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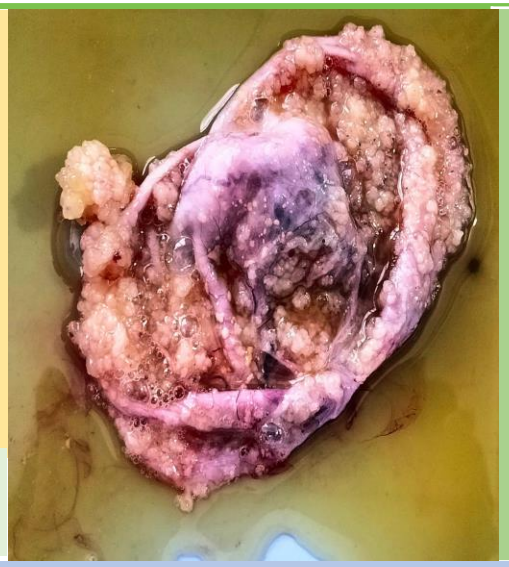
Title: A Rare Case of Endometrial Carcinoma: A Case Report and Review

INTRODUCTION:

Endometrial carcinoma most often occurs in women in their sixth and seventh decades of life, with 75% of cases occurring in women older than 50 years of age. About 90% of women with endometrial carcinoma have vaginal bleeding or discharge as their only presenting symptom[1]. Less than 5% of women diagnosed are asymptomatic. Endometrial hyperplasia occurs in 5% to 10% of patients with postmenopausal uterine bleeding. Less than 10% of patients with postmenopausal bleeding have endometrial cancer. The endometrioid type of adenocarcinoma accounts for about 80% of endometrial carcinomas.

OBJECTIVE: To study a case of 51-year-old nulligravida female patient diagnosed with endometrial carcinoma.

CASE REPORT: A 51-year-old, nulligravida came with complaints of PV spotting for 3 months, for which she underwent an endometrial biopsy. On examination, the abdomen was soft, and nontender, and the uterus was normal in size & retroverted with bilateral fornixes free and nontender. The biopsy had an impression with features suggestive of endometrial hyperplasia with focal atypia, diagnosed with endometrial carcinoma. Under epidural along with spinal anaesthesia type I essential hysterectomy with pelvic sentinel lymph node biopsy was performed. The biopsy impression was histological type: Endometroid carcinoma with squamous differentiation, histological grade 3 with myometrial invasion of >50%(1.5cm), and no lymphatic or vascular invasion or distant metastasis, with FIGO Stage II C. Postoperatively after stabilizing, the patient was referred to a higher centre for locoregional radiotherapy.



DISCUSSION

Most patients with endometrial cancer present with postmenopausal bleeding should take preventive measures by undergoing diagnostic dilatation & curettage, a transvaginal ultrasound, CT, MRI, pelvic examination, endometrial biopsy, counselling regarding undergoing further surgical staging, including hysterectomy, bilateral salpingo oophorectomy, and peritoneal cytology. Lymph node assessment is necessary for most patients but may be omitted in patients with negligible risk of lymphatic spread. Post-operative adjuvant radiotherapy and chemotherapy in selected patients with endometrial cancer decreases the risk of local (vaginal/pelvic) recurrence. Radiotherapy is the best treatment option. A 5-year survival rate in endometrial cancer is approximately 75%.

CONCLUSION

About 15% to 25% of endometrioid carcinomas have areas of squamous differentiation. According to FIGO grading system proposed in 1989, tumors are grouped into three grades: grade 1, 5% or less of the tumor shows a solid growth pattern; grade 2, 6% to 50% of the tumor shows a solid growth pattern; and grade 3, >50% of the tumor shows a solid growth pattern[2]. Radiotherapy is the best treatment option for patients with isolated local–regional recurrences who have not received prior radiation[3]. The molecular biology of endometrial cancer has specific targeted chemotherapeutic strategies.

REFERENCES:

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