Clear cell adenocarcinoma of the colon arising in endometriosis: a rare variant of primary colonic adenocarcinoma

Colonic adenocarcinomas composed predominantly or exclusively of cells with clear cytoplasm are extremely rare. Considerable diagnostic difficulties can arise in distinguishing primary colonic clear cell adenocarcinoma and metastatic carcinoma from sites such as ovary or kidney. Here, we describe a case of primary colonic clear cell adenocarcinoma that probably arose in endometriosis. The possible presence of endometriosis was only appreciated on review and after the examination of multiple levels and extra histological sections.

A 65 year old woman presented with cramping lower abdominal pain and the passage of blood and mucus from the rectum. Barium enema showed an apparently malignant stricture of the rectosigmoid and she underwent an anterior resection. Preoperative serum CA125 was not measured. At surgery, the clinical impression was of a primary colorectal tumour. Small haemorrhagic nodules were present on the pelvic and abdominal peritoneum, suggestive of endometriosis. There were multiple metastatic lesions within the liver. Both ovaries and kidneys appeared normal.

The surgical specimen consisted of a 30 cm length of colon. A polyoid ulcerated tumour covered the mucosa and infiltrated through the full thickness of the colonic wall. Histology of the tumour showed an ulcerated surface. The tumour was composed entirely of cells with abundant clear cytoplasm and prominent cell membranes (fig 1A). Several growth patterns were present. Much of the tumour had a pronounced papillary pattern, with hyalinised cores covered by tumour cells (fig 1A). Tubular and solid areas were also identified. There was moderate nuclear pleomorphism and low mitotic activity, with a formal mitotic count revealing 1–2 mitoses/10 high power fields. Areas of necrosis were present and there was extensive perineural and lymphatic away from the tumour. Calcified psammoma bodies and intracytoplasmic psammoma bodies and intracytoplasmic lipid were also present. The adjacent colonic mucosa showed no dysplasia. The tumour infiltrated through the full thickness of the colonic wall into the surrounding fat.

The tumour was situated within the fat, on the external surface of the tumour, a cystic structure was present. This had an epithelial lining, which focally consisted of a single layer of plump cells with abundant eosinophilic cytoplasm (fig 1B). These cells merged with a single layer of cells with abundant clear cytoplasm, similar to those seen within the main tumour. Surrounding the cyst a fibrous stroma was present but no definite endometrial type stroma was identified. Histology of a liver biopsy taken at the time of laparotomy showed metastatic clear cell carcinoma.

Immunohistochemical staining showed diffuse strong positive membrane staining of tumour cells with CA125 (fig 2A) (CIS Bio International, High Wycombe, UK). There was also diffuse strong positivity for cytokeratin 7 (CK7; Dako, Ely, UK) (fig 2B), but no staining for CK20 (Dako), which stained adjacent normal colonic mucosa. Staining for type IV collagen (Dako) and laminin (Dako) showed positivity of the hyalinised cores within the papillary areas. The cells lining the cystic structure stained strongly with BerEP4 (Dako).

We consider it probable that the colonic clear cell carcinoma in this case arose in endometriosis. This is based on the presence of a cystic structure at the deep aspect of the tumour, which was lined by cells with eosinophilic cytoplasm. Although endometrial type stroma was not identified, the morphological findings are similar to those that can be seen in long standing endometriosis. In addition, at laparotomy, there was a clinical impression of endometriosis surrounding the tumour with multiple small haemorrhagic pelvic and abdominal peritoneal nodules. The possible importance of this cystic structure was only appreciated after review of the case and examination of multiple levels and extra histological sections. A possible transition was seen within the epithelial lining of the cyst from cells with eosinophilic cytoplasm, suggestive of endometriosis, to cells with abundant clear cytoplasm, similar to those seen within the main tumour. One of us (WGM) has previously observed similar features in ovarian clear cell carcinoma arising in endometriosis. It was thought possible that the cystic structure could have been a mesothelial lined cyst, but this was ruled out by strong positivity of the lining cells for BerEP4.

