

# METASTATIC ADENOCARCINOMA IN THE UTERINE CERVIX

## 転移性子宮頸部腺癌

### A REPORT OF TWO AUTOPSY CASES

#### 2 剖検例の報告

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ATOMIC BOMB CASUALTY COMMISSION

国立予防衛生研究所－原爆傷害調査委員会

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HIROSHIMA AND NAGASAKI, JAPAN

A Cooperative Research Agency of  
U.S.A. NATIONAL ACADEMY OF SCIENCES - NATIONAL RESEARCH COUNCIL  
and  
JAPANESE NATIONAL INSTITUTE OF HEALTH OF THE MINISTRY OF HEALTH AND WELFARE  
with funds provided by  
U.S.A. ATOMIC ENERGY COMMISSION  
JAPANESE NATIONAL INSTITUTE OF HEALTH  
U.S.A. PUBLIC HEALTH SERVICE

原爆傷害調査委員会

広島および長崎

米国学士院—学術会議と厚生省国立予防衛生研究所  
との日米共同調査研究機関

米国原子力委員会、厚生省国立予防衛生研究所および米国公衆衛生局の研究費による

#### ACKNOWLEDGMENT

##### 謝 辞

This study would not have been possible without the valuable advice of Prof. Atsushi Fujiwara of the Department of Gynecology, Hiroshima University School of Medicine. The authors also wish to thank Dr. Arthur Steer, Chief of Pathology, and Dr. Ronald L. Harvey, Research Associate, of the Atomic Bomb Casualty Commission, Hiroshima, for their assistance in the preparation of the manuscript.

広島大学医学部産婦人科・藤原 篤教授のご指導に深甚なる謝辞を述べると共に、ABCC 病理部長・Dr. A. Steer 及び研究員 Dr. R. L. Harvey の多大なご援助に対し、心から感謝する。

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#### SUMMARY

Metastasis to the cervix uteri of tumors of other organs is rarely observed. When the metastatic malignancy is adenocarcinoma it is sometimes very difficult morphologically to differentiate it from primary adenocarcinoma of the cervix uteri.

We have confirmed by autopsy that in two persons with a chief complaint of genital bleeding, and with histologic diagnosis of primary adenocarcinoma of the cervix, the primary malignancy arose in the stomach in one case and the ovary in the other. The second case was particularly of interest because primary adenocarcinoma of the thyroid was also present.

This study indicated that when a histological diagnosis of adenocarcinoma of the cervix uteri is made there is a need to make a detailed examination of the mammary gland, digestive tract, and ovary.

#### INTRODUCTION

Metastatic carcinoma occurs rarely in the uterine cervix. Adenocarcinoma metastatic to the cervix

#### 要 約

子宮頸部への他臓器の悪性腫瘍の転移はまれである。それが腺癌である場合に、原発性子宮頸部腺癌との鑑別が、形態学的にはなほだ困難な場合がある。

われわれは、性器出血を主訴とし、病理組織学的に原発性子宮頸部腺癌と診断された2症例について、剖検により原発巣が胃及び卵巣であることを確認した。ことに症例2は甲状腺腺癌との重複癌であったことも興味のあるところであった。

組織学的に子宮頸部腺癌と診断された場合には、一応、乳腺、消化管および卵巣を精査する必要性を教えられた。

#### 緒 言

子宮頸部への他臓器の悪性腫瘍の転移はまれであり、そ

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presents a cytological and histological dilemma for pathologists in the differentiation of primary cervical adenocarcinoma and metastatic adenocarcinoma.

Two such diagnostic problems are reported here. Each patient had a major complaint of vaginal bleeding and primary cervical adenocarcinoma was initially considered. These diagnoses were based upon cytological and histological preparations. However, subsequent postmortem examination demonstrated that the primary foci for these neoplasms were in the stomach (Case 1) and ovary (Case 2).

## CASE REPORTS

**Case 1.** A 35-year-old (gravida IV, para I, abortion III) Japanese female sales clerk initially complained of irregular vaginal bleeding of about 1 month's duration. Her family history is unremarkable. Menarche occurred at age 12. The patient developed pulmonary tuberculosis at age 18 and at age 26 a right oophorectomy was performed for removal of a cyst.

In March 1970, anorexia and nausea were experienced and epigastralgia was recorded in August 1970. Gastric roentgenographic examinations revealed no abnormalities and a diagnosis of "nervous gastritis" was made. Irregular vaginal bleeding began in November 1970. Pelvic examination demonstrated a hemorrhagic erosion in the region of the cervix. Cytological preparations from this area contained atypical cells of varying size. Histologically, infiltrating neoplastic epithelial cells, some arranged in a tubular pattern were prominent. The diagnosis of uterine cervical adenocarcinoma was made prior to hospitalization.

