



Endometrial Adenosarcoma: Case Report

Mustafa Kandaz^{1*}, Elanur Karaman², Ozan Cem Güler¹, Sevdegül Mungan³ and Adnan Yöney¹

¹Department of Radiation Oncology, Karadeniz Technical University, Turkey

²Department of Medical Oncology, Karadeniz Technical University, Turkey

³Department of Pathology, Karadeniz Technical University, Turkey

Abstract

A 39 year old woman, who had 3 children, was admitted with complaints of abnormal uterine bleeding. Endometrial biopsy was performed and result was found as endometrial adenosarcoma. There were no distant metastases found at imaging. TAH + BSO (Total Abdominal Hysterectomy and Bilateral Salpingo-Oophorectomy) operation was performed and adjuvant chemotherapy (four cyclus ifosfamide, mesna, epirubicin) was given. We did not encounter any problems in monitoring. This case which includes endometrial adenosarcoma is presented because of its rarity.

Keywords: Endometrial adenosarcoma; Malignant mixed mullerian tumor; Vaginal bleeding; Computer tomography

Introduction

The uterine Müllerian adenosarcoma, a mixed mesodermal tumor variant, is described by a glandular proliferation without a typical in a malignant sarcomatous stroma [1]. The endometrial adenosarcoma is a kind of rare endometrial cancer, even if endometrial adenosarcoma is often seen in premenopausal and postmenopausal women. It contains the epithelial benign and malignant stromal component. The case is presented due to a rare tumor. It consists of 8% of uterine sarcomas [2,3]. With monitored in endometrium, it can be seen in localisations such as cervix, fallopian tube, ovarian and paraovarian tissues [3]. It presents as a protuberant polypoid mass in to the cervical channel [4]. Generally, clinical manifestations are non-specific ones, usually common to those of other neoplasias having that localization. They are diagnosed in menopausal patients, the main symptom being represented by vaginal bleeding. It is describe a case of adenosarcoma of the uterine corpus associated with ovarian thecoma, estrogen stimulation may play a role in the development of mesenchymal and mixed epithelial/mesenchymal uterine tumors, including adenosarcoma [5].

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*Correspondence:

Mustafa Kandaz, Department of Radiation Oncology, Faculty of Medicine, Karadeniz Technical University, Trabzon/Turkey, Tel: 04623775595; E-mail: mkandaz61@gmail.com

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Case Presentation

39 year old woman, who had 3 children, has had complaints about vaginal bleeding intermittently since nearly ten years. She hadn't the story of miscarriage, dead birth and curettage. After it was monitored endometrial polyp in pelvic ultrasound scan due to abnormal uterine bleeding, the hysteroscopic polypectomy was done. Its pathology was reported as endometrial benign polyp. During her ongoing process, because of that her vaginal bleeding continues, patient has been reevaluated. Pathology was not determined during the hematologic and the biochemical laboratory analysis. Systemic consultation was founded normal. Of the tumor reagents, CA-125: 39.3U/mL (0-35) was determined a little high. In the ultrasound imaging of the pelvis, the 18x10 mm hypoechoic myoma, in posterior corpus of the uterus, endometrial thickness was 7 mm, right ovary was 23x21 mm, left ovary was 33x27 mm and a follicle cyst which was 18x22 mm was shown in it. In her abdominopelvic computed tomography, the myometrium was showing a heterogeneous contrast staining. Endometrial biopsy was performed and result was found as endometrial adenosarcoma. The total abdominal hysterectomy and bilateral salpingo-oophorectomy surgeries were performed to the patient. In the result of pathology in the macroscopic examination, a tumoral lesion which was in the back wall of the uterus, 6x2 cm, bleeding, hard, solid, grown up to the lumen, ended to the cervical canal at a distance of 1 cm, was monitored. During microscopic examination, it was reported as the 6x2 cm adenosarcoma, the 1/3 myometrial invasion into the middle part, the index Ki-67 was high (30%) and mitosis were rare, about 1-2 on microscopic field with objective X10. Adjuvant chemotherapy (four cyclus ifosfamide, mesna, epirubicin) was given and then the patient was followed.

