A case of synchronous ovarian/endometrial carcinoma

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SUMMARY: A case of synchronous ovarian/endometrial carcinoma.

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The case of a synchronous endometrioid carcinoma of the ovary and of the endometrium found in a young, gynaecologically asymptomatic patient is reported.

The parameters useful to differentiate a synchronous from a metastatic primary cancer are reminded.

KEY WORDS: Synchronous carcinoma.
Carcinoma sincrono.

Introduction

The synchronous carcinoma of ovary and of endometrium is quite rare: less than 10% of women with ovarian epithelial carcinoma develops simultaneously a cancer of the same histotype in endometrium (1, 2). The differential diagnosis between synchronous carcinoma and metastatic carcinoma of the primary cancer is though rather difficult (3).

Few criteria exist to differentiate an ovarian synchronous from a metastatic ovarian cancer (4-6). An ovarian cancer is metastatic when:

1) the endometrial cancer is bigger and more infiltrating;
2) the ovarian cancer is smaller, multi-nodular and solid;
3) is bilateral with extra-ovarian metastasis;
4) both ovarian and endometrial cancer are well or moderately differentiated (2).

On the contrary the cancer is more probably reciprocally metastatic when both ovarian and/or endometrial cancers are highly undifferentiated (2, 4).

Case report

A gynaecologically asymptomatic 42 y.o. para 0000 women with normal cycles, carrier of inert IUD since four years, offers for a routine pelvic echography. Affected by schizophrenia, host in a District Community, assumes psychotropic (clozapine, diazepam, carbolitium, aloperidolo) and antiparkinson (biperidene) drugs.

Transvaginal echography shows "IUD in situ; multilocular solid-cystic 58x65 mm diameter complex lamp of the right ovary with intracystic vascularisation; normal left adnexa. No free fluid".

CA 125 40.7 U/ml (n.v. 1-35); normal other markers. The pelvic contrast Computerized Tomography evidences in the right adnexal area a solid oval mass of 70 mm max. diameter characterized by central dis-homogeneous contrastographic enhancement. The mass marks the bladder without infiltrations. No evident pe-
ritoneal thickening and free fluid. Few 1 cm diameter lymph nodes in the right side of the pelvis (Figure 1).

A laparotomic surgical approach is programmed (7). The peritoneal liquid and the right adnexa are sent for extemporary exam. The answer confirms a well differentiated solid-cystic endometrioid adenocarcinoma with recurrent notes of squamous differentiation; the neoplasia perforates in a single point the capsule: pT1c.

Left ovaro-salpingectomy, total hysterectomy, appendectomy, infracolic omentectomy, multiple lymph nodeectomy and peritoneal washing follow the extemporary diagnosis.

The patient is discharged in fourth post-operatory day.

**Histology**

The pathologist confirms an ovarian well differentiated endometrioid carcinoma (Figure 2) with notes of squamous metaplasia. The endometrial histology shows a moderately differentiated endometrioid carcinoma (Figure 3) infiltrating half of myometrium and the cervical stroma: pT2. Cervix, left ovary, appendix, omentum, lymph nodes and peritoneal fluid are free of neoplastic cells.

**Discussion and comment**

No comments inherent endometrium are mentioned in echographic and radiologic preoperative procedures but the correct positioning of IUD.

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When both ovarian and endometrial cancers are well or moderately differentiated and only one ovary is interested, high are the possibilities it is a synchronous carcinoma. Bilateral ovarian neoplastic presence and extra-ovarian metastasis and high in-differentiation of both ovarian and/or endometrial cancer orientate for metastatic ovarian or endometrial cancer (2, 4).

The presence of a synchronous ovarian endometrial carcinoma may be ascribed to the growth of the ovarian superficial epithelium which has an embryologic origin from Müller ducts. In few cases the neoplasia may origin from an endometriotic cyst even if frequently the endometrioid carcinoma and the endometriotic cysts do not coexist (8, 9). If not, in some women the ovarian endometrioid carcinoma may be present adenomatous endometrial hyperplasia (10). Metastasis from primitive endometrial carcinoma may be difficult to differentiate from a synchronous neoplasia because the endometrial and the endometrioid carcinoma are the two types of sierous neoplasies which more easily metastatize ovaries.

Conclusion

We reputed useful to report a case of synchronous ovarian-endometrial adenocarcinoma because rare and exceptional in a young asymptomatic women with regular cycles.

References