On admission, the patient was moderately well-nourished, was 152.5 cm tall, and weighed 43 kg. A lower abdominal midline operative scar was well-healed and bilateral firm inguinal 0.5–2.0 cm masses were present. Additionally, a hard, fixed, approximately 8 cm diameter mass was palpable in the region of the uterus and left adnexa. Congestion and a focal hemorrhagic erosion were identified in the cervix. Vaginal smears from this area showed many large, myxopioctic, atypical cells.

A biopsy from the same site contained atypical epithelial cells infiltrating the submucosa, signet ring cells were present elsewhere and positive for mucin (Figure 1). Apparent tubules are formed by these neoplastic cells and suggest adenocarcinoma of the endocervix or endometrium with local extension or a focus of metastatic adenocarcinoma.

れが腺癌の場合は、原発性子宮頸部腺癌との鑑別が細胞診あるいは組織診によっても困難な場合がある。

本報告ではこのような診断の問題点二つについて記述する。われわれは、性器出血を主訴として来院し、細胞診及び組織診で原発性子宮頸部腺癌と当初診断され、その後剖検により原発巣が胃(症例1)及び卵巣(症例2)であることが確認された転移性子宮頸部腺癌の2例を経験した。

## 症 例

**症例1:** 35歳の女性(妊娠4回, うち出産1回, 中絶3回), 店員。主訴は約1か月間にわたる不正性器出血。家族歴に特記すべきことはない。既往歴として, 初経12歳, 18歳時肺結核, 26歳時右卵巣のう腫により右卵巣剥出術を受けている。

1970年3月ごろ, 食欲不振, 悪心があり, 8月には心窩部痛を訴えたが, 胃レントゲン検査において特別な所見は認められず, 「神経性胃炎」と診断された。同年11月, 不正性器出血を来し, 子宮腔部に出血性びらんを認め, 細胞診により大小不同の異型細胞が認められた。組織診でも上皮性腫瘍細胞が浸潤性増殖を示し1部では明らかな腺腔構造が認められ, 子宮頸部腺癌と診断されて入院した。

入院時の所見は, 身長152.5 cm, 体重43 kg, 栄養中等度。下腹部に正中手術瘢痕を認め, 両側鼠径部に直径0.5–2 cm大の弾性硬の腫瘤を触れた。さらに, 子宮, 左側付属器の部位には直径8 cmの硬い腫瘤を触れ, 可動性は不良であった。子宮腔部は充血気味で, 出血性びらんを認めた。細胞診では著明な粘液産生性大型異型細胞を多数認めた。

生検材料では粘膜下に浸潤増殖する異型上皮細胞が認められた(図1)。他所に印環細胞が認められ, ムチン陽性を示した。明らかな腺腔構造が形成され, 子宮頸部又は体部原発の腺癌あるいは他臓器よりの転移癌が考えられた。



Results of gastroscopy and upper-gastrointestinal roentgenography were suspicious for gastric carcinoma. Subsequent exploratory laparotomy in January 1971 demonstrated an inoperable adenocarcinoma of the stomach with widespread metastases. Radiotherapy and chemotherapy were initiated postoperatively. In June, a colostomy was performed to relieve a chronic ileus. The patient died on July 14.

Postmortem examination revealed approximately 100 ml of purulent ascites and a diffusely thickened abdominal wall. Histological sections from the stomach showed markedly atypical infiltrating epithelial cells with cytoplasmic vacuoles. The vacuoles contained mucicarmine positive granules. Some of the neoplastic cells formed tubules indicative of adenocarcinoma tubulare (Figure 2).

The left ovary was replaced by an approximately 5 cm diameter, white, firm mass with a nodular surface. Histologically, the tissue contained neoplastic cells exhibiting two patterns (medullary carcinoma and scirrhous carcinoma), and a Krukenberg's tumor was considered. Metastatic tumor nodules in the uterine body and cervix have similar microscopic patterns.

The pathoanatomical diagnoses include: (1) adenocarcinoma of the stomach with metastatic carcinoma in the left lung, pancreas, ileum, transverse colon, liver, left adrenal, left ovary, uterine body, cervix, urinary bladder, pulmonary hilar, and retroperitoneal lymph nodes; and (2) status post-colostomy and right oophorectomy.

