

Endometrial Cancer. Case Report and Review of the Literature

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ABSTRACT

Endometrial cancer is one of the main gynecological cancers worldwide, risk factors play a very important role, and very recently it has been associated with obesity. There is a classification with 7 different types of endometrial tumor. Hysterectomy continues to be the primary treatment in patients with endometrial cancer, adjuvant treatment depends on the stage and prognosis of the patient.

KEYWORDS: Endometroid, Hysterectomy, Biopsy, Carcinoma

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INTRODUCTION

Endometrial cancer is the second most common gynecologic malignancy worldwide, originating in the endometrium, due to chronic estrogenic stimulation. It mainly affects postmenopausal women. The average age at diagnosis is 60 years, the incidence is from 75 to 79 years in 85% of cases, and only 5% before 40 years of age. The most significant risk factors are age, race, metabolic syndrome, obesity, nulliparity, tamoxifen, raloxifene, aromatase inhibitors, unopposed estrogen exposure and genetic predispositions to endometrial cancer.^{1,2,3}

It is divided into two large groups, according to their clinicopathological characteristics: Type I: endometroid, and type II: not related to estrogen exposure. They include endometroid grade 3 and non-endometroid subtypes: serous, carcinosarcomas, clear cell, mixed and undifferentiated.⁴ The WHO classification describes 7 different tumor types: endometroid carcinoma which comprises 80% of endometrial cancer, usual type and variants, mucinous adenocarcinoma 1-9%, serous carcinoma which represents less than 10% of endometrial cancer, clear cell carcinoma <5%, neuroendocrine carcinoma, mixed carcinoma, undifferentiated carcinoma, and undifferentiated carcinoma.⁵

Endometroid carcinoma is the most common carcinoma accounting for 75 to 80% of cases. Histologically they are composed of tall wall-to-wall aligned columnar cells with no intervening stroma and the glands have a smooth luminal contour. Most of these tumors express estrogen and progesterone receptors on the surface. Endometroid carcinoma

is graded using the FIGO grading system, which takes into account the architectural pattern and nuclear grade: Grade 1: Less than 5% solid growth pattern. Grade 2: 6-50% solid growth pattern. Grade 3: >50% solid growth pattern.⁶

The diagnosis is made through the histopathological study of the endometrial biopsy, which can be performed by various methods: ambulatory endometrial biopsy, fractionated uterine curettage and hysteroscopy. Taking into account that the gold standard for endometrial tissue sampling is the biopsy guided by hysteroscopy.^{1,7}

Treatment in early stages is surgical, based on total abdominal hysterectomy, bilateral salpingo-oophorectomy and pelvic lymphadenectomy. No adjuvant treatment is recommended for this group, as it is not beneficial. The recommended adjuvant treatment for intermediate risk and high intermediate risk is tailored according to clinical risk factors. The high-risk group should receive radiotherapy or chemotherapy. Patients presenting with residual disease in the pelvis and limited distant metastases, rely on chemotherapy and radiotherapy to minimize local and distant recurrent risk. Metastatic disease may benefit from optimal cytoreductive surgery. The preferred adjuvant/neoadjuvant regimen is Carboplatin plus Paclitaxel.⁸

OBJECTIVE

To present a case of a 23-year-old female patient diagnosed with endometroid carcinoma.

MATERIAL AND METHODS

Female patient, 23 years old, who began 3 months ago with

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edema of the right pelvic limb, in addition to a feeling of abdominal heaviness, and intestinal constipation, frank dysmenorrhea, self-medicated with NSAIDs, with moderate improvement, then began with intermittent pain and a feeling of mass in the abdomen. Within her medical history, heredofamilial antecedents: Diabetes Mellitus 2 and Systemic Arterial Hypertension, she denies a history of cancer. Personal pathological history: denies chronic degenerative diseases, denies allergies, denies surgeries, denies transfusions, denies previous hospitalizations, complete vaccination schedule, non-pathological personal history: adequate hygiene, inadequate nutrition in quality and quantity, sedentary, passive smoking, positive ethylism referred to as social, drug addictions denied, no tattoos, lives with 3 pets, dogs, gynecological history: menarche at 9 years of age, irregular amenorrhea type cycles of up to 120 days, followed by hypermenorrhea and dysmenorrhea, untreated, denies active sexual life, nulliparous. Cervical cytology denied, somatometry: height 1.65 m, weight 110 kg, BMI 35, obesity grade III.

Laboratory and imaging studies were requested, prolactin 17.280 ng/ml, estradiol 11.800 pg/ml, FSH 9.190 mIU/ml, LH 4.430

mIU/ml T3 total 1.010 ng/ml, T4 total 8.910, TSH 3.750 U/ml. The pelvic ultrasound showed a heterogeneous irregular mass of 20 x 14 cm, it was decided to perform a contrasted abdominal tomography, where an anteverted uterus was observed with an increase in its dimensions at the expense of a solid lesion, measuring 21.5 x 14.1 x 14.4 cm, in the right adnexa a cyst of simple appearance was observed.

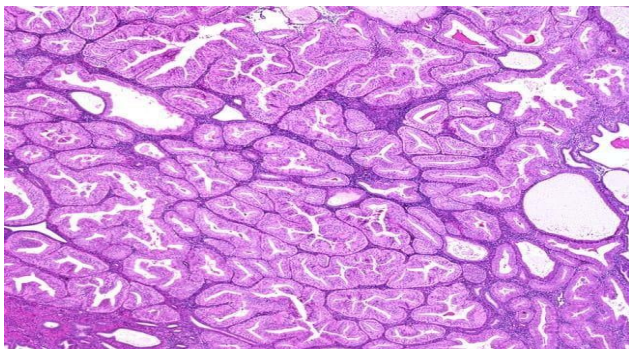


Figure 1. Endometroid carcinoma, invasion into the smooth muscle bundles of the myometrial wall of the uterus.

RESULT

In view of the diagnostic suspicion based on clinical data and tomographic findings, the patient underwent exploratory laparotomy with infraumbilical midline incision, under peridural block at L2-L3 level, and an irregular tumor lesion was identified. The definitive macroscopic histopathological study indicated endometroid carcinoma in both ovaries and uterus, with peritoneal implant.

CONCLUSIONS

Although there is ample scientific evidence supporting the risk factors associated with endometrial cancer, with the age of onset being more common in older women, it is also being diagnosed in younger and younger women. Young or premenopausal women diagnosed with endometrial cancer tend to have obesity, anovulatory cycles, or a genetic predisposition to develop this disease. Given its impact on early age of onset, more case-control studies are warranted to learn more about the risk factors involved in early endometrial cancer.

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