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.\(^1\)\(^2\) 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 crampy 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 protruded from the mcosa 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 lymphovascular permeation, both within the tumour and within submucosal and serosal lymphatics away from the tumour. Calfied psammoma bodies and intracytoplasmic periodic acid Schiff (PAS) positive eosinophilic hyaline inclusions were also present. The adjacent colonic mucosa showed no dysplastic features. The tumour infiltrated through the full thickness of the colonic wall into the surrounding fat.

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 excluded by strong positivity of the lining cells for BerEP4.

Malignant transformation in endometriosis was first described by Sampson in 1925,\(^6\) 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 demonstrate its presence unequivocally. Tumours that can arise in endometriosis include endometrioid adenocarcinoma, clear cell carcinoma, squamous carcinoma, endometrioid stromal sarcoma, adenosarcoma, and carcinosarcoma.\(^6\)\(^7\)

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 extratubal endometriosis, and several such cases have been reported.\(^8\) Endometrioid type adenocarcinoma has occasionally been described arising in colonic endometriosis,\(^9\) and we are aware of a single previous report of clear cell carcinoma arising in endometriosis of the sigmoid colon.\(^9\)

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.\(^10\) 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 extratubal endometriosis. When confronted with an extratubal 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 is of clinical importance, because chemotherapeutic regimens will differ from those administered for a typical colonic adenocarcinoma.

W G McCULLAGH V DE SI AL P G TON ER
Department of Pathology, Royal Group of Hospitals Trust, Grosvenor Road, Belfast BT12 6BH, Northern Ireland

C H CALV E RT
Department of Surgery, Ulster, North Down and Ards Hospitals Trust, Dundonald BT12 6HR, Northern Ireland


Retroperitoneal extraskeletal osteosarcoma

Extraskelatal osteosarcomas are rare malignant mesenchymal neoplasms characterised by the direct production of osteoid or bone by tumour cells. By definition, they are located by the direct production of osteoid or bone by osteosarcoma. Retroperitoneal extraskeletal osteosarcoma, although not rare, was not identified. Because of the lack of an identifiable nerve sheath tumour with heterologous elements, and differentiated liposarcoma. A combined sarcomatous part was not identified. Also, the lack of an identifiable nerve sheath tumour with heterologous elements, and differentiated liposarcoma. A combined sarcomatous part was not identified. However, the tumour does not seem to arise from those administered for a typical colonic adenocarcinoma.

Correspondence

W G McCULLAGH
Department of Pathology, Royal Group of Hospitals Trust, Grosvenor Road, Belfast BT12 6BH, Northern Ireland

C H CALV E RT
Department of Surgery, Ulster, North Down and Ards Hospitals Trust, Dundonald BT12 6HR, Northern Ireland

Figure 1 Axial contrast enhanced helical computed tomography (CT) scan demonstrates a large mass with extensive mineralisation in the medial 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.

Figure 2 Photomicrograph of the tumour mass demonstrates the spindle shaped tumour cells with abundant deposition of osteoid matrix (haematoxylin and eosin stained; magnification, ×200).
diameter. Moreover, this lesion demonstrated ossification throughout a large part of the tumour and not at the periphery as is seen in myositis ossificans. Furthermore, the adjacent muscles were normal. Differentiating our patient’s tumour from other malignant retroperitoneal sarcomas that can show bone formation is more difficult.

In conclusion, this case demonstrates that radiological imaging can help in the diagnosis of extraskelatal osteosarcoma. However, a biopsy is mandatory for a definitive diagnosis.

C S P VAN RISWIJK
J G S T A LIENG
H M KROON
Department of Radiology, Leiden University Medical Center, Building C1-0, PO Box 9606, 2300RC Leiden, The Netherlands
P C W HOGENDOORN
Department of Pathology, Leiden University Medical Centre

Immunohistochemical demonstration of oestrogen and progesterone receptors

The excellent paper by Rhodes and colleagues provides a valuable insight into the factors that might cause interlaboratory variability in the immunohistochemical demonstration of oestrogen receptors, now probably the most frequent histopathological test that determines specific patient treatment. There is, however, one section of the paper where the statistical analysis may be causing confusion, rather than clarity.

