Ovarian cystadenocarcinoma with unusual presentation

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Abstract

The authors present a case report of a female patient 49 years old, admitted in a hospital ward with multiple lymphadenopathies and respiratory symptoms in which the diagnosis of serous ovarian cystadenocarcinoma was made by post-mortem examination. The clinical condition was related with the presence of vast lymphatic dissemination mostly upper-diaphragmatic which is unusual in this type of neoplasm.

Keywords: multiple lymphadenopathies, serous ovarian cystadenocarcinoma, upper diaphragmatic dissemination.

Introduction

Ovarian neoplasms are very frequent in women being the most described as the first cause of gynecological malignant tumor.[1]

Epithelial tumors represent around 85 to 90% of ovarian primary malignant tumors, being the serous cystadenocarcinoma the most frequent with 60 to 80% of cases.[1,2,3] It occurs more often in Euro Caucasian women, in the peri- and postmenopausal period with a maximum of incidence from 45 to 65 years of age.[3,4]

Ovarian cystadenocarcinoma dissemination happens initially through contiguity and intraperitoneal invasion, followed by the lymphatic route and seldom the haematogenic route.[5]

Despite of existing in around 50% of cases, at the time of diagnosis, an invasion outside of the abdominal cavity, it emerges mainly in a context of widespread intraperitoneal dissemination.

In the literature, we do not find reference to a predominately upper diaphragmatic metastization of this disease.

Recently we saw a patient with ovarian serous cystadenocarcinoma with revealing symptoms related to the presence of a widespread upper diaphragmatic lymphatic dissemination, contrasting with the scarce local regional invasion of the tumor.

Case Report

I.C.R., female patient, 49 years of age, Euro Caucasian, long-term "resident" at Miguel Bombarda Hospital due to oligophrenia. She was admitted in a Medicine Service in March 92 due to polyadenopathies of etiology to be clarified. The clinical history was known only to the extent that three weeks before being admitted she had started a clinical condition featured by coughing with sputum followed by effort dyspnoea, having simultaneously non-selective anorexia and asthenia; without fever or thoracalgia as well as no other complaints. Due to a progressive deterioration of the symptoms and existence of multiple adenomegalies of the neck ganglionary chains, she was referred to the Emergency Service of St Antonio Capuchos Hospital by her origin hospital doctor being then admitted.

On the admission objective exam, it is to be highlighted: severe mental retard with emotional volatility and poor cooperation to supply anamnesis data, harmonic obesity, discolored skin and mucosa but hydrated; apyrexia as well as all the remaining vital endpoints within normal range; neck enlargement due to a number of cervical and supra-clavicular, bilateral, bulky (with 2 to 4 cm of diameter), confluent, increased consistency, adherent to surface plans, painful to palpation; absence of adenomegalies in the remaining ganglionary chains; pulmonary ausculta-

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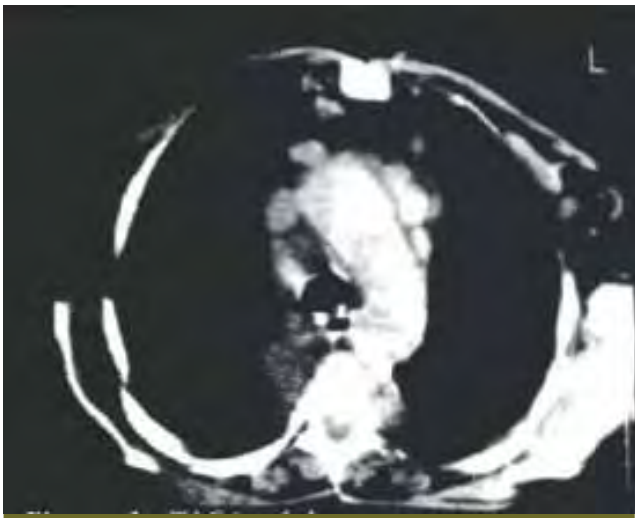
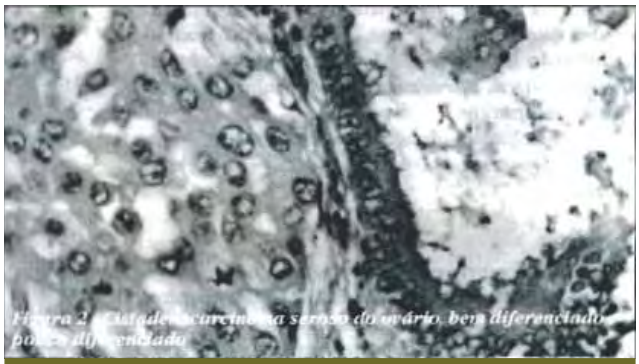


Thorax CT.

FIG. 1



Ovarian serous cystadenocarcinoma, well differentiated poorly differentiated.

FIG. 2

tion with crepitant cracklings audible on the lower 1/3 of both hemithoraxes. The remaining observation was negative.

