Case Report

Synchronous ovarian serous carcinoma and squamous cell cervical carcinoma

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Abstract
Concurrent different histopathological types of gynecologic tumors arise rarely. We present ovarian serous and cervical squamous cell carcinoma formed synchronously. A 68 year-old-patient with gravida 1 parity 1, admitted to our hospital with complaint of abdominal distention. We determined distended abdomen due to acid, hypertrophic and erosional cervix, normal uterus size, free parametrial areas and massive lesion filling whole douglas. After acid cytology sampling, cervical and endometrial biopsies were taken. The patient was underwent optimal debulking (according to the Gynecologic Oncology Group, optimal cytoreduction is defined as the largest residual tumor nodule measuring 1 cm or less) and systematic pelvic and paraaortic lymph-node dissection. Pathological diagnosis resulted as ovarian serous carcinoma stage 3C and synchronous squamous cell cervical carcinoma stage 1B1 (The International Federation of Gynecology and Obstetrics staging system). Finally, combination chemotherapy of adjuvant carboplatin and paclitaxel together with radiotherapy were applied but she died after 22 months due to progressive disease. Thus, preoperative assessment must be done very carefully as surgens come across with synchronous gynecologic tumors.

Key words:
Ovarian neoplasms, synchronous neoplasms, uterine cervical cancer

Introduction
In the woman genital system tumors, concurrent frequency of cervix and ovary cancer is 0.025 % [1]. Ovarian and endometrial tumors are most common synchronous gynecologic tumors and it is especially rare to diagnose two different types of histopathologic tumor [2, 3, 4, 5, 6]. In ethiopathogenesis of this type of tumors, the reason occurs to be a genetic basis which is exposed to same carcinogen or which enables a tumor development. Association of ovary and endometrium tumors constitutes a great part of the tumors that are seen concurrently in the woman genital system [7, 8, 9, 10]. Cervix and ovary tumors can also be very rarely seen concurrently. In this study, we present the case that is diagnosed with cervical squamous cell carcinoma and serous carcinoma of ovary.

Case presentation
A 68-year-old gravida 1 parity 1 patient referred to our center with the complaints of abdominal distention and foot edema. In the bimanual pelvic examination, abdominal distention due to acid and fixed pelvic mass and hypertrophic cervix was determined. After acid cytology sampling, cervical and endometrial biopsies were taken. The patient was prepared for surgery under general anesthesia, and pre-operative assessment was completed by taking acid cytology.
The patient underwent laparotomy on April 2009. In the operation, there was nearly one liter of ascites in the abdomen. Uterus, adnexial tumor tissue, bladder, omentum and sigmoid colon were in the form of conglomerate mass and obliterated douglas pouch. There was peritonitis carcinomatosa. Miliary tumor implants found on pelvic side walls and subdiaphragmatic area. There was no tumor on liver and spleen but detected on sigmoid colon serosa. Omental cake has been detected also. Optimal debulking surgery with total abdominal hysterectomy, bilateral oopherectomy, omentectomy, appendectomy, pelvic and paraaortic lymphadenectomy were performed. No complications occured during or after the operation.

In the final pathology report, squamous cell carcinoma of cervix (Figure 1) and serous carcinoma of ovary (Figure 2) was reported. The cervix presented with squamous cell carcinoma about 2 cm in depth and width. Totally 42 lymph node (30 pelvic 12 paraaortic lymph node) harvested and ovarian serous carcinoma metastasis was found in pelvic and paraaortic lymph nodes. The final surgical-pathologic stage of cervical squamous cell carcinoma was stage 1B1 and serous ovarian carcinoma was 3C. Adjuvant chemotherapy with carboplatin (area under the curve, 5) and paclitaxel (175 mg/m2) was prescribed monthly and after this treatment regimen, concomittant chemoradiotherapy for cervix carcinoma was applied. Because of increased level of CA-125 serum level, liposomal doxorubicin and carboplatin regimen continued as second line chemotherapy. After finishing six courses of adjuvant chemotherapy, multiple metastases detected and hyacamptine (4 mg/m2) applied as salvage chemotherapy but she died after 22 months with progressive disease.

Discussion

Concurrent tumors are rarely seen. In the study of Eisner and his friends that was done by examining the histopathology results of 3863 patients who were diagnosed with woman genital malignity: only in 0.7 % of the patients, concurrent tumor was seen. Concurrent endometrial and ovarian tumors constitute the majority (0.3%) of these cases. Only in one patient (0,025%) was diagnosed with concurrent ovarian and cervix tumor [1]. Axelrod et al. reported only 3 cases with synchronous ovarian and cervical carcinoma among 2362 synchronous gynecologic malignancy patients [11]. In the study of Wung and his friends that was done on 861 patients with genital system cancer, they have reported cervix carcinoma and ovary carcinoma in two patients. Histopathologic type of the tumor found squamous cell carcinoma in one of the cases while it was adenosquamous carcinoma in the other case. In both cases, the histopatho-
logic that assessed that concurrent frequency of different types of histopathologic cancers may occur when two different types of cells are affected or there is a disorder in genetic structure. Especially, familial cancer inclination is considered to be the reason [13]. There was no history of cancer in the roots of our patient. For this reason, genetic analysis is not processed in the patient. There was no exposure to carcinogen in the medical history of the patient. No human papilloma virus (HPV) infection was present in the medical history. HPV was not detected in the material examined. We did not performed any cervical smear due to rarity of synchronous ovarian and cervical tumor and unfortunately skipped cervical cancer.

Prognosis in concurrent tumors is relatively good. Especially with endometrium or cervix carcinoma, concurrent ovary tumors can be diagnosed in early periods. This is because symptoms in cervix and endometrium tumors generally appear in early periods while symptoms in ovary cancers appear in late periods [14]. In our case, the patient referred to our clinic primarily with the complaints of ovarian tumor. In the clinic board of our patient, there was no complaint or examination finding that would make us think of cervical tumor. It is very important to evaluate patients with cancer suspicion because the treatment course is dependent on this evaluation. It is fundamental to sweep all systems of the patients starting with a careful medical history. Especially keeping in mind the concurrent tumor possibility, woman genital system should be examined by doing pathologic sampling. This is very important for the next step of the treatment. In concurrent tumors; the treatment of dominant disease has priority. For this reason, we have started the treatment of our patient with paclitaxel and carboplatin treatment regimen. In addition to this, radiotherapy was added to the treatment.

In conclusion, concurrent tumors of different histopathologic type can be seen even if they are rare. For this reason, during preoperative evaluation of this type of cases, care should be given because the surgical procedure and treatment schema after the surgery can show changes according to this evaluation.

Conflict of Interest

Authors declare no conflict of interest

References