

Inguinal Fungating Mass in Carcinoma Ovary- A Rare Case Report.

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Abstract: Cancer that forms in the tissue of the ovary is called ovarian cancer. Ovarian tumours, other than highly malignant sarcomas and teratomas which spread by the blood stream to the lungs, rarely produce remote metastasis. The lymph nodes most likely to be involved are the aortic group. The incidence of inguinal lymphadenopathy from ovarian carcinoma at presentation is rare. We present a case of 55 year old female patient who presented with right inguinal fungating mass in a case of carcinoma ovary with raised CA-125 levels and review of relevant literature.

INTRODUCTION

Groin swelling has lot of differentials and if lymphadenopathy is there, differential diagnosis involves infectious processes, immunologic conditions, malignant processes, storage diseases, and a variety of miscellaneous disorders. The neoplastic causes include lymphoma, and metastatic disease usually due to primary tumors of the genital (vulva, vagina, and cervix) or anorectal locations, lower extremity melanoma, and basal cell or squamous cell skin carcinoma. Lymphadenitis may be caused due to various bacterial infections of skin and deeper tissues of the lower limb and genitalia. Incisional biopsy of the mass with immunohistochemistry will usually bring out the diagnosis and the primary lesion in neoplastic disease whereas tissue culture of the mass may be employed in certain infective causes¹.

In cases of carcinoma ovary, the routes of lymphatic spread are in 3 different directions. a) within the infundibulo-pelvic ligaments to the paraaortic and paracaval lymph nodes b) sub ovarian plexus to the obturator and pelvic lymph nodes and c) and supposedly through bilateral round ligaments to external iliac and deep inguinal lymph nodes. Isolated inguinal lymph node metastases without any extended intra-abdominal spread is a rare event in patients with ovarian carcinoma². This case report is about a patient who primarily presented with a fungating inguinal mass which on biopsy was traced to be inguinal node with metastatic deposits and the primary was later found to be ovary.

CASE REPORT

A 55 year old female, a known hypertensive on regular treatment presented with mass in right groin since 1 year. The mass was initially small in size and progressively grew to the present size over 1 year. There was no history of lump anywhere else in the body, per vaginal discharge or bleeding. General physical and per rectal examination was normal. Per vaginal examination was normal. On local examination 10 x 10 cm large fungating mass was present in the right inguinal region (Fig 1). Blood investigations other than TLC (19,700) were normal.

Colonoscopy done was normal, PAP smear showed few cells with high Nucleo- Cytoplasmic ratio. CT scan revealed large fungating mass in right inguinal region, pelvic and inguinal lymph node enlargement and bilateral adnexal lesions (Fig.1). MRI pelvis revealed large fungating right inguinal mass, pelvic and inguinal lymph node enlargement, bilateral adnexal lesions and bulky posterior cervix (Fig. 1). PET scan done showed metabolically active disease in left adnexal mass (Fig. 1).

Cervix biopsy revealed acute on chronic cervicitis. Biopsy of the fungating mass was done which showed metastatic carcinomatous deposits in inguinal lymph nodes.

CA-125 levels were raised (679 IU/L). Diagnosis of carcinoma ovary with inguinal metastasis was made. Plan for the patient is chemotherapy followed by debulking surgery of mass and later on total hysterectomy with bilateral salpingo-oophorectomy for staging and prognosis of tumor.

DISCUSSION

Most ovarian cancers are either ovarian epithelial carcinoma or malignant germ cell tumor. Ovarian cancer with groin lymph node metastasis is rare. In rare cases, ovarian cancer can directly metastasize to groin even in relatively initial tumor growth phase. PET scan may play a role in diagnosis of occult



Figure 1 : Large inguinal mass (L) with images of MRI (L), CT (R) and PET (R).

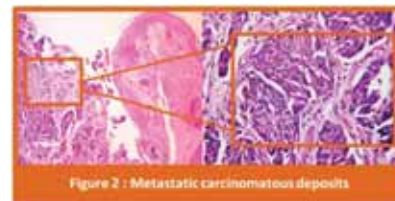


Figure 2 : Metastatic carcinomatous deposits

ovarian tumor³. Distant metastasis is unusual at presentation and during the course of ovarian cancer. The most common site for distant metastasis are pleura, liver, lung and lymph nodes⁴. Primary ovarian lymphatic drainage occurs via the infundibulopelvic ligament to paraaortic nodes⁵. Involvement of pelvic lymph nodes is a risk factor for recurrence of epithelial ovarian cancer in ipsilateral inguinal lymph nodes. Surgical excision of the inguinal lymph node metastasis may play a role in improving the survival of these patients. Inguinal lymph node metastasis is a rare site of involvement in both primary and recurrent ovarian cancer⁶. The most common route of spread in epithelial ovarian carcinoma is lymphatic dissemination and transcelomic spread to adjacent viscera. Lymphatic drainage occur mainly via infundibulopelvic ligament to paraaortic lymph nodes; hence these nodes are at highest risk of involvement through lymphatics that run parallel to ovarian vessels less commonly, lymphatics traverse the subovarian plexus in the broad ligament to the obturator and pelvic lymph nodes. In addition lymph vessels that follow the round ligament of the uterus pass through the inguinal canal and drain in to superficial inguinal lymph nodes and can also reach the contralateral ovary by traversing across the uterine fundus⁷.

The prognostic significance of lymph node metastasis in ovarian cancer is still controversial and researches have paid most attention to investigating the prognostic impact of paraaortic lymph node metastasis⁸. The purpose of reporting this case is to delineate the importance of considering rare possibilities like ovarian carcinoma as the differential diagnosis in cases of inguinal lymphadenopathy in females.

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