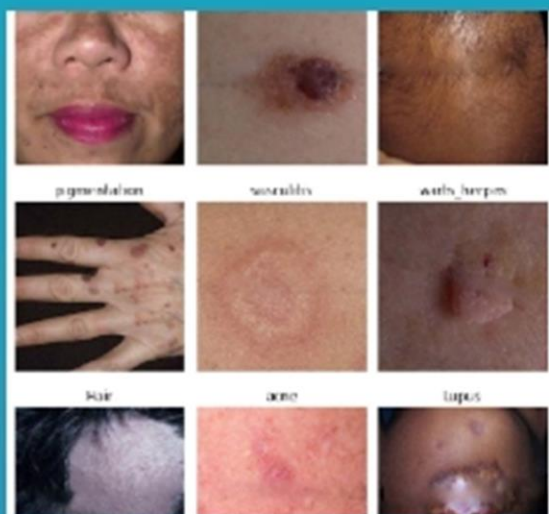


ISSN: 2835-1568 CODEN: USA DOI: 10.51521



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**CLINICAL IMAGE**

# Isolated Uterine Cervix Plasmacytoma Treatment Conundrum

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Received Date:  
31-10-2023  
Revised Date:  
05-11-2023  
Accepted Date:  
07-11-2023  
Published Date:  
14-11-2023

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**Citation:**

Kalu Samuel, William Ryan Huddleston, Simon Rajendran, Aaron Niblock (2023). Non-Hodgkin's Malignant Lymphomas of the Palatine Tonsils: A Case Report. *World J Case Rep Clin Imag.* 2023 October-November; 2(2)1-4.

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**Introduction**

A 64-year-old female presented with post-menopausal bleeding per vagina. Vaginal speculum examination revealed a 15 mm cervical polyp (0.1 g) which was excised at the time of colposcopy (Image A & B). Interestingly, histology reported a heavy infiltrate of plasmacytoid cells (Image C). Positivity was demonstrated with CD79a, CD138 and

**Abstract**

Solitary plasmacytoma is a type of plasma cell tumour that can either be present in the bone marrow as a Solitary Bone Plasmacytoma (SBP) or the soft tissue as an ExtraMedullary Plasmacytoma (EMP). In the case of both the distinction from other plasma cell dyscrasias such as multiple myeloma is based upon clinical, serological, histological and radiological studies. Solitary plasmacytoma is rare and accounts for 3-5% of all plasma cell malignancies [1]. They occur more in men than women (65% to 35%) with a median age of 55 years [2]. The axial skeleton is the most common site of SBP. However, if the plasmacytoma is an EMP approximately 85% of these lesions occur in the head and neck mucosa. We present a case of solitary extramedullary plasmacytoma confined to the cervix resulting in significant therapeutic and management implications owing to this unusual site of disease.

MUM1; there was kappa light chain restriction as seen on kappa in situ hybridisation (Image D).

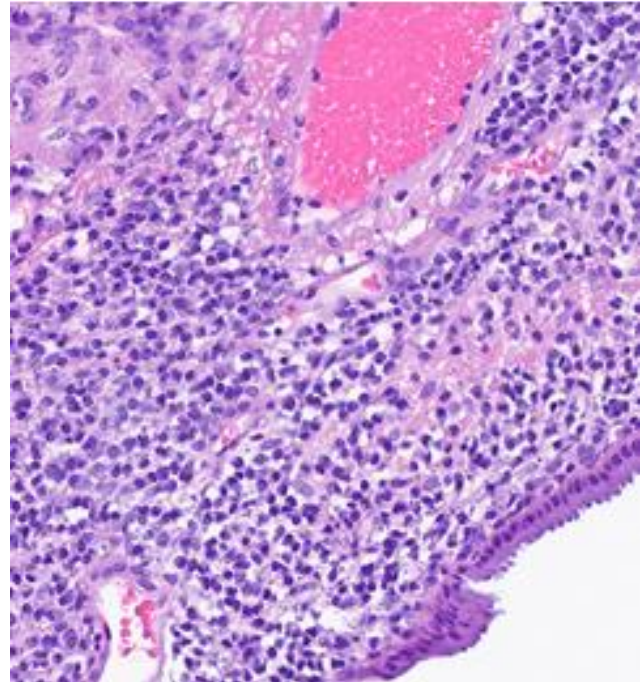
On referral to the haematological services a multiple myeloma screen was carried out. Relevant blood tests revealed a normal haemoglobin, calcium and kidney function. Serum free kappa / lambda light chain ratio was normal at 0.94 and no paraprotein was detected. PET CT scan showed no evidence of systemic or localised bone or marrow abnormality and no significant lymphadenopathy. There was no uptake around the uterine cervix, suggesting no residual disease; these findings were later supported by a dedicated MRI of the pelvis. Bone marrow biopsy had no clonal plasma cells.

