Synchronous Multiple Primary Carcinomas of Ovary and Cervix: A Case Report.

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Abstract

A patient with synchronous multiple primary carcinoma of cervix and ovary is described. A 50 year old patient presenting with abdominal pain and distension over the last four months and two months history of offensive vaginal discharge, weight loss and no contact bleeding. The patient had total abdominal hysterectomy and bilateral salpingoophorectomy. Microscopic examination of the uterus and ovary revealed moderately differentiated squamous cell carcinoma and serous cystadenocarcinoma respectively. This suggests multiple primary malignancies. The follow up of the patient was unremarkable. There is need to differentiate between primary and metastatic tumour especially when they involve multiple organs.

Introduction

The occurrence of multiple primary malignant tumours in the same patient at the same time or at different times has been reported in developed countries[1]. There were few reported cases of multiple primary malignant tumours among the Africans black population [2,3]. This may be because of inadequate follow-up of cancer patients and also inadequate investigative facilities such as histopathology service[4]. The rarity of this condition has prompted us to report this case.

Case History

A 50 year-old Para 11^{+2} woman whose last child birth was 9 years ago and last menstrual period was 2 months prior to presentation. She presented with a four-month history of abdominal pain and distention in our gynaecology clinic. She also complained of 2 months history of watery offensive vaginal discharge but no itching and no history of contact bleeding. She had anorexia and loss of weight with occasional vomiting and constipation. There was no history of chronic cough. She menstruated for four days in a regular cycle of 28-31 days, no dysmenorrhoea or menorrhagia. There was no history of contraception. There is no history of chemotherapy or radiation therapy.

Physical examination revealed a moderately built woman who was afebrile, not pale, anicteric and had no pedal oedema. Her pulse rate was 93 beats per minute, regular and full volume and the blood pressure was 110/80mmHg. Both the cardiovascular and respiratory systems were normal. Abdominal examination revealed a grossly distended abdominal mass corresponding to a 22-weeks gestation. The mass was firm non-tender and mobile in all directions. The liver, spleen and kidneys were not palpably enlarged. Fluid thrill was elicited. Vaginal examination revealed a healthy vulva and vagina. On digital examination, the cervix was firm and the os was closed while on speculum examination, the cervix was erythematous but there was no contact bleeding. The abdominal mass moved without the uterus. A diagnosis of ovarian malignancy was made. Peduculated uterine fibroid was considered as a possible differential.

Her packed cell volume was 38% and the total white blood cell count was $6.4x10^9$L, with a normal differential count. The liver and the renal function tests were normal. The chest X-ray revealed no pathology. Cervical swab yielded no bacterial growth. Abdomino-pelvic ultrasound revealed normal liver and kidney. There was a huge mass with multiple mixed echogenic areas. The uterus could not be identified due to the huge mass.

At surgery, the ovaries were enlarged, irregular and cystic measuring 14x9x7cm on the right and 17x7x6cm on the left, no adhesions to any structure. The cut surface showed multinodular, grayish-yellow areas and cystic areas containing yellowish gelatinous material and clear serous fluid. The cervical stump was infiltrated with tumour. The uterus was corresponding to about 8 weeks gestation, pale but no gross metastasis. Both uterine tubes looked healthy. The pelvis was grossly normal. She had abdominal total hysterectomy, bilateral salpingoophorectomy and omentectomy. About 2.5 litres of ascitic fluid was drained. The ovaries weighed about 1.0kg. Her recovery was uneventful and was discharged on the 9th day post-operative.

She came for follow-up after a month and she had no complaints. Histopathology report revealed serous cystadenocarcinoma of the ovary and squamous cell carcinoma of the cervix infiltrating the uterus (moderately differentiated).

Discussion

Synchronous cancers involving the female genital tract are well-recognized phenomenon[4]. Warren and Gates[5] established the criterion for the diagnosis of multiple

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primary malignant tumours. Each of the tumour must be distinct, must be definitely malignant and must not be a metastasis of another tumour. Ilesanmi et al[6] in Ibadan, Nigeria reported four cases of synchronous carcinomas of cervix and ovary. In all the cases, the ovarian and cervical tumours were adenocarcinoma. Manolitsas et al[7] also reported synchronous ovarian and cervical squamous intraepithelial neoplasia where Human Papilloma Virus (HPV) was linked to squamous intraepithelial neoplasia of the ovary and cervix. In this case the ovary is diagnosed as serous cystadenocarcinoma and the cervix as invasive squamous cell carcinoma. HPV does not infect the columnar epithelium or cause neoplasia of adenocarcinoma and therefore this lesion represent a separate primary lesions rather than metastatic disease. However, the coexistent of neoplastic transformation in embryologically related epithelia has been well documented[8]. The possible cause of second malignancy in a patient receiving chemotherapy and/or radiation therapy from a primary malignancy is well established which was not in this case.

In conclusion, multiple primary malignancies are rare and can be missed if thorough investigations were not carried out on our patients especially those with cancers. The lack of adequate diagnostic facilities in the developing countries may also be another factor for underestimating the incidence of multiple primary malignancy.

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