

Supraclavicular Lymph Node Metastasis of Gynecological Malignancies: Two Case Reports

Jinekolojik Malignitelerin Supraklaviküler Lenf Nodu Metastazı: İki Olgu Sunumu

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ABSTRACT

Most of the head and neck metastatic masses originate from the upper respiratory tracts. Urogynecological cancers are rarely seen in distant organ metastases. Metastasis of gynecologic malignancies is usually associated with left supraclavicular lymph node involvement due to lymphatic system drainage. In supraclavicular lymph node metastases, cases with primary endometrium carcinoma are considered as poor prognosis. Because of poor prognosis, palliative treatment of neck metastases can be performed first, followed by debulking surgery in appropriate patients, followed by low dose regional radiotherapy options. In this text; one case with endometrioid type of endometrial adenocarcinoma and the other case of ovarian cancer are reported with the literature.

Key Words: Endometrioid-type, endometrial adenocarcinoma, ovarian carcinoma, supraclavicular lymph node

ÖZET

Baş ve boyun metastazik kitlelerin çoğu üst solunum yollarından kaynaklanmaktadır. Uzak organ metastazlarından özellikle ürojinekolojik kanserler nadir izlenmektedir. Genellikle jinekolojik malignitelerin metastazında lenfatik sistem drenajı nedeniyle sol taraf supraclaviküler lenf nodu tutulumu gözlenmektedir. Supraklaviküler lenf nodu metastazında, primeri endometrium karsinomu olan olgular kötü prognoz olarak değerlendirilmektedir. Prognozun kötü olması nedeniyle, boyun metastazlı hastalara öncelikle palyatif tedavi uygulanabilir, uygun hastalarda tümör azaltıcı cerrahi, sonrasında ise düşük doz rejyonel radyoterapi seçeneklerini uygulanabilir. Bu yazıda boyuna metastaz yapan, biri endometrioid tip endometrial adenokarsinom, diğeri over kanseri olan iki olgu literatür eşliğinde bildirilmektedir.

Anahtar Kelimeler: endometrioid tip, endometrium adenokarsinom, over karsinom, supraclaviküler lenf nodu

Introduction

Most of the head and neck metastatic masses originate from the upper respiratory tracts. Distant organ metastasis is rare. These metastases are usually caused by the lung, breast, gastrointestinal tract and genitourinary system. (1,2) Gynecologic cancers are not frequent in the literature for neck mass etiology. Cases with supraclavicular lymph node metastasis of endometrial carcinoma are rarely seen and poor prognosis. It has been reported that neck metastasis of endometrial carcinoma occurs by pelvic and paraaortic lymph via for up to mediastinal. (3)

In this text, two cases of neck metastasis with endometrioid type endometrial adenocarcinoma and ovarian cancer have been reported.

Case 1

A 72-year-old female patient was referred our clinic with a necrotic mass of 5x4 cm in the left supraclavicular region. At the neck magnetic resonance imaging, a mass lesion in the left supraclavicular region of 65x43mm was attributed to metastatic lymphadenopathy because of central necrotic peripheral contrast enhancement. (Figure 1)

A fine needle aspiration biopsy of the neck was reported as the definitive carcinoma metastasis. The positron emission tomography (PET) of the patient, which was investigated for etiology and origin, was more viewed to intense in the uterus central section. It was observed hypermetabolic area that about 58x84 mm at the left supraclavicular lymph node area. (Figure 2)

