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ENDOMETRIAL CARCINOMA IN A YOUNG FEMALE: REPORT OF TWO CASES

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ABSTRACT: Endometrial cancer (EC) is the most common gynecologic malignancy in developed countries and affects predominantly postmenopausal women. It is estimated, however, that 15%–25% of women will be diagnosed before menopause. Total abdominal hysterectomy, bilateral salpingooophorectomy (BSO), and surgical staging are usually performed in the treatment of endometrial cancer. Further treatment is tailored according to the presence or absence of various risk factors. That conservative treatment of early-stage endometrial adenocarcinoma in young women wishing to preserve fertility should be considered in carefully selected cases. Assisted reproductive technologies may be helpful for immediate achievement of pregnancy in such patients.
We report managements of two young patient of endometrial carcinoma.

KEYWORDS: Endometrial adenocarcinoma; young women; Risk factors; prognosis; treatment.

1 INTRODUCTION

Endometrial carcinoma is a disease of peri- and postmenopausal women. It is relatively rare in the young age group (younger than 40 years old) and accounts only for 2.1–14.4%. [1].

While hysterectomy with bilateral salpingo-oophorectomy with assessment of the retroperitoneal lymph nodes is standard initial treatment for endometrial cancer, younger women may desire fertility sparing options. [1]. Published studies have frequently categorized stage I endometrial cancer patients as low-risk, intermediaterisk, and high-risk for recurrence on the basis of surgical pathologic findings. Recommendations for adjuvant therapy are based on the estimated risk for disease recurrence [2]. We report the two cases of the endometrial cancer: the first a 26-year-old patient with an endometrial cancer diagnosed at Stage IA grade 1 according to the FIGO 2000 classification and second patient a 33years old with an endometrial cancer at grade I de l'OMS [3].

2 CASE S PRESENTATIONS

A 26-year-old nulligravidia, 1, 60 in height, weighing 55 Kg, was firstly presented to her local hospital with 10 months of menorrhagia. She was non-smoker and she had not been taking any hormonal treatments or oral contraceptives. Her menstrual period was normal. There is no past history or family history of diabetes or hypertension. A transvaginal ultrasound showed uterine fibroid making 6 x 5 cm with submucosal component and a thick endometrium of 18 mm. The ovaries were normal. A recent cervical smear test had been negative. The patient underwent myomectomy by laparotomy. The histopathological examination revealed well differentiated an endometrial adenocarcinoma stage IA grade 1 according to the FIGO without myometrial invasion on the resected portion of the myometrium. The patient was then referred to our hospital for further managements. Physical examination revealed a healthy non-obese female. Pelvic examination was normal and a transvaginal ultrasound revealed a normal size uterus with an endometrium 10 mm of thickness. During the further assessment, a MRI scan hasn't shows anomalies. The other abdominal organs were lesion-free. It was decided by the surgeon and oncologist that patient should undergo surgery. Patient underwent a total hysterectomy with bilateral salpingo-oophorectomy and pelvic lymph-adenectomy. Histopathological examination of the operated specimen revealed no residual

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tumor or lymph node involvement. The surgery was followed by vaginal curietherapy. She remains well with no evidence of recurrence at 12 months follow ing her operation.

A 33 years old primigravida 1,62 cm, 68 kg, without past history of chronic pathology or family history neoplasic diseases, she is not non smokers. She was initially presented 4 months of menorrhagia without others symptoms. The physical examination was normal, and no signs of hyperestrogenism, the pelvic examination no anomaly found. Endovaginal ultrasound was did showed intrauterine fibrome about 16/13mm that deviates endometrial cavity. A cervical smear test had been negative. An operating hysteroscopy was decided which was showed about a myome in posterior wall of uterus, which was resected ,the anamatopathology examination which came back in favors of an endometrial adenocarcinoma of stade I according to the WHO classification. Patient underwent a total hysterectomy with bilateral salpingo-oophorectomy and bilaterales pelvic lymph-adenectomy. The definitive report of the anatomo-pathological examination made following conclusion: An endometrial adenocarcinoma of the grade I of the WHO classification with infiltrating more of 5O percent of the myometrial thickness. The parameters and the appendix are not infiltrated. Absence of vascular emboles, The bilateral ilio-obturatre cleaning-out returned healthy. The patient was sent in the service of radiotherapy for a complementary curitherapy.

3 DISCUSSION

Endometrial cancer is primarily a disease of postmenopausal women. However, 20%–25% of them are diagnosed before the menopause and 2%–14% occur among younger women (less than 40), Endometrial carcinomas in young women have traditionally been thought to be less aggressive than those in older women [4, **5**].

The most reported risk factors of endometrial cancer are anovular cycles associated with polycystic ovarian syndrome (PCD), hypertension, diabetes, obesity, use of tamoxifen, Women with breast or colon cancer, Pelvic radiation, Younger patients with endometrial carcinoma tend to have a history of estrogen use or hormone-related disorders such ovarian dysfunction, chronic anovulation, infertility, obesity and PCO (odds ratio: 3.1; 95% confidence interval, [6].

Most cases of endometrial cancer are diagnosed in early stage because of abnormal uterine bleeding as the presenting symptom in 90% of the cases [2,7]. The two our cases there is no risk factors and they presented abnormal vaginal bleeding.

