Low-Grade Endometrial Stromal Sarcoma in a Young Woman: A Case Report

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Article Info

ABSTRACT

Endometrial stromal sarcoma is a rare condition, constituting nearly 0.2% of all reproductive tract malignancies. The condition mainly affects the peri-menopausal population; however, it can occasionally be found in younger women and adolescents. Here, this is a case of a 20-year-old primiparous female who was referred to us with the main complaint of vaginal bleeding (menometrorrhagia), ongoing for 6 months after delivery. Her sonography report indicated a 5 cm intra-cavitary mass suspicious for myoma or placental polyp. Given the pathology report of low-grade endometrial stromal sarcoma (LGESS) on samples obtained through hysteroscopy and D&C, she underwent total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAH+BSO). Endometrial stromal sarcoma is a rare uterine malignancy of mesenchymal origin that should be considered, even in very young patients.

Keywords: Endometrial stromal sarcoma, Hysteroscopy, Low-grade, Uterine sarcoma

Introduction

Constituting only 0.2% of uterine malignancies and nearly 20% of uterine sarcomas, low-grade endometrial stromal sarcoma (LGESS) is an uncommon neoplasm of the reproductive tract in women (1).

While other uterine cancers show age predilection towards the postmenopausal population, ESS mainly presents in peri-menopausal women. Clinically, ESS is often misdiagnosed as benign conditions, e.g., leiomyoma; the diagnosis is usually confirmed post-operatively based on histopathological evaluation of tumor specimens (2, 3).

Given its nonspecific clinical manifestations, diagnosis of ESS is often delayed, negatively affecting its prognosis (4).

ESS has recently been reclassified by WHO into three categories, namely: low-grade ESS (LG-ESS), high-grade ESS (HG-ESS), and undifferentiated uterine sarcoma. Lesion's morphological similarity to endometrial stromal cells in their proliferative phase, the mitotic rate, and clinical behavior were the three factors on which this classification was based (5).

Given its post-hysterectomy discovery in most cases and the rarity of the condition, hysterectomy has consistently been the treatment approach considered for ESS in literature (6).

The present case is reported due to the patient's young age at diagnosis and the disease's rarity.

Case Presentation

We report a 20-year-old primiparous female with a history of vaginal delivery 6 months before her referral with a complaint of vaginal bleeding...
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On transvaginal sonography, she had an intracavitary lesion measuring about 5 cm, suspicious of myoma or placental polyp. She underwent hysteroscopy, D&C, and colposcopy. On hysteroscopy, a 5 cm mass was found on the anterior wall of the uterus, which was resected and sent for pathologic examination and the colposcopy biopsy result was normal. The pathology report showed low-grade endometrial stromal sarcoma (Low-grade ESS) (Figure 1 A, B). A pathology review confirmed low-grade ESS. IHC study indicated positive Vimentin and CD10 (Figure 1) but was negative for CK and WT1. Her case was discussed in a multidisciplinary session, and she decided to get a second pathology review. A pathology review could not discriminate between endometrial stromal nodule and low-grade endometrial stromal sarcoma.

A: Photomicrograph of low-grade stromal sarcoma showing proliferation of spindle shaped cells (H&E staining ×100)

B: High power field view of low-grade stromal sarcoma composed of mild atypical spindle shaped cells (H&E staining ×400).

C: Positive immunostaining for CD10 in low grade stromal sarcoma

Chest and abdominal computed tomography (CT) were normal. Transvaginal sonography, 3 months after the first hysteroscopy, showed 35×24 mm hyper-heterochronic mass in the left anterolateral region of the uterus, extending from the endometrial layer to serosa. Pelvic MRI revealed a 43×40 mm intramural myoma with homogenous enhancement and pressure effect on the uterus's endometrium from the left anterolateral mass (Figure 2).

The patient was a candidate for complete resection of the mass by laparotomy and hysteroscopy. Hysteroscopy revealed endometrial hyperplasia, and two separate endometrial nodules were resected. In laparotomy, a 3 cm intramural myoma in the left anterolateral wall of the uterine body with pressure effect into the uterine cavity in hysteroscopy was excised abdominally. Endometrial curettage just beneath the mass was done.
Low-grade ESS was confirmed on pathologic examination of mass, nodules, and attached endometrium. Taking this report into account, along with a multidisciplinary team decision and consultation with the patient, she underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAH+BSO) after fertility preservation. Four oocytes were retrieved, and 3 embryos were reserved.

There was no residual tumor in the hysterectomy specimen, and IHC was positive for ER and PR.

After 27 months of follow-up, she has not developed any problems in physical examination or chest and abdominopelvic CT scans.

**Discussion**

Endometrial stromal sarcoma is a rare condition, constituting nearly 0.2% of all reproductive tract malignancies, its incidence is about 2 per million women; in comparison, endometrial cancer affects 700 per million women (6).

In 2014, endometrial stromal tumors were classified by the WHO into four categories, namely: endometrial stromal nodule (ESN), low-grade endometrial stromal sarcoma (LGESS), high-grade endometrial stromal sarcoma (HGESS) and undifferentiated uterine sarcomas (UUS) (2).

ESS is an uncommon tumor, mainly affecting perimenopausal women, with a median age at presentation ranging between 45 and 55 years. However, younger women and adolescents are not spared, as was the case in our 20 years old patient. Reviewing the medical literature, five cases of young patients with low-grade ESS were reported (Table 1).

Usual presenting features for the condition include abnormal uterine bleeding, postmenopausal bleeding, abdominal pain, and pelvic mass (7). In our reported case, the patient had abnormal uterine bleeding about 6 months after vaginal delivery. Her ultrasound indicated myoma or placental polyps, which, at that stage, were the most likely diagnoses in this patient.