In the clinical study performed the following results were obtained: normocytic normochromic anemia (Hb=11,5g/dL, Htc=32.2%, MCV=86.1 fl, MCH= 29.8g, MCHC=34.6%): ESR = 66 and on the first hour; iron = 17 µg/dL: transferrin = 216 µg/dL, normal ferritin; normal reference values both on the kidney and liver function; negative BK search in the sputum; negative HIV-1 and HIV-2. Thorax teleradiography revealed cardiothoracic ratio above 50%, with heterogenous hypo transparent of badly defined limits at the level of the lower 1/3 in both pulmonary fields and with signs of right pleural effusion of small dimensions.

Cervical ultrasound confirmed multiple ganglionary formations at this level, of variable echogenicity and dimensions, some confluent, distributed on the supraclavicular fossa and on the anterior and posterior cervical triangles. Thorax CT showing: multiple bilateral infiltrate at pulmonary level, with a round nodular condensation on the medium 1/3 right hemi-thorax; bilateral pleural effusion; nodular formations involving the big vessels supra-aortic, peri-cava and peri-aortic related with adenopathies and pericardial effusion (*Fig. 1*).

During admission the patient revealed difficulty adjusting to the hospital environment in the ward, presenting a slight breathing difficulty and verifying subfebrile temperatures in afternoon episodes (37.5° C). Ganglionary biopsy was scheduled which was not performed, because the patient died on the day the exam was booked without any apparent terminal accident. The autopsy revealed the presence of an ovarian serous cystadenocarcinoma, bilateral, with hilum ganglionary metastasis, paratracheal and cervical, apart of an extensive invasion of the lymphatic vessels in upper diaphragmatic organs such as the lung, pleura, heart and thyroid (*Fig. 2 and 3*).

Discussion

Before a clinical condition of insidious onset featured by polyadenopathies and vague breathing complaints, in a patient "residing" in a hospital environment, the initial diagnosis was raised as an infectious process, namely pulmonary tuberculosis and/or ganglionary, not neglecting other possibilities, namely the lymphoproliferative disease. In this specific case, the clinical diagnosis of ovarium neoplasm might have been difficult due of the absence of complaints of the gynaecology forum. It is accepted however that if those complaints existed she would omitted it due to the referred mental deficit. It is however known that often gynecologic complaints are, in this kind of tumor relatively rare or seldom valued by patients reason why often they are not referred.

The severe prognosis of variable malignant tumors, namely cystadenocarcinoma, is due precisely to the circumstance of two thirds of cases being diagnosed in advanced stages of the disease, [2] as the early symptoms are very unspecific. Also there are not complementary

3A – Ovarian cystadenocarcinoma ganglionary metastasis, some psammoma bodies can be seen 3 B, C, D - Lymphatic invasion by ovarian cystadenocarcinoma cells on the thyroid (B), heart (C) and lung (D).

FIG. 3

tests of early screening of such situations, namely tumor markers with high specificity. The most common marker, CA 125, is usually normal in the early stages of the disease, and might be increased in the gynaecology benign pathology. It is more useful on the post-surgical follow-up to screening any recurrence and to monitor how the disease is progressing during and after due to the adjuvant therapy.[4,6]

The initial dissemination of the serous ovarian cystadenocarcinoma is made usually by the local regional contiguity and intra-abdominal and only then through the lymphatic and blood route. Distant metastasis, presumably through the blood, can be found in the liver, lungs, pleura, kidney, bone, adrenal, bladder and spleen, in a decreasing frequency order. [5]

At the time of the diagnosis, the lower diaphragmatic dissemination is thus frequent. However there is an associated metabolization outside the abdominal cavity in 50% of cases.[1] These tumors are therefore diagnosed in later stages of the disease emerging usually as conditions of the gastroenterology forum (abdominal pain or even in situations of bowel occlusion).

In this patient and different from usual, there was not a local regional invasion, limiting to a lower diaphragmatic metastization to the commitment of some ganglia in the liver hilum. It was thus predominating an extensive invasion upper diaphragmatic involving several ganglionary chains a part of the lung, pleura, heart and thyroid.

In the international literature it was not found the description of any case involving the thyroid, being the references of pulmonary and pleural invasion described only in the context of widespread abdominal disease.

More rarely, isolated spleen metastases have been observed.[8]

However the particularity of dissemination in the present case, the evolution did not differ from most cases of ovary neoplasm, in special of cystadenocarcinoma, keeping a severe prognosis.

The therapeutic measures used in this situation include a radical surgical resection; radiotherapy in limited disease or in surgical minimal residual disease, post-surgical polychemotherapy (systemic or intraperitoneal) with cisplatin, carboplatin, cyclophosphamide and adrimicin among other cytostatic. Among other antitumour agents should also to be mentioned

paclitaxel, a product identified in 1971 as a natural component extracted from the yew "Taxus Brevifolia".[8,9] Its action mechanism, identified in 1979, includes the depolymerization of microtubules, making them non-functioning, blocking this way the cell division. Among other malignant tumors, paclitaxel is used since 1989 in the ovarian cancer refractory to other cytostatic. Today, it is being studied its use as a first line of treatment on stage III and IV of this neoplasm, isolated or associated to cisplatin, carboplatin and cyclophosphamide.[9] ■

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