Endometrial carcinoma in young nulliparous women poses a challenge for diagnosis and management, the diagnosis is often delayed and then conservation of the uterus is not feasible, the first step in the diagnostic patients with postmenopausal bleeding or suspected endometrial cancer in non menopausal womens is the measurement of endometrial thickness, followed by endometrial sampling, saline infusion sonography can be used to distinguish between focal and diffuse pathology, hysteroscopy should be used as the final step in the diagnostic pathway of women with postmenopausal bleeding[2,4,5,7].

Both our patients the initial diagnosis was intrauterine fibrome first one by a transvaginal ultrasound and second by hysteroscopy but anatomical examination made diagnosis of endometrial carcinoma. In the young women, the adenocarcinoma is usually a well differentiated, endometrioid type lesion, associated with minimal myometrial invasion, early-stage disease (According to the studies of Evans-Metcalf et al and Fahri et al it seems that the frequency of Grade 1 tumors was higher in young women, reaching 90%) and good prognosis [1,8].

Endometrial cancer is generally staged according to the International Federation of Gynecology and Obstetrics (FIGO) system [2,9].

Young patients who develop endometrial cancer usually have risk factors that are related to unopposed estrogen stimulation, thus primary hormonal therapy with progesterone, as an alternative treatment for surgery, offers them the only option to preserve their fertility [6, 7, and 9].

Surgery is the classic treatment for endometrial cancer, it consists of total hysterectomy and bilateral salpingo-oophorectomy, with a pelvic and aortic lymphadenectomy if required, Curietherapy and radiotherapy are indicated when there is a high risk of recurrence [10, 11].

In our patients, the first patient, the histopathological examination revealed well differentiated an endometrial adenocarcinoma stage IA grade 1 according to the FIGO without myometrial invasion while second one An endometrial adenocarcinoma of the grade I of the WHO classification with infiltrating more of 5O percent of the myometrial thickness, complementary curitherapy was undergo for two patients.

According to the international literature, it appears that the most important factor for conservative treatment is selecting the “ideal patient”. That is: A well-differentiated endometrial carcinoma that does not deeply invade the myometrium.

Absence of suspicious pelvic or pre-aortic nodes. Absence of synchronous ovarian tumors. No contraindications for medical treatment. The patient understands and accepts that this is not a standard treatment. The patient should show her desire to complete the follow-up protocol [4,11].

4 CONCLUSION

The young women affected by endometrial cancer are often nulliparas with a past history of infertility and thus are very anxious to preserve their fertility; this constitutes a dilemma for the patients as well as their physicians. Standard treatment for these patients includes hysterectomy with bilateral salpingo-oophorectomy.

REFERENCES

[1] Joshua P, kesteron and James fanning. Fertility-sparing treatment of endometrial cancer: options, outcomes and pitfalls. J Gynecol Oncol. 2012 Apr; 23(2): 120–124.
[2] N. Colombo, E. Preti, F. Landoni, S. Carinelli A. Colombo, C. Marini & C. Sessa. Endometrial cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Ann Oncol. Ann Oncol. 2013 Oct; 24 (6) vi33-8.
[3] Kupets R, Le T. The Role of Adjuvant Therapy in Endometrial Cancer. J Obstet Gynaecol Can. 2013 Apr; 35(4):375-9.
[4] Fadhlaoui A1, Ben Hassouna J, Khrouf M, Zhioua F, Chaker A.Endometrial Adenocarcinoma in a 27-Year-Old Woman. Clin Med Insights Case Rep. 2010(3):31-9.
[5] Tran BN1, Connell PP, Waggoner S, Rotmensch J, Mundt AJ. Characteristics and Outcome of Endometrial Carcinoma Patients Age 45 Years and Younger. Am J Clin Oncol. 2000 Oct; 23(5):476-80.
[6] Parslov M1, Lidegaard O, Klintorp S, Pedersen B, Jønsson L, Eriksen PS, Ottesen B. Risk factors among young women with endometrial cancer: A Danish case-control study Am J Obstet Gynecol. 2000 Jan; 182(1 Pt 1):23-9.
[7] Garg K1, Shih K, Barakat R, Zhou Q, Iasonos A, Soslow RA, Endometrial carcinomas in women aged 40 years and younger: tumors associated with loss of DNA mismatch repair proteins comprise a distinct clinicopathologic subset. Am J Surg Pathol. 2009 Dec;33(12):1869-77.
[8] Olawaiye AB1, Boruta DM 2nd. Management of women with clear cell endometrial cancer A Society of Gynecologic Oncology (SGO) review. Gynecology Oncol. 2009 May; 113(2):277-83.
[9] Salha O1, Martin-Hirsch P, Lane G, Sharma V. Endometrial carcinoma in a young patient with polycystic ovarian syndrome: first suspected at time of embryo transfer. Hum Reprod. 1997 May; 12(5):959-62.
[10] A. Goodman and B. Goff. Endometrial Cancer: Screening, Diagnosis, and Surgical Staging. Humana Press, a Part of Springer Science + Business Media60327(1)044-1_2.
[11] Kalogera E, Dowdy SC, Bakkum-Gamez JN. Preserving fertility in young patients with endometrial cancer: current perspectives. Int J Womens Health. 2014 Jul 29(6):691-70129; 6:691-701.