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Case Report

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HIGH-GRADE SEROUS ENDOMETRIAL CARCINOMA ASSOCIATED WITH BASAL ADENOID CARCINOMA OF THE UTERINE CERVIX ABOUT A CASE

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ABSTRACT

We report the case of a 65-year-old patient, postmenopausal for 10 years, who presented with postmenopausal metrorrhagia for 3 months, in whom biopsy curettage of the endometrium showed high-grade serous endometrial carcinoma, who underwent exploratory laparotomy with enlarged colpohysterectomy, bilateral adnexectomy, bilateral pelvic curage, omentectomy and appendectomy, and discovered basal adenoid carcinoma of the uterine cervix on anatomopathological examination of the operative specimens.

KEYWORDS: high-grade serous endometrial carcinoma; basal adenoid carcinoma of the uterine cervix; enlarged colpohysterectomy; bilateral adnexectomy; appendectomy; omentectomy; bilateral pelvic curage; radiotherapy; anatomopathology.

INTRODUCTION

Serous endometrial carcinoma is considered a high-grade carcinoma, often arising after the menopause and often manifesting as post-menopausal metrorrhagia.

Basal adenoid carcinoma of the uterine cervix is a rare tumor deriving from the basal reserve cells of the squamous epithelium. It occurs mainly in post-menopausal women, is infiltrative and associated with HPV 16 infection. It is often asymptomatic and discovered on a conization or hysterectomy specimen performed for another pathology, such as the serous endometrial carcinoma described in our case.

CASE REPORT

65-year-old female, gravida 6, para 5, history of spontaneous abortion at 2 months, hypertension on treatment, postmenopausal for 10 years, presenting with postmenopausal metrorrhagia for 3 months.

Pelvic magnetic resonance imaging showed an endometrial lesional process classified FIGO IA, without pelvic adenopathies, with endometrial thickening of 24 mm.

Biopsy curettage of the endometrium showed a high-grade serous endometrial adenocarcinoma with absence of vascular emboli.

After a multidisciplinary consultation, the patient underwent an exploratory laparotomy. On exploration, there was a neoformation of the posterior aspect of the right broad ligament, which was removed and sent for histological study.

enlarged colpohysterectomy with bilateral adnexectomy and bilateral pelvic curage, appendectomy and omentectomy.

Anatomopathological examination of the surgical specimens showed:
-high grade serous endometrial carcinoma infiltrating less than 50% of the myometrium, stage: pT1a N0 Mx, FIGO: stage IA.
-basal adenoid carcinoma of the uterine cervix extending 0.7 cm horizontally, 0.4 cm in depth and located 0.3 cm from the nearest anterior border, stage: pT1a Nx Mx, FIGO: stage IA2.
-no vascular emboli.
-right and left uterine horns free of tumour infiltration.
-annexes, vaginal flanges and parametrium free of tumour.
- right pelvic curage : 5N-/5N.
-left pelvic curage : 8N-/8N.
-omentectomy: non-specific chronic fibro-inflammatory changes, absence of lesion suspected of malignancy.
-neoformation of the posterior aspect of the right broad ligament, morphological appearance compatible with a

lipocytic lipoma and absence of histological evidence of malignancy.
-appendix of normal morphology, with no histological evidence of malignancy.

The patient presented with a postoperative upper gastrointestinal obstruction 15 days after surgery. An emergency exploratory laparotomy showed evisceration and incarceration of the ileal loop, 1 metre from the last ileal loop, with signs of distress and perforation. Segmental bowel resection was performed, removing the necrotic loop and performing a terminal-terminal bowel anastomosis and saline lavage.

Pathological examination of the bowel resection showed non-specific acute inflammatory changes with no tumour lesions.

The patient's case was presented again at a multidisciplinary consultation meeting, which decided to carry out radiotherapy and surveillance.

