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IMAGE | ENDOSCOPY

Gastric Metastasis of an Ovarian Granulosa Cell Tumor Diagnosed in a Patient with Worsening Reflux

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CASE REPORT

A 60-year-old woman with a 2-year history of T1a NX M0 ovarian granulosa cell tumor (GCT) status post total abdominal hysterectomy with bilateral salpingo-oophorectomy presented with worsening reflux, abdominal pain, nausea, and loss of appetite. Esophagogastroduodenoscopy showed multiple gastric polyps with white tops and patches of necrotic appearing mucosa (Figure 1). Biopsy of the gastric polyps showed extensive surface ulceration and necrosis with associated atypical epithelioid and spindle cell proliferation (Figure 2). Although the immunohistochemical markers for sex cord-stromal tumors are negative, the histomorphology is similar to the patient's prior ovarian GCT (Figure 3). An extensive immunohistochemical marker panel performed to exclude the other common entities was negative. Thus, this most likely represents a metastasis from the ovarian GCT. Metastatic workup revealed bilateral metastatic pulmonary nodules, enlarged paraesophageal and paraaortic lymph nodes, and a brain metastasis. Patient was a poor surgical candidate and did not tolerate chemotherapy. Repeat imaging showed disease progression; she refused palliative chemoradiation and chose comfort measures.

GCT is a rare sex cord-stromal tumor associated with low malignant potential.[1] This tumor has a strong tendency for late recurrences, with an incidence of 25–30%, and is associated with a poor prognosis.[1] Once the tumor recurs, it is fatal in 80% of cases. Most recurrences occur within 10 years after the initial diagnosis (median 4–5 years).[1-4] Prognostic factors that affect the 5-year survival rate include tumor rupture, tumor stage, tumor mitotic rate, and residual disease. Common sites of metastasis are

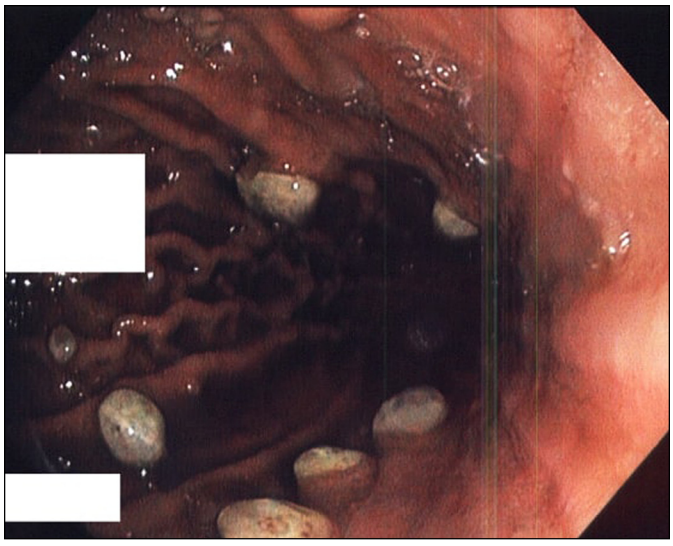

Figure 1. Esophagogastroduodenoscopy shows multiple gastric polyps with white tops and patches of necrotic appearing mucosa.

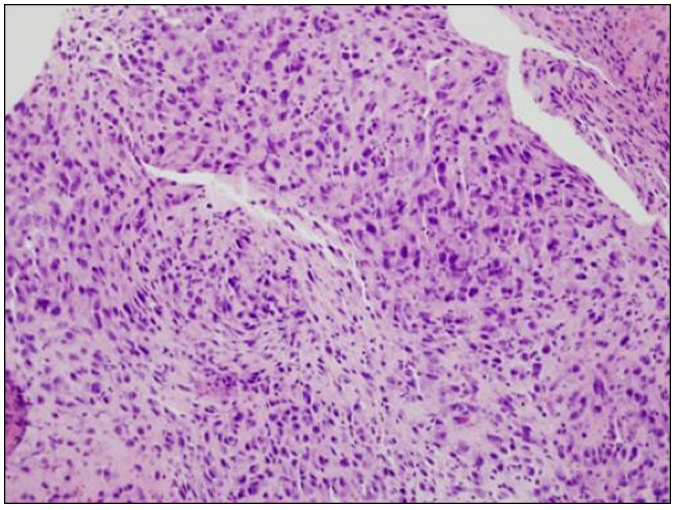

Figure 2. Gastric polyp biopsy showing atypical epithelioid and spindle cell population.

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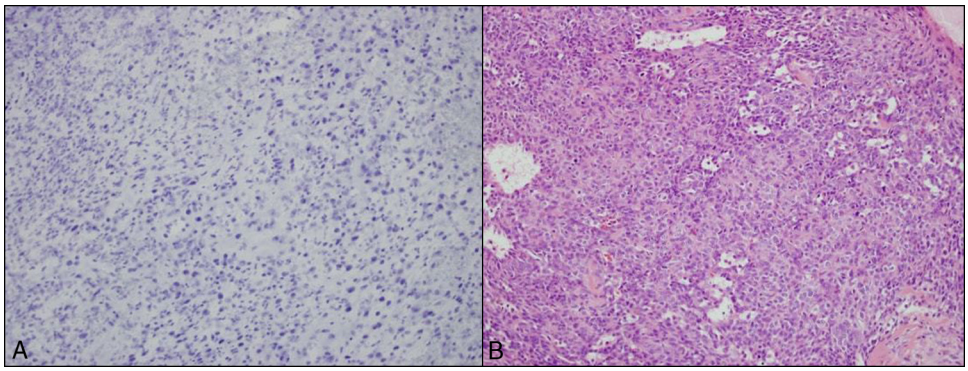

Figure 3. Histomorphology of the gastric polyp showing (A) negative calretinin immunostain of prior tumor and (B) immunostain of present tumor.

within the pelvis and the lower abdomen, with rare cases in the lung, liver, brain, bone, diaphragm, abdominal wall, and adrenal gland.[1-3] Patients should be kept on a long-term follow-up protocol even if the primary tumor is occult.[2] Patients with advanced metastatic GCTs are treated with aggressive surgical debulking and postoperative chemotherapy (platinum-based), especially in cases of widespread metastasis.[4,5]

DISCLOSURES

Author contributions: J.S. Klair and K. Soota wrote the manuscript and reviewed the literature. A. Vidholia provided the pathology images and reviewed the literature. C.M. Berkowitz revised the manuscript. JS Klair is the article guarantor.

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Informed consent was obtained for this case report.

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