

Case Report

An Innocuous-Looking Abdominal Wall Swelling in an Endometrial Cancer Survivor

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ABSTRACT

This case report describes a rare example of a solitary abdominal wall metastasis in a middle-aged endometrial cancer (EC) survivor 3 years following disease-free status. Following induction chemotherapy, she had a margin-negative surgical excision of the abdominal tumor. Surprisingly, the patient has been disease-free for more than 3 years after the operation. This emphasizes the necessity of addressing single metastasis amenable to surgical resection, as well as the need for diligent monitoring to discover recurrences sooner. Understanding rare locations of recurrence, such as the abdominal wall, is critical for optimum EC therapy and care. The data given in this article adds to the existing body of information on atypical presentations and recurrent EC therapy. Additional research is required to develop evidence-based guidance.

KEYWORDS: Abdominal wall tumor, endometrial cancer, metastasectomy, oligometastasis, survival

INTRODUCTION

Endometrial cancer (EC) is the second-most common cancer worldwide and is diagnosed commonly in elderly women.^[1] Surgery is the primary modality of treatment for uterus-confined disease, followed by adjuvant radiotherapy and/or chemotherapy for high-risk cases. Despite adequate treatment, around 5%–20% of the patients develop disease recurrence^[2,3] depending upon the diverse pathological types (including molecular subtypes), tumor aggressiveness, treatment responsiveness, and disease stage. In a study of 758 women with EC, distant site recurrences were more common (64%) than pelvic (25.3%) and lymph node (10.7%) recurrences.^[4] The occurrence of recurrent tumors has a substantial impact on survival rates, particularly concerning the 5-year overall survival (OS). Pelvic recurrences are associated with a reduced OS of 55%, while extra-pelvic recurrences exhibit an even lower OS of only 17%.^[5]

Isolated solitary metastasis in EC survivors with controlled primary is an atypical presentation and patients with good performance status with resectable tumors should not be denied curative treatment.^[6] We discuss the case of an older EC survivor who presented

to us with an isolated abdominal wall metastasis with managed primary and a 3-year disease-free interval.

CASE REPORT

In 2017, a 53-year-old woman had staging laparotomy and adjuvant chemoradiotherapy to treat FIGO stage II (cervical stroma invasion without extrauterine extension). EC an extrafascial complete hysterectomy, bilateral salpingo-oophorectomy, infracolic omentectomy, and bilateral pelvic and para-aortic lymphadenectomy were all part of the staging laparotomy. Histopathology revealed a margin-negative resection, grade II (moderately differentiated) endometrioid adenocarcinoma penetrating the cervical stroma, no lymph node metastases, and no lymphovascular/perineural invasion. Molecular analysis was not carried out. She had adjuvant external beam radiation using the intensity-modulated radiotherapy

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method for 5 weeks, with a total dosage of 45 Gray administered in 25 segments. She then had intravaginal brachytherapy with cylinders/SORBO applicator, which delivered a dosage of 7 Gray over 3 weekly portions. She was closely observed until March 2020, when a routine check-up revealed painless abdominal swelling. She had noticed the tumor for 4–5 months but had remained mainly asymptomatic. She had a good performance status. Her physical examination revealed a hard parietal mass in the umbilical region adjacent to the previous laparotomy scar, along with a small incisional hernia. The genital examination did not reveal any evidence of local recurrence.

