

Case Report (VI)

Carcinoma Cervix Presenting as Bone Marrow Metastases – A Case Report.

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SUMMARY

Very few cases of carcinoma cervix presenting as bone marrow metastases have been reported in literature. This case report describes a patient of carcinoma cervix presenting as bone marrow metastases. The salient clinical, radiological and laboratory features have been discussed.

INTRODUCTION

Bone metastases from carcinoma cervix occur frequently. However, bone marrow metastases from squamous cell carcinoma of cervix is rare¹.

We present a case of 40 years old female who presented with bone marrow metastasis and was subsequently diagnosed as a case of carcinoma of uterine cervix.

Case :

A 40 years female presented with pain in right lower limb of one month duration. Physical examination revealed mild pallor. There was no organomegaly or lymphadenopathy.

Investigations Hb-10.5g; Total leucocyte count- $21.7 \times 10^9/L$; Platelets count - $300 \times 10^9/L$; MCV - 67.9 fl; MCH - 24.8 Pg; MCHC - 36.6 gm/dl & differential leucocyte count was within normal limits. Peripheral blood film showed no significant abnormality. Biochemical investigations were within normal limits

Radiological investigation showed pathological fracture neck femur (Right side).

Ultrasound abdomen showed space occupying lesion in liver which was reported as inflammatory. C.T. scan bone showed multiple punched out lytic lesions and clinical diagnosis of multiple myeloma was suspected. Urine for Bence Jones protein was negative. Serum electrophoresis showed hypoalbuminaemia with increased globulin fraction. No M-Band was seen. Serum alkaline phosphate was 391 IU/L.

Bilateral bone marrow aspiration and trephine biopsies were done. Right sided aspirate smears were suggestive of metastatic squamous cell carcinoma (Fig. 1) while left sided smears were particulate and showed all the three hemopoietic elements within normal limits. Right sided trephine biopsy showed tumour deposits of squamous cell carcinoma (Fig. 2) and cytokeratin for malignant cells was positive. Left sided trephine biopsy showed normal hemopoietic elements. No malignant cells were seen. Following this, gynaecological examination was advised which revealed an exophytic growth on uterine cervix. A biopsy of the growth confirmed the diagnosis of squamous cell carcinoma.

DISCUSSION

The use of bone marrow biopsy in non hematological malignancy is in staging of disease, monitoring responses to therapy and in identifying recurrences. A positive marrow advances the stage of disease obviating the need for further diagnostic procedures.²

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Fig. 1 :- Right sided bone marrow aspirate smears showing cluster of metastatic squamous cells (x40).



Fig. 2 :- Right sided trephine biopsy showing tumour deposits of squamous cell carcinoma (x40).



Marrow metastases have been described virtually in all types of malignancies.³ The most common hematological abnormality suggestive of infiltration of marrow, though not specific, is leucoerythroblastic picture.⁴ However in our case, all the hematological parameters were within normal limits.

The most common site of metastases in carcinoma of cervix is lumbar vertebrae followed by pelvic bones.⁵ In our case, the site of metastases were pelvic bones.

The incidence of bone marrow metastases in cancer of cervix is not known while bone metastases is documented in 0.5% of patients at presentation and in 16 % on autopsy.⁵

Gynaecological tumours rarely spread to the marrow, hence bone marrow trephine biopsy is not routinely undertaken in the staging work up of cervical cancers. However in our patient, carcinoma of cervix was diagnosed subsequent to the detection of metastatic squamous cell carcinoma in bone marrow.

Bone metastases in patients with cervical cancer is an infrequent finding which is associated with severe dysfunction and other signs of local and distant failure and short life expectancy.⁶

In absence of definite treatment recommendations, subjects are treated with radiotherapy and chemotherapy.

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