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# LETTERS TO THE EDITOR

## A Primary Ovarian Leiomyosarcoma with Micro-Invasive Features (Stage I): Is Surgical Excision Enough?

To the Editor:

Primary leiomyosarcoma of the ovary (POLMS) is extremely rare. Current opinion is undecided as to what is the best modality of treatment to offer these patients and the role of adjuvant therapy [1–3]. We report a case of ovarian leiomyosarcoma in an Afro-Caribbean female with tumor invading but still confined within the ovarian capsule, managed by surgical excision and no adjuvant therapy.

A 50-year-old black female presented with a 5-month history of abdominal pain and distention. Her menses had become erratic and unpredictable over the past year. This was attributed to her being perimenopausal. There was no history of weight loss or significant other medical history. Examination revealed a large mass in the left lower quadrant arising out of the pelvis, probably ovarian, which was confirmed by sonography. No ascites was seen. All other organs appeared normal. At laparotomy, for total abdominal hysterectomy and bilateral salpingoophorectomy, the mass proved to be a tumor of the left ovary, confined to the said organ and measuring 14 cm × 12 cm × 15 cm. Histology revealed a well differentiated tumor composed of large, plump spindled cells arranged in fascicles, with prominent rounded nuclei. Mitotic figures were between two and five per high-power field. Cells were seen to invade the capsule but did not penetrate it.

At 24 months, follow-up chest x-ray, abdominal ultrasound, and CT scan showed no evidence of recurrence. No adjuvant therapy was ever administered to the patient.

Monk *et al.* suggest that routine adjuvant radiotherapy and chemotherapy may have no additional benefit, especially in disease confined to ovaries [1]. Rasmussen *et al.* described long-term survival following repeated cytoreductions in recurrent disease and although their patient initially received ifosfamide, adjuvant therapy was believed to have no benefit. They also suggested that these tumors may be hormone sensitive [4]. However, as POLMS are so rare, it is quite difficult to assess these therapeutic options and their efficacy. We believe our case provides support to the emerging view that in cases where there is cancer confined to the ovary, surgical excision alone without adjuvant therapy may lead to a satisfactory outcome.

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To the Editor:

We have several concerns regarding "Long-Term Outcomes of Therapeutic Pelvic Lymphadenectomy for Stage I Endometrial Adenocarcinoma" by Mohan *et al.* [1]:

1. Surgical staging, and certainly an extensive lymphadenectomy as described by the authors, was not the standard therapy for endometrial cancer in the 1970s and early 1980s. Were these patients part of a protocol ? If they were selected by a retrospective chart review, the possibility of a significant selection bias cannot be ignored since only 159 evaluable stage I endometrial cancer patients were identified over a 23-year period.

2. Comparing the authors' results with those from a series that had a less extensive lymphadenectomy is not valid. Any study with an extensive LN dissection is likely to find an advantage in the subset of patients with negative nodes when compared to less extensively staged patients; the latter group, the so-called "LN negative" patients, will include some with occult disease in the nondissected LNs. This is simple "stage migration." Thus, the authors' patients are a selected subset



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