Endometrial adenocarcinoma extending to the uterine cervix in a premenopausal lady with negative cervical screening history, initially unsuspicious pelvic scans and unremarkable endometrial histopathological studies

A 46 year-old lady with frequent presentations to DEM for heavy periods with clots for 16 months. Initial pelvic US scan showed thickened and heterogenous endometrium in the fundus portion, measuring up to 16mm; increased endometrial vascularity with hyperplasia were also noted. Her CST has been normal. She underwent hysteroscopy D&C as CAT 1: polypoid endometrium suspicious of hyperplasia, three polyps in the anterior uterine wall and one polyp in the posterior uterine wall. Polyps were removed with curette and mirena was inserted.Histopathology study showed benign endometrial polyps and normal endometrium with secretory changes.

Later, speculum examination was done by gp for routine cst. The GP noticed an abnormal cervix and referred her for colposcopy. The CST showed no HPV with unsatisfactory LBC. Stis screen was negative. On colposcopy, the right side of the cervix was obscured due to what appeared to be some adhesion; acetowhite area that extended across the transformation zone and a significant contact bleeding of ectropion; a biopsy was taken from that area; the histopathology showed chronic cervicitis. CST repeated at time of colposcopy and was normal.

A year later, she presented to dem for heavy vaginal bleeding with clots. She had blood transfusion for acute hb drop down from 125 to 97 in 24 hours.Pelvic US scan showed features of adenomyosis, no uterine masses identified and mirena was in place. Her bleeding was controlled medically with tranexamic acid, ponstan and primolut-n.

A month later, she presented again to dem with heavy pv bleeding.Pelvic US scan showed large poorly circumscribed, hypervascular solid mass in the rt cervix/lower uterus segment warranted further ix. CT abdo-pelvis with contrast: bulky appearance of the uterine cervix which would be better assessed on ultrasound or MRI; no evidence of metastatic disease.

Tumour markers: ca 125 was 124, ca 19.9 was 55 (both elevated). CEA and HCG were normal

MRI pelvis: a large mass involving cervix, lower 1/3rd of uterus and the region of vaginal fornices. This corresponds to stage IIB. No metastasis nor lymphadenopathy. Normal both adnexa.

The patient underwent examination under general anaesthesia as well as LLETZ ,hysteroscopy d&c, endocervical curetting , pr examination , cystoscopy and replacement of mirena : 5cm cervical mass with increased nodularity at 9 o'clock site; sloughy tissue within the endocervical canal; pr examination and cystoscopy were unremarkable.

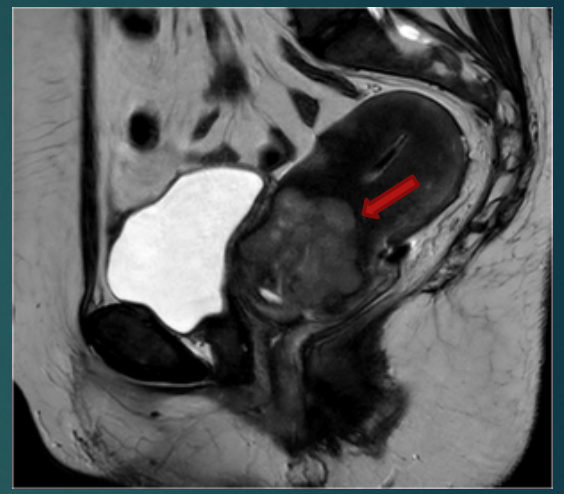
Histopathology results:
1. Endometrial curettings: adenocarcinoma.
2. Endocervical curettings: adenocarcinoma.
3. LLETZ biopsy: adenocarcinoma.
Primary endometrial adenocarcinoma of endometrioid type, with extension into the cervix.

Her father has bowel cancer and her sister has lynch syndrome (hereditary non-polyposis colorectal cancer (hnpcc)).

The patient was referred to gynaeoncology. She had open hysterectomy, bilateral salpingo-oophorectomy and debulking of pelvic lymphnodes with adjuvant therapy consideration. She was referred for genetic studies and colonoscopy (lynch syndrome is a risk factor for endometrial cancer).

Case discussion:
Endometrial cancer(ec) is the most common gynecologic malignancy in resource-abundant countries. Endometrioid carcinoma is the most common histologic type of endometrial carcinoma and of uterine malignancy overall. Endometrioid tumours tend to have a favorable prognosis and typically present at an early stage with abnormal uterine bleeding.The incidence peaks between ages 60 and 70 years, but 2 to 5 percent of cases occur before age 40 years [1]. Patients under age 50 who develop EC are often at risk because of chronic anovulation and/or obesity or estrogen therapy (ie, high estrogen level)[2-4].Total hysterectomy with bilateral salpingo-oophorectomy is standard for endometrial carcinoma at IIB stage (tumour invading the stromal connective tissue of the cervix but not extending beyond the uterus) [5]. Decisions about adjuvant therapy for endometrial carcinoma are based upon clinicopathologic factors (eg, stage, grade, tumour size, and patient's age). Other factors may also impact adjuvant therapy decisions (eg, lower uterine segment involvement, positive peritoneal cytology).Post-treatment surveillance is aimed at the early detection of recurrent disease[6]: 1)review of symptoms and physical examination including speculum and bimanual pelvic exam every three to six months for two years, then every six months or annually. The frequency of examinations depends upon the risk of persistent or recurrent disease. In a randomized trial, vaginal cytology, laboratory, or imaging investigations did not improve survival relative to physical examination only, even in high-risk patients [7]. 2) genetic counselling for patients with a family history suggestive of lynch syndrome (hereditary nonpolyposis colon cancer) or the finding of microsatellite instability on tumour screening.

MRI pelvis



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