In table 6, the degrees of agreement between the participant and organising laboratory’s assay on spare sections from the in house tumours, are 0.70 and 0.74, respectively, indicating good agreement by both the participants and the organising laboratory.

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 k 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 Assurance Scheme for Immunocytochemistry (NEQAS-ICC) organising laboratories’ IHC assay on spare sections from the same cases, as evaluated by the “Quick score” method. As quite rightly deduced by Dr Cross, the rationale behind using k statistics for this part of the study, in addition to the Wilcoxon’s matched pairs signed ranks test and the y2 goodness of fit test, was to emphasise the lack of agreement between the pairs of matching slides. This was reflected in the negative k scores, and the significant differences shown in the results of the other statistical tests, indicating a degree of agreement that was worse than would have occurred by chance alone.

In retrospect, we agree that the way the k statistics were calculated and the way the results were expressed may have been confusing, and we welcome this opportunity to clarify the results by repeating the calculations using a 4 × 4 contingency table and by calculating the single k statistic suggested by Dr Cross, using the formula detailed by Robertson et al in 1981. Table 1 gives the results of this analysis.

This approach yields a k coefficient of 0.19 when the Quick scores are evaluated by one of the authors (AR) and 0.20 when evaluated by a second (BJ). Although “yardsticks” are arbitrary and should not be slavishly adhered to, k values less than 0.4 are generally considered to show poor agreement. As suggested by Dr Cross, a weighted k statistic might be more appropriate, because a misclassification between distant categories is of greater importance than a misclassification between adjacent ones, and we have therefore also performed these calculations. Although the weighted k statistics of 0.30 (AR) and 0.34 (BJ) are slightly higher than the unweighted k values, they are still less than 0.4, confirming that agreement between the two assays is poor.

Lastly, to emphasise that the differences observed resulted predominantly from differences in the sensitivities of the IHC assays and the organising laboratories’ assay on the same in house tumours, are 0.70 and 0.74, respectively, indicating good agreement by both the participants and the organising laboratory.

These findings support those of previous studies that have used the Quick score method of evaluation.

In summary, we conclude that the results of these additional tests suggested by Dr Cross support and clarify those published in our original study. They emphasise that the significant differences observed in the Quick score evaluation of the IHC assay results for ER on in house tumours are caused by differences in the sensitivities of the IHC assays used by the laboratories, and not by differences in the Quick score method of evaluation.
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 antimesenteric border, and a bread bag clip, now secured with a plastic sticky tab, was found. The patterns of the muscularis propria and mucosa 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 plane of circular folds, 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. The muscularis mucosae passes around and deep to it. 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 eyelet; the eyelet 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 mechanism of formation of this loop is difficult to determine. The bread bag clip has sharp tooth-like pincers, and would be expected to cause crushing and necrosis of the 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 mucosa shown by actin immunocytochemistry suggest that the clip has “caught up” the small bowel wall in two places, bringing the “mucosal crest” of each into apposition with apparent mucosal fusion to form a bridge.

Review of the literature has identified six previous reports of medical problems arising from the accidental ingestion of bread bag clips. Problems arising included gastrointestinal bleeding, small bowel obstruction, and intestinal perforation. Complications may arise long after ingestion, and there may be no recall of the ingestion. Although bread bags are now secured with plastic sticky tape, bread bag clips may still be encountered and the potential for late symptomatic presentation in relation to a retained bread bag clip remains.

Correspondence

A Rhodes
Department of Histopathology, University College London Medical School, London WC1E 6JF, UK

B Jasani
Immunocytochemistry and Molecular Pathology Unit, University of Wales College of Medicine, Cardiff CF4 4XN, UK

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Dietary dangers: ingestion of a bread bag clip

D S Cook

*J Clin Pathol* 2001 54: 79
doi: 10.1136/jcp.54.1.79

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