

An Atypical Presentation of Endometrial Carcinoma

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Abstract

Background: Endometrial carcinoma is the fourth most common malignancy in women. It is mostly manifested by postmenopausal or irregular vaginal bleeding.

Case Report: We report a case of endometrial carcinoma with atypical symptoms and signs due to chronic vulval dystrophy which is not a risk factor for endometrial carcinoma but it effected the clinical picture. The clinical presentation and abdominal ultrasound findings suggested an adenexal cyst. However at laparotomy, the findings were suggestive of endometrial carcinoma with haematometra and hydrocolpos. She was successfully managed by total abdominal hysterectomy and bilateral salpingo-oophorectomy along with vaginal and urethral dilation. The histopathology confirmed endometrial carcinoma. Vulval biopsy showed chronic vulval dystrophy with no atypical cells, which responded to local steroid treatment.

Conclusion: In cases of atypical presentation, endometrial carcinoma can be missed by an unsuspecting clinician. Coexisting disease may complicate the clinical picture. However management according to guidelines may prevent misdiagnosis and suboptimal treatment.

Key Words: Endometrial carcinoma, atypical presentation of endometrial carcinoma, hydrocolpos, chronic vulval dystrophy.

Cite this article as: Iftikhar T, Rafique A, Alam J, Sultana N. An Atypical Presentation of Endometrial Carcinoma. J. Soc. Obstet. Gynaecol. Pak. 2016; Vol 6(4):197-200.

Introduction

Endometrial carcinoma is a disease of old age, 75% cases are in post-menopausal women and 25 % cases are premenopausal.¹ The worldwide incidence ranges from 26/100,000 women per year.² Endometrial carcinoma is usually diagnosed at an early stage because most common presenting complaints are postmenopausal or irregular vaginal bleeding.³ When diagnosed at an early stage it is treatable with surgery alone and carries a good prognosis. The first line specific investigations are transvaginal ultrasound and endometrial biopsy.⁴ The leading treatment option is total abdominal hysterectomy and bilateral salpingoophorectomy. In advanced stages radiotherapy, chemotherapy and hormone therapy is also recommended.⁴

Some causes of vulval dystrophy are lichen sclerosis, allergy, deficiency states and monilial vulvitis. Vulval dystrophy can progress to vulval intraepithelial neoplasm and there is also predisposition to vulval

squamous cell carcinoma, but there is no association with endometrial carcinoma.

We report a case of endometrial carcinoma with atypical presentation in a postmenopausal patient. The patient suffered from two different diseases i.e. endometrial carcinoma and chronic vulval dystrophy, which effected presentation of each condition.

Case Report

A 65 year old patient was admitted in the gynaecology ward of Rawal General Hospital. She was para 4 and menopausal for the 25 years. She presented with lower abdominal pain for six months, localized to suprapubic region, and progressively increasing in intensity. There was no complaint of postmenopausal bleeding, and apart from weak stream she had no urinary or bowel complaints. In her past history she had severe dyspareunia and perineal discomfort for 25 years. She gave no history of recent weight loss, any

gynaecological problems like pelvic inflammatory disease, local allergy, and vaginal surgery. There was no relevant past medical, surgical or family history. She belonged to low socioeconomic group.

She was a frail female with vital signs within normal range. Abdominal examination, revealed a 16 weeks mass which was soft, mobile, smooth and non-tender. She had no ascites, or palpable inguinal lymph nodes. On pelvic examination labia majora and labia minora were atrophic. Urethral meatus was small in size. Vaginal opening was completely closed and there was no bulge at the introitus. Digital examination could not be performed. Rectal examination revealed anterior bulging rectal mucosa which was smooth and mobile.

All general investigations were within normal range. CA 125 was 25 units. Abdominal pelvic ultrasonogram showed right adnexal cyst of 7.4 x 6.8 cm. Uterus was not visualized due to large mass. CT scan was advised for pre-operation staging but was refused by the patient due to high cost. Our provisional diagnosis was an adenexal cyst based on clinical evaluation and abdominal pelvic ultrasonogram. Her vulval complaints may be due to lichen sclerosis.

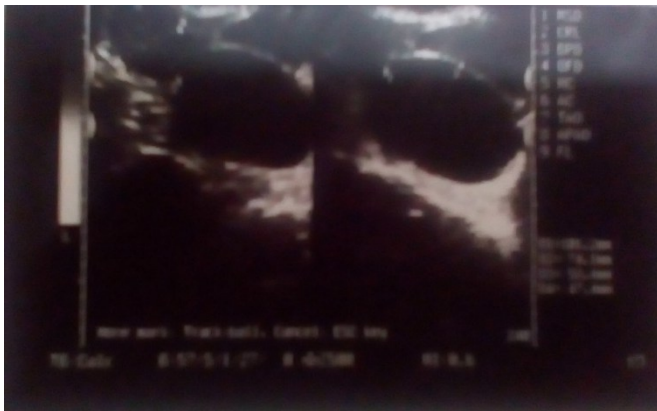


Figure 1: Ultrasound report of the patient giving impression of an adenexal cyst

Her staging laparotomy was planned with vulval biopsy to be taken after the operation.