The most common site of occurrence of ESS is the uterine corpus though extra-uterine sites are not spared. Compared to the other two types of uterine sarcoma, women with low-grade endometrial stromal sarcoma (LGESS) often present at a younger age, as exemplified by our 20 years old patient. Local spread of ESS to the vagina, fallopian tubes, ovaries, bladder, and ureters is possible, and the disease can metastasize distally to extra-pelvic sites such as lungs and heart. At
presentation, the extra-uterine disease is observed in up to 30% of cases with low-grade ESS (8).

Table 1. Five cases of low-grade ESS in young patients reported in the literature

<table>
<thead>
<tr>
<th>Author</th>
<th>Age</th>
<th>Parity</th>
<th>Size</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Follow-up</th>
<th>Recurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arab et al. (the present case)</td>
<td>20</td>
<td>1 y/o</td>
<td>5 cm</td>
<td>Pathologic examination after myomectomy (hysteroscopic + laparotomy)</td>
<td>TAH* and BSO* + letrozole</td>
<td>27 months</td>
<td>No recurrence at 27-months</td>
</tr>
<tr>
<td>Chang et al., (11)</td>
<td>27</td>
<td>0 y/o</td>
<td>4.6 cm</td>
<td>Pathologic examination after hysterecomy</td>
<td>TAH and salpingectomy + medroxyprogesterone acetate + tamoxifen</td>
<td>11 months</td>
<td>No recurrence at 11-months</td>
</tr>
<tr>
<td>Dong et al., (12)</td>
<td>25</td>
<td>0 y/o</td>
<td>5 cm</td>
<td>Final pathologic and IHC examination</td>
<td>Fertility-preserving local mass resection and endocrine therapy</td>
<td>18 months</td>
<td>No recurrence after 3 years</td>
</tr>
<tr>
<td>GÜZİN et al., (13)</td>
<td>21</td>
<td>1 y/o</td>
<td>9 cm</td>
<td>Final pathologic examination after myomectomy</td>
<td>TAH and BSO, pelvic lymph-node dissection, an appendectomy, omentum biopsy</td>
<td>3 years</td>
<td>No recurrence after 3 years</td>
</tr>
<tr>
<td>Koskas et al., (10)</td>
<td>34</td>
<td>0 y/o</td>
<td>15 mm</td>
<td>Pathologic examination after hysteroscopic resection</td>
<td>Hysteroscopic resection. Resection of recurrent masses + Letrozole (refused hysterectomy by patient)</td>
<td>6 months</td>
<td>Severe peritoneal recurrence after pregnancy</td>
</tr>
</tbody>
</table>

* TAH, total abdominal hysterectomy; BSO, bilateral salpingo-oophorectomy; ICSI, Intracytoplasmic sperm injection;

Its resemblance to conditions such as leiomyoma makes the clinical and radiological diagnosis of ESS challenging. As was the case in our patient, ultrasound lacks specificity and can suggest an incorrect diagnosis of more prevalent conditions such as adenomyosis or leiomyoma. Even histologically, especially in the presence of myxoid, epithelioid, and fibroblast changes, ESS may be incorrectly identified as other conditions such as leiomyoma, uterine leiomyosarcoma (LMS), or other sarcomas, making the pathological identification a challenge too. Three experienced pathologists reviewed the specimens in the present case to achieve an accurate diagnosis. IHC study can prove useful in diagnosing ESS. While muscle-specific Actin, SMA, and Desmin are expressed in ESS, leiomyoma, and LMS, diffuse CD10 immunoreactivity is a valuable marker of ESS. CD10 is a sensitive marker of normal endometrial stroma and ESS; our patient had positive CD10 on immunohistochemistry. CD10 is negative in most cases of cellular leiomyoma (8).

Total abdominal hysterectomy with bilateral salpingo-oophorectomy is the surgery recommended as the final resort for LGESS treatment. The presence of steroid receptors in ESS raises concerns about the stimulation of residual disease by estrogen secreted by the ovaries; thus, the recommendation for oophorectomy (9). Koskas et al., (10) in their case study, concluded that definitive surgery should be considered as soon as ESS is diagnosed and should not be postponed. This was based on their finding of a dramatic progression of LGESS in the form of severe peritoneal recurrence in their 34-year-old patient who became pregnant after her ESS was conservatively managed. Thus, in our patient, given the positive estrogen and progesterone receptors, complete abdominal hysterectomy with bilateral salpingo-oophorectomy was suggested and performed, despite her young age.

Hormonal therapy may have a role in treating cases with advanced disease (6).

A third to a half of LGESS patients develop a recurrence (1). Recurrences are reported to have occurred between 3 months and 23 years after treatment, with a median of about 3 years (10).

Although controversial, many factors are suggested to be prognostically significant for the condition, including age, menopausal status, tumor size and stage, mitotic count, histologic grade, and involvement of surgical margins by tumor (7).

For LGESS with recurrent disease, medroxyprogesterone, gonadotropin-releasing hormone (GnRH) analogue, and aromatase inhibitors are the suggested hormonal therapies. Compared to other types of uterine sarcoma, LGESS is reported to have a higher survival rate (1).

With a 5-year survival rate of 60%, low-grade ESS has a prognosis similar to that of endometrial carcinomas; the rate drops to 25% for patients with high-grade lesions. Behtash et al., (7). Reported a five-year survival rate of 96% for LGESS patients in their study.

Given its rarity, only a few case reports and retrospective analyses with small sample sizes have been reported for ESS (7).
Conclusion
Endometrial stromal sarcoma is a rare uterine malignancy of mesenchymal origin. Although rare, diagnosis of endometrial stromal tumors should be considered whenever a patient comes with a large uterine polyp and fibroid-like symptoms.

Acknowledgments
None.

Conflict of Interest
The authors declare no conflict of interest.

References


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