**Case 2. (MF [redacted])** A 50-year-old (gravida III, para II, abortion I) housewife complained of irregular vaginal bleeding. Her father died of pancreatitis at age 54 and her brother died of liver cirrhosis at age 36. She had menarche at age 15 years and menopause at age 47. She was exposed to the Hiroshima atomic bomb in a building 900 m from the hypocenter and subsequently experienced acute radiation symptoms such as epilation, diarrhea, and burns. In 1954, an operation was performed to correct uterine retroflexion and bilateral cataracts were removed in 1965. In December 1957, a partial thyroidectomy was performed. For about 6 years prior to this operation she was treated for nodular goiter. Microscopically, the thyroid surgical specimen contained papillary follicular adenocarcinoma of the thyroid (Figure 3).

Vaginal bleeding was noted in February 1972. Biopsy of the uterine cervix showed atypical epithelial cells with a papillary pattern and occasional tubular configurations. Adenocarcinoma

胃内視鏡検査、および上部消化管透視により胃癌が疑われた。1971年1月試験開腹により、広汎な転移を伴う胃腺癌を認め、手術不可能であった。術後、放射線療法および化学療法を施行した。6月にイレウス症状が著明となり、人工肛門造設術を施行したが7月14日死亡した。

剖検所見では腹腔内に膿性の腹水約100 mlを容れ、腹壁は瀰漫性に肥厚していた。胃の組織像は異型性の強い浸潤性腺癌で、ムチカルミン陽性顆粒を含む空胞を有し、Adenocarcinoma tubulareに相当すると考えられた(図2)。

左側卵巣は直径5 cmで表面結節状の白色硬の腫瘤に置換されていた。組織学的には髓様癌と硬性癌の像を呈し、Krukenberg 腫瘍に相当するものであった。鏡検で子宮体部、頸部にも転移巣が認められ、いずれも同様の所見を呈していた。

主要病理解剖学的診断: (1) 胃腺癌、転移: 左肺、脾、回腸、横行結腸、肝、左副腎、左卵巣、子宮体部及び頸部、膀胱、リンパ節(肺門及び後腹膜)。 (2) 人工肛門造設術及び右卵巣摘除後。

**症例 2 (MF [redacted])**: 50歳の主婦(妊娠3回。うち、出産2回、中絶1回)。主訴は不正性器出血。家族歴では父が54歳時脾臓炎で死亡。弟が36歳時肝硬変で死亡。既往歴としては、初経は15歳、閉経は47歳。広島において原爆に被爆(爆心より900 mの屋内)、急性症状として、脱毛、下痢、熱傷があった。1954年子宮後屈症及び1965年両眼の白内障で手術を受けた。1951年ごろより結節性甲状腺腫の治療を続け、1957年12月、部分的甲状腺切除術を受け、組織学的に甲状腺乳頭状濾胞腺癌の像を呈していた(図3)。

1972年2月性器出血が出現。子宮頸部の生検では1部で腺腔を形成していながら乳頭状に増殖する胃型上皮細胞



of the uterine cervix was the original diagnosis. Subsequently, a mass in the left supraclavicular fossa was removed which was microscopically similar to the uterine cervical biopsy. Metastatic adenocarcinoma of the thyroid was therefore the revised diagnosis.

On admission the patient was 153 cm tall and weighed 48.5 kg. An elastic, hard, thumb-sized mass was palpable in the left supraclavicular fossa. The body of the uterus was approximately 5 cm in diameter. The cervix was hemorrhagic and firm.

Roentgenographic examination of the chest and upper gastrointestinal tract revealed no abnormalities. Radiotherapy and chemotherapy were started for adenocarcinoma of the uterine cervix and the patient was discharged in May 1972. Readmission occurred in August 1972. Pelvic roentgenography suggested metastatic carcinoma in the pelvic wall. Radiotherapy was abandoned and chemotherapy was administered. A swelling was found in the left supraclavicular fossa in January 1973 and local radiotherapy was administered. The patient died in October 1973.

Postmortem examination revealed 2800 ml of clear yellow ascitic fluid. The left ovary was completely replaced by a 5 cm diameter tumor and the right ovary was atrophic and infiltrated by tumor. Numerous fibrous adhesions and tumor nodules were present in the pelvis. Tumor spread throughout the peritoneal cavity was apparent. Two endometrial polyps were also found. The pleural cavities contained clear yellow fluid (left 2700 ml, and right 800 ml). The left lung was collapsed at the hilus. The pleural surfaces were gray-white and markedly thickened. The right lung showed marked congestion and edema. The intestines were bound down by many fibrous adhesions. A transmural tumor nodule was seen in the ascending colon which was focally ulcerated on the mucosal aspect. The right lobe of the thyroid was surgically absent and gross evidence of tumor recurrence was not present. The left brachiocephalic, subclavicular and internal jugular veins contain recent thrombus.

