Meeting January 23 1970

Cases and Short Papers

Mixed Mesodermal Tumour of the Ovary Arising in Pelvic Endometriosis

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Mrs E P, aged 36, para-0. Housewife
History: Admitted 26.3.69 complaining of central abdominal pain for three days. On examination the abdomen was distended by an irregular swelling reaching the umbilicus. Pelvic examination revealed a mass arising from the right adnexal region separable from a small retroverted uterus. A provisional diagnosis of ovarian neoplasm was made.

Operative findings: The peritoneal cavity was filled with gelatinous necrotic tissue infiltrating the greater omentum. Its origin was traced to a ruptured right ovarian cyst. There were patches of endometriosis in association with the ovary. The uterus, left ovary and tube were normal. A right salpingo-oophorectomy was performed and the tumour tissue removed piecemeal along with much of the omentum.

The initial post-operative course was satisfactory, but the patient's condition gradually deteriorated and she died six weeks later.

Pathology: Histology of the right ovary revealed endometriotic stroma showing malignant characteristics. The glands lined by columnar epithelium appeared orderly in some sections (Fig 1) and frankly malignant in others (Fig 2). Osteoid tissue was also present (Fig 3). The histological findings were consistent with mixed mesodermal tumour.

At post-mortem there was no evidence of malignancy elsewhere in the abdomen or pelvis. The uterus was normal and the endometrium free from tumour.

Comment

Mixed mesodermal tumours of the ovary are exceedingly rare and are said to arise from ectopic müllerian tissue. In discussing malignant transformation of ovarian endometriosis Sampson

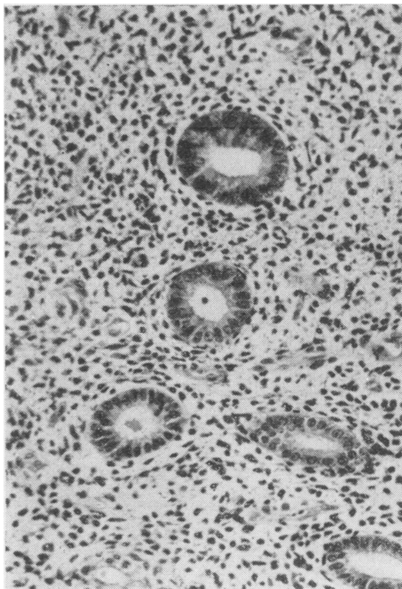

Fig 1 *Orderly endometrial glands surrounded by malignant stroma*

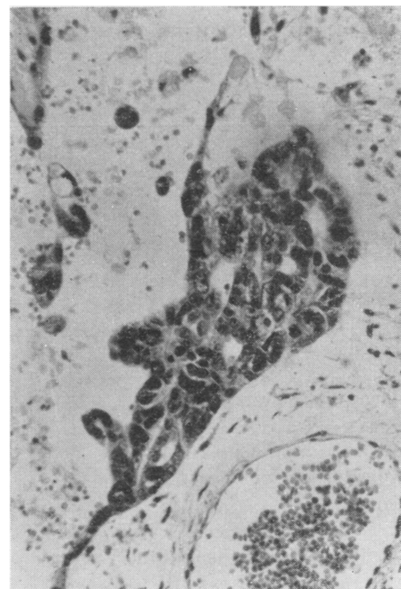

Fig 2 *Malignant endometrial tissue*

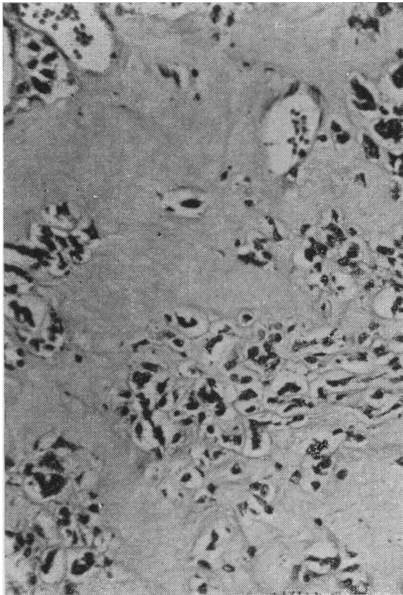

Fig 3 *Stroma differentiating into osteoid tissue*

(1925) stated two necessary criteria: (1) The demonstration of both carcinoma and benign endometrium in the same ovary. (2) The exclusion of cancer invading the ovary from some other source. Because the overall histological picture and autopsy findings satisfy these criteria we suggest that the tumour in this case arose from endometriosis.

REFERENCE
Sampson J A (1925) *Arch. Surg.* 10, 1

Positive Vaginal Cytology Recurring after Total Hysterectomy for Carcinoma-in-situ of the Cervix (Three Cases)

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The discovery of the pre-invasive stage of carcinoma of the cervix led gynæcologists to hope that invasive cancer of the cervix could be eradicated by adequate treatment of the in-situ lesion. Experience has shown that this is not true in every instance, as the following cases illustrate:

Case 1 Vaginal cytology became positive eighteen months after operation. Biopsy showed the presence of invasive squamous carcinoma, but radiotherapy failed to prevent further spread. The patient died five years after her initial recurrent positive vaginal smear, from carcinomatosis.

Case 2 Positive vaginal cytology recurred nineteen months after operation. Biopsy failed to locate the origin of the malignant cells seen on the smear. Vaginal cytology remains intermittently positive and the patient is under close review, but no further treatment has been given.

Case 3 Positive vaginal cytology returned five years after the initial operation. Radiotherapy was given after confirmatory biopsy which showed carcinoma-in-situ of the vaginal vault.

These cases pose interesting questions about the extent of the abnormal epithelium when the initial diagnosis was made and about the etiology of carcinoma of the cervix and vagina. They also illustrate the dilemma of the clinician who is confronted by the recurrent positive vaginal smear.

Extrauterine Pregnancy

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A 34-year-old West Indian woman attended at thirty weeks gestation in her fifth pregnancy, having failed to progress past twenty-four weeks gestation in any of the previous pregnancies. Her past obstetric history involved two abortions at twelve weeks gestation and two at twenty-four weeks. Myomectomy and salpingostomy had been performed between the second and third abortion. A Shirodkar suture was inserted after the fourth abortion but was later removed.

The patient returned from the West Indies at 30 weeks gestation in her fifth pregnancy. There was no evidence of cervical dilatation and the pregnancy had progressed without incident. An elective Cæsarean section was planned at four days before term on account of a persistent transverse lie. At operation, the uterus was only slightly enlarged and the fœtus was lying in a gestation sac above and anterior to the uterus. A live male infant weighing 6 lb 5 oz (2·86 kg) was delivered. Liquor was present and the placenta was attached to the posterior surface of the gestation sac, which was receiving its blood supply via the right infundibulo-pelvic ligament. The gestation sac containing the placenta was easily removed *in toto*. There was no evidence of fœtal abnormality.

Although the findings at operation suggested a primary ovarian pregnancy, this was not supported by histological evidence; it is therefore suggested that this was a secondary intraligamentous pregnancy.