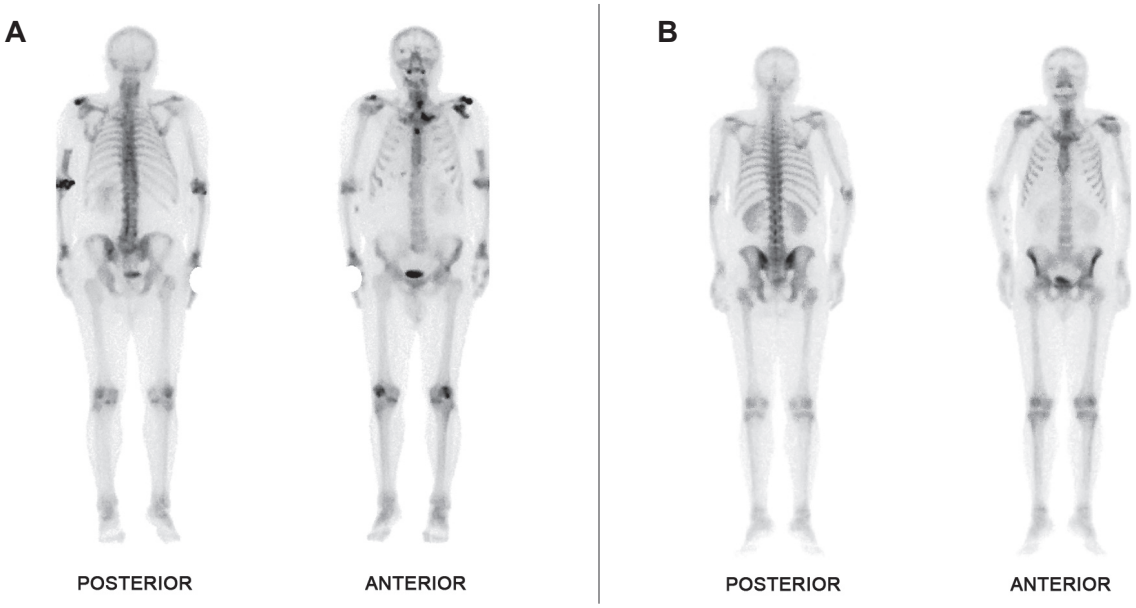

Figure 2. A: bone scintigraphy showing multiple bone metastases; **B:** complete response of bone metastases after treatment.

tive regimen in patients who suffer from severe adverse effects of the drug.

References

1. Montie JE, Stewart BH, Straffon RA, Banowsky LH, Hewitt CB, Montague DK. The role of adjunctive nephrectomy in patients with metastatic renal cell carcinoma. J Urol 1977; 117: 272-275.
2. Medical Research Council Renal Cancer Collaborators. Interferon-alpha and survival in metastatic renal carcinoma: early results of a randomized controlled trial. Lancet 1999; 353: 14-17.
3. Bard RH, Mydlo JH, Freed SZ. Detection of tumor angiogenesis factor in adenocarcinoma of kidney. Urology 1986; 27: 447-450.
4. Facchini G, Perri F, Caraglia M et al. New treatment approaches in renal cell carcinoma. Anticancer Drugs 2009; 20: 893-900.
5. Ansari J, Glaholm J, McMenemim R, James ND, Hussain SA. Recent advances and future directions in the management of metastatic renal cell carcinoma. Anticancer Agents Med Chem 2010; 20: 225-235.

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Late recurrence of granulosa cell tumor of the ovary with synchronous gastric signet-ring cell carcinoma

Dear Editor,

A 65-year-old nulliparous lady had a history of right ovarian cyst detected by a transvaginal ultrasound 10 years ago. She had a total abdominal hysterectomy and bilateral salphingo oophorectomy. The pathological diagnosis was granulosa cell tumor (GCT) of the ovary. Three cycles of adjuvant paclitaxel-cisplatin chemotherapy were administered. After 9 years, she complained of dyspepsia and heartburn. An endoscopic biopsy from a gastric ulcer revealed a signet-ring cell gastric carcinoma. Total gastrectomy and esophagojejunostomy were performed and, since cancer was at an early stage, she did not receive adjuvant chemotherapy. Two months after the operation a follow-up abdominal CT scan revealed a mass in the right ovarian space. Exploratory laparotomy showed a nodular lesion at the round ligament of the right ovarian space. Biopsy of this lesion

was consistent with recurrent ovarian GCT. The patient was treated with postoperative adjuvant chemotherapy (bleomycin, etoposide and cisplatin [BEP]).