Microscopically, histologic sections from the ovary showed papillary adenocarcinoma of ovary with many psammoma bodies (Figure 4). Sections from the neck of the left cervical venous thrombus showed early organization. The uterus contained two endometrial polyps and metastatic carcinoma from the ovary. Lymph nodes from the left neck have tiny metastatic foci from the thyroid as well as from the ovary.

を示し、子宮頸部腺癌と診断された。その後、左鎖骨上窩に腫瘤を認め摘出したところ子宮頸部生検像と同様の所見を呈し、転移性甲状腺腺癌と診断が改訂された。

入院時所見：身長 153 cm，体重 48.5 kg。左鎖骨上窩に母指頭大の弾性硬の腫瘤を触れ、子宮体部は直径 5 cm で、頸部は出血性で硬かった。

入院後の経過：上部消化管、胸部レントゲン検査に異常を認めず、子宮頸部腺癌に対する放射線療法及び化学療法を施行し、1972年5月退院した。同年8月再入院。骨盤レントゲン検査により転移像を骨盤壁に認め、放射線療法を断念し化学療法を施行した。1973年1月左鎖骨上窩に腫瘤を認め、同部に放射線療法を施した。患者は1973年10月死亡した。

剖検所見：腹腔内には2800 mlの黄色透明液を認めた。左卵巣は直径5 cmの腫瘍に置換され、右卵巣は萎縮し腫瘍浸潤を示していた。骨盤腔には多数の線維性癒着及び腫瘍結節を認め、後腹膜腔にも腫瘍結節を認めた。子宮内腔には2個の子宮内膜ポリープを認めた。両側胸腔には黄色透明液を容れ(左2700 ml：右800 ml)，左肺は肺門へ圧排され、肋膜は灰白色で著明に肥厚していた。右肺は著明なうっ血と水腫を呈していた。腸管は互いに癒着し、上行結腸では腫瘍結節が粘膜面に突出し、一部で潰瘍を形成していた。甲状腺右葉は外科的に切除されており、肉眼的には再発を認めなかった。左腕頭、鎖骨下及び内頸静脈内腔には比較的新しい血栓を認めた。

組織学的に、卵巣腫瘍は多数の砂粒小体を伴う乳頭状腺癌を呈した(図4)。左頸部静脈の血栓は初期の器質化を呈していた。子宮には2個の子宮内膜ポリープ及び卵巣からの転移癌を認めた。左頸部のリンパ節には卵巣癌の転移及び甲状腺癌の微小転移巣を認めた。

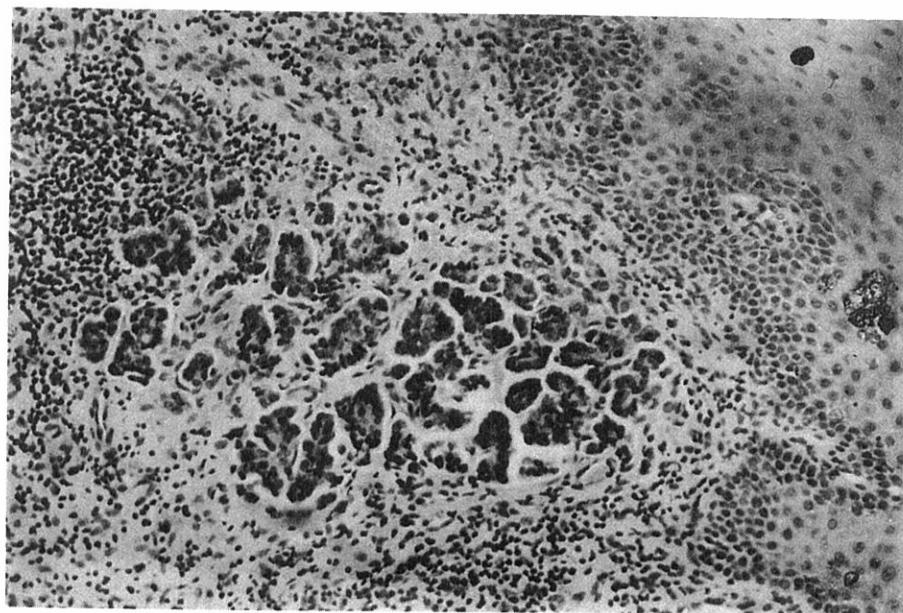


Figure 1 Case 1. Biopsy of uterine ectocervix shows adenocarcinoma invading the submucosa.  
 図1 症例1. 子宮頸部の生検材料は粘膜下に浸潤する腺癌を示した。

