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A Case of Low Grade ESS Presenting As Abnormal Uterine Bleeding

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Abstract: *One of the rarest types of uterine cancers is endometrial stromal carcinoma, a uterine cancer that accounts for less than 1% of the reproductive organ cancers. It occurs in the age group of 40-50 years. Endometrial cancer develops from the glands whereas ESS from different types of cell. ESS tends to be less aggressive and occurs in women younger than the average age for uterine cancers. An young patient of 31 years complained of irregular bleeding per vagina (P/V) following medical termination of pregnancy of 2 months gestation.USG of pelvic organs revealed products of conception and check curettage done and the products sent for histopathological examination. They report as products of conception. Irregular bleeding continues and the patient was sent for magnetic resonance imaging and the report was ? Gestational trophoblastic neoplasia . Serum HCG levels are found to be elevated. Second curettage done and the histopathological report of endometrium is pill enodometrium without use of oral contraceptive pills. As the bleeding per vagina continues and the USG repeat.USG suggests enlarged uterus with irregular polypoidal mass with fluid collection in the uterine cavity. Third check curettage done at GGH and the material sent for histopathological examination. The report was again the products of conception with no evidence of molar pregnancy. In view of persistant bleeding P/V , enlarged uterus of 14 weeks, laparotomy done and total abdominal hysterectomy done. Both tubes and ovaries are healthy and they are preserved. The histopathological report was low grade Endometrial Stromal Sarcoma (ESS).*

Keywords: *endometrial stromal sarcoma, abnormal uterine bleeding, medical termination of pregnancy, ultrasonography,magnetic resonance imaging, histopathological report, gestational trophoblastic neoplasia, GGH(Government General Hospital).*

I. Introduction

Cancers arising from mesodermal structures like muscles and connective tissues are called sarcomas. Uterine sarcoma is a rare form of malignancy occurring in 2-5% of all patients with uterine malignancies with an incidence of 1-2 cases per 1 lakh women in general population.ESS are very rare malignant tumours that make up approx 10% of all uterine sarcomas but only 0.2% of all uterine malignancies. Based on the tumour margin status and cytological features WHO classifies ESS into benign endometrial stromal nodule and endometrial stromal sarcoma.ESS does not infiltrate into myometrium.ESS can be low grade(LGESS) which tends to be slow growing or high grade(sometimes known as undifferentiated ESS) which may grow more quickly.

Possible Risk Factors:

- Prior use of medications that effect the harmone oestrogen such as tamoxifen
- Radiation of the uterus or pelvic areas between 5 and 25 years
- African American ethnicity
- Recent studies shows a possible association with thyroid disease although this is not a confirmed risk

ESS Symptoms:

- Abnormally long or heavy bleeding per vagina
- Pelvic pain
- Lump in abdomen /pelvis

Diagnosis:

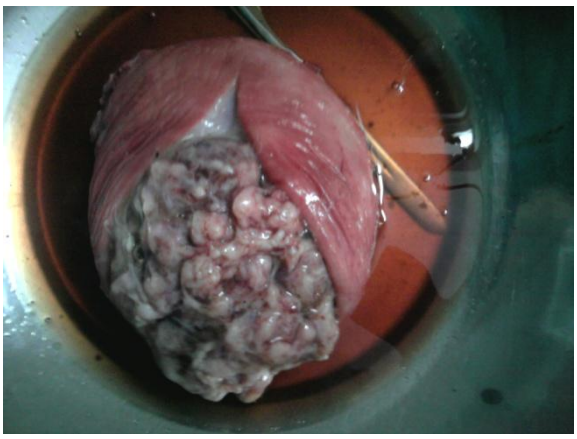
1) By histopathological examination of endometrial cells collected during D & C procedure
2) Final diagnosis only be made after hysterectomy
   Mitotic activity is low in LGESS (less than 10/10 high power fields)

When diagnosed early, the 5 year survival rate for LGESS is greater than 90%. Primary therapy is surgery followed by external radiation/harmone theraphy or chemotheraphy. In one third to one half of the cases recurrences are also there. Recurrences may occur even after 20 years. Recurrences may be treated by harmone or chemotheraphy (in particular ifosfamide)

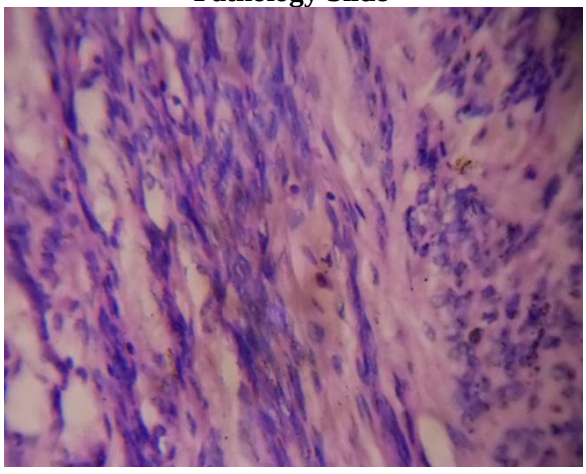
II. Case Report

A young lady of 31 years $P_1L_1A_6$ presented with irregular bleeding per vagina since 3 months. History of medical termination of pregnancy of 2 months gestation. For irregular bleeding per vagina she underwent USG followed by check curettage, as bleeding continues she underwent MRI. MRI suggested of ?GTN .serum HCG titres done.HCG titres elevated from 76.4 m IU/ml on 21.3.2013—1150.7 m IU/ml on 12.4.2013. On second check curettage, the HPE report was pill endometrium. In the month of May she admitted to GGH with the same c/o irregular and heavy bleeding. Clinically the patient is anaemic, uterus is enlarged to 14 weeks size and third USG done and the report as enlarged uterus with evidence of irregular hyper echoic areas of 7.2 * 5.2 cms noted in uterine cavity. Ovaries normal. Impression –retained products of conception. Third curettage was done and the HPE report was retained products of conception. No evidence of molar pregnancy. Total abdominal hystrctomy done. Cut section of uterus shows grey white polypoidal growth in the anterior wall of the uterus within the myometrium surrounded by cream colour gelatinous material. The growth not entering into the uterine cavity. The HPE report of specimen was LGESS. The post operative period uneventful. The patient sent to cancer hospital for further management.

Specimen Photo



Pathology Slide



Radiotheraphy

After Clinical examination and stage workup patient was treated with adjuvant beam radioatheraphy to pelvis 5000 cGY/25 fractions, 5 day per week from 22-08-2013 to 24-09-2013 and 3 fractions of high dose brachytheraphy 600cGY to vault and 4cms of vagina on 09-10-2013, 18-10-2013 and 28-10-2013. Patient tolerated radiotherapy well. Till now no evidence of recurrence and no history of dyspareunia

III. Discussion

In this case ESS missed inspite of third check curettage and the material sent for HPE as the entire tumor is within the myometrium. It was diagnosed only after sending the uterus specimen for HPE. In this patient, no risk factors were identified except ? history of 6 MTPs . The reason for elevated HCG is idiopthic. Cases of successful pregnancy with ESS is recorded.

IV. Conclusion

In all cases of enlarged uterus with abnormal uterine bleeding ESS may be kept in mind as a part of DD. Because of possibility of recurrence, lifelong follow-up is necessary. Lifelong followup by physical examination every 3 months in the first 2 years, every 6 months in the next 3 years. Thereafter annually. Anual Chest X-ray, CT/MRI of the total abdomen indicated.

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