

Pelvic Serous Adenocarcinoma

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1. Summary

The serous borderline ovarian tumors are unique among the borderline ovarian tumors in that invasive or noninvasive peritoneal implants may occur in 35% of cases [1,2]. Occurrence of the serous adenocarcinoma without the possibility of histopathological finding of the origin of the tumor is very rare and commonly is called pelvic serous carcinoma. Most probably origins in fimbrial part of the tube, more rarely in serous ovarian tunica or pelvic peritoneum. In this case report we demonstrate the possibility of extended surgical resection in case of presence of invasive peritoneal implants. In his case report we refer to 75-year old patient with findings of tumorous formation of solid soft tissue and fluid cystic part of ovary with close infiltration [1]

2. Introduction

The term “borderline tumors” or “semi malignant tumors” were first presented in 1929. Howard Taylor described this group of ovarian serous cyst-adenomas. Until 1955 there were only serous tumors described suspiciously malignant ovarian tumors [1]. First compact mentioning of ovarian mutinous with suspicious of malignant growth were described approximately around 1955 from collecting the data of study from Cleveland Clinics [3]. Definitive classification of potential ovarian malignant tumors was set by FIGO [International Federation of Gynecology and Obstetrics] in 1971. WHO classification of ovarian tumors from 1973 brought synonym for borderline ovarian tumors under classification of “carcinomas with low malignant potential” [8]. Evolution of definite classification were developed for almost 75 years. Synonyms of this group of tumors [such as suspiciously malignant ovarian tu-

mors, semi-malignant tumors, carcinomas with low malignant potential] belong to the group of epithelial ovarian tumors showing some signs of malignancy in matters of histopathology or biology of the [4]. The most common term which is used is most specifically borderline ovarian tumor [BON]. Special group of this kind of tumors are the ones originated from serous layers of ovaries, Fallopian tubes or peritoneum without the possibility of finding the primary origin clinically or even histo-pathologically. This kind of malignancies should be described in general terms of pelvic high-grade serous adenocarcinoma [1,2].

3. Case Report

75-year old patient admitted with signs of obstruction icterus painful form and ultrasonography verification of choledocho-cholecystolithiasis and large pelvic mass with solid and fluid parts (Figure 1).

Elevation of inflammatory markers, bilirubin, and obstruction of hepatal enzymes. In first round there as conservative approach treatment decided with performing of ERCP with EPS [endoscopic papillosphincterectomy] with extraction of concrement and input of duodenal-biliary stent. In further diagnostic we realized CT with finding of tumorous formation in lower pelvis with solid soft tissue and fluid parts with close infiltration on recto-sigma part of large intestine, left ureter and left iliac vasa (Figure 2 and 3).

Diagnostic oncomarkers CEA and CA 125 were in normal range, CA 19-9, HE4 and ROMPO ROMA 21,2 were elevated [3,4,5,7,10]. After precise preparation and treatment by antibiotics the patient underwent surgery with cooperation of oncology surgeon Christian Bartko, MD.

Surgical performance was done by central laparotomy, findings of abdominal organs were normal without any pathology signs or metastasis pores in the abdomen controlled up to liver, stomach. No fluid in the abdomen or in pelvic area. There was dominant finding of tumorous mass completely obliterating pelvis (Figure 4).

There was no knowledge whether there could be infiltration of recto-sigmoid part of the intestine and there was very intimate breach to left ureter and left iliac vasa. Step-by-step deliberation of ureter, iliac as a an rectosigma shown on the picture: (Figure 5 and 6).

There has been bilateral adnexectomy, hysterectomy to unknown result of potential infiltration of intestines, lower resection with partial meso-rectal excision. Also performed dissection of para-aortal lymph nodes up to aortal bifurcation.

According to fact that the peroperational histology was negative for malignancy although all the findings were suspicious for this case we did not perform paraaortal dissection of lymph nodes.

