

Isolated precaval adenopathy after surgically treated endometrial cancer

Nicolae Bacalbasa^{1,2}, Irina Balescu³, Claudia Stoica^{4,5}, Cristina Martac⁶, Valentin Varlas^{1,7}, Andrei Voichitoiu^{1,8}, Lucian Pop^{1,8}, Sorin Petrea⁹, Mihaela Vilcu^{9,10}, Iulian Brezean^{9,10}, Corina Grigoriu^{1,11}

¹Department of Obstetrics and Gynecology, "Carol Davila" University of Medicine and Pharmacy, Bucharest, Romania

²Department of Visceral Surgery, Center of Excellence in Translational Medicine, Fundeni Clinical Institute, Bucharest, Romania

³Department of Visceral Surgery, Ponderas Academic Hospital, Bucharest, Romania

⁴Department of Anatomy, "Carol Davila" University of Medicine and Pharmacy, Bucharest, Romania

⁵Department of Surgery, Ilfov County Emergency Hospital, Bucharest, Romania

⁶Department of Anesthesiology, Fundeni Clinical Institute, Bucharest, Romania

⁷Department of Obstetrics and Gynecology, Filantropia Clinical Hospital, Bucharest, Romania

⁸Department of Obstetrics and Gynecology, "Alessandrescu-Rusescu" National Institute of Mother and Child Care, Bucharest, Romania

⁹Department of Surgery, "Dr. I. Cantacuzino" Clinical Hospital, Bucharest, Romania

¹⁰Department of Surgery, "Carol Davila" University of Medicine and Pharmacy, Bucharest, Romania

¹¹Department of Obstetrics and Gynecology, Emergency University Hospital, Bucharest, Romania

ABSTRACT

Endometrial cancer is recognized to be one of the most commonly encountered malignancies, which is usually diagnosed from early stages of the disease. Even though, in certain cases recurrences might occur, in such cases different therapeutic strategies might be proposed, depending on the extent of the lesions. The aim of the current paper is to report a case of a 56 year old patient with previously treated endometrial cancer, diagnosed with a solitary precaval adenopathy which was successfully surgically removed.

Keywords: adenopathy, endometrial cancer, surgery

INTRODUCTION

Endometrial cancer is one of the most commonly encountered malignancies affecting women worldwide; hopefully, most cases are diagnosed in early stages of the disease due to the fact that this malignancy is usually associated with worrisome features such as postmenopausal vaginal bleeding, which is easily observed by the patient; in these conditions, most patients self address to hospital once the first episodes of bleeding appear and the diagnostic can be established in an early stage of the disease [1]. In these cases the first intent treatment is represented by surgery with curative intent, consisting of total hysterectomy with bilateral adnexectomy and pelvic lymph node dissection; accordingly to the final histopathological result, the association of adjuvant radiotherapeutic or chemotherapeutic treatment will

be established. In cases in which the final histopathological result demonstrates the presence of an early stage disease, adjuvant treatment is not mandatory, an active follow up protocol being recommended [2-4]. The aim of the current paper is to report the case of a 56 year old patient with previous history of surgically treated early stage endometrial cancer who was diagnosed during the follow up protocol with an isolated precaval adenopathic mass which was successfully resubmitted to surgery.

CASE REPORT

The 56 year old woman with medical history of arterial hypertension and diabetes mellitus was initially investigated for postmenopausal vaginal bleeding two years previously. At that moment a hysteros-

Corresponding author:

Nicolae Bacalbasa

E-mail: nicolae_bacalbasa@yahoo.ro

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FIGURE 1. The final aspect after total hysterectomy with bilateral adnexectomy, pelvic lymph node dissection