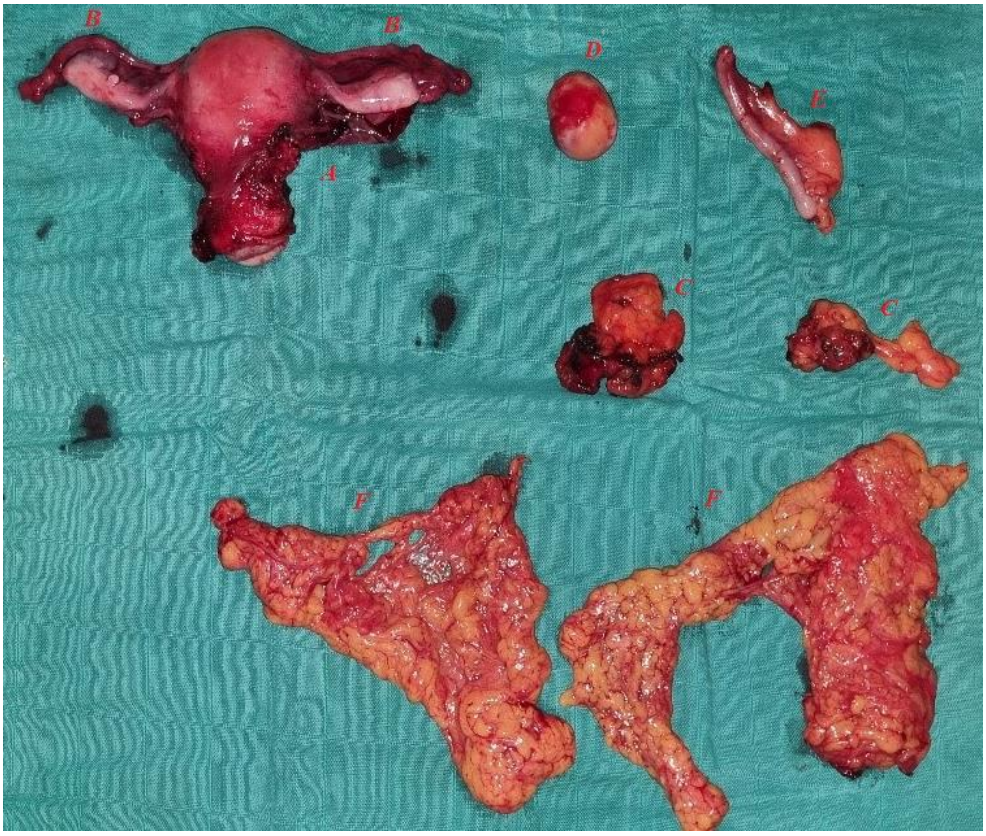

Figure 1: enlarged colpohysterectomy (A), bilateral adnexectomy (B), bilateral pelvic curage (C), neoformation of the posterior aspect of the right broad ligament (D), appendicetomy (E), omentectomy (F).

DISCUSSION

Endometrial cancer is common in older women, and is often associated with co-morbidities. It occurs in the majority of cases after the menopause (mean age of onset 69 years), and overweight is the primary etiological factor.[1]

Endometrial cancers were classified into two groups according to histological type: type I, endometrioid, considered to have a good prognosis, and type II (non-endometrioid), serous, clear-cell and carcinosarcoma, with a poorer prognosis.

In 2020, the WHO published a new version of the classification of endometrial cancers, including the emergence of new entities.[2]

A binary distinction between low-grade (FIGO grades 1-2) and high-grade (grade 3) can also be used.[3] Serous carcinomas are considered high-grade endometrial carcinomas.[4]

