



## Case report

# Primary leiomyosarcoma of the omentum presenting as an ovarian carcinoma, case report and review of the literature

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## ABSTRACT

Primary omental leiomyosarcoma is a rare tumor. We report a case of successfully resected omental leiomyosarcoma whose presentation mimicked ovarian carcinoma. Symptoms of abdominal distension and discomfort that lasted 8 months followed by pain lead to a diagnosis of a large mass in the abdomen. Physical examination revealed a large, over 20 cm tumor, suspected to be of ovarian origin. A small amount of ascites was found on Computerized Tomography (CT) and ultrasound (US) scans. Total abdominal hysterectomy with bilateral salpingo-oophorectomy, omentectomy and tumor debulking procedure was planned. Laparotomy revealed normal uterus ovaries and tubes with a leiomyosarcoma of the omentum which was completely resected successfully. Only 26 cases of primary leiomyosarcoma of the omentum were previously described in the literature. A review of the literature is also presented.

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## 1. Introduction

Primary leiomyosarcoma of the greater omentum is a rare pathologic entity, and the literature includes only 27 cases including this one (Table 1). The pre-operative diagnosis of these tumors is difficult and the diagnosis is usually made post operatively.

We report a case of a 55 year old woman with clinical symptoms of abdominal distension and discomfort followed by pelvic pain. The omental origin of the tumor could not be identified using CT and US scans. We also review the literature.

## 2. Case report

A 55-year-old, previously fit and well woman, presented with increasing abdominal distension and discomfort for 8 months and pelvic pain that began a few days prior to presentation. A CT scan was performed as part of the evaluation and demonstrated a huge abdominal mass, measuring more than 20 cm in cross section in the left side of the abdomen. A small amount of ascites was also noted. The mass had some large draining vessels on the left side and there was also infiltration of the fat in the upper abdomen on the left side suggesting peritoneal disease. The mass was presumed to be ovarian in origin. Tumor markers were taken as part of the evaluation and her CA-125 levels

were elevated at 527 U/ml, the levels of CEA, CA15-3 and CA19-9 were normal. Pelvic ultrasound scan was also performed and a 20 × 12 cm heterogeneous lower abdominal mass with cystic and solid components was found (Fig. 1). The uterus and contralateral ovary could not be well visualized. The nature of the lesion was uncertain according to the ultrasound scan. Ovarian carcinoma was suspected with high probability and the patient was consented for laparotomy, total abdominal hysterectomy, bilateral salpingo-oophorectomy, omentectomy and tumor debulking.

At the time of surgery, a 23 × 20 × 13 cm irregular mass arising from the omentum and appearing to be parasitic in nature was found, the mass had extensive recruitment of huge vessels from the omentum. The pelvis was obliterated by adhesions consistent with old endometriosis. The ovaries were small and adherent to the posterior uterus. The findings were not consistent with gynecologic malignancy. The liver, diaphragmatic surface, and all peritoneal surfaces were normal. The small bowel and colon were normal and a frozen section analysis of the mass suggested sarcoma. Omentectomy was performed and the tumor removed intact, no further omental spread was noted. Following division of adhesions, total abdominal hysterectomy and bilateral salpingo-oophorectomy were also performed.

Histologically the tumor had the classical appearance of a leiomyosarcoma (Fig. 2). The tumor seemed to be arising from the smooth muscle in blood vessel walls in the omentum. Histopathologic examination revealed a multinodular but smooth outer surface of the tumor and foci of fleshy and pale cream-yellow with mucoid/mixoid areas underneath. The microscopic examination confirmed the

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**Table 1**  
Review of previously reported cases of primary omental leiomyosarcoma, diagnosis, management and outcome.