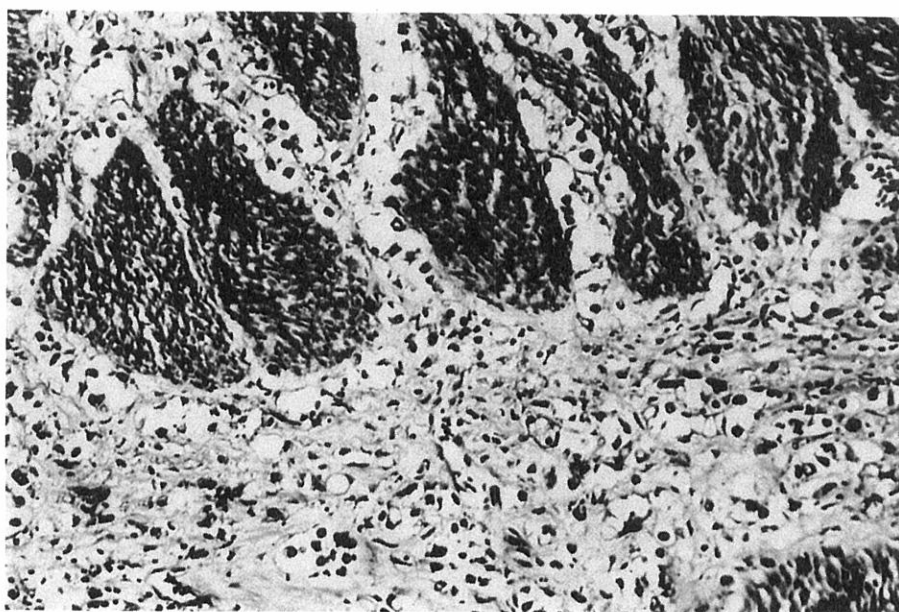
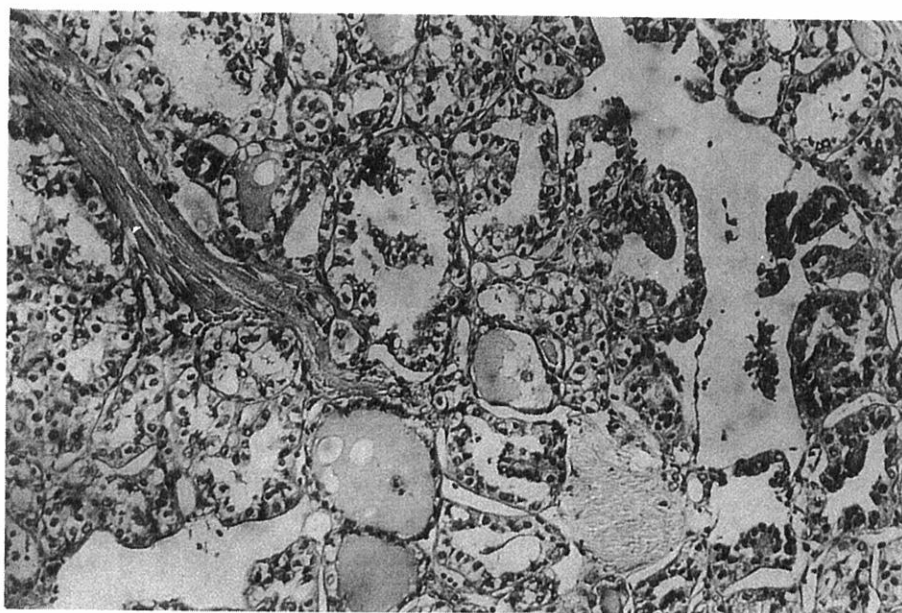
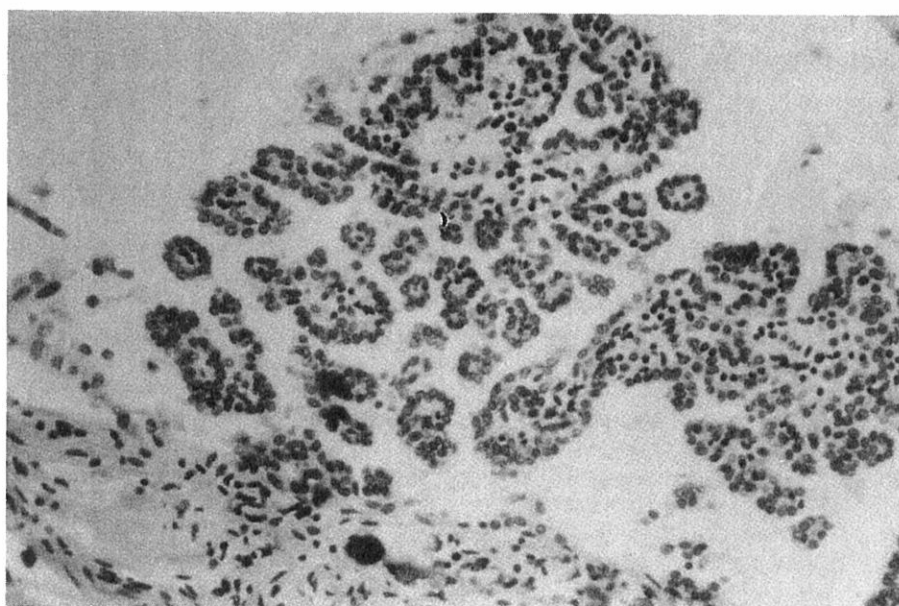