Malignant transformation in endometriosis was first described by Sampson in 1925, who recommended that three criteria be met for a definitive diagnosis, namely: (1) there should be histological evidence of endometriosis in close proximity to the tumour; (2) no other primary site of malignancy should be identified; and (3) the histological appearance of the tumour should be compatible with an origin in endometriosis. In our patient, only the second and third of these criteria were fully satisfied. However, these criteria are restrictive because in many cases the tumour may completely obliterate pre-existing endometriosis, making it impossible to confirm its presence unequivocally. Tumours that can arise in endometriosis include endometrioid adenocarcinoma, clear cell carcinoma, squamous carcinoma, endometrioid stromal sarcoma, adenosarcoma, and carcinomas.

Clear cell adenocarcinoma of the ovary is associated with pelvic endometriosis in 50–70% of cases and a quarter of ovarian clear cell carcinomas can be shown to arise in endometriotic cysts. It should therefore be no surprise if occasionally a clear cell carcinoma of ovarian type should arise in extragynocarcinomas. In our patient, the strong positivity of tumour cells with CA125 provides evidence of Mullerian derivation. Although focal immunoreactivity can be present in primary colonic carcinoma, positivity to this extent is unusual. The strong immunoreactivity for CK7, combined with CK20 negativity, is also in keeping with an ovarian type primary, the converse pattern of staining being expected in a primary colonic neoplasm. A further histological pointer to an ovarian type tumour was the presence of calcified psammoma bodies. The ovaries and kidneys appeared grossly normal at laparotomy, helping to exclude the possibility of a colonic metastasis from an ovarian or renal primary.

In summary, we describe an unusual case of primary colonic clear cell adenocarcinoma that has probably arisen in extragynocarcinomas. When confronted with an extragynocarcinomas tumour with the histological appearances described above, pathologists should consider a primary of ovarian type and an origin in endometriosis. The demonstration of endometriosis might require the examination of multiple levels and extra histological sections. Even then, residual endometriosis might not be definitely dem-
onstrated because it may be completely obliterated by tumour. Confirmation that a tumour is of ovarian type may be of critical importance, because chemotherapeutic regimens will differ from those administered for a typical colonic adenocarcinoma.

W G MCCLAGGAGE
V N DESAI
P G TONER
Department of Pathology, Royal Group of Hospitals Trust, Grosvenor Road, Belfast BT12 6BH, Northern Ireland

C H CALVERT
Department of Surgery, Ulster, North Down and Ards Hospitals Trust, Dunonald BT16 0RH, Northern Ireland

Correspondence


Retroperitoneal extraskelatal osteosarcoma

Extraskelatal osteosarcoma are rare malign teaspoons mesenchymal neoplasms characterised by the direct production of osteoid or bone by tumour cells. By definition, they are located away from the skeleton and may be resected surgically. The most common location of these tumours is the lower extremity, especially the thigh, followed by the upper extremity and the retroperitoneum.

We report the radiological presentation of a retroperitoneal extraskelatal osteosarcoma, which may be helpful in the consideration of its differential diagnosis. A 68 year old man presented with a painless palpable mass in the right side of the abdomen. A previous trauma was denied. The patient was not on anticoagulant medication. Except for a cholecystectomy in 1986, his medical history was unremarkable. Physical examination revealed a firm mass measuring approximately 10 × 10 cm. Laboratory findings were within normal limits, with the exception of a slightly raised alkaline phosphatase concentration of 140 U/litre (normal range, 40–120).

Plain radiography of the abdomen demonstrated a large ill defined dense lesion projecting over the right side of the pelvis. Contrast enhanced helical computed tomography (CT) of the abdomen identified a large, non-homogeneous soft tissue mass in the right side of the retroperitoneum (fig 1). The tumour measured 9 × 12 × 14 cm. The main part of the mass was predominantly mineralised; the lateral side showed a large soft tissue mass with low density in the centre suggestive of necrosis or haemorrhage. The radiological features suggested an osseous, rather than chondroid, nature because of the poorly defined and homogeneous aspect of the mineralisation. The tumour border of the mass was in close anatomical proximity to, but clearly separate from, the adjacent right kidney on three dimensional reformattting. The tumour definitely did not arise from adjacent osaceous structures and the psoas muscle was compressed by the tumour.

