

Endometrial cancer: 'Access denied'

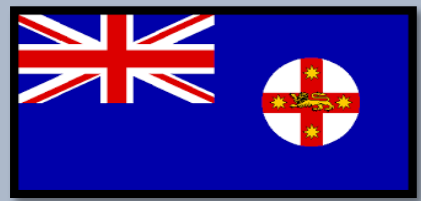
A review of the forgotten voice of mental and physical disability in gynaecology oncology in Australia.



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Introduction

The voice of an intellectually and physically disabled woman is often forgotten when discussing, investigating and managing endometrial cancer in women with disabilities. This case report explores the need to start strategies for collaborative application of resources to optimize a woman's experience who is living with disabilities and endometrial cancer.

Case description

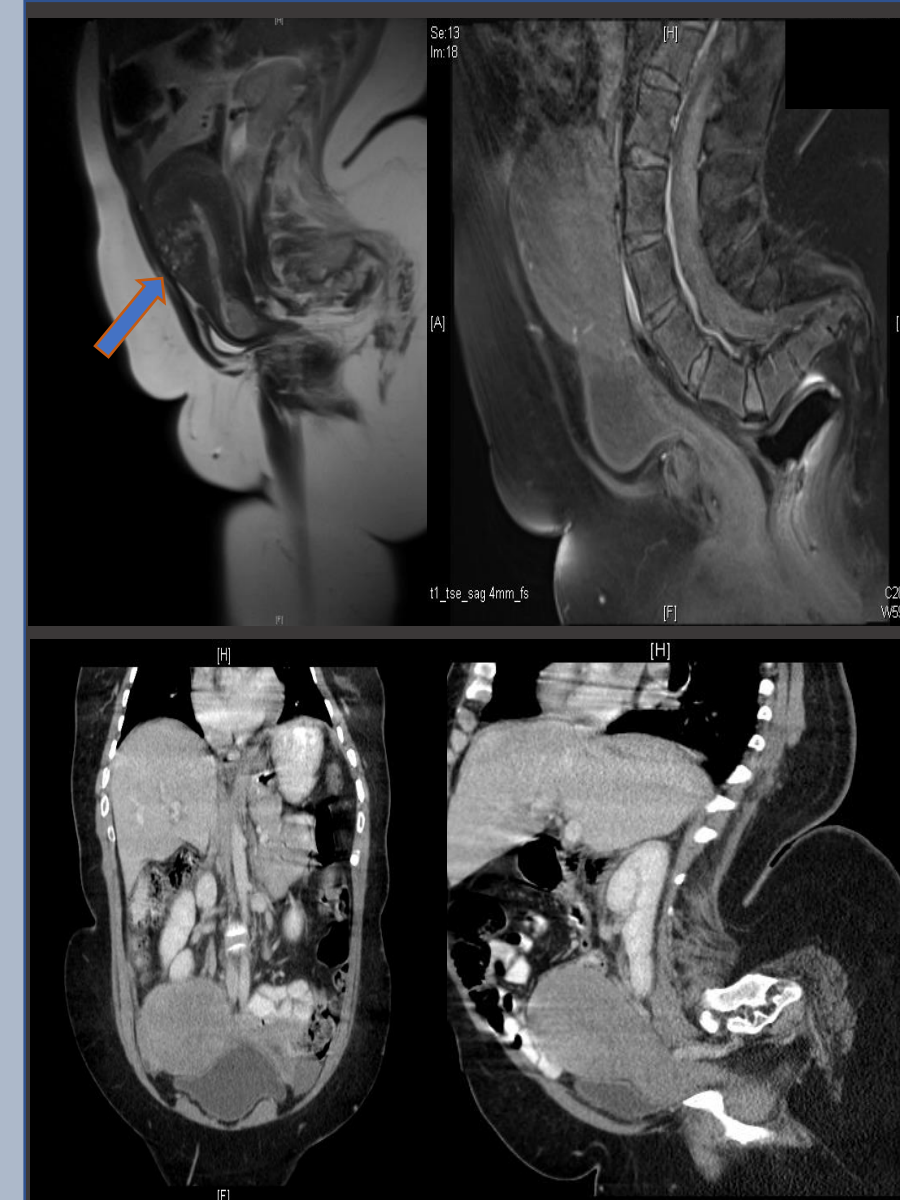
A 41 year old premenopausal woman with severe intellectual disability and physically debilitating osteogenesis imperfecta presented with a 2-year history of abnormal uterine bleeding (AUB) and unsuccessful hormonal treatment. After two failed hysteroscopies due to her severe bony-pelvic abnormalities, limiting access vaginally; the decision for a hysterectomy was made without a histological diagnosis. An Australian Guardianship Tribunal granted permission for both diagnostic and treatment of her AUB and suspicion of endometrial cancer. *The ESMO-ESGO-ESTRO-2014 Consensus* current recommendations and levels of evidence in management of endometrial cancer are evaluated in context of the case.

