Combined chemotherapy and irradiation therapy after radical surgery for leiomyosarcoma of the vulva

A case report

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Summary

Radical surgery failed to remove a leiomyosarcoma of the vulva completely, and residual tumour was left. Chemotherapy did not inhibit further local growth or the occurrence of secondary lesions in the lung. Irradiation therapy of the pelvis, including the area of the tumour, then successfully inhibited any further local growth, as evidenced by a marked decrease in size and eventual disappearance of the mass; however, the patient succumbed to distant metastasis.

Case report

A 47-year-old multiparous white woman was referred to the gynaecological unit at Johannesburg Hospital in March 1984 with a diagnosis of leiomyosarcoma of the vulva. She had presented to her general practitioner with a 2-month history of a painlessly enlarging mass in the left labium majus. Believing that it was a Bartholin’s cyst, he had proceeded to incision and drainage of the cystic mass. Biopsy of the floor of the cyst, however, provided a diagnosis of leiomyosarcoma of the vulva. He then referred the patient to Johannesburg Hospital.

On admission the patient was in good physical condition, with the chest and abdomen normal. A mass measuring 6 x 6 cm was palpable in the left labium majus. The mass was non-tender, firm in consistency and minimally mobile. No inguinal lymph nodes were palpable. Extensive investigations at that time revealed no secondary tumour deposits.

Ten days after admission the patient underwent a radical vulvectomy with bilateral inguinal lymph node resection. However, at operation it was found that not all the tumour could be resected, since it was firmly adherent to the left subpubic ramus of the pelvis. Every effort was made to remove as much tumour as possible. Histological examination confirmed the presence of a leiomyosarcoma with numerous mitoses per high-power field present. The tumour extended to the lines of incision. No malignant cells were seen in the lymph nodes.

The patient made an uneventful recovery. However, in view of the fact that residual tumour was known to be present, as well as the high number of mitotic figures per high-power field, the size of the tumour and the extension of malignant cells to the lines of incision, chemotherapy consisting of doxorubicin 80 mg and dacarbazine 600 mg was given at 3-weekly intervals.

In June 1984, after three courses of chemotherapy, the patient noticed the reappearance of a nodule on the left side of the introitus. Examination revealed an irregular, non-tender mass, measuring 3 x 4 cm, which extended cephalad to involve the lower third of the vagina and was fixed to the left subpubic ramus of the pelvis. Despite the chemotherapy, chest radiographs confirmed the presence of secondary deposits in the lungs.

In view of the poor response of the tumour to radical surgery and chemotherapy it was decided to commence irradiation therapy immediately. This was given by means of a linear accelerator delivering 6 megavolts as a daily dose of 180 rad to a field 30 x 22 cm involving the entire pelvis and area of local recurrence. The total dose given was 5 500 rad.

The mass decreased dramatically in size and at the end of the course of irradiation no further tumour was palpable. However, despite the combination of chemotherapy and irradiation, and the good local response of the tumour, the secondary deposits in the patient’s chest continued to enlarge. Her condition deteriorated rapidly and she died in August 1984.

Discussion

All authors appear to agree that radical vulvectomy with bilateral lymph node resection is the cornerstone of treatment of sarcoma of the vulva. In the event of local recurrence, it is stated that persistent surgical excision may result in cure. However, whether adjuvant therapy should be offered is still uncertain. Di Saia et al. have suggested additive chemotherapy consisting of vincristine, actinomycin D and cyclophosphamide. This regimen has also been suggested for advanced uterine sarcomas. However, it is the policy of the soft-tissue sarcoma clinic at the Johannesburg Hospital to administer doxorubicin and dacarbazine to all patients with sarcomas.

It has been stated, and the view is generally held, that radiotherapy does not alter the evolution of the disease. However, as suggested by Smith et al., and certainly as substantiated in our case, leiomyosarcoma of the vulva may in fact respond dramatically to radiation therapy; possibly all patients with a leiomyosarcoma of the vulva should be offered adjuvant combined chemotherapy and irradiation postoperatively.

We feel that in future the management to be recommended in these cases is: (i) radical surgery — radical vulvectomy with bilateral lymph node resection; and (ii) postoperatively — deep radiotherapy (5 500 rad), doxorubicin and dacarbazine.

REFERENCES


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Two-dimensional echocardiography in the diagnosis of amoebic pericarditis

A case report

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Summary

A patient’s pericardial effusion was confirmed by two-dimensional echocardiography, which also indicated an amoebic liver abscess as the source. The importance of routine liver scanning in investigation of pericardial effusion is emphasised.

Case report

A 62-year-old man was admitted to hospital moribund, with cardiac tamponade. He had a sinus tachycardia of 140/min, an unrecordable blood pressure, a jugular venous pressure greater than 15 cm in the erect position, palpable apex beat with increased cardiac dullness and on auscultation soft heart sounds and an extracardiac splashing sound were heard. The respiratory rate was 50/min and there was tender hepatomegaly of 14 cm. There was a 3-week history of cough, dyspnoea and shoulder pains, and a week before referral the patient had been seen at another hospital with pyrexia of 39°C, blood pressure 100/70 mmHg and a normal chest and heart. An enlarged tender liver became larger during the week. He had been referred with the provisional diagnosis of cardiac tamponade. Chest radiographs taken before referral showed a minimal increase in the size of the heart shadow. In view of the tamponade, immediate echocardiography was arranged. The patient’s condition was such that ultrasonography was performed while he was seated in a wheelchair. A pericardial effusion was confirmed and immediate pericardiocentesis was performed.

The aspirate had the appearance of anchovy sauce and so the patient was moved to an examination couch for ultrasonography of the liver. This showed a large liver abscess (Fig. 1) communicating with the pericardial sac; further aspiration drained 500 ml of anchovy sauce material. The patient improved, the pulse rate falling to 112/min and his blood pressure rising to 90/60 mmHg with 10 mm of paradoxus. He was treated with intravenous and oral metronidazole and oral chloramphenicol and improved over the next 48 hours. Two days after admission ultrasonography was repeated and although the pericardial effusion was still present, no abscess cavity could be found in the liver. Three days after admission the patient complained of chest pain, the pulse rate was 120/min, blood pressure 100/70 mmHg with pulsus paradoxus of 10 mm, jugular venous pressure raised by 10 cm and increased cardiac dullness. To ensure adequate drainage of the pericardial sac an inferior pericardiotomy was performed and a rubber catheter was left in the pericardial sac for 4 days’ of underwater drainage. When the drain was removed a small amount of clear straw-coloured fluid flowed from the wound. The patient made an uneventful recovery. The anchovy sauce aspirate grew Escherichia coli.

Fig. 1. Sub-xiphisternal view of liver and heart (two-dimensional ultrasonographic sector scan). The liver abscess (abs) is seen communicating with the pericardial sac (Pe) (rv = right ventricle; Li = liver).