

Peritoneal Cancer-an Atypical Clinical Case



Totev T^{*1}, Gorchev G² and Tomov S²

¹Department of Gynecology, St. Marina University Hospital, Bulgaria

²Oncogynecology Clinic, Medical University, Bulgaria

Received: March 05, 2018; Published: March 14, 2018

*Corresponding author: Tihomir P Totev, St Marina University Hospital, Department of Gynecology, Bulgarska aviatsia str, Pleven, 5800, Bulgaria, Tel: +359 888848326; Email: t.totev@mail.bg

Abstract

We present a 51-year-old female admitted for treatment of ovarian cancer with a diagnosis based on inguinal lymph node biopsy. After PET/CT, followed by surgery, the final diagnosis was peritoneal cancer. The primary site was not found and the only clinical sign was that of bilateral inguinal lymph node enlargement.

Keywords: Primary Peritoneal Cancer

Introduction

Primary peritoneal cancer (PPC) is a rare malignancy (0.67/100 000) [1]. Its clinical presentation mimics that of ovarian cancer, which ranks seventh among the neoplasms in females worldwide with an incidence of 6.3/100 000 [2]. PPC incidence has demonstrated an increase at a faster rate than ovarian cancer [1]. The signs of PPC, ovarian cancer and fallopian tube cancer closely resemble each other, and their staging and treatment are the same [3,4]. Over 50% of patients with PPC present with a poor performance status [5]. This neoplasm has also a poor prognosis and a median survival of 11-24 months.

Case Presentation

A 51-year-old patient was admitted with a working diagnosis of ovarian cancer. The diagnosis had been made after histological and immunohistochemical investigation of a biopsy sample from inguinal lymph node. The past history included laparoscopically-assisted vaginal hysterectomy without adnexa because of uterine myoma ten years ago. A month prior to admission, the patient underwent laparoscopic cholecystectomy (for cholecystolithiasis) and inguinal lymph node biopsy. After histology of an enlargement (sized 2x1cm) of the left inguinal lymph node metastasis of a differentiated serous ovarian carcinoma was suspected. PPC was also suspected. Immunohistochemistry revealed, as follows: WT1 (+), CA 125 (+), ER (+), and mammaglobulin (-).

PET/CT scans were performed. The only metabolically active lesions were located in the right ovary (SUVmax-6.0) and two inguinal right lymph nodes, sized 15 and 10 mm, respectively

(SUVmax-3.6) Laparoscopic bilateral adnexectomy was performed and omental biopsy specimen was collected. Right inguinal lymph node dissection was made. Laparoscopy revealed a normal left ovary and slight enlargement of the right ovary. No pathological changes of abdominal organs were detected. Histology of the removed adnexa did not prove the presence of a tumor despite the data obtained by PET/CT scans of metabolic activity. Peritoneal washing cytology, however, revealed the presence of papillary complexes of tumor cells. The two metabolically active right inguinal lymph nodes were infiltrated with a low-grade serous papillary carcinoma with the respective immunohistochemistry characteristics. The final diagnosis was primary peritoneal cancer IVB/Tx N0 pM1; G1.

Discussion

Distant metastases are the first sign in about 15 % of malignancies. In some of these cases, comprehensive histological, immunohistochemical and image investigations do not reveal the primary site. In the case we report, two laparoscopies within a month had been performed and the primary site had not been detected. A probable origin from inguinal lymph nodes endosalpingiosis was discussed, but the peritoneal washing cytology manifested a presence of tumor cells. A very limited number of cases of inguinal lymph node mass as the first and only sign of ovarian carcinomas have been reported [6]. Our case of PPC is similar to them.

References

1. Goodman MT, Shvetsov YB (2009) Rapidly increasing incidence of papillary serous carcinoma of the peritoneum in the United States: fact or artifact? *Int J Cancer* 124(9): 2231-2235.

2. Ferlay J, Shin HR, Bray F, Forman D, Mathers C, et al. (2010) Estimates of worldwide burden of cancer in 2008. *Int J Cancer* 127(12): 2893-2917.
3. Cannistra SA, Gershenson DM, Recht A (2011) Ovarian Cancer, Fallopian Tube Carcinoma, and Peritoneal Carcinoma. In: De Vita VT, Lawrence TS, Rosenberg SA, eds. *De Vita, Hellman, and Rosenbergs Cancer: Principles and Practice of Oncology*, (9th Edn.), Lippincott, Williams, Wilkins, Philadelphia, USA, pp. 1368-1391.
4. FIGO Guidelines (2014) Staging classification for cancer of the ovary, fallopian tube, and peritoneum. *Int J Gyn Obst* 124(1): 1-5.
5. Komiyama S, Nishijima Y, Kondo H, Nomura H, Yamaguchi S, et al. (2018) Multicenter Clinicopathological Study of High-Grade Serous Carcinoma Presenting as Primary Peritoneal Carcinoma. *Int J Gynecol Cancer*.
6. Bacalbasa N, Balescu I, Balalau C, Ionescu O, Stoica C (2018) Normal Size Ovary Carcinoma Syndrome with Inguinal Ovarian Cancer Lymph Node Metastases - A Case Report and Literature Review. *In Vivo* 32(2): 385-389.



This work is licensed under Creative Commons Attribution 4.0 License

Submission Link: <https://biomedres.us/submit-manuscript.php>



Assets of Publishing with us

- Global archiving of articles
- Immediate, unrestricted online access
- Rigorous Peer Review Process
- Authors Retain Copyrights
- Unique DOI for all articles

<https://biomedres.us/>