

An Endometrial Adenocarcinoma Patient with Isolated Clavicular Metastasis

Qi Wan Yang*

School of Biosciences, The University of Porto is a Portuguese public research university located in Porto, Portugal

Abstract

Adenosarcoma of the uterus is a rare uterine tumour that usually begins in the uterine lining (endometrium). This type of tumour contains both benign (noncancerous) and malignant elements (low-grade sarcoma). Affected individuals may experience abnormal vaginal bleeding, an enlarged uterus, and tissue protruding from the external os (external opening of the uterus that leads into the cavity of the cervix). It most commonly affects postmenopausal women, but it can affect women of any age. Hyperestrogenemia (high blood oestrogen levels), chemotherapy, or radiotherapy are all risk factors for the condition.

Keywords: Endometrial cancer; Clavicle metastases; Palliative radiotherapy

Introduction

Adenosarcoma of the uterus is a rare uterine tumour that usually begins in the uterine lining (endometrium). This type of tumour contains both benign (noncancerous) and malignant elements (low-grade sarcoma). Affected individuals may experience abnormal vaginal bleeding, an enlarged uterus, and tissue protruding from the external (external opening of the uterus that leads into the cavity of the cervix). It most commonly affects postmenopausal women, but it can affect women of any age. Hyperestrogenemia (high blood oestrogen levels), chemotherapy, or radiotherapy are all risk factors for the condition. Following breast, colorectal, lung, and cervical cancer, endometrial carcinoma is the sixth most common cancer in females worldwide. In females, it is the fourth most common in developed countries and the seventh most common in developing countries [1]. Adenocarcinoma accounts for approximately 90% of uterine carcinomas. Endometrial carcinoma typically spreads through local invasion or lymphatic spread. Hematogenous spread is relatively uncommon. The lung, liver, and brain are the most common sites for distant metastases. Metastasis to bone occurs in less than 15% of advanced cancer patients and is typically limited to the pelvis and vertebrae [2].

A 60-year-old postmenopausal female presented to another hospital's gynaecology OPD with complaints of vaginal bleeding and pelvic pain for 6 months. A biopsy of the endometrium revealed high grade endometrial adenocarcinoma. A year ago, she underwent surgical staging with a radical hysterectomy and bilateral salpingo-oophorectomy. The findings matched FIGO stage IIIA grade 3 endometrial adenocarcinomas. She was referred to our institute's outpatient department for postoperative radiotherapy [3]. After proper consent, the patient was discussed in a multidisciplinary clinic and was scheduled for adjuvant radiotherapy to the entire pelvis at a dose of 50 Gy in 25 fractions using a 4 field technique, followed by intravaginal brachytherapy. She began complaining of pain and swelling in the left clavicular region during treatment (after receiving 14 Gy in 7 fractions of pelvic radiotherapy). On local examination, the swelling was approximately 33 cm in diameter, hard, fixed to underlying structures, tender, and covered by normal overlying skin. The swelling was getting bigger and bigger. The general physical examination revealed nothing noteworthy.

Cancer cells spread through the body in stages. These steps are as follows:

- Growing into or invading nearby normal tissue
- Moving through the walls of nearby lymph nodes or blood vessels
- Travelling through the lymphatic system and bloodstream to other parts of the body
- Stopping in small blood vessels at a distant location, invading the blood vessel walls, and moving into the surrounding.
- Tissue growing in this tissue until a tiny tumour form causing new blood vessels to grow, allowing the metastatic tumour to coexist.

A lytic lesion in the medial one-third of the left clavicle was discovered on a chest X-ray PA view. The swelling's Fine Needle Aspiration Cytology (FNAC) revealed metastatic adenocarcinoma [4]. On that basis, a full metastatic workup was performed, which revealed no evidence of disease elsewhere. The final diagnosis was stage IV B endometrial adenocarcinoma with clavicle metastasis. The patient's ongoing adjuvant radiotherapy was stopped, and palliative radiotherapy of 20 Gy in 5 fractions to the clavicle was administered. Later, zoledronic acid was also administered. She was then scheduled for systemic chemotherapy with Paclitaxel and carboplatin, but she declined and returned 3 months later with severe breathing difficulties and a 1010 cm increase in the size of her metastatic swelling. Despite the best supportive care, patient expired after 5 months of initial diagnosis because of the disease progression.

Several case reports describe unusual sites of endometrial carcinoma bony metastases, including the calcaneum, humerus, mandible, talus, metatarsals, and skull [5]. In cases of poorly differentiated adenocarcinoma treated with only local palliative radiotherapy to the bone, which is like our case, survival after bone metastasis was poor.

***Corresponding author:** Qi Wan yang, School of Biosciences, The University of Porto is a Portuguese public research university located in Porto, Portugal, E-mail: yang_wan@gmail.com

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A case of metastatic high grade endometrial adenocarcinoma with bone metastasis was reported, and the patient survived for more than 16 months on multimodality treatment, which included bone metastasis surgery, hormone therapy for the primary disease, and local radiotherapy for metastasis. A case of poorly differentiated endometrial adenocarcinoma with isolated mandibular metastasis was reported. After a total abdominal hysterectomy and bilateral salpingo-oophorectomy, she received radiation therapy to the mandible and six cycles of chemotherapy with Paclitaxel and Carboplatin. She had a full recovery and lived for more than 14 months .

To the best of our knowledge, only two cases of endometrial adenocarcinoma metastasis to the clavicle have been reported. The first case had multiple lung metastases, the second had humerus metastases, and our patient had isolated clavicular metastasis [6].

Our report presented has three main peculiar features:

1. Endometrial carcinoma presenting with bony metastasis, which is a rare entity.
2. An extremely rare site of metastatic tumor, located in the clavicle.
3. The lesion as a single bone metastasis, which is uncommon in such high-grade cases.

For a good clinical outcome, the most common treatment for bone metastasis is surgical removal of the lesion (if possible), radiation therapy to the metastatic site, and chemotherapy [7]. In addition to zoledronic acid, our patient received local radiotherapy to the clavicle. According to a case report, bisphosphonate was added because it has been shown to have a modest improvement in skeletal-related event-free survival. Despite being scheduled for systemic chemotherapy, the

patient did not comply, deteriorated rapidly, and died about 3 months after being diagnosed with bone metastasis.

Conclusion

In patients presenting with abnormal bony swelling and tenderness, metastatic endometrial adenocarcinoma should be considered as a differential diagnosis. Early detection and treatment of such cases is critical, as aggressive treatment with a multimodality approach leads to longer survival [8]. In these cases, a high level of suspicion is required. Bone scans or standard X-rays can be used. If a combined modality is not possible, symptoms should be relieved.

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