Figure 2 Case 1. Histologic section from the stomach demonstrates numerous signet-ring cells which are positive for mucin. Tubular patterns, identified in the metastatic lesions, are not present in the stomach.  
 図2 症例1. 胃の組織像はムチン陽性印環細胞を示す。転移部に認められた腺腔像は胃には認められない。



*Figure 3 Case 2. Surgical specimen from the thyroid shows papillary follicular adenocarcinoma.*

図3 症例2. 甲状腺の手術標本は乳頭状濾胞腺癌を示す.



*Figure 4 Case 2. Autopsy specimen from the left ovary shows papillary adenocarcinoma with psammoma bodies.*

図4 症例2. 左卵巣の剖検標本は砂粒小体を伴う乳頭状腺癌を示す.

Pathoanatomical diagnoses: (1) papillary adenocarcinoma of left ovary with metastatic adenocarcinoma in right ovary, uterus, urinary bladder, stomach, colon, adrenals, lungs, pericardium, pleurae, diaphragm, left breast, bone marrow, and lymph nodes (mesenteric, bilateral cervical, bronchial, and bilateral axillary); (2) ascites, 2800 ml; (3) hydrothorax (left 2700 ml, right 800 ml); (4) atelectasis, left lung due to pleural effusion; (5) congestion and edema of right lung; (6) thrombus of left cervical veins of the neck; (7) status post-partial thyroidectomy, right lobe (for carcinoma of thyroid) with metastatic carcinoma in left cervical lymph node; (8) two endometrial polyps; (9) status post-operation for retroflexion of uterus; and (10) fatty metamorphosis of liver.

## DISCUSSION

Metastatic adenocarcinoma in the uterine cervix is regarded as rare.<sup>1</sup> Charache,<sup>2</sup> Wallach and Edberg,<sup>3</sup> and Stemmermann<sup>4</sup> have previously reported this occurrence. Esposito et al<sup>5</sup> described two cases of carcinoma of the sigmoid colon which metastasized to the uterine cervix and analyzed 78 cases of metastatic adenocarcinoma in the uterine cervix. The primary neoplasm was located in the following organs in order of decreasing frequency: breast (41 cases), stomach (23 cases), lung, kidney, pancreas, and sigmoid colon. Pomerance and Mackles<sup>6</sup> studied 29 cases of secondary uterine cervical adenocarcinoma and found the following primary sites of adenocarcinoma: (a) pelvis—endometrium (16 cases), ovary (6), fallopian tube (1), and rectum (1); and (b) extrapelvis—breast (2), stomach (1), lung (1), and colon (1). The reasons for the rare occurrence of metastatic adenocarcinoma in the cervix are unknown but Wallach and Edberg<sup>3</sup> suggest several possibilities: (1) the uterine cervix is small as a target organ for metastasis and has a small blood supply, when compared with the liver and lungs, (2) the general lymphatic drainage of the uterus is directed away from the cervix, (3) the cervix is not suitable for tumor growth because it is composed of firm muscular and connective tissue and (4) the cervix is not carefully examined during routine autopsy.