Figure 1  Axial contrast enhanced helical computed tomography (CT) scan of the abdomen demonstrated a large mass with extensive mineralisation in the mediasnal part of the tumour, as well as an area of decreased attenuation laterally compatible with necrosis. The psoas muscle is compressed. However, the tumour does not seem to arise from this structure.

Magnetic resonance imaging (MRI) demonstrated a mass surrounded by a pseudocapsule near but not originating from the lower pole of the right kidney. In addition to the ossified zone, the mass contained areas of necrosis, old haemorrhage, or secondary lacunae formation filled with protein substance indicated by intermediate signal intensity on T1 weighted sequences and very high signal intensity on T2 weighted images. Based on the clinical history and radiographic findings, the diagnosis of an extraskelatal osteosarcoma was suggested.

Macroscopically the tumour specimen revealed a 19 × 12 × 9 cm tumour including the resected margins, partly bony, partly firm, partly weak of consistency, with a white pink colour. There was a large cystic area, measuring 7 × 6 cm filled with serous fluid.

Microscopically the tumour was composed of storiform oriented bundles of spindle shaped tumour cells, admixed with areas of polygonal shaped tumour cells with abundant deposition of primitive osteoid matrix in between (fig 1). The osteoid matrix showed a trabecular arrangement and was focally admixed with chondroid forming areas. In these fields, the tumour cells showed lacunae. In all areas the tumour cells showed moderate pleomorphism and mitotic activity of up to eight mitoses per 10 high power fields. No areas of necrosis were seen. No relation with a pre-existing nerve could be documented. Immunohistochemically, the tumour showed diffuse reactivity with antibodies against vimentin and focal reactivity with antibodies against the S-100 protein in the chondroid containing fields and the spindle cells. Antibodies directed against neurofilaments and p53 showed no reactivity. The differential diagnosis included high grade extraskelatal osteogenic sarcoma, malignant peripheral nerve sheath tumour with heterologous elements, and dedifferentiated liposarcoma. A combined liposarcomatous part was not identified. Because of the lack of an identifiable nerve sheath, suggestive of a primary nerve sheath tumour, focal reactivity only with S-100, and neurofilaments being negative, the diagnosis was extraskelatal osteogenic sarcoma.

Extraskelatal osteosarcoma is a rare tumour, constituting approximately 1% of all soft tissue sarcomas and approximately 4% of all osteosarcomas.1–3 Although primary osteosarcomas of bone occur predominantly in the first decades of life, extraskelatal osteosarcomas are rarely encountered under 40 years of age.4

The pathogenesis of the tumour is unclear; the tumour may occur and be induced at sites that have received previous radiotherapy. In addition, a history of trauma has been reported in 12–30% of patients. There are cases described in which extraskelatal osteosarcoma is presumed to be preceded by myositis ossificans lesions.4–6

Few reports of extraskelatal osteosarcoma have detailed the radiological findings of this rare neoplasia.7–10 The imaging techniques showed a large soft tissue tumour, for a large part, demonstrating ossification, located in the retroperitoneum. Another primary osteosarcoma of bone was not found elsewhere in the body. On T1 weighted sequences the tumour was hypointense and isointense compared with muscle, and exhibited high signal intensity on T2 weighted imaging in the lateral part of the tumour, suggesting necrosis, haemorrhage, or secondary lacunae formation filled with protein substance. This latter correlated with the histological findings. Compression but no involvement of the psoas muscle, as visualised by CT, was confirmed.