GCTs of the ovary account for < 5% of all ovarian neoplasms. Two different types of GCTs have been defined: the juvenile and the adult types [1]. GTCs characteristically have a low malignant potential and a tendency for local spread and high local recurrence rates, sometimes many years after the initial diagnosis. Five-year survival rates usually are 90-95% for stage I tumors compared to 25-50% for patients presenting with advanced-stage disease. Although 5-year survival rates are quite good, GCTs have a propensity for late recurrence, some of them occurring as many as 37 years after diagnosis [2,3]. The tendency for late recurrence makes GCTs unique among malignant ovarian tumors. It is thought that recurrent tumors arise from peritoneal seeds which begin at a point of contact between the primary tumor and a lower abdominal or pelvic structure [3]. In our case the recurrent mass was localized at the round ligament. Although there is no standard therapy, surgery is the primary choice of treatment which alone provides cure in cases with disease confined to the ovaries and it is similar to that used for epithelial ovarian cancers. Recurrent tumors can be treated with surgical resection, post-operative chemotherapy or radiotherapy. Radiotherapy could play some role in advanced or recurrent disease with minimal residual tumor after operative debulking. Chemotherapy appears advisable in patients with large residual disease, inoperable recurrences, or metastases [1]. Due to the low incidence of these tumors, randomized studies assessing the value of postoperative adjuvant therapy in high-risk patients could not be possible up to date. Therefore, it is still not clear whether the use of postoperative treatment actually confers a survival advantage. Nevertheless, adjuvant platinum-based combination chemotherapy is considered in patients with advanced or metastatic disease [2]. The overall response rate to BEP combination, which is considered to be an effective regimen with tolerable toxicity as a first-line chemotherapy, was reported as 83% in metastatic sex-cord/stromal tumors of the ovary [2].

Signet-ring cell carcinoma can arise in many organs, but it usually occurs in the gastrointestinal tract, especially in the stomach (90% of the cases) [4].

To our knowledge this is the first case with two coexisting tumors composed of signet-ring cell gastric carcinoma and recurrent GCT.

References

1. Uygun K, Aydiner A, Saip P et al. Granulosa Cell Tumor of the Ovary: Retrospective Analysis of 45 Cases. Am J Clin Oncol 2003; 26: 517-521.
2. Schumer ST, Cannistra SA. Granulosa cell tumor of the ovary. J Clin Oncol 2003; 21: 1180-1189.
3. Ayhan A, Salman MC, Velipasaoglu M et al. Prognostic factors in adult granulosa cell tumors of the ovary: a retrospective analysis of 80 cases. Gynecol Oncol 2009; 20: 158-163.
4. Kunisaki C, Shimada H, Nomura M et al. Therapeutic strategy for signet ring cell carcinoma of the stomach. Br J Surg 2004; 91: 1319-1324.

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Mitral valve myxoma: usefulness of cardiovascular magnetic resonance imaging

Dear Editor,

Although not uncommon, cardiac myxoma presents a significant finding due to its deleterious effect on morbidity and mortality [1]. Heart valves are extremely rare locations for this tumor, either as primary site or site of recurrence.

A 58-year-old female patient was admitted due to progressive dyspnoea and orthopnoea. Twelve-lead ECG revealed normal sinus rhythm and no signs of acute ischemia. Transthoracic echocardiography (TTE) revealed an intracardiac mass (4.8 × 3.5 cm) in the left atrium prolabing in the diastole through the mitral valve into the left ventricle. Cardiac MRI (CMRI) was performed in order to differentiate primary cardiac tumor and thrombus. The examination confirmed the TTE findings of left atrial myxoma, which arose from the atrial side of the anterior mitral leaflet prolapsing through the mitral valve (Figure 1).

The patient underwent surgical resection of the tumor. Intraoperative findings confirmed the short attachment pedicle of the tumor to be on the atrial side of the anterior mitral valve in close proximity to the mitral annulus. The tumor was completely excised.