



## Endometrial carcinoma presenting as infertility in a young woman

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### Introduction

Endometrial carcinoma usually occurs in women above 40 years of age and presents as abnormal vaginal bleeding. It is very rarely seen in a young woman. We present a case of endometrial carcinoma in a young woman who presented with primary infertility.

### Case report

Mrs. SK, aged 28 years, attended the out patient clinic on 8<sup>th</sup> July, 2000 with complaints of infertility for the last 12 years. No obvious cause for infertility in the couple was found. Her menstrual cycles had been fairly regular in the past and she bled for 3-4 days every 28-30 days. However for the last 1 ½ months she was having irregular vaginal bleeding sometimes needing four pads a day and at other times none.

The general physical examination and pelvic examination were unremarkable except that she was slightly overweight. Her urine pregnancy test was negative. She requested that she wanted all her investigations at one time as she came from a rural area only for a short time.

Her husband's semen analysis was found to be normal. The menstrual blood was checked for acid fast bacilli (AFB) and was found to be negative. It was now decided that we would carry out a D and C, and diagnostic laparoscopy with chromotubation at the same time.

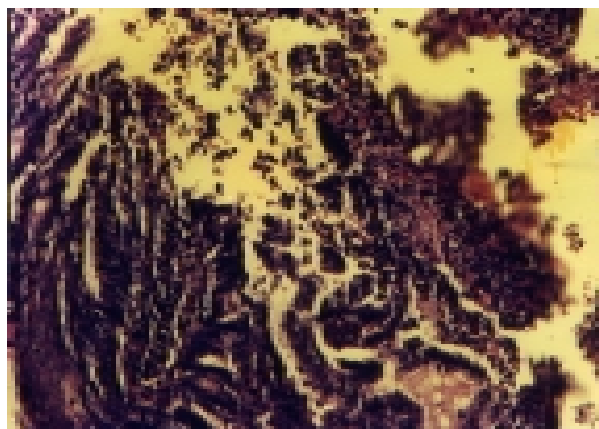
At the time of D and C, plenty of fleshy curettings were obtained which were sent for histology and for AFB. The uterocervical length was 7 cm. On diagnostic laparoscopy,

the uterus appeared to be normal sized. The right tube and both ovaries appeared normal but the left tube was slightly edematous with flimsy adhesions to the surrounding tissues. On chromotubation, only the right tube was found to be patent. The histology of the endometrial curettings showed an adenomatous hyperplasia of the endometrium with well differentiated grade 1 papillary carcinoma.

A subsequently performed CT scan showed bulky uterus with smooth endometrium and focal attenuation in lower segment with normal ovaries.

At laparotomy the uterus and ovaries appeared normal. There was no free fluid in the pelvis. The pelvic and para-aortic lymph nodes were not enlarged. A total abdominal hysterectomy with bilateral salpingo-oophorectomy with pelvic lymph node sampling was performed. On opening the uterus, a friable growth measuring 1 cm in diameter was seen at the fundus and the myometrium did not seem to be involved.

The histopathology report showed marked adenomatous hyperplasia of the endometrium with well-differentiated papillary endocarcinoma. (Figure 1) confined only to the



**Figure 1.** Endometrial adenocarcinoma magnification x20.

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endometrium. The cervix, tubes and ovaries were normal. The lymph nodes showed reactive histiocytosis with no metastasis in any of the nodes. A diagnosis of stage I grade-I endometrial carcinoma was made and the patient did not need any further treatment.

*Post script* - The patient was well on follow-up study done in March 2005.

### Discussion

The median age of patients with endometrial cancer is 61 years with 75 - 80% of women being postmenopausal and only 3-5% being less than 40 years<sup>1</sup>. The younger women with endometrial carcinoma tend to be obese and suffer from chronic anovulation. The diagnosis is usually made in a routine course of investigations for infertility or irregular vaginal bleeding.

The standard treatment for endometrial carcinoma is total abdominal hysterectomy with bilateral salpingo-oophorectomy unless the tumor is extremely widespread or the patient is medically unfit for surgery. The gynecologist is in a dilemma when treating a young woman with endometrial carcinoma who wishes to preserve fertility. In the literature, a few cases of conservative management of endometrial carcinoma stage I (grade I) have been reported<sup>2</sup>. For a successful outcome, a strict clinical staging in the form of physical examination and imaging with ultrasound, CT or MRI and a cautious evaluation of histological grading by a pathologist are required. This is then followed by at least 6 months of progestogen therapy and evaluation of response by endometrial sampling.

We did not consider conservative management with progestogens in our patient for the following reasons

1. The data is limited on such a management.
2. Close follow-up is required to monitor the response of progestogens, which would not have been possible in our patient because of her circumstances.
3. Hysterectomy is advisable once the woman has completed her family. Given the history of infertility for years and the presence of a blocked tube, our patient would have required some form of assisted reproduction, which she could not afford. So although the diagnosis and the management plan came as a shock to her, she accepted the surgical treatment as her best option.

There was a major concern over the fact that a laparoscopic chromotubation had been performed before the histology report was available and it is known that with this procedure endometrial cells can disseminate into the peritoneal cavity in about 15% of cases<sup>3</sup>. We thought that the chances of dissemination were higher in our patient as a D and C had also been performed at the same time. Fortunately the peritoneal washings were negative at the time of laparotomy and our patient did not require any adjuvant radiotherapy.

### References

1. Shaw RW, Soutter WP, Stanton SL. Gynecology 2nd edn. London, Churchill Livingstone 1997;585.
2. Jobo T, Imai M, Kauraguchi M et al. Successful conservative treatment of endometrial carcinoma permitting subsequent pregnancy; report of two cases. *Eur J Gynaecol Oncol* 2000;21:119-22.
3. Kulenthiran A, Jeyalakshmi N. Dissemination of endometrial cells at laparoscopy and chromotubation - a preliminary report. *Int J Fertil* 189;34:256-8.