The radiological differential diagnosis of extraskelatal osteosarcoma includes benign and malignant lesions that show mineralisation. The most important benign lesions are calcified haematomas and myositis ossificans. Several mesenchymal tumours can show reactive or metaplastic bone formation—for example, synovial sarcoma, epithelioid sarcoma, liposarcoma, and malignant peripheral nerve sheath tumour.1 Both possible benign lesions could be ruled out. The first because the patient definitely denied previous trauma. Furthermore, the patient did not use anticoagulant medication and the aorta was normal on all studies. Myositis ossificans was unlikely because there was no previous trauma and because of the large size of the lesion. Most myositis ossificans lesions measure 3–6 cm in

Figure 2  Photomicrograph of the tumour matrix demonstrates the spindle shaped tumour cells with abundant deposition of osteoid matrix (haematoxylin and eosin stained; magnification, ×200).
high expressing tumour as a low expressing tumour—is more important than misclassification between adjacent categories, a weighted κ statistic might be appropriate. It should also be remembered that the quick method of scoring will be subject to observer variability, but the figures in the paper (for example, figs 8 and 9) demonstrate that it is an obvious difference in the intensity of staining, rather than interpretative, variation, that accounts for the difference in the results.

None of these minor points should detract from the very important results of Rhodes et al., which have important implications for any laboratory running an immunohisto-chemical service assessing oestrogen and progesterone receptor expression.

S S CROSS
Section of Pathology, Division of Genomic Medicine,
University of Sheffield, Beech Hill Road,
Sheffield S10 2RX, UK

The authors’ reply

We would like to thank Dr Cross for his interest shown in our article and for his kind and constructive comments.

Cohen’s κ statistic was used in our study to compare the degree of agreement between the immunohistochemical (IHC) sensitivity for oestrogen receptors (ER) achieved by 152 laboratories on in house breast tumours, to that achieved by the UK National External Quality Assessment Scheme for Immunocytochemistry (NEQAS-ICC) organising laboratories’ IHC assay on spare sections from the very important results of Rhodes et al., which have important implications for any laboratory running an immunohisto-chemical service assessing oestrogen and progesterone receptor expression.

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S S CROSS
Section of Pathology, Division of Genomic Medicine,
Dietary dangers: ingestion of a bread bag clip

During a routine postmortem evisceration, a segment of jejunum of approximately 20 cm was noted to be doubled back upon itself, with fibrous adhesions joining the two halves of the loop creating a “U” shape. The segment of jejunum was opened along the mesentery, to highlight muscle, were sliced across, the cut running parallel to the base of the eyelet; there was no muscularis propria running over the bridge of tissue that retained the clip. The muscularis mucosae passes around and deep to it. There was a small amount of muscle within the tissue bridge itself but this did not appear to run in continuity across the top of the tissue bridge. The mechanism of formation of this loop is difficult to determine. The bread bag clip has sharp tooth-like pincers, and would be difficult to determine. The bread bag clip has caught up the small bowel wall if attachment occurred. Re-epithelialisation of the bowel wall is recognised to take place after crush injury; this phenomenon has been exploited in the past in double barrelled colostomy formation and closure in the Paul-Mikulicz surgical procedure (now obsolete). The patterns of the muscularis propria and mucosae shown of a mucosal bridge through the clip suggest that it had been present in this particular segment of jejunum for a considerable time. Its presence was unrelated to the cause of death, which was given as coronary artery atherosclerosis, and there was no evidence to suggest that the presence of the bread bag clip had caused problems during life.

The segment of jejunum removed was sliced across, the cut running parallel to the places circles, to cut the mucosal bridge longitudinally. Sections were submitted for histopathological examination. A haematoxylin and eosin stain and an actin immunocytochemistry stain, to highlight muscle, were studied (fig 2). Although there was considerable postmortem autolysis, it was evident that the bread bag clip had been held within a mucosal lined eylet. The actin stain showed the muscularis propria curving to run below the base of the eylet; there was no muscularis propria running over the bridge of tissue that retained the clip. The muscularis mucosae similarly did not run in continuity across the top of the eylet; the eylet was within the lamina propria and the muscularis mucosae passes around and deep to it. There was a small amount of muscle within the tissue bridge itself but this did not appear to run in continuity across the top of the tissue bridge.

The presence was unrelated to the cause of death, which was given as coronary artery atherosclerosis, and there was no evidence to suggest that the presence of the bread bag clip had caused problems during life.
Retroperitoneal extraskeletal osteosarcoma

C S P Van Rijswijk, J G S T A Lieng, H M Kroon and P C W Hogendoorn

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