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A CASE REPORT: ADENOSARCOMA OF UTERUS IN A YOUNG NULLIGRAVIDA

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ABSTRACT

A 33 yr old nulligravida lady who underwent a Haultains procedure for uterine inversion 6 months back came with complaints of excessive bleeding per vaginum. On examination, uterus was corresponding to about twenty weeks of gestation. Usg done shows 6*5 cm polyp arising from fundus. Endometrial aspiration was done. Report suggestive of adenosarcoma of uterus. Patient underwent debulking surgery. Bilateral salpingoopherectomy could not done as ovaries were adhered to bowel on both sides and patient's relatives were not interested in colostomy or bowel resection. On postoperative day 12, patient was started on first cycle of chemotherapy. Inj Adriamycin, Inj Ifosfamide along with Mesna were given. Now she has completed 6 cycles of chemotherapy followed by EBRT for residual disease.

Conclusion: Adenosarcoma is a rare variety of Malignant Mixed Mullerian tumor of low malignant potential with benign glandular and malignant stromal component. This is most common in postmenopausal female and the most common presentation is abnormal uterine bleeding. There are only few cases reported in literature. Lack of awareness of this entity may lead to misdiagnosis in a young patient.

INTRODUCTION

Mullerian adenosarcoma is a variant of mullerian mixed mesodermal tumor of the uterus with low malignant potential which is typically composed of benign glandular epithelial elements admixed with malignant sarcomatous stroma. This rare tumor contributes to only about 8% of all uterine sarcomas.[1]The most common site of origin is endometrium, although there are case reports on adenosarcoma of cervix, myometrium and fallopian tubes.

CASE REPORT

A 33 year old nulligravidous lady came with complaints of foul smelling discharge per vaginum and was diagnosed with chronic uterine inversion. She underwent Haultain's procedure in Dec 2015. Patient was on follow-up. After 6 mon, she presented with complaints of bleeding per vaginum. Abdominal examination showed uterus with hard mass corresponding to 20 weeks of gravid uterus and lower limit was not able to be made out. USG showed a large polypoidal growth arising from the fundus. Endometrial aspiration was done. The histopathology showed irregular polypoidal tissue lined by benign squamous to low columnar epithelium. Mesenchymal components were highly cellular and composed of spindle shaped cells showing moderate pleomorphism with frequent atypical mitosis of 2 to 5/hpf and was suggestive of adenosarcoma of uterus.

MRI showed large heterogeneous mass lesion with hyperechoic area mainly in posterior wall of uterus (16.3*8.2*7.6 cm) and reaching up to fundus. Endometrium lining is not separately visualized. Adnexa could not be visualized. There was no evidence of lymphadenopathy.

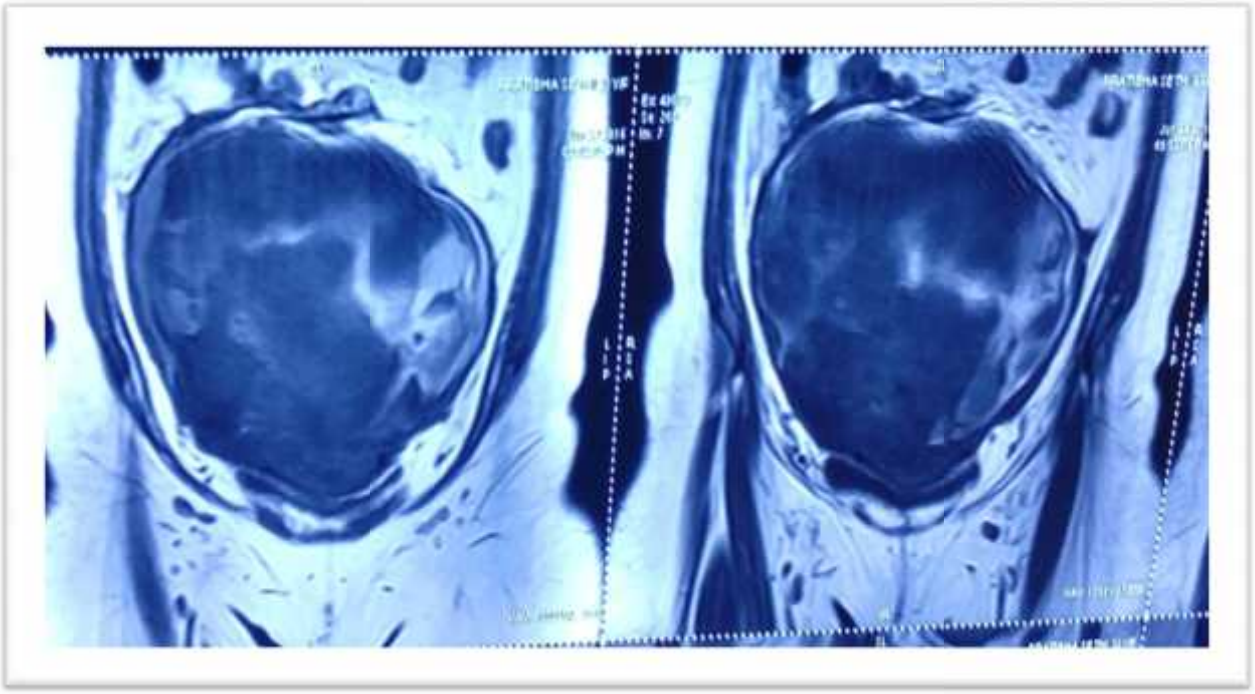

Figure 1: MRI showing grossly enlarged uterus with loss of complete architecture of uterine anatomy and no differentiation of endomyometrial junction

Patient underwent debulking surgery along with infracolic omentectomy. Per operative findings were uterus corresponding to about 22 wks gestation identified and was adhered to bowel, omentum and peritoneum. A breach was identified over right side of fundus of 3*2 cm through which friable tumor material was protruding. Cervix was densely adhered to descending colon. As relatives were not willing for colostomy, cervix with part of uterus that was adhered to colon could not be removed. Bilateral ovaries could not be visualized.