Number (reference)	Age (years)	Sex	Symptoms	Imaging	Preoperative diagnosis	Tumor size and Spread	Treatment	Outcome
1 (Stout et al., 1963)	38	M	Abdominal mass and pain	NA	Abdominal mass	Implants on small bowel and peritoneum Tumor described as 'Huge'	Biopsy	Died 48 h post-op.
2 (Stout et al., 1963)	29	F	Mass, uterine bleeding, abdominal	NA	Uterine bleeding, abdominal mass	3 omental tumors 3 cm, 5 cm and 6 cm. Peritoneal implants.	Hysterectomy. Excision of tumors	Died 18 months post-op.
3 (Stout et al., 1963)	26	F	Pain	NA	Uterine bleeding, abdominal distension Abdominal mass	20 cm omental tumor, fibroid uterus, hemoserous ascites	Hysterectomy. Excision of tumors	Died 36 h post-op. due to PE
4 (Weinberger & Ahmed, 1997)	68	F	Abdominal mass	NA	Abdominal mass	NA	Omentectomy	Alive 2.5 years follow-up
5 (Weinberger & Ahmed, 1997)	80	M	Pain	NA	Abdominal mass	NA	Omentectomy	Died 6 months post-op.
6 (Tanimura et al., 1980)	52	F	Abdominal mass	NA	Abdominal mass	11 × 26 × 15 cm	Excision	Alive 3 years follow-up
7 (Tanimura et al., 1980)	46	M	Pain	NA	Epigastric pain	8 × 10 × 10 cm, spread to stomach	Excision	Alive 7 years follow-up
8 (Fattar et al., 1981)	52	M	Abdominal mass	Angiography Right gastroepiploic artery	Abdo	4.2 kg tumor with peritoneal seeding	Excision	NA
9 (Dixon et al., 1984)	85	M	Fullness	Angiography – normal	Hemorrhagic ascites	6 cm	No treatment	Died within 2 days from presentation
10 (Schwartz et al., 1991)	40	M	Pain	CT – mass	Abdominal mass	10 cm	Excision, omentectomy	Alive 1.5 years follow-up
11 (Lee et al., 1991)	42	F	Abdominal mass	US CT	Abdominal mass	20 cm	NA	NA
12 (Lee et al., 1991)	60	M	Abdominal mass	US CT	Abdominal mass	20 cm	NA	NA
13 (Lee et al., 1991)	55	M	Abdominal mass	US CT	Abdominal mass	10 cm	NA	NA
14 (Langlieb et al., 1992)	46	F	Abdominal mass + pain	CT	Ovarian carcinoma	20 cm	Excision, hysterectomy + BSO, omentectomy	NA
15 (Mahon et al., 1993)	51	M	Abdominal mass	CT				
16 (Ishida et al., 1999 Mar)	44	M	Abdominal mass	CT US Angiography - gastroepiploic artery	Omental tumor	28 × 25 cm	Excision, omentectomy	Alive 6 months follow-up
17 (Tanimura et al., 1980)	48	M	Abdominal mass			50 g, greater omentum	Excision	Died (post-op)
18 (Tanimura et al., 1980)	29	F	NA			6 × 5 × 3 cm, greater omentum	Excision	Recurrence, died
19 (Tanimura et al., 1980)	26	F	Abdominal distress			20 cm, greater omentum	Excision	Died (post-op)
20 (Tanimura et al., 1980)	32	M	Abdominal distress			6 × 4 cm, gastrohepatic omentum	Excision	Died-metastasis
21 (Tanimura et al., 1980)	70	F	Abdominal mass			22 × 14 × 13 cm, gastrohepatic omentum	Excision	Died-metastasis
22 (Tanimura et al., 1980)	55	M	Abdominal distension			Multiple, greater omentum	Excision	Died-metastasis
23 (Tanimura et al., 1980)	43	M	Abdominal mass			22 × 19 × 12 cm, gastrohepatic omentum	Excision	NA
24 (Tsurumi et al., 1991)	59	M	Abdominal mass	US, CT, angiography, laparoscopy		Greater omentum	Excision	Alive
25 (Kimura et al., 1997)	58	M	Pain, nausea			Lesser sack	Excision	
26 (Koga et al., 2002)	63	F	Abdominal mass		Leiomyosarcoma	12.5 × 9 × 8 greater omentum and 6 liver metastases	Excision + chemotherapy	Alive
27 (our case)	55	F	Abdominal mass and pain	US, CT	Ovarian carcinoma	23 × 20 × 13 cm	Excision	Alive

diagnosis of sarcoma with moderately cellular interlacing fascicles of spindle cells with a high degree of mitotic figures and atypical forms along with areas of mixoid change and coagulative tumor necrosis. Immunohistochemical staining was diffusely positive for desmin and smooth muscle actin, and strongly negative for S100 and CD34 in keeping with leiomyosarcoma. The rest of the omentum was free of tumor.

The uterus, cervix, ovaries and fallopian tubes showed no evidence of disease, a positron emission tomography (PET) scan demonstrated no further suspicious lesions. The case was reviewed at the gynecologic oncology tumor board and also at the specialized sarcoma unit tumor board meetings and both advised no adjuvant chemotherapy or radiotherapy.

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