Carcinoma Cervix in a Prolapsed Uterus

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The occurrence of carcinoma cervix in a prolapsed uterus is a rare occurrence in general gynaecological practice. We present a case of carcinoma cervix developing in a prolapsed cervix.

A 70 years old postmenopausal woman, para 8 with 6 living issues, presented in January, 2000 in the outpatient department of Obstetrics and Gynaecology of All India Institute of Medical Sciences with complaints of a mass prolapsing out per-vaginum for the last 10 years. The prolapsing mass was painless and reducible. Prolapse was aggravated in the squatting posture. She also had history of foul smelling blood stained discharge along with the prolapsing mass. She was anorexic and had lost 6 kgs of weight over 2 months. There were no bladder or bowel symptoms. She was non smoker and teetotaller. She and her spouse neither had extramarital sexual contacts or suffered from any sexually transmitted disease. In all her pregnancies, she had full term normal vaginal delivery at home.

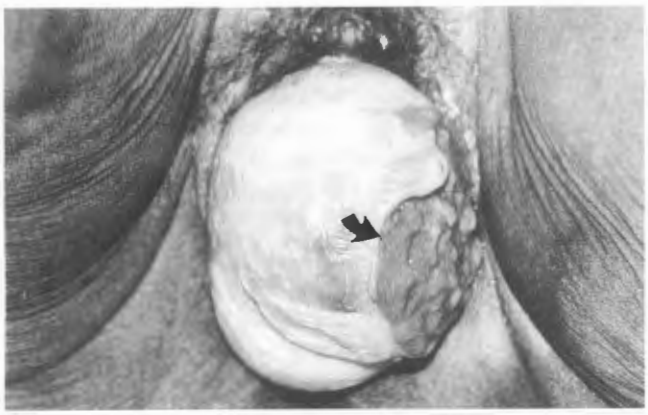

Fig. 1: Showing a growth and upper 1/3 of anterior vaginal wall (arrow)

Her general physical examination revealed no abnormality. On per speculum examination, there was a third degree uterocervical descent associated with cystocoele, enterocoele and rectocoele. There was an ulcerated, fragile, 6 x 7 cms growth involving cervix and upper one third of anterior vaginal wall (Fig. 1). The margin of this growth was everted and it bled on touch. On vaginal examination, there was supravaginal elongation of cervix. The prolapsed uterus was reducible and normal in size. Rectal examination revealed infiltration of the left parametrium in the medial two-third.

Her blood count, liver function tests, renal function tests, blood sugar and serum electrolytes were within normal limit. Histopathology of cervical biopsy revealed keratinising squamous cell carcinoma. Cystoscopy was suggestive of bullous edema. The patient therefore had stage II (b) cervical cancer with uterovaginal prolapse. In consultation with radiotherapist she was planned for whole pelvis external radiotherapy followed by brachytherapy. A total of 50Gy of external radiotherapy was delivered in 27 fractions (each fraction of 150 cGy, 5 days per week). Midline shield of 5cm was used to restrict the dose of 50Gy in the central part. Four field box technique was used to limit the area of radiation. The upper margin of the field was kept at the level of L4-L5 vertebrae, lateral margin was kept 2 cm lateral to bony pelvis and the lower margin was kept below the obturator foramen covering the prolapsed uterus and cervix. Two weeks after completion of the external radiotherapy, she was evaluated again and subsequently brachytherapy (30 Gy over 24) hours) was delivered by LDR system using cesium 137 through central tendom with two ovoids. The patient was followed initially at 2 weeks, and then monthly for six months. The repeat cytology frm the cervix was found to be negative for carcinoma, and she was doing well at 6 months follow up.