Results

Mandatory workup and pathological assessment for diagnosis of endometrial cancer could not be carried out and imaging including: CT scan, transabdominal ultrasound and MRI were relied upon to primarily assess her suspected disease.

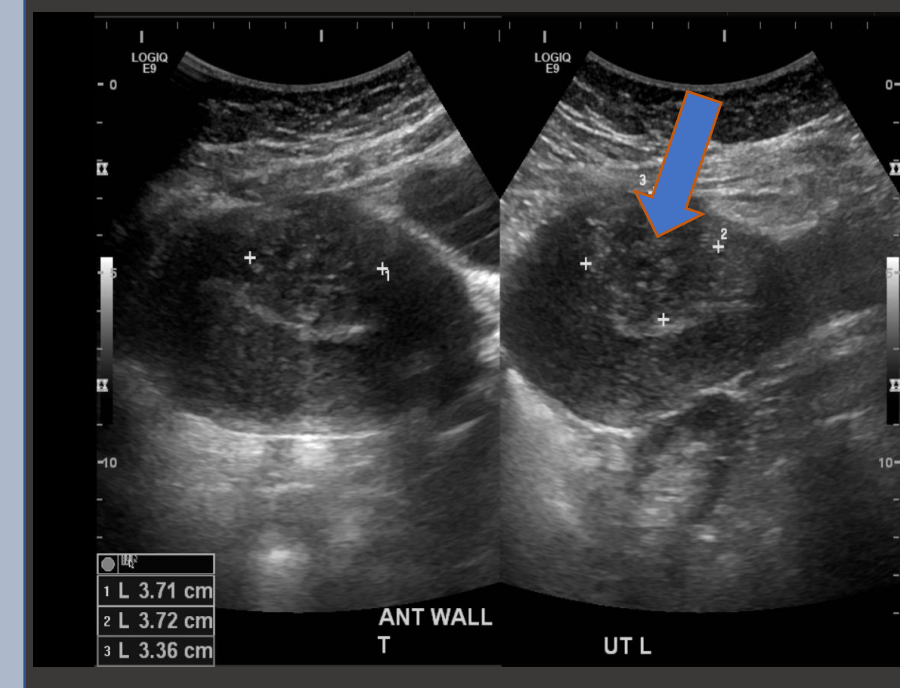
An abdominal hysterectomy, bilateral salpingectomy and ovarian conservation was performed. The histopathology post-operatively confirmed stage 1A grade 1 endometrioid adenocarcinoma (EAC). The time from initial Gynaecology Oncology referral to final histopathology was 9 months.

