

Surgical management of a case of recurrent carcinoma cervix: a case report

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ABSTRACT

Worldwide cervical cancer is the fourth most common cancers among females. Pelvic recurrence, distant metastases, or a combination of both can occur in patients of carcinoma cervix. A 42-year-old P2L2 with a history of carcinoma cervix stage 3-b came to our OPD for routine follow up. Two year back she was managed with chemoradiation for her primary carcinoma which had parametrium extension. There was a 1 × 1 cm lesion on the anterior vaginal wall which was diagnosed to be cervical recurrence. Patient underwent total abdominal hysterectomy with bilateral salpingo-oophorectomy with pelvic lymphadenectomy. Patient is disease free till now. Treatment decisions should be individualised based on the performance status of the patient, the site of recurrence and/or metastases, the extent of metastatic disease, and prior treatment.

Keywords: Carcinoma cervix, Pelvic recurrence

INTRODUCTION

Worldwide cervical cancer is the fourth most common cancers among females. Pelvic recurrence, distant metastases, or a combination of both can occur in patients of carcinoma cervix. Following primary surgery or radiotherapy in women with stage IB-IIA cervical tumors with no evidence of lymph node involvement, the recurrence rate has been reported to be around 10%-20%. While the relapse rate of those with nodal metastases and/or more locally advanced tumors is up to 70%.¹⁻⁴ The majority of recurrences occur within 2 years of diagnosis, and the prognosis is poor, with most patients dying as a result of uncontrolled disease. Treatment decisions should be individualised based on the performance status of the patient, the site of recurrence and/or metastases, the extent of metastatic disease, and prior treatment.⁵ Performing radical hysterectomy for patients with recurrent carcinoma cervix

is rarely done. Here the case is describing recurrent carcinoma cervix for which this case performed surgical management.

CASE REPORT

A 42-year P2L2, with a history of carcinoma cervix stage -3 B, came to study OPD for routine follow up. Two-year back she was managed with chemoradiation for her primary carcinoma which had parametrium extension. She was a known case of diabetes mellitus on medication. On examination there was mild pallor and rest of her general and abdominal examination findings were within normal limit. On per speculum examination there was a lesion of size 1 x 1 cm in anterior vaginal wall extending from cervix. CT scan was reported as bulky vaginal wall. Biopsy of the lesion revealed it to be mucin secreting adenocarcinoma. So, a provisional diagnosis of recurrent carcinoma cervix was made. Patient underwent radical

hysterectomy with bilateral salpingoophorectomy with pelvic lymphadenectomy (Figure 1 and 2). The intraoperative and postoperative course was uneventful and she was discharged on 7th post-operative day. Patient is disease free till now.

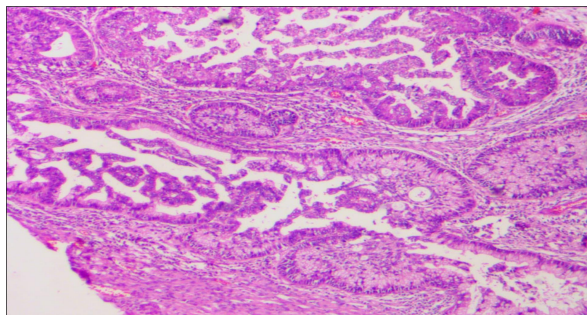


Figure 1: Histopathology picture showing moderately differentiated adenocarcinoma of cervix.

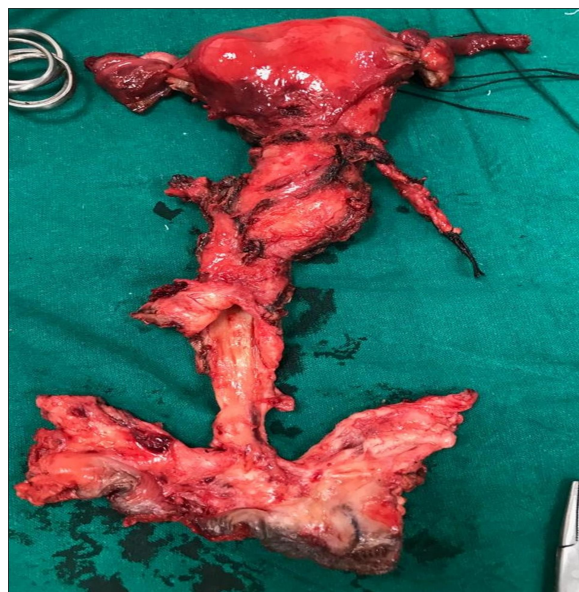


Figure 2: Surgical specimen.

DISCUSSION

Recurrence rates of carcinoma cervix have been described from 30 to 60%. Previous laparotomy, previous radiation, radiation > 6,000 cGy to the pelvis, radiation within 1 year of exenterative surgery, weight > 200 lb, age > 60 years, margin status, node status, and triad of trouble-hydronephrosis, leg edema, and leg pain are some of the factors that are associated with an increased risk of recurrence.⁶⁻⁹

A thorough clinical examination should be performed to define the type of recurrence, central recurrence versus a lateral or diffuse recurrence. Central disease is a relatively homogeneous tumor usually derived from the

retained cervix and vagina in case of primary radiation or from the vaginal cuff and central scar where surgery was opted as primary therapy. Central disease may extend to the pelvic side wall.¹⁰ In contrast, side wall disease is heterogeneous. Most pelvic recurrences have a diffuse growth pattern fixed to one or both pelvic side walls. These fixed recurrences are felt at physical examination as “pelvic fibrosis” with or without a dominant mass. Thus, pelvic fibrosis is an ominous finding significantly related to nodal disease and fixation to pelvic side wall. Such recurrences are common after surgery followed by radiotherapy. Most patients who relapse locally after primary radiotherapy are not candidates for further radiotherapy, and pelvic exenterative surgery is the only potentially curative approach for these patients. The 5-year survival rate for patients who undergo total pelvic exenteration ranges from 30%-60%.¹¹⁻¹⁶ Identification of the clinical and histopathological factors that predict recurrence and survival after pelvic exenteration may improve the ability to better select patients who are potentially curable with radical surgery. The prognostic factors that have been identified include disease-free interval, size of recurrence, and preoperative lateral side wall fixation.⁸⁻¹² The prognosis is better for patients with a disease-free interval greater than 6 months.

Several authors have reposted the use of radical hysterectomy to treat patients with recurrent or persistent uterine cancer following definitive radiotherapy/chemoradiation.¹⁷⁻¹⁹ With the current advances in radiotherapy delivery techniques, the recurrences rates have reduced and such procedures have become a rarity. Patients up to 2 cm lesion, confined to the cervix with no evidence of hydronephrosis, are candidates for the procedure. As for any surgery performed after radiotherapy, there is a higher incidence of complications after this procedure. The complications include urinary tract infections, wound-related complications, thromboembolic complications, bowel obstruction, bladder dysfunctions and voiding problems, ureteral injury, and vesicovaginal and rectovaginal fistulae.²⁰

CONCLUSION

Recurrence rates of carcinoma cervix have been described from 30 to 60%. A thorough clinical examination should be performed to define the type of recurrence, central recurrence versus a lateral or diffuse recurrence. Identification of the clinical and histopathological factors that predict recurrence and survival after pelvic exenteration may improve the ability to better select patients who are potentially curable with radical surgery. Treatment decisions should be individualised based on the performance status of the patient, the site of recurrence and/or metastases, the extent of metastatic disease, and prior treatment.

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