



Contents lists available at ScienceDirect

International Journal of Surgery Case Reports

journal homepage: www.casereports.com

Inguinal lymph node presenting as the delayed site of metastasis in early stage endometrial carcinoma: Case report



Shomaila Amir M. Akbar^a, Mutahir A. Tunio^{a,*}, Wafa AlShakweer^b, AbdulAziz AlObaid^c, Mushabbab AlAsiri^a

^a Radiation Oncology, Comprehensive Cancer Center, King Fahad Medical City, Riyadh, 59046, Saudi Arabia

^b Histopathology, Department of Cytogenetics, Pathology, King Fahad Medical City, Riyadh, 11525, Saudi Arabia

^c Women's Specialized Hospital, King Fahad Medical City, Riyadh, 59046, Saudi Arabia

ARTICLE INFO

Article history:

Received 5 November 2016

Received in revised form 17 January 2017

Accepted 17 January 2017

Available online 19 January 2017

Keywords:

Early stage endometrial cancer

Inguinal lymph node

Metastasis

ABSTRACT

INTRODUCTION: Inguinal lymph nodes are the frequent sites of metastasis for malignant lymphoma, squamous cell carcinoma of anal canal, vulva and penis, malignant melanoma and squamous cell carcinoma of skin over lower extremities or trunk. Anatomically, endometrial carcinoma is less likely to spread to the superficial or deep inguinal lymph nodes, thus metastatic involvement of these lymph nodes can easily be overlooked.

CASE PRESENTATION: Here-in we report a case of a 65-year old Saudi morbid obese female, who presented with left inguinal lymphadenopathy as initial delayed site of metastasis almost 19 months after the initial treatment for FIGO IA endometrial carcinoma. Patient underwent left inguinal lymph node dissection. Histopathology confirmed metastatic endometrial adenocarcinoma, positive for cytokeratin (CK-7), estrogen receptor (ER) and progesterone receptors (PR), negative for CK-20 and CDX2. Following the post-surgery recovery, she was given extended field radiation therapy to para-aortic, pelvis and bilateral inguinal lymph nodes with concurrent cisplatin chemotherapy followed by high dose rate brachytherapy. **CONCLUSION:** Inguinal lymph nodes as delayed site of metastasis in early endometrial carcinoma is extremely rare entity. Incorporation of FDG-PET during the preoperative screening of inguinal nodes may be helpful. The impact of lymph node dissection and adjuvant radiation therapy on survival needs to be established.

© 2017 The Authors. Published by Elsevier Ltd on behalf of IJS Publishing Group Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

1. Introduction

Metastatic spread of endometrial carcinoma is quite predictable, initially through lymphatic spread followed by hematogenous, and direct routes. The most common sanctuaries for endometrial carcinoma are regional lymph nodes (internal, external and common iliac), ovaries, lung, and peritoneum [1]. It is very uncommon for endometrial carcinoma to metastasize in inguinal lymph nodes [2].

Recent data from a large surgical series of 266 patients who underwent total abdominal hysterectomy (TAH), bilateral salpingo-oophorectomy (BSO) and systematic pelvic and para-aortic lymphadenectomy for endometrial cancer from 1993 to 2010 has reported extremely low incidence of inguinal nodes metastasis (0.38%) [3].

Here in we present a case report of 65-year old female, who presented in our tertiary care hospital with painful left inguinal lymphadenopathy as initial delayed site of metastasis 19 months after the surgical treatment for FIGO IA endometrial carcinoma.

2. Case report

A 65-year-old Saudi morbid obese woman (body mass index = 41 kg m²) was diagnosed with endometrial carcinoma in March 2014. She underwent total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAH and BSO), without lymph node dissection (LND). Histopathology revealed endometrioid adenocarcinoma of 3 cm in size, grade III, in lower uterine segment (LUS) and invading less than 50% of myometrium. Lymph-vascular space invasion (LVSI) was also positive (Fig. 1). Cervix, fallopian tubes and ovaries were unremarkable. She was staged according to the International Federation of Gynecology and Obstetrics (FIGO) staging system 2009 as FIGO IA. After TAH/BSO, patient lost to follow up without any adjuvant radiation therapy.

In October 2015, she presented with the history of left groin painful lump for three months, however, she denied any weight

* Corresponding author.

E-mail addresses: saakbar@kfmc.med.sa (S.A.M. Akbar), drmutahirtonio@hotmail.com, mkhairuddin@kfmc.med.sa (M.A. Tunio), walshakweer@kfmc.med.sa (W. AlShakweer), abalobaid@kfmc.med.sa (A. AlObaid), masiri@kfmc.med.sa (M. AlAsiri).

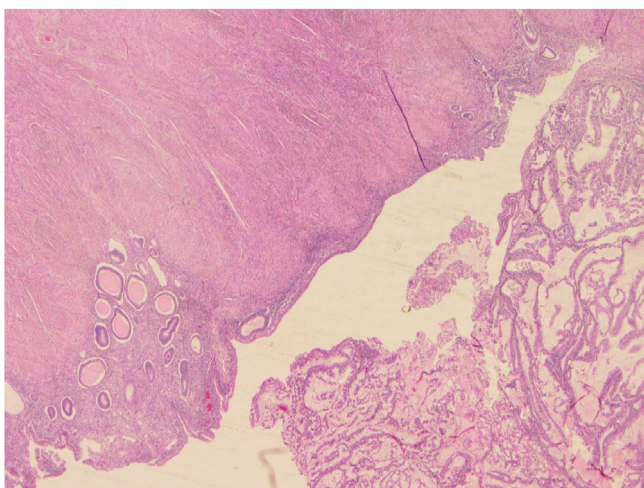


Fig. 1. Histopathology (hematoxylin and eosin staining) showing poorly differentiated endometrioid endometrial adenocarcinoma with invasion of myometrium less than 50%.