Thus the diagnosis of a solitary extramedullary plasmacytoma arising in the uterine cervix was made. This is

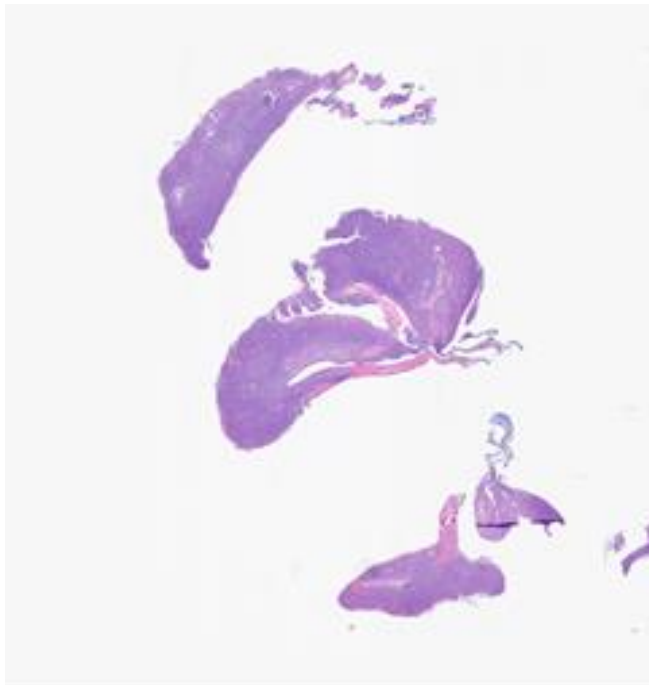
a relatively rare diagnosis but involvement of the cervix is even more unusual. Imaging as part of work up suggested no evidence of residual disease following polypectomy, however the biopsy margins were not clear. The documented treatment of choice for Plasmacytomas is radiotherapy given with curative intent (>40 Gy) which can result in long term disease-free survival in approximately 65% of patients with EMP [3].

Initial worked up for localised radiotherapy raised concerns of the risk of secondary malignancies at this highly sensitive site. This case was discussed at the radiotherapy oncologists, gynaecology and the haematology MDMs as well as expert opinions. However, it was a difficult decision weighing up the risk of radiotherapy verses proceeding to a hysterectomy in the long term. The patient was educated with regards the risk/benefit of both options. She decided to proceed with localised radiotherapy. The daily preparation and side effects experience by the patient for months during treatment was awful making the treatment decision on future cases even more difficult to decide.

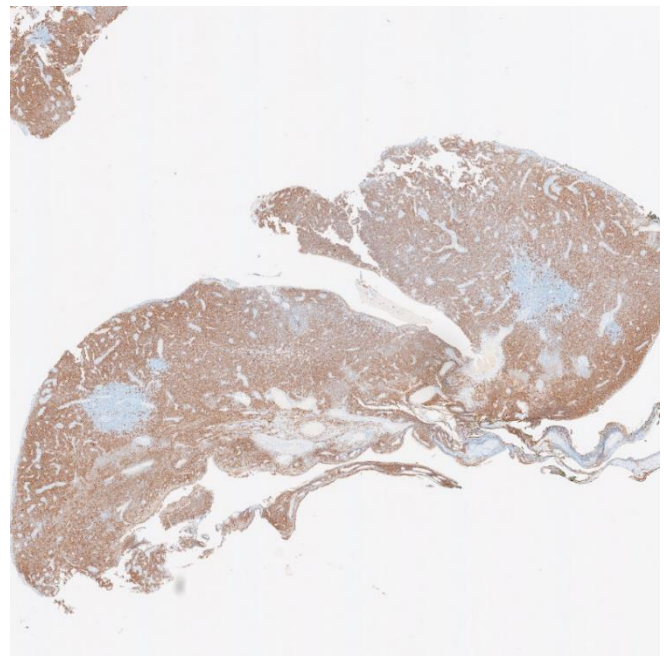
For EMP up to 50% of patients will go on to develop Myeloma within 2 years and disease progression at this point is similar to patients diagnosed with de novo symptomatic myeloma [4].



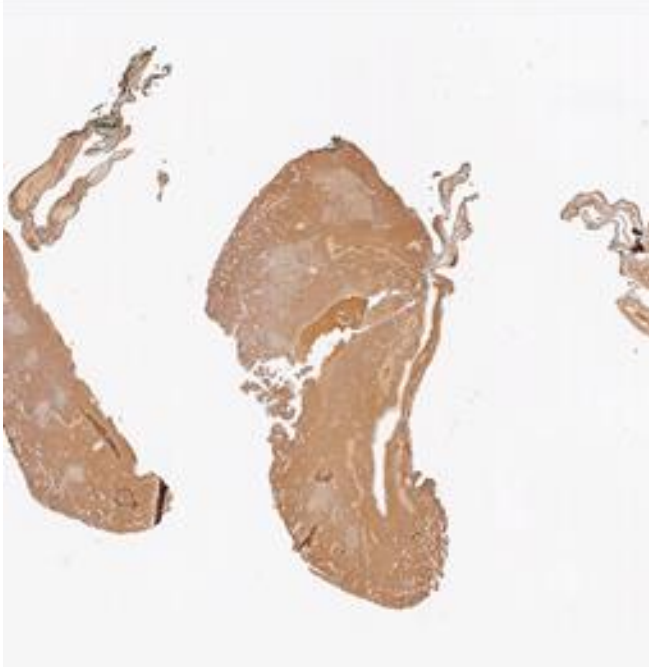
**Image B:** High power view demonstrating the preserved epithelium and vasculature. Diffuse infiltrate of medium sized homogeneous cells throughout the subcutaneous tissue.



**Image A:** Low power view of the polyp excised.



**Image C:** Diffuse infiltrate stains with CD138 confirming the presence of plasma cells.



**Image D:** The plasma cells stain with Kappa ISH confirming their clonal nature.

**Conflicts of interest:** There is no potential competing interests

**Ethical Consideration:** None

**Acknowledgements:** None

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