Contrast-enhanced computed tomography (CT) scan [Figure 1] demonstrated an irregular, heterogeneously enhancing lesion measuring 3.3 cm × 3.1 cm × 1.9 cm in the anterior abdominal wall at the left paramedian location, accompanied by mild adjacent fat stranding. Fine-needle aspiration cytology guided by imaging confirmed metastatic adenocarcinoma. Whole-body positron emission tomography (PET)-CT scan did not reveal any distant metastasis. The case was reviewed by a multidisciplinary tumor board, and the patient received six rounds of induction chemotherapy (cisplatin and paclitaxel) before surgery to evaluate tumor biology. A reassessment PET-CT scan following completion of chemotherapy indicated stable disease without new metastatic sites. Considering the patient's good performance status, solitary metastatic site, and stable disease after chemotherapy, she underwent wide local excision of the anterior abdominal mass and abdominoplasty. Histopathological examination confirmed the presence of metastatic adenocarcinoma of endometrial origin (grade I without any lymphovascular or perineural invasion) – all margins were negative. The postoperative period was uneventful. Subsequently, she has been undergoing annual whole-body PET-CT scans. The latest scan in April 2023 indicated the absence of any active metabolic lesions in her body. She remains under active surveillance.

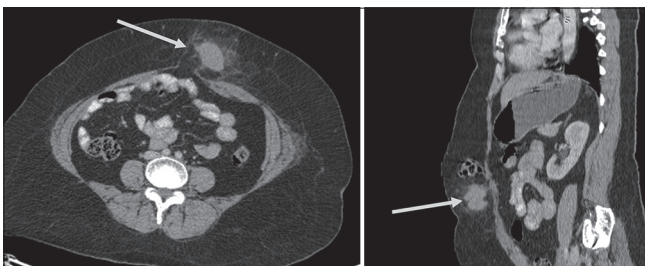


Figure 1: (a) Axial and (b) Sagittal section of the contrast-enhanced computed tomography scan of the abdomen shows an irregular heterogeneously enhancing lesion (arrow) measuring 1.9 cm × 3.3 cm × 3.1 cm in the anterior abdominal wall at the left paramedian location with mild adjacent fat stranding and a small incisional hernia

DISCUSSION

EC is a common malignancy, and despite advancements in treatment strategies, a significant number of patients develop disease recurrence. The management of recurrent EC is complex, and the site of metastasis plays a critical role in determining the optimal treatment approach. In this case, the patient developed an isolated abdominal wall metastasis, highlighting the importance of recognizing and understanding uncommon sites of recurrence. The decision to pursue surgical resection following stable disease after induction chemotherapy was based on several factors, including the patient's good performance status and the resectability of the tumor. The successful outcome of the patient, remaining disease-free for over 3 years postintervention, underscores the potential benefits of curative treatment for patients with isolated metastases.

The findings from this case report have important clinical implications. First, it emphasizes the significance of managing solitary metastasis amenable to surgical resection. While isolated metastases in EC survivors are rare, patients with favorable prognostic factors, such as good performance status, favorable tumor biology, and resectable tumors, should be considered for curative treatment options. Second, it underscores the need for close surveillance to detect recurrences at earlier stages, as early identification and intervention can lead to improved outcomes. The case also highlights the importance of a multidisciplinary approach in managing recurrent EC. The decision-making process involving a multidisciplinary tumor board ensures that various perspectives and expertise are considered, leading to a more comprehensive and personalized treatment plan.

Patients with oligometastatic disease who are not suitable candidates for surgical resection may be eligible for ablative radiotherapy, provided that the number of lesions is fewer than five, the primary tumor is under control, and the tumor biology is favorable.^[7] In cases where the recurrence cannot be effectively treated with local therapies such as surgery or radiotherapy, the patient is managed as having disseminated disease. Treatment options in such cases include systemic palliative chemotherapy, hormonal therapy (particularly for low-grade endometrioid tumors), and/or best supportive care.

CONCLUSION

This case report highlights the successful management of an isolated abdominal wall metastasis in an EC survivor. It emphasizes the need to evaluate curative treatment options for individuals with isolated metastases, as well as the importance of close surveillance to detect

recurrences at an earlier stage. Further research endeavors are warranted to expand our understanding and provide evidence-based guidelines for managing isolated metastases occurring in unusual anatomical sites.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given her consent for her images and other clinical information to be reported in the journal. The patient understands that her name and initials will not be published and due efforts will be made to conceal her identity, but anonymity cannot be guaranteed.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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