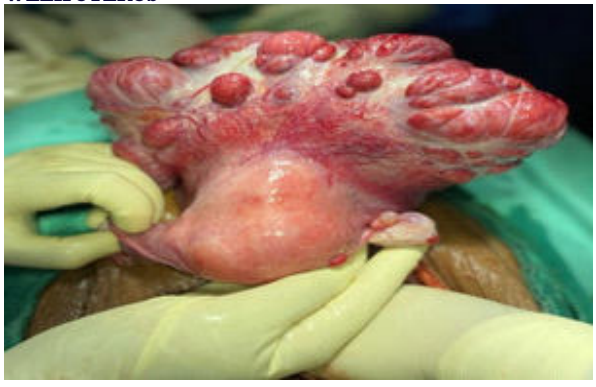

FIGURE 2 : LEIMYOSARCOMA WITH URERUS WITH BILATERAL TUBES AND OVARIES

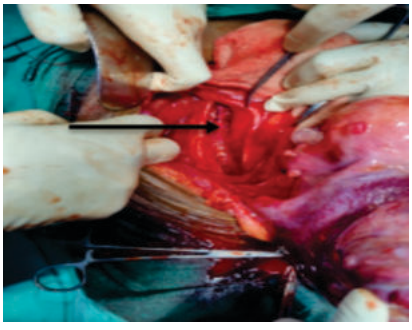

Figure: 3 INTERNAL ARTERY LIGATION AT ORIGIN

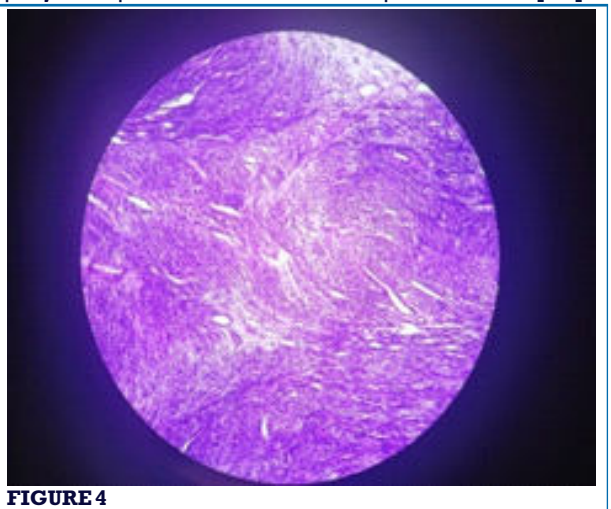

FIGURE 4

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