Definitive histology surprisingly confirmed clinical suspicions of malignity: structures of ovarian benign serous cystadenoma included structures of high-grade serous adenocarcinoma infiltrating conglomerate of fimbrial part of Fallopian tube and implantation sections on peritoneum and contra-lateral adnexal structures. There were examined 12 pericolic lymph nodes and in one case it was positive for malignant metastasis od adenocarcinoma. In general it is very poblemtic to find the primary source of timorous process most probably common from fimbrial part of Fallopian tube or upper layer of ovary or peritoneum. In this case od suspicion there is suggested and advices to classify the tumor as pelvic high-grade serous adenocarcinoma [10]. In postoperational period the patient was without any gynecological or surgical complications [6] (Figure 7-9). With descendent recto-anastomosis

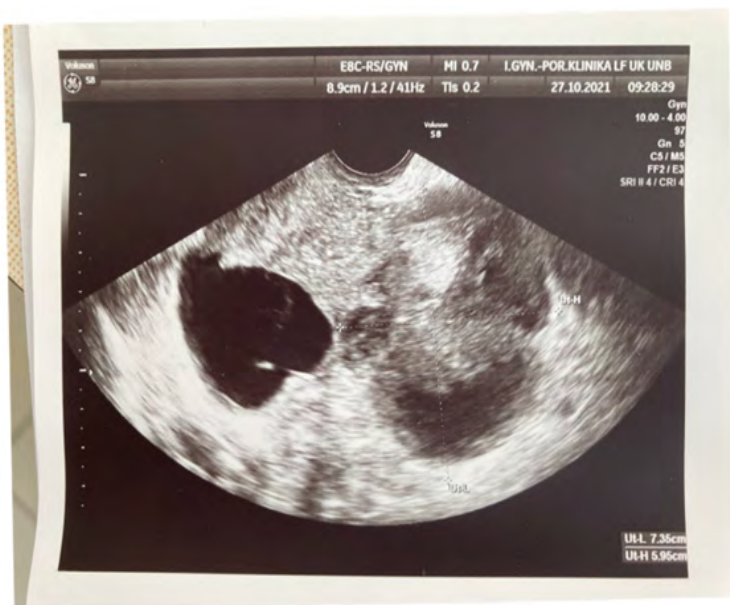


Figure 1: Sonography findings of pelvic tumor mass of unknown origin

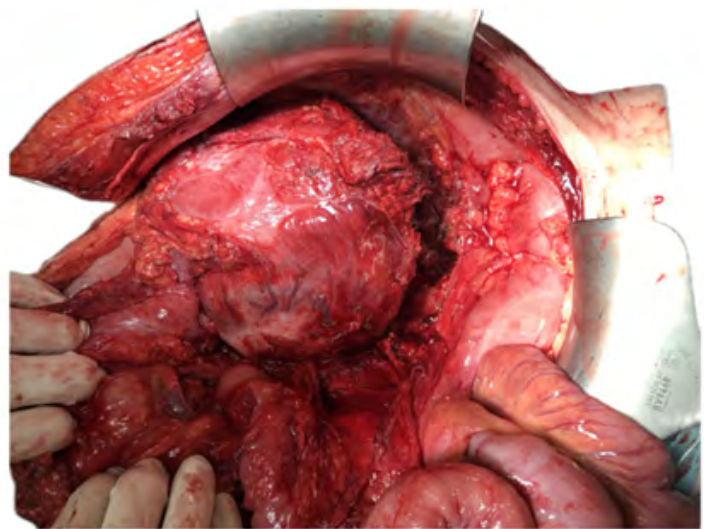


Figure 2: Infiltration of rectosigmoid part and contralateral adnex



Figure 3: Mobilization an en-block resection of tumor, uterus, bilatera adnex and rectosigma

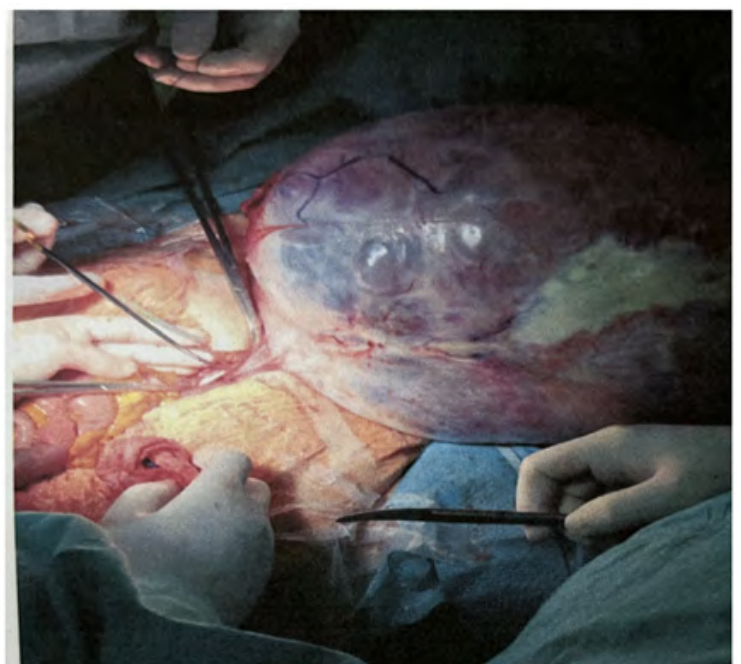


Figure 4: Extirpated tumor



Figure 5: Omental implantations



Figure 6: Infiltration of rectosigmoid part of intestine



Figure 7: Regional dissection of lymph nodes [sampling]