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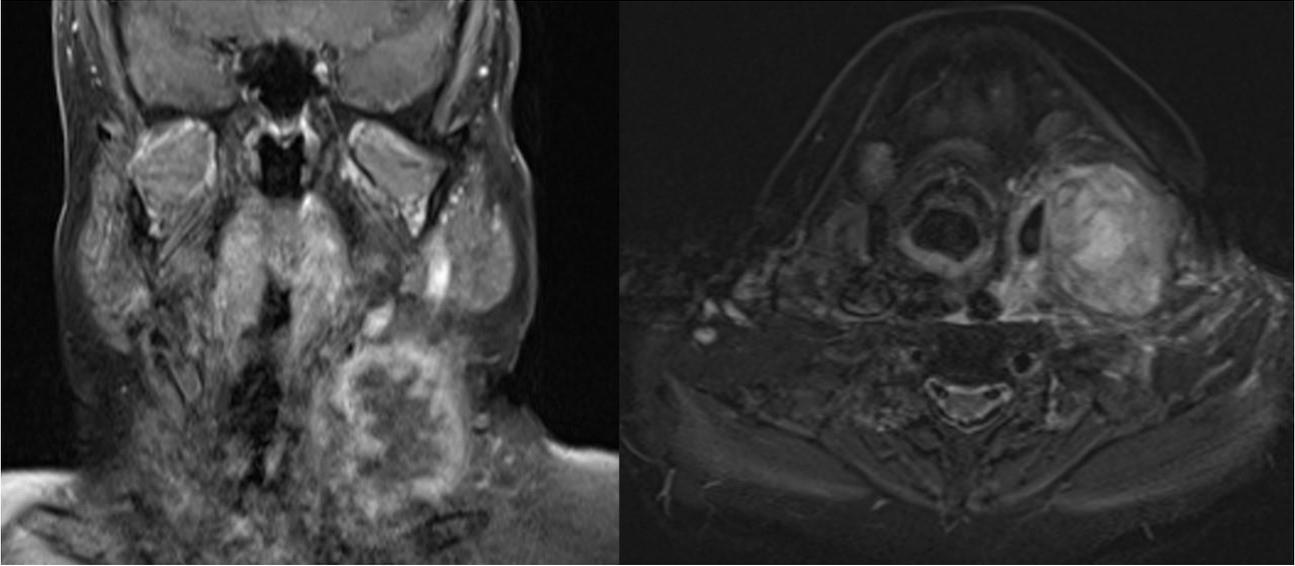


Fig. 1. MRG: Sagittal image of the lymph node showing ventricular necrotic peripheral contrast on the left. Axial view of left supraclavicular lymph node 65x43 mm on the right

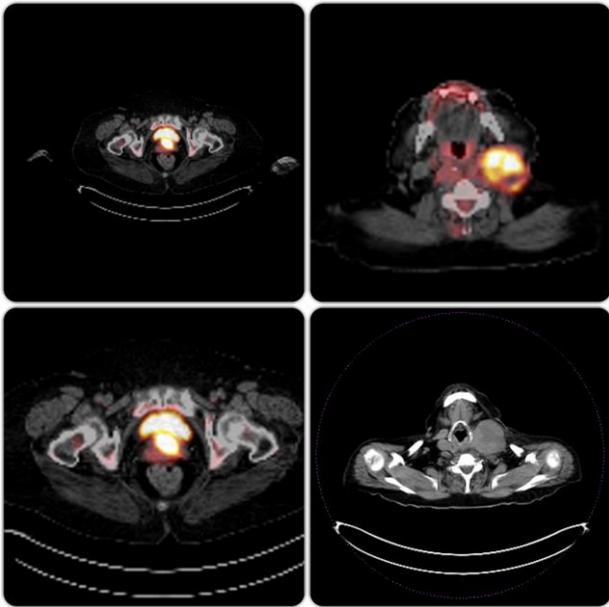


Fig. 2. MRG and PET: Correlation of MR imaging with PET showing left supraclavicular metastatic lymph node involvement

According to results, endometrioid type endometrial adenocarcinoma was observed in endometrium biopsy of the gynecological evaluation. Pathological investigations were consistent with endometrial adenocarcinoma. We were not thought surgery to the patient in terms of gynecological. Chemotherapy started when the patient was referred to medical oncology. The case was ex after 6 months.