To confirm gynaecological origin, the CK7, CK20, PAX8 antibody panel is used (level 2, grade B). Tumours of gynaecological origin are CK7+/CK20- (except mucinous carcinomas) and PAX8+ (except undifferentiated endometrial carcinomas often PAX8- and mucinous carcinomas PAX8 inconstantly +). For guidance on cervical versus endometrial or adnexal origin, particularly in the case of endometrioid adenocarcinoma, the P16, monoclonal CEA, RE/RP, vimentin panel is used. Tumors of cervical origin are most often P16+ (homogeneous, diffuse, high-intensity labeling), ACE+, RE-, RP-, vimentin-, whereas adenocarcinomas of endometrial or adnexal origin have

heterogeneous mosaic p16 labeling with positive receptors (RE+, RP+), ACE -, vimentin+. These data should always be compared with clinical findings. WT1 is the most useful marker for differentiating serous adenocarcinoma of endometrial origin from adnexal origin, but this differential diagnosis remains very difficult (level 2, grade B). In serous endometrial adenocarcinomas, WT1 expression is usually negative or focal, so the presence of intense, diffuse WT1 expression should prompt a search for an adnexal origin.[4]

Determination of tumour histological type is based on morphology, but immunohistochemistry can aid histological classification and improve inter-observer reproducibility, particularly in high-grade endometrial carcinomas, where reproducibility is average even with pathologists specializing in gynecology.[4] A panel of antibodies is used, at least p53, RE and RP (level 2, grade B), as there is no single antibody specific to a given type, but rather expression profiles for each tumour type, although exceptions may exist.

the initial diagnostic work-up for serous endometrial carcinoma includes endovaginal ultrasound and pelvic MRI to assess local extension;[5] TAP scan and 18FDG PET scan for distant extension, depending on prognostic factors.[6]

18FDG PET scan can detect and specify lymph node metastases (pelvic and lumbo- aortic) and extra-pelvic xtension.[7]

Lynch syndrome, linked to a constitutional deficiency in one of the MMR system genes (MLH1, MSH2, MSH6, and PMS2), is associated with an increased risk of endometrial cancer. The cumulative risk of endometrial cancer at age 70 ranges from 16% to 54%, depending on the mutated genes involved.[8] Most cases are endometrioid adenocarcinomas. More rarely, serous endometrial cancers may be associated with a constitutional BRCA 1 or 2 mutation (cumulative risk of 3% in mutated patients).[9,10,11,12]

The treatment of endometrial carcinomas is essentially based on histopathological data of histological type, grade, stage and vascular emboli.

In our case described, stage IA serous endometrial carcinoma high grade, we performed an enlarged colpohysterectomy with bilateral adnexectomy, bilateral pelvic curage, appendectomy and omentectomy.

Basal adenoid carcinoma is a rare cervical tumor (< 1%), deriving from the basal reserve cells of the squamous epithelium. It occurs mainly in post-menopausal women, with an average age of 60 (19 to 91), in association with CIN III. The lesion is infiltrative and associated with HPV 16 infection, and shows immunohistochemical overexpression of P16.[13] It is more common in black women. It is an asymptomatic tumor, giving no masses or lesions visible macroscopically. It may be discovered by chance on a conization specimen for high-grade cervical intraepithelial neoplasia, or on a hysterectomy specimen for endometrial cancer, as in our case.[14] The tumour is small, found deep in the cervical stroma without surface extension. It consists of small nests and masses with rounded contours, surrounded by a palisading layer. Cells are basaloid, with small, oblong, hyperchromatic nuclei. There is no mitosis. There is no nuclear pleomorphism. The center of the massifs is often occupied by a small glandular structure bordered by a cubic epithelium. The lumen contains an eosinophilic secretion. Other masses are centred by a squamous differentiation. There is no associated desmoplastic reaction stroma. There are no vascular emboli.[13,14,15,16]

CONCLUSION

High-grade serous endometrial carcinoma is seen in post-menopausal women. Post-menopausal metrorrhagia is the most frequent symptom. It may be associated with basal adenoid carcinoma of the uterine cervix. Treatment of stage IA serous endometrial carcinoma consists of enlarged colpohysterectomy with bilateral adnexectomy, bilateral pelvic curage, appendectomy and omentectomy with, in our patient's case, adjuvant radiotherapy and surveillance.

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