

โรคมะเร็งปากมดลูกกระจายไปต่อมน้ำเหลืองที่คอและ มะเร็งทนต์ลุกลามหายได้เอง : รายงานผู้ป่วย ๑ ราย

Metastatic uterine cervical carcinoma with spontaneous and complete regression of the metastatic lesion: A Case Report and Literature Review.

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Abstract

The spontaneous regression of cancer is rarely reported or proven. But occasional case reports challenge researchers to search for the factors influence these events. More understanding may improve cancer treatment in the future. A 48-year-old Thai woman with confirmed diagnosis of uterine cervical carcinoma stage IIIB was treated using radiotherapy and concurrent chemotherapy. After complete treatment for 3 months, supraclavicular lymph node metastasis was found and pathologically confirmed. The patient refused palliative radiotherapy at the lymph node because she wanted to practice like a Buddhist nun in the temple during Buddhist lent months. Further follow-up, spontaneous regression of metastatic supraclavicular lymph node was found up to 18 years.

Key Words: Uterine cervical carcinoma, Metastases, Spontaneous regression

บทคัดย่อ

การหายไปได้เองของโรคมะเร็งนั้นพบและพิสูจน์ว่าเป็นจริงมีรายงานน้อยมาก แต่ก็มีรายงานอยู่ประปรายและเป็นที่ทำทนายบรรดานักวิจัยให้พยายามศึกษาหาปัจจัยที่เกี่ยวข้องกับการหายไปได้เองของโรคมะเร็ง โดยความรู้ความเข้าใจเรื่องนี้ที่เพิ่มขึ้นอาจช่วยให้การรักษาโรคมะเร็งได้ผลดีขึ้นในอนาคต รายงานผู้ป่วย ๑ ราย อายุ ๔๘ ปี ได้รับการวินิจฉัยว่าเป็นมะเร็งปากมดลูกระยะที่ IIIB รักษาด้วยรังสีรักษาร่วมกับเคมีบำบัด หลังจากรักษาครบ เมื่อมาตรวจติดตามผลการ

รักษาที่ ๓ เดือนพบว่ามีกระจายของโรคไปต่อมน้ำเหลืองที่คอ ผลการตรวจทางพยาธิวิทยาของต่อมน้ำเหลืองที่คอยืนยันว่าเป็นมะเร็งชนิดเดียวกับที่ปากมดลูก ผู้ป่วยขอไม่รับการรักษาด้วยรังสีรักษาเนื่องจากต้องการเวลาปฏิบัติธรรมช่วงเข้าพรรษา เมื่อติดตามผลการรักษาต่อไปพบว่ามะเร็งทนต์ลุกลามหายได้เองจากการติดตามผลการรักษาที่ ๑๘ ปี ก็ไม่พบรอยโรคทั้งที่ปากมดลูกและต่อมน้ำเหลืองที่คอ

A Thai female age 48 years presented at Rajavithi hospital on February 25, 1990 because of vaginal discharge and bleeding with abdominal pain. Physical examination was done and found exophytic cervical mass, size 5 centimeters. No supraclavicular lymph node was palpable. Histopathological report of the cervix on March 2, 1990 was invasive squamous cell carcinoma, large cell keratinizing type. Complete staging investigations including CBC, BUN/Cr, chest radiography, scintigraphy using I131 Hippuran and cystoscopy revealed normal findings. Vaginal examination under narcosis was done on March 6, 1990 with one gynecological oncologist and two radiation oncologists. The diagnosis of cervical carcinoma stage IIIB was made because of extension of the tumor to right pelvic side wall. Radiation therapy was started on March 19, 1990 using Co60 machine with whole pelvic field, anterior and posterior parallel opposing port, and Mitomycin-C 30mg infusion intravenously as concurrent chemotherapy. After 40Gy/4weeks, whole pelvic field was shield with lead block 3x10 centimeter with the dose of 10Gy/1week. Brachytherapy was given using RALSTRON-20B (High dose rate Co60 source) from April 19, 1990 to May 10, 1990 with twice weekly fractions for 7 fractions (500cGy/fraction). During May 7 to 17, 1990 additional parametrial field boost with 10Gy/1week was given. The patient tolerated the treatment very well. No immediate complications were observed.

The patient came for 3 months follow-up on June 15, 1990. Physical examination including pelvic examination found no lesion at the cervix, but suspected of small lymph node diameter about 0.8 centimeter at left supraclavicular area. Surgeon was consulted for biopsy. Oral chemotherapy was given using 5-FU tablet (100mg) twice daily for 10 days. Histopathological report of the left supraclavicular lymph node on June 26, 1990 demonstrated metastatic squamous cell carcinoma. Palliative radiotherapy at left supraclavicular area was planned but patient refused. She came for follow-up on August 10, 1990 with left supraclavicular lymph node, diameter 1.5 centimeter. The patient still refused radiation because she wanted to practice like a Buddhist nun in the temple during Buddhist lent months. In September 1990, she came back with mild back pain. Lymph node diameter 2.5 centimeters at left supraclavicular area was noted. Bone scan

showed single lesion at right sacroiliac joint, metastasis or sacroiliitis. Chest radiograph was normal. After Buddhist lent months, on October 12, 1990, she came for forth follow-up. Physical examination found no lymph node at left supraclavicular area. Regular follow-up every 2 to 3 months was made until three years after treatment of the primary carcinoma of cervix and no evidence of disease recurrence was observed. The patient still came back every 6 months up to 10 years. Yearly check up continued until her last visit in March 24, 2008. No evidence of disease observed at the last follow-up on October 12, 2008.