Fig. 2. Computed tomography of pelvis showing enlarged left inguinal lymph node of size 2.4 × 2.6 cm.

loss. Physical assessment revealed a large tender, mobile left inguinal mass of size 2.5 × 2.5 cm without any discoloration of overlying skin. The rest of examination was unremarkable.

Abdomino-pelvic computed tomography (CT) scan revealed enlarged left inguinal lymph node of size 2.4 × 2.6 cm (Fig. 2) and right external iliac lymph node 1 × 1.2 cm. CT- positron emission tomography (PET) imaging showed left inguinal node with standardized uptake volume (SUV_{max}) 15.2 and the left para-aortic and external iliac nodes with SUV_{max} 17.9 (Fig. 3a and b). No other distant metastasis were seen.

Excisional biopsy was negative for any malignancy. Since the suspicion of metastatic disease was high, patient underwent left inguinal LND in December 2015. Specimen was positive for metastatic endometrial carcinoma with immuno-positivity for cytokeratin (CK-7), estrogen receptor (ER) and progesterone receptors (PR) and immuno-negative for CK-20 and CDX2 (Fig. 4a–d).

Patient was recovered very well after surgery. Based on decision of multidisciplinary team (MDT), patient was given postoperative radiation therapy (PORT) to para-aortic, pelvic and bilateral inguinal lymph nodes (45 Gy in 25 fractions @ 1.8 Gy/fraction) followed by boost to left inguinal region (14.4 Gy @ 1.8 Gy/8 fractions to complete 59.4 Gy) with concurrent cisplatin on Day 1 and 22,

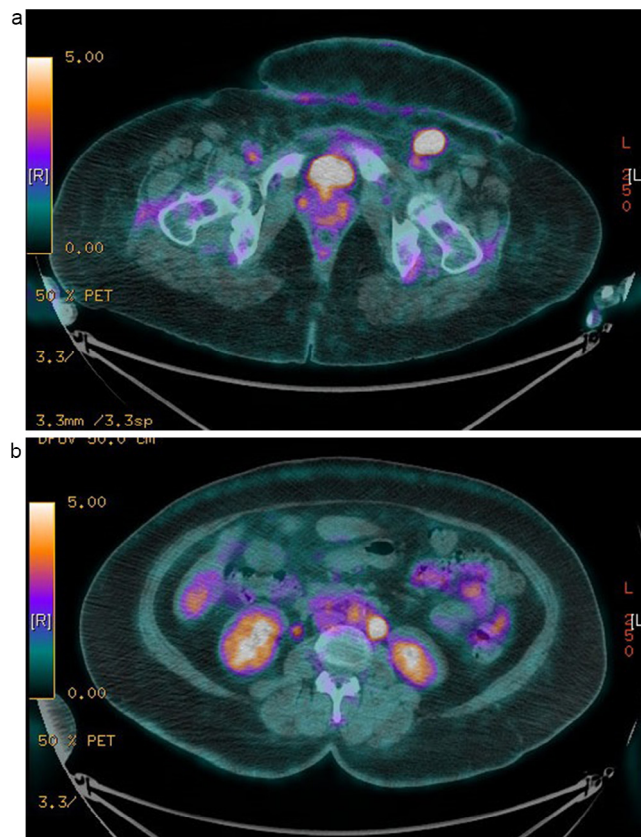


Fig. 3. CT-PET imaging showing (a) hypermetabolic left inguinal lymph node (SUV_{max}=15.2) and (b) hypermetabolic left para-aortic lymph node (SUV_{max}=17.9).

followed by high dose rate (HDR) brachytherapy 15 Gy in 3 sessions. Following completion of PORT in February 2016, she was given duplet chemotherapy carboplatin and docetaxel 3 cycles, which she finished in May 2016. At one year after inguinal resection, patient was doing well without any clinical or radiological evidence of locoregional recurrence and distant metastasis.

3. Discussion

Metastatic involvement of inguinal lymph nodes in early stage endometrial carcinoma is extremely rare manifestation, with only four case reports published so far Table 1 [4–7]. The precise mechanism of inguinal node metastasis remains doubtful. However, in first case, inguinal node metastasis was believed to be related with unopposed estrogen stimulation of occult metastasis in inguinal nodes, as that patient was treated with estrogen replacement therapy [4].

In our patient, possible hypotheses of inguinal lymph node involvement are; (a) micro-metastasis inoculation into the lower abdominal scar and subsequently metastasis to the inguinal nodes through superficial lymphatic pathways along the left inferior epigastric artery, or (b) postoperative formation of neo-vascularized channels from tumor bed to inguinal lymph nodes, causing such an unusual spread of FIGO IA endometrial cancer to inguinal nodes [8] or (c) possibility of missing these lymph nodes during initial preoperative screening (especially limitation of physical examination and CT imaging in morbid obese patients). None of previously published case reports have mentioned the radiological evidence of enlarged inguinal nodes prior to surgery. Magnetic resonance imaging (MRI) can be helpful to evaluate these inguinal node metastasis in such morbid obese patients. However, the size and shape

Download English Version:

<https://daneshyari.com/en/article/5732970>

Download Persian Version:

<https://daneshyari.com/article/5732970>

[Daneshyari.com](https://daneshyari.com)