An apparent general lack of interest in metastatic cases, according to Stemmermann,<sup>4</sup> is due to the rarity of the disease. However, among 223 cases of infiltrating uterine cervical carcinoma, Pomerance and Mackles<sup>6</sup> discovered that 29 of 54 cases of adenocarcinoma were metastatic adenocarcinoma. Perhaps this disease occurs with greater frequency than previously thought.

病理解剖学的診断: (1) 左卵巣乳頭状腺癌, 転移: 右卵巣, 子宮, 膀胱, 胃, 結腸, 両副腎, 両肺, 心のう, 胸膜, 横隔膜, 左乳腺, 骨髄ならびにリンパ節(腸間膜, 両側頸部, 傍気管支および両側腋下), (2) 腹水, 2800 ml, (3) 胸水(左2700 ml: 右800 ml), (4) 左肺胸水による無気肺, (5) 右肺うっ血及び水腫, (6) 左頸部静脈血栓, (7) 甲状腺右葉切除後(甲状腺癌), 転移: 左頸部リンパ節, (8) 子宮内膜ポリープ2個, (9) 子宮後屈術後, (10) 肝脂肪変態.

## 考 察

転移性子宮頸部腺癌はまれなものとされ,<sup>1</sup> これに関し従来 Charache,<sup>2</sup> Wallach 及び Edberg<sup>3</sup> ならびに Stemmermann<sup>4</sup> の報告がある. Esposito ら<sup>5</sup> は2例の子宮頸部への転移を示したS状結腸癌を報告し, 子宮頸部の転移腺癌の78例を分析した. 原発巣は下記の部位に存在していた: 41例が乳房, 23例が胃であり, そのほかに肺, 腎, 膵およびS状結腸であった. Pomerance 及び Mackles<sup>6</sup> は29例の転移性子宮頸部腺癌中, (a) 骨盤腔では, 子宮内膜(16例), 卵巣(6例), 卵管(1例), 及び直腸(1例); (b) 骨盤外臓器では, 乳腺(2例), 胃(1例), 肺(1例)及び結腸(1例)に原発性腺癌を認めたと報告している. 子宮頸部への転移性腺癌がまれである理由は不明であるが, Wallach 及び Edberg<sup>3</sup> は幾つかの理由を挙げている. すなわち, (1) 子宮頸部は転移の標的としては小さく, 肝や肺に比して血流量が少ない, (2) 全般的なリンパの流れは子宮頸部から流れ出る方向にある, (3) 子宮頸部が硬い平滑筋及び結合組織より成るので腫瘍の増殖に適さない, (4) 子宮頸部は剖検時にあまり注意深く調べられない, などである.

一方, Stemmermann<sup>4</sup> は, 症例が少ないのは一般に転移癌には興味をもたれないことも関係していると述べ, Pomerance 及び Mackles<sup>6</sup> は, 223例の浸潤性子宮頸部癌中54例が腺癌で, そのうち29例が転移であったと報告していることから, 実際には, これまでに考えられていた以上に, かなりの頻度でみられるものと思われる.

Metastases to the uterine cervix are probably lymphogenous, hematogenous, invasive, or disseminative. Stemmermann<sup>4</sup> states that metastatic adenocarcinoma of the stomach which is found in the uterus, ovary, and pelvic peritoneum probably had lymphatic dissemination. If metastatic adenocarcinoma of the stomach is found in the uterus and pelvic peritoneum but not the ovary, the tumor spread was probably hematogenous. If this is true, the adenocarcinoma of Case 1 was disseminated through lymphatic channels. Case 2 can be considered either due to lymphatic spread or salpingogenous or invasive dissemination of the tumor. Graham and van Niekerk<sup>7</sup> studied 119 consecutive patients with ovarian carcinoma and found malignant cells in 35 cases (30%) by vaginal cytology. The source of the malignant cells in the vaginal smear was sought by reviewing each case for evidence of metastatic implants in either the cervix, endometrium, or fallopian tubes. Metastatic lesions were found in the cervix or vagina in 7 cases, in the endometrium in 5 patients, and in the fallopian tubes in 8 cases. Malignant cells were identified in the vaginal smears of all of the patients with metastatic implants in the vagina, cervix, or endometrium and in 5 of the 8 patients with metastatic lesions in the fallopian tubes.