Case 2

A 67-year-old woman was admitted to the hospital with a complaint of abdominal pain and swelling

in her abdomen. She has been on menopause for 20 years and has been having intermittent bleeding. The patient was vaginal bleeding about 20 days at last 3 months. Endometrial biopsy of the patient who referred to the external center for this reason was reported as atrophic endometrium. She swollen on his left mandible 45 days ago and so dentist had her tooth pulled. But swelling on the left mandible continued and she was prescribed antibiotics because of dental abscess. The patient was admitted to the emergency room again, due to abdominal pain. Heterotopic hypodense area about 196x90mm with pelvic placement on abdominal tomography revealed a solid mass (ovarian cancer, endometrial cancer?) that could not be clearly distinguished from ovarian, uterine or surrounding intestinal segments. Peritoneal and omental soft tissue densities were monitored as peritoneal carcinomatosis. In addition, a mass lesion that can't be clearly distinguished from the gall bladder in soft tissue densities in the inferior proximity of the bile sac, primary bile duct cancer or metastases was reported. Metabolic markers (CA 19.9, CA 125, CA 15.3, CEA, AFP) were requested, cervicovaginal smear and PET appointments were taken to determine the primer reason of neck metastasis. CA-19.9, 36.4 U / mL mildly elevated, CA-125 was elevated as 1041 U / mL, CEA, CA 15.3 and AFP were evaluated as normal. Smear was reported as inflammation. PET could not be done. The patient was directed to department of otolaryngology and oncology with the idea that the mass in the left submandibular region of the ovarian cancer was metastatic. The patient was

evaluated by oncology and the interventional radiology was guided by peritoneal biopsy. She could not be biopsied for poor general condition. One week later, the patient was referred to the emergency room with general condition impairment and the same day, she was died because of massive pulmonary thromboembolism.

Discussion

Some tumors are known to be able to metastasize to the neck; such as, lung, breast, esophagus, stomach, liver, gastrinoma, renal cell carcinoma, bladder, endometrial cancer, prostate, testicular cancer and central nervous system malignancies. (4) Supraclavicular lymph node metastasis of genitourinary malignancies is rare. (3)

Only 5 (0.15%) of the 3230 patients with neck metastasis due to gynecologic malignancy were of endometrial cancer origin in the study by Oosaki et al.(5) In 1965, Friedman and Osborn observed gynecological malignancy of 2 patients in the study including 72 patients with head and neck metastases. They noted that both were leiomyosarcoma. (1)

Atmaca et al. reported the first case of endometrioid type endometrial adenocarcinoma of the neck metastasis in 2013. (6) In our case, we present neck metastasis (case 1) which is the primary endometrioid type endometrial adenocarcinoma. We think that we report the second of neck metastasis in endometrioid type endometrial adenocarcinoma in the literature.

In 2012, Kojima et al. reported neck metastatic lesion with endometrial adenocarcinoma by performing lower and middle jugular neck dissection. (7) Lee YC et al. reported that they applied endoscopic surgery with regional low-dose radiotherapy for laryngeal metastatic endometrial adenocarcinoma in 2014. (8)

Ovarian cancer is rarely reported and up to 4% of supraclavicular lymph node involvement has been reported in autopsy of 100 ovarian cancer patients. (9) The 5-year survival rate of patients with retroperitoneal and neck metastatic ovarian cancer is between 58% and 84% respectively and this rate falls to between 18% and 36% in patients with peritoneal carcinomatosis. (10)

Primary cause of supraclavicular lymph node metastatic cases was surrounding tissue malignancies. Gynecological causes are seen rarely. The diagnosis is made histopathological with an

anamnesis, physical examination, laboratory tests and fine needle aspiration of neck mass. In gynecological malignancies it is important to evaluate with PET in terms of distant organ metastasis. PET is standard at follow-up of the treatment. Palliative treatment and tumor-reduction surgery in appropriate patients, followed by low-dose regional radiotherapy options can be recommended.

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