

Hydronephrosis Secondary to Uterovaginal Prolapse and Mixed Malignant Mullerian Tumor-An Interesting Case Report

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Abstract: This is a patient's convoluted presentation with Mixed Malignant Mullerian Tumor (MMT) who came to us as a case of hydronephrosis and a detailed clinical workup of her renal condition led us to diagnosing her as suffering from uterovaginal prolapse with Mixed Malignant Mullerian Tumor side by side. In the real sense, her actual malady was masked by her kidney condition and after surgery, which is the primary treatment¹, she was found to have Malignant Mixed Mullerian Tumour in its early stage. The patient was operated and followed up and post operatively she did well.

Key words: Hydronephrosis, uterovaginal prolapse, Malignant mixed Mullerian tumour (MMT)

CASE PRESENTATION

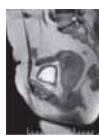
A 60 year old para 4 Kashmiri woman, presented to an Urologist with complaints of a recurring bilateral flank pain of few months duration. This was associated with a feeling of being unwell. All her deliveries were normal vaginal births with postpartum period being uneventful. She was post menopausal for the past 8 years with no history of postmenopausal bleeds. Physical examination revealed a moderately ill looking woman who was not wasted and mildly pale. The abdomen was soft and non-tender with no palpable mass. She was evaluated with an Ultrasound KUB, X ray KUB region and Urine examination. Ultrasound showed bilateral grade 11 hydronephrosis and hydroureter with bulky uterus, X ray KUB did not pick up any radio opaque shadow in KUB region and urine examination revealed full field pus cells.

In her diagnostic work up, her haemoglobin was 10.5 and the rest of her haemogram was within normal limits. Her renal function tests and liver function tests were within normal limits. Her urine for culture and sensitivity was sterile. IVU done showed a grade 3 hydronephrotic left kidney with hydroureter with delayed contrast excretion plus grossly dilated calyceal system of right kidney. No calculus seen. RENAL SCINTIGRAPHY displayed grossly dilated PCS of Rt. kidney, enlarged left kidney with decreased perfusion. Gfr =63.3. Urologists initial impression was high pressure bladder. Meanwhile patient was referred to us for bulky uterus. A speculum vaginal examination revealed a grade 3 uterovaginal prolapse with a congested cervix. She had a mixed consistency discharge from the vagina which was non-foul smelling. A bimanual examination revealed a non tender bulky uterus with mildly restricted mobility and free fornices. We decided to go for MRI pelvis and diagnostic D & C.

MRI pelvis with GAD study showed heterogeneously enhancing mass lesion within endometrial cavity extending into cervical canal as described likely malignant.

The patient was counseled about treatment and further management and consented to a diagnostic D&C, the histopathology of which revealed Mixed Malignant Mullerian pathology. She subsequently underwent laparotomy and a radical hysterectomy was performed along with repair of prolapse. Intraoperatively it was confirmed that uterovaginal prolapse was the cause of hydronephrosis. There was no parametrial infiltration per op and no ascites either. Vaginal cuff was not involved.

HPE of the specimen revealed carcinosarcoma (*Malignant mixed mullerian tumour*). Myometrial invasion less than 50 percent, cervix not involved, margins uninvolved, no regional lymph node metastasis. Primary tumor –



T1aN0M0.

Postoperatively, the patient fared excellently. On follow up repeat ultrasounds showed improvement in hydronephrosis.

DISCUSSION

The incidence of hydronephrosis and hydroureter is variable. Recent literature varies prevalence at 25/323 (7.7%) and 31/189 (17.4%)^{1,2,3}. The hydronephrosis can be unilateral also. The prevalence of hydronephrosis is higher in older patients and increases with increasing severity of prolapsed⁴. Malignant mixed Mullerian tumours are commonly found in post menopausal women with utero-cervical cancer but what sets this patient's situation apart is her oblique presentation as a kidney patient and her evaluation and diagnosis went all around to the end point of genital cancer. Histopathology of her cancer revealed an epithelial and sarcomatous component and these tumours are aggressive, but in her case was caught early. The hydronephrosis was a result of the drag of the genital organ prolapse which lead to stretching of the ureters and obstructive nephropathy.

Managing of this category of malignancy is challenging, especially in low resource settings, due to the relative rarity of this disease.^{5,6} Due to this, clearly defined guidelines for management are not defined and thereby the lack of evidence of treatment protocol outcomes. Imaging techniques and modalities are a potent tool in the diagnostic armamentarium. Early diagnosis and timely surgery followed by radiotherapy as an effective back up, is the key⁷.

CONCLUSION

This case clearly gives us an example that when a postmenopausal women comes with vague urological & gynaecological complaints of immediate or near recent onset and has other apparent systemic manifestations that can mislead or be misinterpreted, it is wise to be extra vigilant and be aware of the human body's subtle masquerades to hide the primary root of the main problem.

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