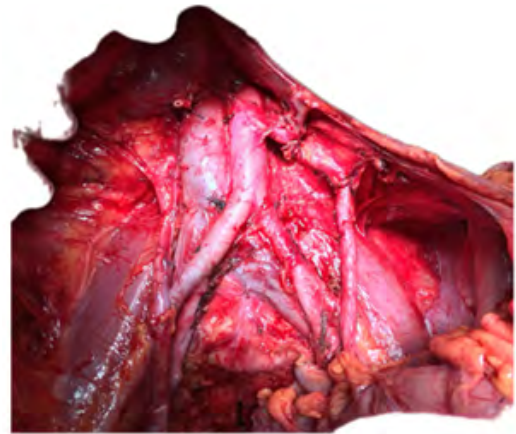


Figure 8: Complete paraaortocaval dissection of lymph nodes alongside a.mesenteri inferior

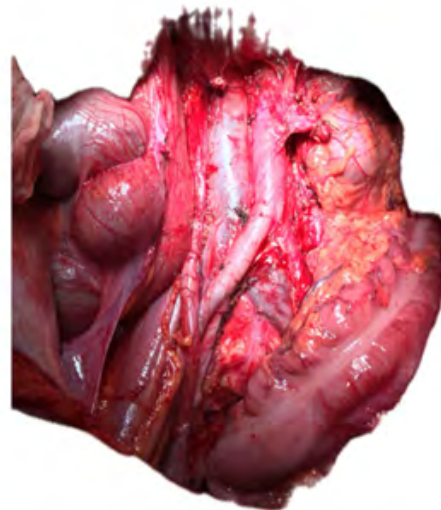


Figure 9: Complete paraaortal dissection with high ligature of mesenteric superior artery in case of infiltration of rectosigmoid part of intestine

4. Discussion

Basic surgical approach is performing hysterectomy, bilateral adnexectomy, omentectomy, followed by precise pathological examination and in case of occurrence of pathological exsudate it is necessary for it's cytologic examination [11]. The need for regional lymphonodectomy is controversial. Many studies didn't show significant difference in survival in patients with regional lymphonodectomy performed. On the other side performing lymphonodectomy didn't lad to increased morbidity in these patients. According to experiences status of regional lymph nodes doesn't show negative prognostic factor [9]. In these times with using modern operation techniques as harmonic scalpel and ligasure the regional dissection of pelvic lymph nodes should become a routine surgical treatment without worries of increasing morbidity of patients and it belongs to safe methods of the only possible exact diagnostic treatment and examination of lymph nodes and it is leading to exact classification with adequate follow-up adjuvant therapy. Adjuvant chemotherapy is indicated in patients with residual signs of disease, presence of invasive peritoneal infiltrations and for patients with clinically progressed disease. Chemothera-

peutic sequences are used as usual as in cases of epithelial ovarian carcinoma. Benefit of adjuvant chemotherapy wasn't confirmed by any retrospective randomized study. The knowledge of incidence of borderline ovarian tumors spreads according to specialized histopathological diagnostic criteria with increasing tendencies.

5. Conclusion

The basis treatment of pelvic tumors is surgical resection. In localization in gynecological primary areas is the range precise - hysterectomy, bilateral adnexectomy, omentectomy and appendectomy. In cases of higher suspicious forms and occurrence of infiltration of intestine or peritoneal infiltrations it is necessary to modify the range of resection. Locoregional pelvic lymphonodectomy is a safe method for precise staging of the disease by exclusion or confirmation of the metastatic infiltration of lymphatic nodes [12]. This approach doesn't bring higher surgical risk to the patient. Adjuvant treatment is reservations for more complicated cases and forms especially with occurrence of residual disease. There is need in dispensarisaion and follow-up observation of all these patients in specific terms to avoid or find the locoregional recidivism of the disease [13].

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