

Coexistent Uterine Myoma, Colon Adenocarcinoma Ureteral Duplication in A Young Female Patient

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Uterine leiomyomas are the most common solid pelvic tumor and a common indication for hysterectomy in women. Ureteral duplication may be genetically determined by an autosomal dominant trait with incomplete penetrance. Colorectal carcinomas are the second most common internal malignancy. When the literature is reviewed we could not find any report showing a relationship among these pathologic conditions. To our knowledge so far, this is the first report describing the incidental finding of leiomyoma uteri, double ureter and colon adenocarcinoma in a young female patient, therefore this case is presented.

Key Words: Leiomyoma Uteri, Ureteral Duplication, Colorectal Carcinoma.

Genç Bir Hastada; Myoma Uteri, Kolon Adenokarsinomu ve Üreteral Duplikasyon Birlikteliği

Öz geçmişinde genital sistem kanseri hikayesi olan kadınlarda kolorektal kanser görülme riskinin artmış olmasına rağmen, uterin myom varlığı ile kolon kanserleri arasında herhangi bir ilişki bildirilmemiştir. Öte yandan bazı gastrointestinal sistem lezyonları ile üreteral kollektör sistem duplikasyonunun birlikte görülebilmesine rağmen, uterin myoma, kolon kanseri ve üreteral dublikasyonun birlikteliği rapor edilmemiştir. Biz, bu üç farklı patolojik bulgunun genç bir hastadaki rastlantısal birlikteliğini, tanı ve tedavisindeki yaklaşım şeklini tartıştık.

Anahtar Kelimeler: Leiomyoma Uteri, Üreteral Duplikasyon, Kolorektal Karsinoma.

Although women with a history of genital cancer are at high risk of colorectal cancer, there is no relationship between the colon carcinoma and uterine leiomyoma.¹⁻³ Double ureteral collector systems are a rare coincidental congenital pathologies.⁴ Some gastrointestinal tract lesions may be accompanied with duplication.⁵ but there is not any report that suggest the presence of a relationship among the duplication, colon cancer and uterine leiomyoma. Leaning on this case we emphasize that if one of these lesions had been determined, the possibility of the other lesions should have been kept in mind and further investigations should be carried.

CASE

A 32-year old woman, gravida 4, parite 3, D&C 1, defined left lower back pain, hypermenorrhea accompanied with constipation. First physical examination was made by urologists and a renal calculi was considered. IVP was performed and interestingly revealed incidentally double ureteral system on left kidney and a mass related to genital tract (Figure 1), therefore the patient had been consulted with our clinic. Transvaginal ultrasonography revealed an intramural leiomyoma located in sized 54x48x55 mm, making pressure on the endometrium. Bilateral adnexal areas were normal. Patient was informed about myomectomy and laparotomy was planned. Because of the low hemoglobin level (6.9 g.dl⁻¹) two units blood transfusion was performed before the laparotomy. During myomectomy, microimplantation areas were seen on the large bowel serosa, omentum, ovaries, pelvic periton and visceral peritoneum. Multiple biopsies were taken from these areas for frozen section and it was reported as possible mucinous cistadenocarcinoma gastrointestinal or gynecologic origin (Figure 2). Both ovaries were evaluated as normal except the microimplantations. Intraoperative consultation was obtained from general surgeons for detecting the origin of the carcinoma. The mass sized 10x8 cm was palpated at the descendan colon. Left hemicolectomy,

appendectomy, omentectomy, and transverse sigmoidostomy were performed. During the operation double ureter were observed at the left side. Histopathologic examination revealed adenocarcinoma of the descending colon including mucinous component and leiomyoma uteri with dystrophic calcification (Figure 3).

Figure 1: Duplication of the renal collecting system (black arrow) and leiomyoma with dystrophic calcification (white arrow) in intravenous pyelogram.)



Figure 2: Mucinous carcinoma in frozen section of peritoneal microimplantation (HEX200)

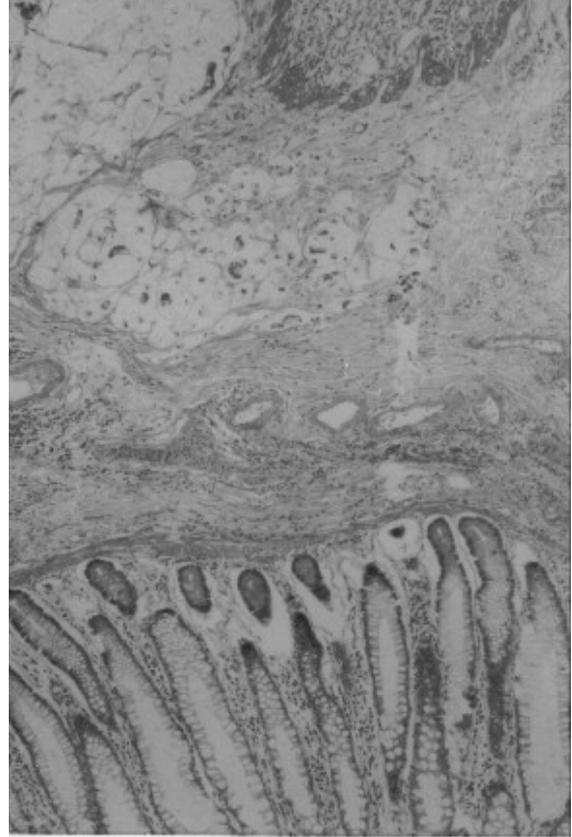


Figure 3: Degenerated and hyalinized leiomyoma (HEX100)



DISCUSSION

Uterine leiomyoma is the most common benign tumor of the female reproductive tract.¹ Postmenopausal women with clinically enlarging uterine leiomyomas have a 1.5 fold increased risk of developing endometrial cancer.⁶ Although there is an isolated report about colorectal carcinoid tumors accompanied with uterine leiomyoma,⁷ we did not find any finding in the literature to suggest the relation between colorectal cancer and uterine leiomyoma. Genetic factors are also important in the etiology of colorectal cancers.^{2,3} Patients with a

family history of colorectal cancer have an increased risk for development of the same malignancy.³ In spite of our patient's young age there was no family history suggesting genetic cancer predisposition. Women with a history of breast, ovarian, or endometrial cancer are at increased risk of colorectal cancer.³ On the other hand there is no relationship between the colorectal carcinoma and uterine

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leiomyoma. Duplication may be accompanied with other nonurologic anomalies such as gastrointestinal tract and cardiopulmonary lesions.⁵ But we could not find any of these anomalies in our patient. We suggest that, before myomectomy, all other abdominal organs should be evaluated including laboratory and radiologic examination. We did not perform rectal sigmoidoscopy that is routinely indicated for patients with colorectal carcinoma, because our preoperative diagnosis was only uterine myoma and we did not expect such a pathologic condition before myomectomy. During the myomectomy procedure if there are any suspicious pathologic conditions such as pelvic adhesion, peritoneal implantation, endometriosis and ovarian cyst, it must be evaluated carefully, and treated surgically. If necessary, biopsy must be obtained from these lesion. After routine examination of the genital vicera and labarotory testing of the patient with uterine leiomyoma and low hemoglobin level, fecal occult blood testing (FOBT) should be performed for differential diagnosis of anemia.

In summary, when one of these lesions is determined, physician should be alert and carefully perform

examinations of other organs. In case of existence of some different symptoms and findings such as constipation and low hemoglobin concentration, gastrointestinal tract evaluation should be carried. This evaluation must include in some noninvasive tests such as FOBT, abdominal ultrasonography and comprehensive history of patient.

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