Discussion

Uterine sarcomas contain less than 1% of gynecological cancers and 2%-5% of all uterine cancers [6]. Uterine sarcomas (leiomyosarcoma, endometrial stromal sarcoma, adenosarcoma and carcinosarcoma) are heterogenous malignant group that has common pathological and clinical aspects. Uterine adenosarcoma was firstly designated in 1974 by Clement and Scully [7]. The tumor has epithelial component and stromal component. The epithelial benign component has inactive or proliferative endometrial glands. The mesenchymal component, which shows malignant features, seems to low-grade stromal sarcoma. In sarcoma to us component, mesenchymal elements such as striated muscle, cartilage and fat are available [8].

Endometrial adenosarcomas begin as polyp from the endometrial surface, and then invade in myometrium. They have often the low-malignant potentials. In adenosarcomas, it has been constated about the rate of 24% of relapse and notified that the degree of myometrial invasion is, in case of relapse, an important factor of risk [8,9].

In the etiology of adenosarcoma, the history of pelvic radiation and taken part of tamoxifen was located [10,11]. In 10-25% of patients having this disease, it is seen that there is the story of pelvic radiation as a etiological factor. In the patients who have breast cancer and are using tamoxifen, the increased risk is founded because it is based on the estrogenic effect on uterus. Then, it is notified in the patients that the benign uterine bleeding has begun almost 5-25 years before [12-14]. In our event, there isn't the tamoxifen use and story of pelvic radiation but the story of the benign uterine bleeding was existed in 10 years before the diagnosis.

Carcinosarcoma and adenofibroma exist in the seperative diagnosis of endometrial adenosarcoma. When adenofibroma consists of benign epithelium and stroma, the degrees of carcinomatous and sarcomatoid differentiation in carcinosarcoma must be evaluated. Even if the managements of endometrial carcinosarcoma and adenosarcoma are similar, its prognosis and results are different. They differ in terms of having epithelial components from other sarcomas of uterus, and having benign epithelial component from mixed malign mesodermal tumors.

In consequence of clinical and pathologic analyses that Clement and his friends made in 10 events of Mullerian adenosarcoma in 1989, they defined a sub type of excessive sarcomatous component. In this sub type, risk of relapse was determined much higher in metastasis and rate of death [15]. The presence of sarcomatous component in 25% more than the total volume of tumor was identified as sarcomatous excessive proliferation. There are high mitotic activity in mesenchymal elements [3,8,16]. In these events, the histological particularities deal with the poor prognosis; extra uterine spread in the diagnosis, myometrial invasion, sarcomatous excessive proliferation at mesenchymal component, endovascular invasion and the presence the elements of rhabdomyosarcoma [7,17]. Follow-up cure is planned for the patient because of the risk of relapse and metastasis. Adjuvant chemotherapy is planned for our event because of the risk of relapse and metastasis.

The rate of relapse in uterine adenosarcoma is 25-40% and a distant metastasis is determined in 5% of patients [16-18]. Mostly, relapse only consists of sarcomatous component [7,16,18].

The basis of treatment of endometrial adenosarcoma is surgical excision. According to the stage of the disease, the standard surgical

method is based on radical or total hysterectomy and bilateral salpingo-oophorectomy and omentectomy [2]. In our event, total hysterectomy and bilateral salpingo-oophorectomy and omentectomy operations were applied to the patient.

The primary endometrial adenosarcoma is a kind of rare cancer. The diagnosis of the endometrial adenosarcoma is based on the preoperative scanning and the postoperative pathologic analysis. The results of the pathology must be evaluated by an experienced specialist. Because the adenofibroma and carcinosarcoma have the different clinical results, they must be considered in definitive diagnosis. The presence of the high-grade sarcomatous component and the presence of the deep myometrial invasion and the vascular invasion are connected with the poor prognosis and increase the risk of relapse and metastate. These events must be followed for a long time.

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