

“Spindle Cell Sarcoma of Uterine Cervix”- A Rare Case Report

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Abstract- A 40 year old female presented as post-operative case with diagnosed case of spindle cell sarcoma of uterine cervix with multiple liver, lung and scar recurrence. Patient was plan for palliative chemotherapy. Our case is unique is presentation because it's from spindle cell sarcoma which is very rare only 150 case reported in literature.

Index Terms- Spindle cell Sarcoma, Uterine Cervix, Chemotherapy.

I. INTRODUCTION

Uterine sarcomas are rare tumours that account for approximately 1% of female genital tract malignancies and 3% to 7% of uterine cancers [1]. Uterine sarcoma is a disease in which Malignant cells founds in the muscles of uterus or other tissue that support uterus. Incidence of sarcoma is less than 1% of all cervical malignancies. Most common uterine sarcomas are – Leiomyosarcoma (LMS), Liposarcoma, Alveolar soft part sarcoma, Ewing sarcoma/PNET (Primitive Neuro Ectodermal Tumor) and spindle cell sarcomas. Previously treated with radiotherapy to pelvis and tamoxifen for breast cancer are the known risk factor of uterine sarcoma. Bleeding per-vaginal (Post-Menopausal or intermenstrual), mass in vagina, pain or filling off-fullness in lower abdomen and frequent urination or most commonly clinical signs & symptoms of uterine sarcoma. Complete history and physical examination including bi-manual pelvic examination, Pap Test, Trans vaginal ultrasound, Dilatation and Curettage, Biopsy, computed tomography of abdomen & pelvis, CA-125, MRI of pelvis, Cystoscopy and chest X-ray are test to be done for diagnosis & staging of disease.

II. CASE REPORT

A 40 year old female presented in Oncology OPD as a Post – operative case with history of bleeding per-vaginal and discharge per-vaginal since last 4 months. She was operated 1 year back total abdominal hysterectomy was done under spinal Anaesthesia for same complains, after surgery no adjuvant treatment taken by patient. On examination her vital was stable with intact higher mental function, per-abdominal examination showing healthy vertical midline scar, with 2×3 cm² mass over it. On gynaecological examination showing induration over vault which bleed on touch, per rectal examination was normal. Other system and cranial nerves were normal.

Her routine blood count, liver function test, renal function test were within normal limits. Chest X-ray showed multiple canon wall metastases over bilateral lung. CT-scan abdomen and

pelvis showed local recurrences over vault [fig no.1] and scar of anterior abdominal wall [fig no. 2] and liver metastasis [fig no.3]. Biopsy showed spindle cell sarcoma –endometrial stromal type. She was planned for Chemotherapy with Injection Ifosfamide 2 gm/m² with mesna for 3 days, Injection Doxorubicin 50 mg/m² and Injection Carboplatin AUC-5 on 3 weekly bases, now patient on this regimen and completed 3 cycles of chemotherapy and on regular follow-up.

III. DISCUSSION

Uterine sarcoma is rarest form of gynaecological malignancy. Like other sarcomas surgical treatment is first modality available followed by adjuvant chemotherapy or Radiotherapy (RT) or combination of both given depending upon stage of disease? Preoperative imaging is mandatory because uterine sarcoma tends to spread lungs and peritoneum.

Surgery and radiotherapy were the main stay of treatment, but chemotherapy (Doxorubicin based regimen) have shown very good response either as adjuvant setting or sometime in palliative setting in metastatic disease. Hysterectomy with bilateral salpingo-oophorectomy is standard treatment of uterine sarcoma. Surgery is used to diagnose stage and treat uterine sarcoma. After surgery if high risk factors such as close or positive margin, multiple lymph node involvement and extra capsular extension are present than adjuvant Radiotherapy indicated. In metastatic disease palliative chemotherapy or radiotherapy may be given.

Prognosis is poor for those patients with unresectable disease, and chemotherapy should be considered palliative. Single cytotoxic agents with significant activity in uterine LMS include doxorubicin, ifosfamide, and gemcitabine [2]. Multiagent combinations of ifosfamide with doxorubicin, hydroxyurea with dacarbazine and etoposide, and mitomycin with doxorubicin and cisplatin have achieved response rates of 18% to 30% [3]. The best response rate (53%) for metastatic LMS was seen with gemcitabine and docetaxel [4]. Uterine LMS is so rare that randomized trials are not feasible. Uterine sarcomas of the mixed mullerian variety have been noted to respond to cisplatin, ifosfamide, and paclitaxel alone or in combination [5]. In a phase III trial, the combination of ifosfamide with or without cisplatin was found to improve response rates from 36% to 54% and median PFS from 4 to 6 months; however, there was no improvement in median overall survival [6]. A subsequent phase III trial that compared ifosfamide alone to combination ifosfamide/paclitaxel for patients with advanced or recurrent uterine carcinosarcoma showed that the combination improved PFS (hazard ratio, 0.71 [95% CI: 0.51 vs 0.97]; p = .03) and

overall survival (hazard ratio 0.69 [95% CI: 0.49 vs 0.97]; $p = .03$) [7].

There are not clear guidelines for recommending adjuvant RT for uterine sarcomas, given the conflicting data and lack of prospective randomized trial demonstrating a survival benefit for adjuvant RT. In general, RT should be recommended in those patients with substantial risk of loco regional recurrence: high grade tumours, positive nodes, positive margins, or evidence of gross residual disease.

453 patients with uterine sarcomas reported a 53% recurrence rate in malignant mix mullerian tumor (MMMT) and 71% in LMS, with the site of first recurrence being the pelvis in 21% of MMMT (19% in homologous and 24% in heterologous types) and 14% of LMS, respectively. Distant failure, as the first site, occurred in 14% of MMMT and 41% of LMS patients, respectively. Forty percent of patients with MMMT received adjuvant pelvic RT compared with 22% of LMS patients. The pelvic failure was 17% in patients receiving RT compared with 24% for those that did not [8].

Legends:

1. Figure showing vault recurrence.
2. Figure showing scar recurrences over anterior abdominal wall.
3. Figure showing multiple liver metastases.



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