Afr J Med med Sci (1998) 27.135-136

Squamous cell carcinoma of the cervix simulating an advanced malignancy of the ovaries

K.A. Obisesan, A.A. Adeyemo*, A.O. Fawole and O.A. Adesina
*Department of Obstetrics and Gyanecology and *Department of Paediatrics, University College Hospital, Ibadan. Nigeria*

Summary
A 40-year-old woman was diagnosed as having stage II squamous cell cervical carcinoma and managed with radiotherapy. Three months after treatment, she presented with features suggestive of an advanced ovarian tumour including gross abdominal swelling, bilateral ovarian tumours, multiple tumour seedlings in the abdominal cavity and ascites. There was also pleural effusion. Operative findings revealed widespread intra-abdominal metastases whose histology, contrary to expectations, showed squamous cell carcinoma of cervical origin.

Distant metastases from squamous cell carcinoma of the cervix are rare. A high index of suspicion is necessary to detect this unusual mode of presentation.

Keywords: *Cervical carcinoma, distant metastases, ovarian tumour, diagnosis*

Résumé
Une femme de 40 ans a été diagnostiqué avoir un carcinome des cellules cervicales de troisieme degree et a été soignée par radiotherapie. Trois mois après le traitement, elle a presenté les traits suggereant une tumeur ovarienne bilateriale, une tumeur multiple garment dans la cavite abdominale et ascite. Il ya ussi une eflusion pleurale. Les observations operative relevant un eparpillement des metastases intra-abdominales don't l'histology, contrairement aux explications montrent un carcinome cellulaire aux origines cervicale. Les metastases distantes de squamous des carcinomes du cervix sont rares. Un grand indice de suspicion est necessaire pour detecter ce mode inhabituel de presentation.

Introduction

Cervical cancer remains the commonest oncological problem in Nigeria women. The commonest presentation of carcinoma of the cervix is as abnormal vaginal bleeding and the tumour usually spread by direct extension of other organs. It is very unusual of this malignancy to present with an abdomino-pelvic mass.

This report is that of a patient with squamous cell carcinoma of the cervix who presented with an abdomino-pelvic mass which simulated a primary ovarian tumour.

Case report

Mrs H.A., a 40-years-old Para 6^{+1} (6 alive) woman presented with three months history of vaginal bleeding and offensive, watery vaginal discharge. Examination under anaesthesia revealed an enlarged, exophytic, fungatign and friable cervical growth with vaginal and b ilateral parametrial and pelvic wall involvement. The tumour was staged as a stage IIIB cervical carcinoma. Histology confirmed a poorly differentiated, large cell, non-keratinizing squamous cell carcinoma. She was managed with radiotherapy and completed the prescribed course of radiotherapy uneventfully.

Three months after radiotherapy, she presented with progressive abdominal swelling with occasional vomiting, dyspnoea and easy fatiguability. Findings included left pleural effusion, gross ascites and solitary firm nodules in the pouch of Douglas. There were nodules in the rectovaginal space. A chest radiograph showed left pleural effusionf or which the patient had closed thoracotomy tube drainage and subsequent pleurodesis. The haematological indices, eletrolytes and urea, clotting profile and an intravenous urogan were all normal. Carcinoma of the ovary was suspected.

At explotary laparotomy, findings included five litres of serous ascites, huge bilateral cystic ovarian masses (17 cm x 12 cm x 9 cm and 15 cm x 12 cm x 8 cm respectively), a six week sized uterus with tumour deposits on the ventral surface and the pouch of Douglas. There were huge matestatic masses on the omentum. There were multiple seedlings on the peritoneum and the undersurface of the right lobe of the liver. Salpingo-oophorectomy and partial omentectomy were done.

Histology of the ovaries and the omental mass showed extensively infiltrating nests and trabeculae of plemorphic squamous epithelial cells not displaying obvious kertinization. The features were consistent with metastatic poorly-differentiated squamous cell carcinoma of cervical origin.

In view of the advanced nature of the disease and previous history of radiotherapy, the patient is being worked up for chemotherapy. She remains stable post-operatively without recurrence of ascites or palpable abdominal masses.