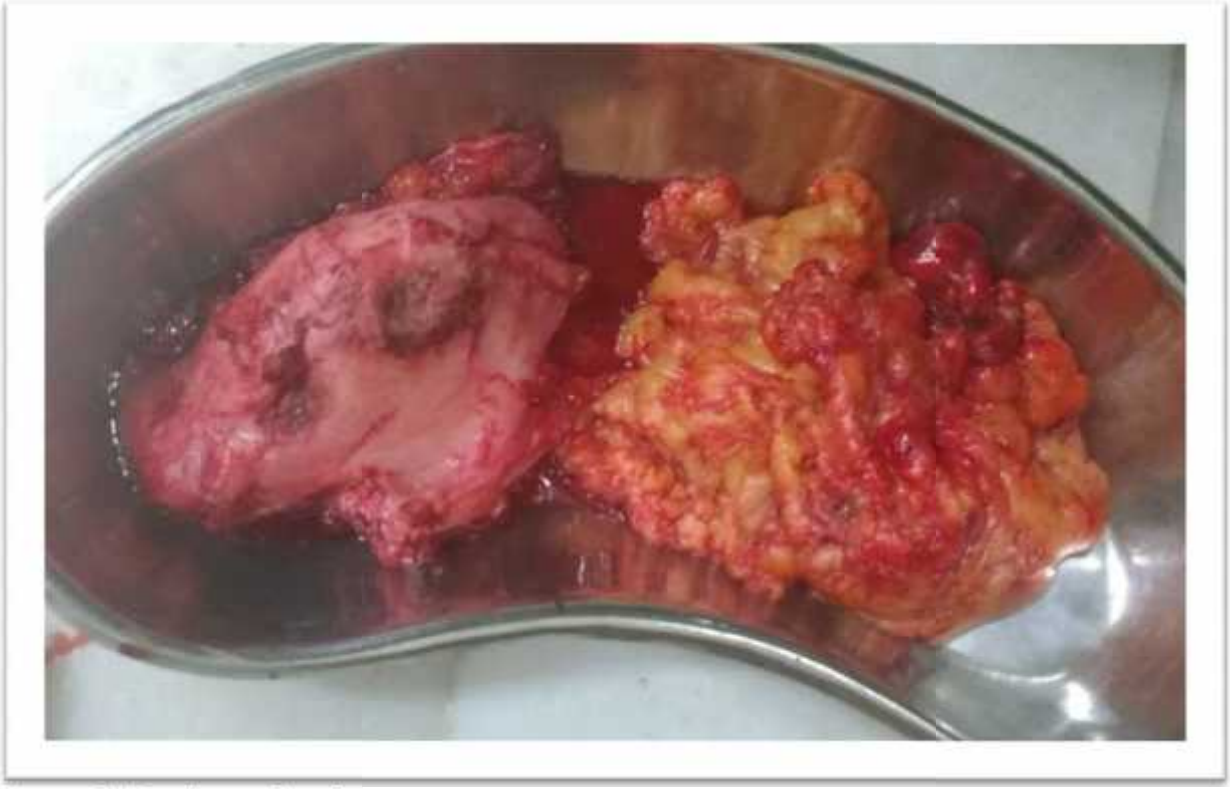

Figure 2: Specimen showing adenosarcoma of uterus with omentum

Postoperative period was uneventful. Final histopathology report confirmed adenosarcoma of uterus and was found to involve myometrium, bilateral parametria, paracervical and lowermost part of uterus up toisthmus. Omentum also had tumor deposits. By FIGO 2009 staging, she was stage IIIB. She was started on chemotherapy on day 14 after suture removal. Inj. Adriamycin 70 mg was given on day 1. Inj. Ifosfamide 3 g with Mesna 600 mg (8 hrly) were given on day 2 to 4. Patient has received 6 cycles by Dec 2016. Then she was under follow up and post chemotherapy MRI was taken, some residual disease was found. She was offered both surgery and radiotherapy and she was also explained about the need for colostomy, hence she refused for surgery. Even though the role of radiotherapy was controversial, patient was given EBRT 25 fractions of total 50 Gy.

DISCUSSION

The most common presentation of adenosarcoma is abnormal vaginal bleeding. The mean age of presentation is 58 yrs.[2] By FIGO 2009 staging, it is staged similar to endometrial stromal sarcomas. In 78% patients, sarcomatous growth was homologous.[2]Presence of myometrial invasion increased the risk of recurrence. Recurrence was most common in vagina or pelvis. Adenosarcomas have been reported in women treated with tamoxifen. The treatment is hysterectomy with bilateral salpingoopherectomy. Role of radiotherapy is controversial. Chemotherapy has been given in cases with myometrial invasion or in beyond stage I. Long term follow up is essential in these patients as there are high chances of recurrence in the presence of myometrial invasion. The younger patients are often misdiagnosed.[3]

The 5 year survival rate for stage I and III adenosarcoma is 79% and 48%.[4] The poor prognostic factors are myometrial invasion ($p = 0.04$), exrauetrrine spread ($p < 0.001$), sarcomatous overgrowth and presence of heterologous elements.[5]

CONCLUSION

Lack of knowledge and rarity of this tumor may often lead to misdiagnosis in younger patients. In a case of recurrent benign polyps, one should always suspect adenosarcoma and consider it as differential diagnosis.

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