Per-operatively the omentum, undersurface of diaphragm and surface of liver were smooth and normal looking. There was no ascites. Uterus was enlarged, greyish, vascular and very friable. Ovaries were atrophic. There was a massive hydrocolpos of 7 x 8 cms ballooning out into the abdomen pushing the uterus backward, filled with 600 ml of seromucinous brownish discharge. Pelvic lymph nodes were not enlarged. On local examination vaginal orifice was completely closed due to fibrosis and urethral opening

was stenosed. On intraoperative consultation pathologist gave provisional diagnosis of endometrial carcinoma but frozen section could not be performed due to lack of facility.

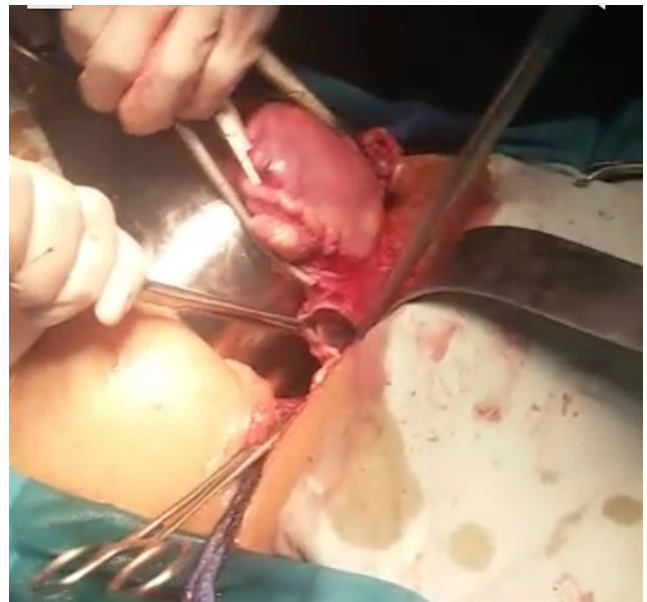


Figure 2: Peroperative finding uterus enlarged and vascular with hydrocolpos.



Figure 3: Horizontal section of uterus after hysterectomy showing irregular endometrial growth.

Total abdominal hysterectomy with bilateral salpingo-oophorectomy performed. Hydrocolpos was drained and vaginal vault closed with interrupted stitches. Vaginal and urethral dilatation performed. Vulval biopsy sent for histopathology.

Post-operative course was uneventful, she was discharged on third postoperative day with follow-up advice. The histopathology report showed "Endometrioid adenocarcinoma, moderately

differentiated, stage 1 B". The report categorized the patient into moderate to high risk. She was referred to the oncologist for further management. Post operation MRI showed "No residual or recurrent disease. No abdominopelvic lymphadenopathy, ascites, liver or lung base metastasis". The oncologist opinion was that no further radiotherapy is required. Patient was advised regular follow-ups. The vulval histopathology report showed chronic vulval dystrophy with no atypical or malignant cells. At six months follow up patient is well, taking regular treatment with steroids for vulval dystrophy with satisfactory response.

Discussion

Two types of endometrial carcinoma are described; Type-I and Type-II tumours.⁵ Type-I tumour develop in a background of thickened endometrium and high circulating estrogens. It is more common in premenopausal women and carry a better prognosis. Type-II tumours are associated with endometrial atrophy and occur in postmenopausal women. The epidemiological observation indicates link between hyperestrogenism and endometrial carcinoma with common causes being PCOS, estrogen only HRT, Tamoxifen. Comorbidities such as obesity, hypertension, and diabetes also show strong linkages.⁶ Our patient was slim and elderly with no condition associated with hyperestrogenism or associated medical disorders. This shows that endometrial carcinoma can occur in women with no obvious risk factors.

Endometrial carcinoma most commonly presents with heavy and irregular menses⁷, post-menopausal bleeding, or persistent vaginal discharge. Our patient did not present with above symptoms so we thought that cause of pain could be the adnexal cyst. The histopathology report showed "Moderately differentiated, endometrioid adenocarcinoma" which is type I tumour. Although our patient was 65 years old, post-menopausal with no evident link to hyperestrogenism, so in certain cases the type of tumour is not age related.

In United Kingdom, transvaginal ultrasound and endometrial biopsy are standard investigations for diagnosing endometrial carcinoma.⁸ For pre-operation staging CT abdomen/ chest / pelvis may be performed because it especially detects grossly enlarged lymph nodes. MRI pelvis shows local extent of disease. In some cases X-ray chest is also advised. In our patient TVS could not be done due to vaginal stenosis and on

abdominopelvic USG uterus was not visualized. This emphasizes the importance of pre operation CT scan / MRI to prevent misdiagnosis and suboptimal treatment.

In patients presenting with symptoms suggestive of endometrial carcinoma and endometrial thickness more than 4 mm endometrial sampling is planned.⁶ According to a study at PIMS hospital hysteroscopy and endometrial biopsy are commonly used in gynaecological practice for assessment of abnormal uterine bleeding.⁹ In cases where intraoperative findings are suggestive of malignancy, intraoperative consultation is sought which include gross evaluation by an expert pathologist and frozen section if facility is available.

