Case Report ISSN (O):2395-2822; ISSN (P):2395-2814

Papillary Squamotransitional Cell Carcinoma Cervix- A Rare Case Report.

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Received: October 2017
Accepted: November 2017

ABSTRACT

Papillary squamotransitional cell carcinoma is an uncommon histopathological variant of squamous cell carcinoma of the uterine cervix, which occurs in postmenopausal women. A 45-year-old woman presented in the gynae OPD with history of postmenopausal vaginal bleeding with cauliflower like growth in the cervix .Patient was examined and biopsy was taken from the growth which reveal the diagnosis of papillary transitional cell carcinoma cervix on histopathology.

Keywords: Papillary squamotranitional cell carcinoma cervix

INTRODUCTION

Papillary squamotransitional cell carcinoma of the uterine cervix is a distinct clinico-pathological subtype of cervical cancer.[1] These tumors have been described at other sites of the female genital tract like the ovary and vagina,[2,3] and were designated as "transitional cell carcinoma" by Albores-Saavedra and Young.[4] Recently, Randall et al. re-designated these tumors as "papillary squamous cell carcinoma."[5] As PSTCC are typically recognized due to its distinctive pattern of papillary growth pattern, these tumors should be segregated from transitional cell carcinoma, squamous papilloma, verrucous carcinoma, papillary serous adenocarcinoma, and cervical intraepithelial neoplasia especially grade III with papillary features.[1,6] Papillary squamo-transitional cell carcinoma can show variety of spectrum such as pure squamous, pure transitional and mixture of both.[7] It shows papillary architecture with fibrovascular cores lined by multi-layered atypical epithelium and is known for local recurrence and late metastasis.[8]

CASE REPORT

A 45 year female P6L6 menopausal since 3 years with history of pain and bleeding since 1 year.

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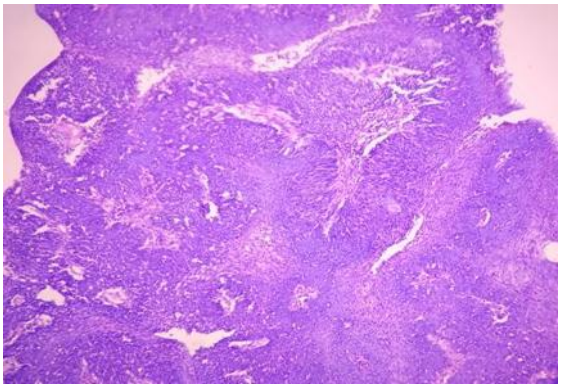

Figure 1: Cervical biopsy superficial fragment of papillary structures each containing a delicate fibrovascular core (H&E stain, Low power).

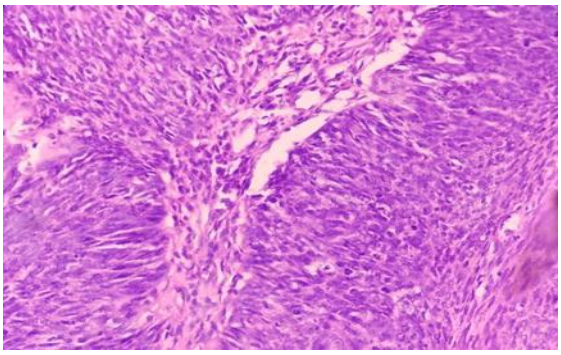

Figure 2: Papillary formation with squamotransitional cells having polygonal shape, distinct cell borders, abundant eosinophilic cytoplasm, pleomorphic nuclei, prominent nucleoli, and occasional mitotic figures (H&E stain, High power).

PAP smear shows atypical squamous cells of undetermined significance with inflammation and haemmorhage. USG reveals multiple intramural

fibroids with cervicitis with cervical fibroid. On per Vaginal examination cauliflower growth is seen on the cervix. Biopsy was taken from the growth and send for histopathological examination. Gross examination shows multiple brownish white STPs 1x1 cm in aggregate. Histopathological examination shows papillary projections with fibrovascular core covered with several layers of atypical epithelial cells. The cells are basaloid with hyperchromatic nucleus with long axis oriented perpendicular to the surface and then is seen minimum maturation with frequent mitosis.

DISCUSSION

PSTCC of the uterine cervix is an extremely rare entity, and the presence of bland-looking basaloid cells or high grade squamous intraepithelial lesions (HSILs), together with scantiness of malignant cells, may lead to underdiagnosis of these histopathological variants.[9,11,12] Thus the identification of the subtle cytological characteristics with clinical correlation is mandatory to conclude diagnostic and staging dilemma. Further, on histopathological specimens, the stromal invasion is very difficult to see unless deep biopsies are taken, which can be a difficult process due to complex papillary architecture of PSTCC. However, in most of reported cases, stromal invasion varies between 55% and 65%.[1,9,10] The clinical presentation of our case was similar to other studies, i.e., elderly lady presenting with postmenopausal bleeding or abnormal pap smear.[5,10]

PSTCC's have a complex architecture enabling only a superficial biopsy. On biopsy, the histological appearances often suggest a superficial lesion, but the diagnosis has to be made on architecture, even if invasion is not seen and atypia is moderate.[1] Our case showed papillary architecture with prominent fibrovascular cores, as reported by other authors as well.[1,5]

Invasion may be difficult to demonstrate histologically unless deep biopsies are obtained. A high index of suspicion and an awareness of this entity are required to make the diagnosis. The assessment of tumor depth in excision specimen is a difficult task because of complex surface papillary architecture of these lesions. This can result in incorrect staging which can affect the patient's treatment and prognosis.[1]

Predominant cell population in our case study was basaloid. Presence of intermediate and basaloid cells in PSTCC has also been reported in a study from Uganda.[13]

Although, the cytokeratin profile of PSTCC is more or less similar to conventional squamous cell carcinoma; the histomorphological observations in combination with immunohistochemistry and prognostic markers like Ki-67 and p53, will help us to distinguish PSCC from transitional cell carcinoma and other borderline papillary lesions of the uterine cervix; and predict its biological behavior as well.

CONCLUSION

PSTCC of uterine cervix is an uncommon histopathological variant, and the true prevalence remained undefined due to presence of bland-looking basaloid cells or HSILs, together with scantiness of malignant cells. PSTCC of uterine cervix is commonly seen in elderly women, known to be associated with HPV and present with delayed locoregional recurrences and distant metastasis. Due to rarity of PSTCC, treatment is similar to squamous cell carcinoma or adenocarcinoma of cervix.

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How to cite this article: Kaur M, Goyal N, Dass C, Bodal VK, Mittal A. Papillary Squamotransitional Cell Carcinoma Cervix- A Rare Case Report. Ann. Int. Med. Den. Res. 2018; 4(1):PT15-PT17.

Source of Support: Nil, **Conflict of Interest:** None declared