The histological patterns of uterine-cervical adenocarcinoma are exceedingly diverse and various classifications are made by investigators.<sup>8,9</sup> Because of this, it is often difficult to determine from the histological findings alone whether the carcinoma is primary or metastatic. That is, Case 1 has myxopoeitic cells, but both primary cervical adenocarcinoma and gastric carcinoma can produce myxopoeitic tumor cells. Case 2 has tumor cells that do not contain mucus, but show papillary proliferation in both the uterine cervix and ovary. Pomerance and Mackles<sup>6</sup> reported an interesting finding regarding the psammoma bodies that were notably present in the ovary. The primary focus in the two cases of metastatic cervical adenocarcinoma presenting psammoma bodies was not the ovary. Although it has been said that psammoma bodies in human tumors occur most frequently in tumors originating in the dura mater, thyroid, and ovary,<sup>10-12</sup> Pomerance and Mackles<sup>6</sup> conclude that the diagnosis cannot be made on the basis of histological findings alone. Therefore, it is necessary to consider the possibility of metastasis from the ovary, breasts, stomach, or intestines in cases of cervical adenocarcinoma. Conversely, it is necessary to examine cytologically the cervix of patients with breast and digestive tract carcinomas.

Case 2, exposed to the atomic bomb in Hiroshima at 900m from the hypocenter, was previously reported

子宮頸部への転移経路は、リンパ行性、血行性、浸潤性、播種性が考えられるが、Stemmermann<sup>4</sup>は子宮、卵巣及び骨盤腹膜に転移のある胃癌はリンパ行性であると言い、子宮及び骨盤腹膜に転移があり、卵巣にない場合は、恐らく血行性であろうと述べている。もしそうであるなら、症例1の腺癌はリンパ行性であり、症例2はリンパ行性、経卵管性あるいは浸潤性が考えられる。Graham及びvan Niekerk<sup>7</sup>は119例の一連の卵巣癌患者について検査した結果膣スミア陽性例は35例(30%)であった。頸部、子宮内膜、または卵管に転移があるかどうかを見るために、膣スミアにおける悪性細胞の出所を追究した。転移巣は7例が頸管あるいは膣、5例が子宮内膜、および8例が卵管であった。膣、頸管、または子宮内膜に転移のあるものの全例、卵管に転移のあるものの8例中5例の膣スミアにそれぞれ悪性細胞が認められた。

子宮頸部腺癌の組織像は非常に多彩であり、諸家<sup>8,9</sup>により種々の分類がなされている。それ故に原発性か転移性かを組織学的所見だけでは判定できない場合が多い。すなわち症例1は、粘液産生細胞より成っていたが、原発性子宮頸部腺癌も胃癌も粘液産生腫瘍細胞を作り得る。症例2は粘液を含まない腫瘍細胞より成っていたが、子宮頸部および卵巣いずれにおいても乳頭状増殖を示していた。卵巣において著明にみられた砂粒小体についてPomerance及びMackles<sup>6</sup>が興味ある所見を述べている。すなわちこの小体の認められた2例の転移性子宮頸部腺癌の原発巣は卵巣ではなかったのである。従来、人体腫瘍において砂粒小体が認められるのは脳硬膜、甲状腺及び卵巣原発の腫瘍において多いとされているが、<sup>10-12</sup> Pomerance及びMackles<sup>6</sup>は組織学的所見だけでは断定し得ないことを結論している。従って、子宮頸部腺癌の病理学的診断を受けた場合には、卵巣、乳腺、胃、または腸からの転移である可能性も考慮する必要があるし、また逆に、乳癌や消化器癌患者の子宮頸部も注意深く検索する必要がある。

次に、症例2は広島において爆心から900mの距離で原爆に被爆しており、甲状腺と子宮頸部の重複癌として既



with cancers of the thyroid and cervix.<sup>13</sup> It is an interesting case with double cancer of endocrine organs (thyroid and ovary) diagnosed at autopsy.

## CONCLUSIONS

Two cases, initially diagnosed as primary uterine cervical adenocarcinoma and subsequently found to have metastatic adenocarcinoma in the cervix, are reported. The primary neoplasms were found at autopsy in the stomach and ovary.

When a diagnosis of cervical adenocarcinoma is made, careful re-examination of the breasts, gastrointestinal tract, and ovaries may reveal the location of the primary neoplasm.

に報告したが,<sup>13</sup> 剖検により内分泌臓器(甲状腺と卵巣)の重複癌ということが判明した興味ある症例である。

## 結 語

当初原発性子宮頸部腺癌と診断されたが、後に転移癌であることが判明した2症例を報告した。剖検により原発巣は胃及び卵巣であった。

次に、子宮頸部腺癌の診断がなされたときには、乳腺、消化管、および卵巣をも注意深く再検査する必要がある。

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