The early stage disease is treated by surgery¹⁰, i.e. total abdominal hysterectomy with bilateral salpingo-oophorectomy with adjuvant radiotherapy if required. Advanced disease is treated by palliative surgery with post-operative adjuvant radiotherapy. Fortunately our patient had early stage disease and after surgery no further treatment was required.

Chronic vulval dystrophy is defined as any chronic skin change of uncertain etiology which effects the vulva. In patients suffering from chronic vulval dystrophy, part or whole of the lesion can progress to vulval intraepithelial neoplasm. There is also prediction to vulval squamous cell carcinoma. But there is no association with endometrial carcinoma. Most common symptoms are local itching and dyspareunia. Our patient had dyspareunia and perineal discomfort. Biopsy is mandatory for diagnosis. Treatment is high potency steroids. Counselling of the patient regarding titration of the regime according to severity is necessary. Perineoplasty is recommended when there is persistent complain of dyspareunia.

Conclusion

In cases of atypical presentation, endometrial carcinoma can be missed by an unsuspecting clinician. A high index of suspicion should be maintained by clinicians working in developing countries where diagnostic facilities may be limited or not affordable poor patients. Coexisting disease may complicate the clinical picture. Through investigations according to guidelines should be performed. Early and correct diagnosis, with proper and timely planned surgery, can result in complete cure of this malignant condition.

ACKNOWLEDGEMENT: We are thankful to the patient for giving permission of her case report to be published.

References

1. Khan RL, Khan YL. Tumors of the Uterus, Tubes & Ligments. In Text Book Of Gynaecology. 6th ed. Lahore: Medical Publications (Lahore); 2011; 232.
2. Lusley DM, Kilby MD. Endometrial Carcinoma: Incidence. Obstetrics & Gynaecology: An Evidence-based Text for the MRCOG. 3rd ed. London (UK) : CRC Press. 2015; 873.
3. Creasman WT. Medscape. [Online].; 2015 [cited 2016 July 23. Available from: [HYPERLINK "http://emedicine.medscape.com/article/254083-clinical"](http://emedicine.medscape.com/article/254083-clinical) \ | "showall" <http://emedicine.medscape.com/article/254083-clinical#showall> .
4. Endometrial Carcinoma Treatment (PDQ®) – Health Professional Version. [Online]. [cited 2016 June 5. Available from: [HYPERLINK "https://www.cancer.gov/types/uterine/hp/endometrial-treatment-pdq"](https://www.cancer.gov/types/uterine/hp/endometrial-treatment-pdq) \ | "section/all" <https://www.carcinoma.gov/types/uterine/hp/endometrial-treatment-pdq#section/all> .
5. Hoffman B, Schorge J, Schaffer J, Halvorson L, Bradshaw K, Cunningham F. Endometrial Carcinoma. Williams Gynecology. 2nd ed. New York (USA) : McGraw-Hill. 2012; 825.
6. Collins S. Endometrial Carcinoma: Risk Factors. Oxford Handbook Of Obstetrics And Gynaecology (Pakistan Edition). 3rd ed. Karachi: Oxford University Press; 2013; 734.
7. Endometrial Carcinoma Treatment (PDQ®) – Patient Version. [Online].; 2016 [cited 2016 July 23. Available from: [HYPERLINK "https://www.cancer.gov/types/uterine/patient/endometrial-treatment-pdq"](https://www.cancer.gov/types/uterine/patient/endometrial-treatment-pdq) \ | "section/all" <https://www.carcinoma.gov/types/uterine/patient/endometrial-treatment-pdq#section/all> .
8. Saso Srdjan, Chatterjee Jayanta, Georgiou Ektoras, Ditre Anthony M, Smith J Richard, Ghaem-MaghamsiSadaf et.al. Endometrial cancer BMJ. 2011; 343 :d3954
9. Mahmud G, Bangash K, Ashraf A. Outpatient Diagnostic Hysteroscopy in Premenopausal Women With Abnormal Uterine Bleeding Below 35 Years Of Age. Journal Of Society Of Obstetricians & Gynaecologists Pakistan. 2012; 2(3): 139-144.
10. Vale CL, Tierney J, Bull SJ, Symonds PR. Cochrane Database of Systematic Reviews. [Online].; 2012 [cited 2016 July 27. "<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003915.pub4/abstract;jsessionid=DBE0127CDEF1AF16109123929140CCFA.f01t02>" <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003915.pub4/abstract;jsessionid=DBE0127CDEF1AF16109123929140CCFA.f01t02> .
11. Laughlin-Tommaso SK. Mayo Clinic. [Online].; 2016. <http://www.mayoclinic.org/diseases-conditions/endometrial-cancer/diagnosis-treatment/diagnosis/dxc-20205802>"
12. Endometrial Carcinoma Treatment (PDQ®) – Health Professional Version. Elsevier; 2016 <https://www.carcinoma.gov/types/uterine/hp/endometrial-treatment-pdq#section/all> .