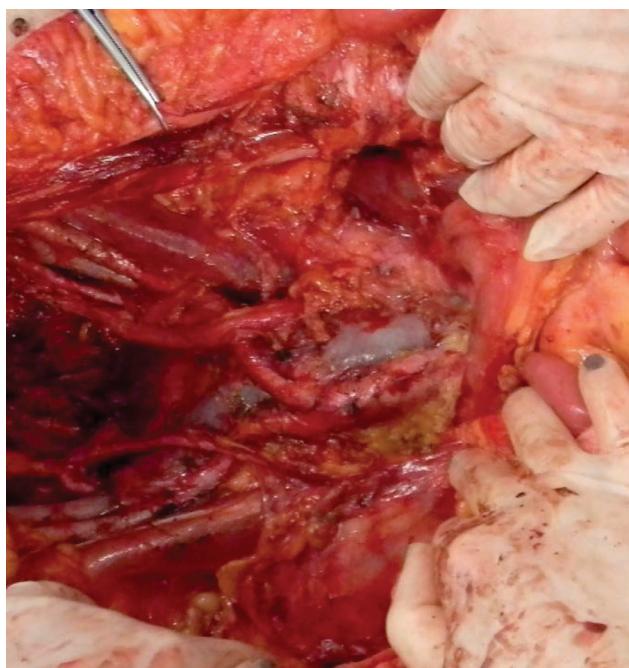


FIGURE 2. The final aspect after removing the precaval adenopathy

copy and biopsy were performed and a endometrioid endometrial carcinoma was diagnosed. The patient was further submitted to a pelvic magnetic resonance imaging which demonstrated the presence of a 12 mm thickness endometrial lining with minimal invasion of the myometrial layer and with the absence of local or distant adenopathies; therefore the patient was submitted to perip parturient surgery consisting of total hysterectomy with bilateral adnexectomy and pelvic lymph node dissection (Figure 1); the

final histopathological result demonstrated a stage IA endometrioid endometrial cancer; meanwhile the studies demonstrated a well differentiated histopathological subtype. All these features enabled the oncologists to consider that no further treatment is needed at that moment and an active follow up protocol was implemented. However, at the two year follow up she was diagnosed with an adenopathic mass at the level of the anterior surface of the inferior caval vein. The patient was further submitted to a positron emission tomography which demonstrated the presence of metabolic activity at this level; meanwhile no other lesions were found. Therefore, after discussing the case in a multidisciplinary team with the medical oncologist and radiotherapist the final decision was to resubmit the patient to surgery. Intraoperatively no other lesions were found and the adenopathy was entirely removed (Figure 2). The postoperative outcome was favorable, the patient being discharged in the third postoperative day. The histopathological studies confirmed the presence of a well differentiated metastatic lesion with endometrioid cancer origin.

DISCUSSIONS

When diagnosed in early stages of the disease, endometrial cancer can be successfully submitted to surgery consisting of total hysterectomy with bilateral adnexectomy and lymph node dissection; depending on the preoperative information regarding the histology of the tumor and aspect of the lymph nodes and on the intraoperative findings – the macroscopic aspect of the removed lymph nodes at the level of the pelvic areas, the presence of the adenopathies at the level of the aortocaval region – the extent of the lymph node dissection is established [5-8].

Therefore it has been widely demonstrated in various anatomy studies that there is a close connection between the uterine corpus and the external iliac and obturator fossa lymph nodes; therefore, even in apparently early stage endometrial cancer a lymph node dissection or at least a lymph node sampling at this level should be performed [9]. However, in isolated cases a direct connection between the uterine corpus through the infundibulopelvic ligament with the para-aortic area and respectively with the lymph nodes located at the level of the inferior gonadal vessels has been described [10]. However, due to the fact that this route has been rarely encountered, para-aortic lymph node dissection is not routinely indicated in low stage tumors especially if a favorable biology of the tumor is demonstrated.

In certain cases, even if a favorable biology of the tumor is encountered, recurrence might develop after a period of time. When it comes to the pattern of spread leading to the development of recurrent disease, different pathways have been reported such as

the peritoneal route – leading to the apparition of peritoneal carcinomatosis, lymphatic route– leading to the apparition of metastatic adenopathies, hematogenous route – leading to the apparition of parenchymatous, distant metastases or direct, local contamination – leading to the apparition of local pelvic recurrences. Depending of the number of lesions and on the prior administrated therapies, in cases in which recurrent lesions are found surgery, radiotherapy or systemic chemotherapy might be taken into account.

In the case we came to present the presence of an isolated tumoral mass in close connection with the greater abdominal vessels enabled us to consider that surgery was the best therapeutic strategy; although the patient did not undergo adjuvant radiotherapy, and therefore, radiotherapy could be taken in consideration, we decided to submit the patient to surgery for multiple reasons: the lesion was an isolat-

ed one, a radical surgical procedure being feasible, the contact with the greater vessels represented a risk factor for accidents when performing a potential radiotherapeutic procedure and, if performing per primam irradiation, we could not have the histological proof that this was a metastatic lesion originating from the surgically treated endometrial tumor.

CONCLUSIONS

Well differentiated endometrial cancer is usually associated with an overall good prognostic especially if diagnosed in early stages of the disease and treated with curative intent. Even though, in certain cases recurrence might occur; depending on the extent and location of the lesion, surgery might be taken in consideration. In cases where isolated lesions are present a favorable biology is expected and therefore, per primam resection is justified.

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