

Case report

Brain Metastasis of Papillary Ovarian Adenocarcinoma

ABSTRACT

Brain metastasis is an uncommon diagnosis in patients with epithelial ovarian cancer, with reported incidences of 1-2%. Serous epithelial ovarian cancer (OC) has an overall grim prognosis and is the major histological subtype that metastasizes to the brain. The average time lapse between the first diagnosis and the onset of cerebral lesions is a direct function of the primary tumor grade and stage. Median survival after diagnosis of brain metastases is 6 months. We would propose that patients treated for ovarian carcinoma could include brain imaging on the list of follow-up studies. In the present study, we identified a patient with brain metastasis of ovarian adenocarcinoma that was treated by removal via surgery followed by six cycles of chemotherapy for 3 years.

KeyWords: Brainmetastases • Surgery • Stereotacticradiosurgery • Whole-brainradiotherapy • Chemotherapy

Introduction

Brain metastasis, which commonly arises in patients with lung cancer, breast cancer and melanoma, is associated with poor survival outcomes and poses distinct clinical challenges[5]. Most brain metastases are the product of primary tumors that originate in the lung (40%–50%), breast (15%–20%), skin (5%–10%), or gastrointestinal tract (4%–6%)[6,7]. Ovarian brain metastasis is a rare finding, as the most common sites of metastatic ovarian cancer include spread to the peritoneum, liver and lymph nodes [8-10]. In the present case report, we presented a patient with brain metastasis of ovarian adenocarcinoma and treated by surgery.

Case Presentation:

A 47-year-old female was brought to the emergency department due to a headache and vomiting. She presents with a 2-month history of progressive headaches that's accompanied by projectile vomiting.

Has a history of blurry vision and memory loss. Also, she reports a history loss of balance that made it difficult for her to walk without support and with a positive history of vertigo. Has no history of convulsions or LOC. Has no prior history of trauma.

Five years prior, the patient had been diagnosed with high-grade serous epithelial ovarian carcinoma stage with peritoneal metastasis. The patient underwent total abdominal hysterectomy, bilateral salphingo-oophorectomy, and omentectomy.

The final histopathology report showed high-grade serous epithelial ovarian carcinoma.

Post-surgery, the patient underwent 6 cycles of chemotherapy and was on regular follow-up.

Comment [D1]: The summary needs to be brief and mention the superior numbers in the results and discussion

Comment [D2]: Introduction Very few references

The follow-up was uneventful for 1 1/2 years. Her last serum CA-125 level was 10.6 1U/ml before being lost to follow-up.

Following this, a non-contrast computed tomography (CT) scan of the brain was advised, which showed a ring-enhancing lesion at the right cerebellum. The lesion associates necrotic areas surrounded by hypodense areas. There was compression of the v4. Radiologically, a probable diagnosis of metastasis was made. Magnetic resonance imaging (MRI) showed right cerebellum tumor. A right suboccipital craniectomy was performed. A biopsy and total resection were performed to Gross examination showed multiple grey-brown to grey-white, soft, friable tissue fragments measuring 6 x 4 x 2 cm in total. Microscopic examination revealed These fragments correspond to a cerebellar parenchyma harboring a carcinomatous process composed of large cells with reduced eosinophilic cytoplasm devoid of signs of mucosecretion and with atypical, voluminous, anisokaryotic nuclei, often clearly nucleolated and richly mitotic. These cells are arranged in trabeculae of variable size or in tubes and papillae in a fibro-inflammatory stroma. . A final diagnosis of metastatic deposits from papillary adenocarcinoma of the ovary was made.

DISCUSSION:

Brain metastases from epithelial ovarian cancer (EOC) are an unusual diagnosis; they account for 1–2% of all CNS malignant tumors, and poor prognosis was reported [1]. 1 Epithelial ovarian carcinoma first spreads by intraperitoneal dissemination and frequently invades metastasis to the pleural cavity, liver, and lung. Brain metastases are more primary tumors of the lung (20–50%), breast, renal, colorectal carcinomas, and melanoma.

Piura and Piura found in their study that the ovarian malignancy is considered to be twice as frequent for CNS metastases of any gynecological cancers, compared with cervical or endometrial cancer [18]. Serous carcinomas are the most common histologic subtype associated with brain metastasis, followed by mixed epithelial, endometrioid adenocarcinoma, mucinous, undifferentiated, and clear cell type 3.

Breast cancer gene 1 (BRCA-1) mutations are also somehow linked to brain metastases in ovarian carcinoma, according to other studies. The BRCA-1 and -2 genes are mutated in up to 10% of ovarian carcinoma cases, linked with aggressive behavior and high rates of metastasizing disease. 4

The brain is the most common location for metastases, with the cerebrum being its predilection site, followed by leptomeninges, and lastly the tocerrebellum. 3 The commonest pathology occurs in the frontal region of the lobe. Four: Symptoms of brain metastases were as follows: headache, nausea/vomiting, confusion/dizziness, decreased mental status/weakness. gait disturbance (general or limb-specific), urinary incontinence/gait disorder, and ataxia/visual symptoms, including diplopia/syncope & seizures. References Most accurate imaging modalities: Combine of contrast-enhanced MRI Brain + CT Scan Based on a CT scan, metastasis appears as a heterogeneously enhancing lesion.

This multimodal treatment strategy is comprised of resection, WBRT, and chemotherapy.

Surgery should be done in case of single brain metastasis and an approachable site or producing a mass effect. If there are multiple metastases, a multimodal treatment approach is recommended. The reported median time from primary diagnosis to the onset of cerebral lesions was between 11 and 46 months and documented association with original tumor grade and stage. [3] 1,4 The median time from grade 3 (poorly differentiated ovarian carcinoma) to brain metastasis was as long as 1.5 years in a German study, which

had a minority of cases and probably the most conservative screening policy. Well- to moderately differentiated ovarian carcinoma patients (Grades 1 and 2): median time interval = 4.73 years After the diagnosis of brain metastases, survival was 6 months, but there is a good outcome for patients with a multimodal treatment approach. Presentation 1 A treatment with surgery, radiotherapy, and chemotherapy has a median survival time of around 20 months >17 for surgery + radiotherapy >>>>>> 9.1 Optune Plus Radiotherapie>>>>>>>> 4.5 only radiotherapie>>> Voyager (RR2: Adding tmz to Durvalumab)>>>>>> 7.5 Only Chemotherapy>> 18 SRS ou GKRS Of these, SRS and GKRS resulted in improved survival. 1

Although serum CA-125 is part of their routine follow-up, its sensitivity for detecting CNS relapse was very low. Brain imaging modalities should be included in the routine post-therapy surveillance of patients with ovarian carcinoma. 1,2

The patient was started on chemotherapy but seen only 6 months later. Additional treatment information was not provided.

CONCLUSION :

Ovarian cancers rarely metastasize to the brain and is associated with poor prognosis. A careful clinical examination and proper therapeutic approach, including chemotherapy and radiotherapy, may lead to prolonged survival.

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