Discussion

Spontaneous regression (SR) is the complete or incomplete disappearance of a disease or cancer with or without inadequate treatment. Everson TC and Cole WH ⁽¹⁾ proposed criteria for SR which composes of 1.) Histopathological confirmed diagnosis of cancer. 2.) Partial or inadequate treatment given. 3.) Long term follow-up with no evidence of disease. SR also includes cases of neoplasia where the disease is not cured or remission is incomplete or non-permanent ⁽²⁾. SR of cancer is very rare and had long history of observation. In 1901 Osler W reported a case of spontaneous disappearance of the secondary growth of breast carcinoma ⁽³⁾. After the early reports, in 1918, Rhodenberg GL reviewed 302 cases of SR in cancer patients ⁽⁴⁾. One large study by Everson TC and Cole WH ⁽¹⁾ published a collection of 176 cases reported during 1900 and 1964 with histological proven or radiograph confirmed. The top four common tumors were hypernephroma, neuroblastoma, malignant melanoma and choriocarcinoma which represented 90 of 176 cases.

In 1990 Challis GB and Stam HJ ⁽²⁾ reported cases from 1966 to 1987 including leukemia, lymphoma and retinoblastoma. The five most common cancers with SR were hypernephroma, lymphoma, leukemia, neuroblastoma and retinoblastoma.

Incidence of SR at approximately 10-20 new cases was reported in English literature worldwide per year ⁽²⁾. But true rate is still unknown because some authors argued that there were many cases not

been reported. Boyers believed that the true rate was about one in every eighty thousand cases ⁽⁵⁾.

For gynecological cancer, SR is extremely rare. Everson TC and Cole WH ⁽¹⁾ reported only 11 from 176 cases (6.25%). Seven cases were epithelial ovarian carcinoma and four were endometrial carcinoma. O'Regan B and Hirshberg C collected 504 SR cases from 1966 to 1987 and reported only 4 cases (0.08%), none of the list was cervical carcinoma. Only 5 uterine cervical carcinoma with SR published ⁽⁶⁾. In 2006, Gaussmann AB ⁽⁷⁾ reported a case of uterine cervical carcinoma with multiple metastases. Lung, pleura, bone, skin and brain metastases were confirmed by CT and CT guided biopsy. Palliative treatment was given but inadequate including cisplatin 50mg/m², except for cranial irradiation. The patient was free of disease after 8 years. Metastasis of endometrial carcinoma with SR was reported by Beller U in 1984 ⁽⁸⁾. Usually cases of disseminated metastases of carcinoma of uterine cervix and uterine corpus have grave prognosis and 5-year survival rate is 0%.

In this patient, the treatment at primary was given according to the tumor stage using teloradiotherapy and brachytherapy with concurrent chemotherapy. There was no treatment at the metastatic site due to patient's willing for the delay. Four months later, the proven metastatic lymph node disappeared. The patient lives 18 years without recurrence, metastases or complication.

The mechanism of tumor regression is still unknown. Many possible mechanisms such as immune system, trauma (especially operative trauma), apoptosis and necrosis, infection are postulate.⁽²⁾ Psychological mechanism is also possible but unexplainable in cellular biology. There was no reporter want to confirm this mechanism. But in this case psychological factor is suspected.

Nowadays most research has focused on mechanisms of immunomodulation because of top common are tumors with immune related. And a large available data consistently agree that the most important factor of tumor regression seems to be apoptosis induced by immunomodulation. Further study of SR will probably play a role on cancer treatment.

References

1. Everson TC, Cole W: Spontaneous Regression of Cancer. Philadelphia, WB Saunders, 1966.
2. Challis GB, Stam HJ: The spontaneous regression of cancer. A review of cases from 1900 to 1987. *Acta Oncol* 1990;29:545–550.
3. Osler W: The medical aspects of carcinoma of the breast, with a note on the spontaneous disappearance of secondary growths. *Am Med* 1901;17–19:63–66.
4. Rhodenberg GL: Fluctuations in the growth rate of malignant tumours in man with special referenceto spontaneous regression: *J Cancer Res* 1918;3:193–221.
5. Boyers LM. Letter to the editor. *JAMA* 1953; 152: 986.
6. O'Regan B, Hirshberg C: Spontaneous Remission: An Annotated Bibliography. Sausalito, CA, Insitute of Noetic Sciences, 1993.
7. Gaussmann AB, Imhoff D, Lambretch E, Menzel C: Spontaneous remission of Metastases of cancer of the Uterine Cervix. *Onkologie* 2006; 159-161.
8. Beller U, Beckman EM and Twombly GH: Spontaneous regression of Advance Endometrial Carcinoma. *Gynecological Oncology* 1984;17: 381-385.