	ESMO-ESGO-ESTRO December 2014 Consensus recommendations:	*Level of Evidence (I, II, III, IV) *Strength *Consensus %	Application to case report:
WHICH SURVEILLANCE SHOULD BE USED FOR ASYMPTOMATIC WOMEN?	There is no evidence for endometrial cancer screening in the general population.	II A 100%	No screening available. History of menorrhagia for 2 year.
WHAT WORK-UP AND MANAGEMENT SCHEME SHOULD BE UNDERTAKEN FOR FERTILITY PRESERVING THERAPY IN ENDOMETRIOID ADENOCARCINOMA GRADE 1?	Patients with grade 1 EAC requesting fertility-preserving therapy must be referred to specialized center. In these patients D&C with/without hysteroscopy must be performed.	V A 100% IV A 97.3%	As endometrial sampling could not be performed, conservative management with hormones could not be considered Two failed hysteroscopy attempts. The first hysteroscopy by a gynaecologist was abandoned due to an anaesthetic related tachycardia on the operating table. A year later after referral to the gynaecology oncology unit the second could not be performed due to limited access vaginally due pelvic-bony abnormalities. The cervix could not be reached
	Grade 1 EAC must be confirmed/ diagnosed by a gynaeco-pathologist.	IV A 100%	Histopathology could not be obtained as limited vaginal access.
	Pelvic MRI should be performed to exclude overt myometrial invasion. Expert ultrasound as alternative	III B 100%	A Pelvic MRI and trans-abdominal ultrasound were performed. Trans vagina ultrasound could not be performed as virgin-intactus.
	MPA/MA is the recommended treatment. However, LNG-IUD with/without GnRH can be considered	IV B 100%	An LNG-IUG could not be inserted as intra-endometrial access not attainable at time of hysteroscopy. Oral progesterone not considered as no histological diagnosis of cancer/hyperplasia
	To assess response, D&C, hysteroscopy and imaging at 6 months must be performed. If no response – standard surgical treatment should be performed.	IV B 100%	No response to hormonal management can be achieved as no hysteroscopy not possible.
	After completion of childbearing a hysterectomy and salpingo-oophorectomy should be recommended. Preservations of ovaries can be considered depending on age and genetic factors	IV B 100%	Ovarian conservation was carried out.
HOW DOES THE MEDICAL CONDITION INFLUENCE SUGICAL TREATMENT?	Mandatory work-up must include: family history; general assessment and inventory of comorbidities; clinical examination, including pelvic exam, transvaginal/transrectal ultrasound; and complete pathological assessment (histotype and grade) of an endometrial biopsy or curettage specimen.	V A 100%	A typical work-up could not be carried out due extreme physical disability and bony deformities, thus histological diagnosis could not be achieved.
	Extent of surgery should be adapted to the medical condition of the patient.	V A 100%	A laparotomy, total hysterectomy and bilateral salpingectomy was performed due risk of MIS in an osteogenesis imperfecta patient.
	In clinical stage 1, grade 1 and 2: At least one of the three following tools should be used to assess myometrial invasion if , LNG-IUD is considered: Expert ultrasound and/or MRI and/or intra-operative pathological examination.	IV A 100%	Intra-operative examination of uterus: bicornuate uterus with polypoidal lesion in both cavities, anterior fibroid .
	Other imaging methods (thoracic, abdominal and pelvic CT scan, MRI, PET scan or ultrasound) should be considered to assess ovarian, nodal, peritoneal or metastatic disease.	IV C 94.6%	No evidence of metastasis or lymphadenopathy.
	Standard surgery is total hysterectomy with bilateral salpingo-oophorectomy without vaginal cuff.	IV A 100%	Total abdominal hysterectomy and bilateral salpingectomy with ovarian conservation.
	Ovarian preservation can be considered in patients younger than 45years old with grade 1 EAC with myometrial invasion <50% and no obvious ovarian or other extra-uterine disease.	IV B 100%	Ovarian preservation performed as patient <45years and <50% myometrial invasion on intra-operative pathological evaluation.
	In case of ovarian preservation salpingectomy is recommended.	IV B 100%	Bilateral salpingectomy performed.
	Minimally invasive surgery is recommended in the surgical management of low-and intermediate risk endometrial cancer.	I A 100%	Laparotomy was performed due to osteogenesis imperfecta bony abnormalities causing minimal vaginal access and anesthetic risk.
WHAT ARE THE INDICATIONS FOR AND TO WHAT EXTENT IS LYMPHADENECTOMY INDICATED IN THE SURGICAL MANAGEMENT OF ENDOMETRIAL CANCER?	Patients with low-risk endometrioid carcinoma have a low risk of lymph node involvement, therefore, lymphadenectomy is not recommended for these patients.	II A 100%	No lymphadenectomy done as our patient was pre-menopausal and assumed to have an early cancer/hyperplasia. Consideration that premenopausal women have earlier stage and favorable prognosis.
WHAT IS THE CURRENT BEST DEFINITION OF RISK GROUPS FOR ADJUVANT THERAPY	In patients with low-risk endometrial cancer, (Stage 1 endometrioid EAC grade 1 or 2, <50% myometrial invasion, LVSI negative) no adjuvant treatment is recommended.	I A 100%	Stage 1A, grade 1, at final histopathology diagnosis and MDT. No adjuvant treatment needed.



MRI and CT Pelvis: A subseptate, 11.5 x 11.5 x 5 cm uterus with multicystic myometrial lesions. A lesion at the anterior myometrium measures 3 cm x 3.5 cm extends from endometrial to serosal surface (arrow). Endocervical canal polyp. No suspicious ovarian lesion. Severe bony abnormalities.

Transabdominal ultrasound. The uterus was anteverted and appeared bulky. The endometrial echo measured 7mm in thickness. There was a 3.7 x 3.4 x 3.7cm iso/hyperechoic, mixed echogenicity lesion in the anterior myometrium (arrow).



Conclusion

This is the first report to explore the limitations and challenges of the literature and application of various current diagnostic modalities, surgical approach and outcomes of endometrial cancer in an intellectually and physically disabled woman in Australia.

References

- Colombo N et al. ESMO-ESGO-ESTRO Consensus Conference on Endometrial Cancer: diagnosis, treatment and follow-up. *Annals of Oncology* 2016; 27: 16-41.