Primary lymphoma of the uterine cervix: a rare constellation of symptoms

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DESCRIPTION

A 40-year-old woman, multiparous, presented to the emergency room with insidious on-setting of pain and swelling of the right lower extremity. The initial workup diagnosed deep venous thrombosis of the affected limb caused by a pelvic tumorous mass originating from the uterine cervix. Anticoagulation therapy was initiated and she was transferred to our gynaecology department for subsequent investigation. On physical examination there were no abnormal findings, namely palpable masses or lymphadenopathies. However, on pelvic examination we detected a bulky cervical mass and carried out an incisional biopsy. The histology report revealed a non-Hodgkin's follicular, large B-cell lymphoma (figure 1). The immunohistochemical study was positive for CD20, CD10, bcl2 and bcl6 and negative for CD5, CD3, CD23 and cyclin D. The pelvic MRI (figure 2) showed a heterogeneous cervical mass, measuring 7.9×7.6×6.9 cm³, with stromal disruption and apparent involvement of the bladder, but not of the uterine corpus and rectum. Venous and lymphatic drainage was

compromised by coalescent pelvic lymphadenopathies associated with right hydronephrosis due to ureter invasion.

The absence of further findings in the thorax CT scan, bone scintigraphy and myelogram led us to stage the tumour as IIE using the Ann Arbor system. She received one cycle of rituximab-cyclophosphamide, doxorubicin, vincristine and prednisone (R-CHOP) followed by eight cycles of rituximab-cyclophosphamide, vincristine and prednisone with complete clinical and imagiological remission.

There was no evidence of clinical recurrence until 45 months, later on a follow-up consultation, she reported of postcoital vaginal bleeding and amenorrhoea. On pelvic examination, the vaginal fornices were obliterated by a cervical mass occupying the proximal half of the vagina. The Pap smear was negative and vaginal ultrasonography confirmed the presence of such mass. However, it was not clear as to its origin being cervical or corporal. The pelvic CT scan and positron emission tomography revealed a hypodense cervical mass with 7×7 cm² compatible with a relapse of the primary non-Hodgkin's cervical lymphoma. In light of this diagnosis, the patient refused surgery, but agreed to a further four cycles of R-CHOP followed by pelvic radiotherapy achieving partial response. Presently, 3 months after ending the radiotherapy treatment, she is asymptomatic.

Figure 1 Uniform, strong CD20 positivity of the neoplastic cells.

Figure 2 Pelvic MRI showing a diffuse hypodense uterine cervical mass, lymphadenopathies causing right hydronephrosis and secondary invasion of the upper femur.

Learning points

- ▶ Female genital tract lymphomas are rare, accounting for 1.5% of extranodal non-Hodgkin's lymphomas and <0.5% of gynaecological cancers.^{1 2}
- ▶ Median age of the affected patients is 40 years (ranging from 27 to 80 years) and the most usual presenting symptoms are vaginal bleeding, perineal discomfort and persistent vaginal discharge.³ This case report, however, has a unique presentation, as its symptoms and signs are associated with the presence of a mass.
- ▶ The actual diagnosis may be difficult to determine, requiring a deep cervical biopsy, but it is of utmost importance as the adequate therapeutic approach is controversial.^{1 3}

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also participated in drafting the manuscript and critically revised the manuscript. JC received and studied the histological samples and revised the work. EP and AR were responsible for the overall content as guarantors.

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