Discussion

The most common presentation of cervical cancer is abnormal vaginal bleeding. The natural history of squamous cell carcinoma of the cervix is that of primary spread by direct extension to adjacent organs [1] as well as embolization through lympatic channels. Distant metastases are unusual. Cartson et al [2] found the occurrence of multiple organ metastases to be more common than single-organ occurrence [2]. Lung, bone and liver were the most frequently involved systems. A post-mortem study of patients with cervical cancer found the lung and liver to be organs most frequently involved, followed by the peritoneum and bone [3].

The patient presented here was initially diagnosed as a case of carcinoma of the cervix before developing features highly suggestive of primary malignancy of the ovary. As mentioned above, ovarian masses, pleural effusion and the gross surgical findings were also in keeping with this assessment until the histological diagnosis was made. Thus, this was atypical presentation which highlights the

Correspondence Dr K.A Obisesan, Department of Obstetrics and Gynecology University College Hospital, Ibadan, Nigera.

importance of a thorough evaluation of any patient with gynaecological cancer.

Features favouring metastatic [3] rather than primary independent ovarian carcinoma in patients with cervical carcinoma coexisting with ovarian tumours include bilateral ovarian tumours, similarity of histology in both tumours, extensive spread of cervical tumour, cervical tumour and commonly lymphatic and/or vascular invasion in either tumour [1]. Several of these features were present in the patient. The diagnostic problems posed by such a patient have recently been reviewed by Rawlings *et al* [4].

Treatment modalities for advanced or recurrent cervical carcinoma include extenterative procedure [5], post operative radiotherapy, radiotherapy alone and radiotherapy followed by adjuvant chemotherapy. Results of a recent Radiation Therapy Oncology Group study sugest that intra-operative radiation followed by external beam therapy improves local control, but provides no significant survival benefit [6]. Having completed a course of radiotherapy at the first presentation, we elected to treat the patient with systemic chemotherapy for the recurrence. Although chemotherapy for advanced/recurrent cancer has not shown great promise, response rates as high as 30% have been reported witn cis-platinum base atherapy [7]. In a phase II Gynaecological Onclology Group trial, Carboplastin was found to have similar activity with a 28% response rate [8]. However, whether systemic therapy will result in long-term survival in this particular patient remains uncertain.

In summary, this is the case of a 40-year-old patient who presented with an abdomino-pelvic mass, ascites, pleural effusion and multiple tumour seedlings in the abdominal cavity which turned out to be squamous cell carcinoma of the cervix rather than a primary ovarian neoplasm. The case illustrates the need for thorough evaluation of any patient with what may look like a classical textbook presentation of a particular tumour as in this case carcinoma of the cervix, which may turn out to be a completely different tumour entirely.

References

1. Disata RJ, Creasman WT. Clinial Gynaecologic Oncology, St. Louis, MO; 1993: 67-70.
2. Cartson V, Delclos L, Fletchen GH. Distant metastases in squamous cell carcinoma of the uterine cervix. Radiology 1967; 88: 961-966.
3. Sotto LSJ, Graham JB, Pickem JW. Postmortem findings in cancer of the cervix. AM. J. Obstet. Gynecol. 1960; 80: 791-794.
4. Rawlings KK, Look K, Ulbright TM. Adenocarciona of the cervix presenting as ovarian cancer: Diagnostic Considerations. Gynecol. Oncol. 1996; 62: 304-308.
5. Monagham JM. The management of advanced and current cervical cancer by pelvic extenteration. In: Shepherol JN (ed). Clinical Gynaecological Oncology,. 2nd Edition. Oxford: Blackwell Scientific Publications. 1990. Pp 98-114.
6. Wolkow HB, Graves GM, Won M, Sause WT, Byhardt RW, Hanke GE. Intraoperative radiation therapy of extrahepatic bilinary carcinoma. A report of RTOG – 8506 Am. J. Clin. Oncol. 199; 15: 323-327.
7. Thipen T, Shingleton H, Homesley, Lagasse L, Blessing J. Cis-platinum in treatment of advanced of recurrent squamous cell carcinoma of cervical cancer. Cancer, 1981; 48: 899-903.
8. Arsenaeu J, Blessing JA, Stehman FB, Mchehee R. A phase II study of Carboplastin in advanced squamous cell carcinoma of the cervix. (A Gynaecologic Oncology Group Study) Invest New Drugs 1986; 4: 187-191.