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Case Report Open Access

# Late Recurrence of Endometrial Carcinoma Mimicking Primary Colon Cancer-Case Report and Review of the Literature

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**Abstract**

The highest risk of recurrence following therapy for early stage endometrial cancer is within 3 years, and the most frequent sites of recurrence are the vaginal vault and the pelvis.

We describe an unusual case of a patient with recurrent endometrial cancer to the wall of the sigmoid colon and adjacent lymph nodes, 15 years after radical therapy for early stage disease. The patient was treated by sigmoidectomy and adjuvant megesterol acetate. She is well more than 4 years thereafter.

## Case Report

A 60 years old woman presented with post-menopausal bleeding and was diagnosed with endometrial carcinoma. She underwent total abdominal hysterectomy and bilateral salpingo-oophorectomy. Her history was remarkable for diffuse large B cell lymphoma that was treated with the CHOP regimen (doxorubicin, cyclophosphamide, vincristine and prednisone) 3 years earlier, achieving a complete response. Pathologically the endometrial tumor was a well differentiated endometroid carcinoma, invading only the inner third of the myometrium. No extra- uterine disease was seen.

The patient continued surveillance and was well for 8 years, when she was diagnosed with recurrent lymphoma. She was treated with the CHOP regimen, dextrazoxan and Rituximab, again achieving complete response. 7 years later the patient underwent a colonoscopy due to increasing constipation. A polypoid mass obstructing the lumen was seen 20 cm from the anal verge. Biopsy of the lesion was consistent with adenocarcinoma. CT scan of the pelvis, abdomen and chest noted only thickening of the lumen of the sigmoid colon, and no other suspicious lesions.

The patient underwent sigmoidectomy and recovered without sequel. 2 ulcerated lesions were seen in the bowl mucosa measuring 6 and 5 centimeters in greatest diameter. Microscopically the tumor involved the mucosa, muscularis and subserosal fat, with lymphovascular invasion. 5 out of 49 lymph nodes examined were involved by the tumor. Tumor morphology was consistent with endometroid carcinoma (Figure 1), and this was supported by positive immunohistochemistry staining for Keratin-7, estrogen and progesterone receptors and lack of staining for CDX-2 and keratin 20.

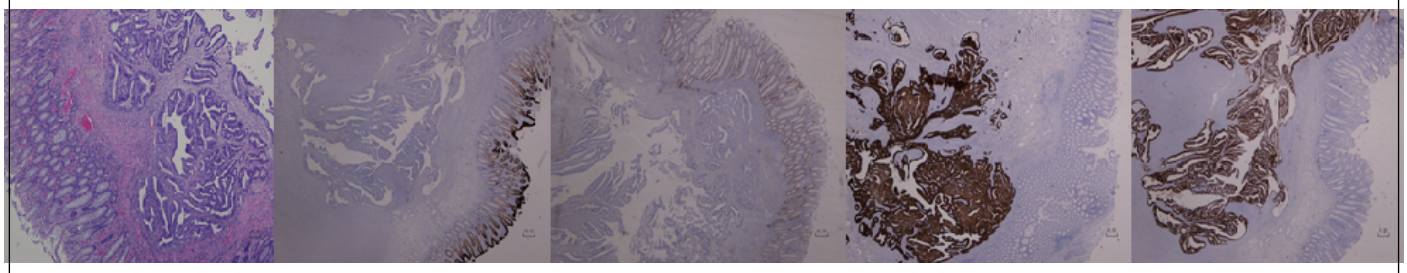

**Figure 1:** Pathological assessment of the surgical specimen [A] H and E staining showing endomtroid type adenocarcinoma in the bowl wall. Immune-histochemical staining with CDX2 [B] and keratin 20 [C] which stain the colonic mucosa, and with keratin 7 [D] and estrogen receptor [E] which stain endometrial carcinoma.

The patient was started on megestrol acetate and has been taking it for 52 months. Currently

she is well without evidence of recurrent disease.

## Discussion

We describe a case of endometrial carcinoma that recurred 15 years after surgery as an obstructing colonic lesion with lymph node metastases, mimicking primary colon carcinoma.

The most frequent sites of endometrial cancer recurrence are the vaginal vault and pelvis [1]. The highest risk pf recurrence in within the first 3 years [2], and very late recurrences are rarely seen.

Only 2 patients with isolated recurrences in the walls of hollow organs have been described in the English literature. Franchello et al. described a case of recurrent endometrial carcinoma to the wall of the rectum 28 years after primary surgery [3]. Tsurumaki et al. described a patient with recurrent endometrial carcinoma to the wall of the urinary tract 11 years after primary surgery [4]. Very late recurrences in the vaginal treated with radiotherapy have also rarely been described [5].

Our patient was initially treated for a low risk endometrial carcinoma. As expected, the other patients that were described with late recurrences also had low or intermediate primary disease - stage 1, grade 1 or 2 endometroid carcinomas. All patients, including our case, were treated with a curative intent for their recurrent disease and were well for a long period of time thereafter.

Tumor spread to the bowl wall probably occurs via hematogeneous spread. The sigmoid colon and the rectum are located in the pelvis; however, recurrences in these organs cannot be viewed as local recurrences. Following radical local treatment the risk of subsequent metastases is not known, and so is the benefit of adjuvant systemic treatment. The tumor in our patient has spread to the adjacent lymph nodes, suggesting a high risk for additional systemic metastases. However, the very long disease free survival suggests a slow-growing malignancy. Thus, the patient was started on adjuvant endocrine therapy and close surveillance.

## Conclusion

Early stage endometrial cancer can rarely recur in the bowl wall, mimicking primary colon cancer. In patients with isolated recurrence, radical surgical therapy seems beneficial.

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