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Endometrial Carcinoma In Young Woman: A Rare Case Report

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Abstract: Endometrial carcinoma is the most common invasive neoplasm of the female genital tract. Most woman are postmenopausal, as the disease is relatively uncommon in young woman. Only 1–8% of endometrial carcinomas occur in woman under 40 years. We reported a case of endometrioid carcinoma in young woman aged 32 years where the incidence is very less. Diagnosis of such cases using various diagnostic modalities is useful in early stages so as to increase the prognosis and outcome. Overall prognosis and outcome of the Endometrial carcinoma is relatively good in young age when compared to that of endometrial cancers occuring in pre-menopausal and post-menopausal age groups. Conservative hormonal therapy is given for young patients who want to conceive but for patients who finished their family , hysterectomy is the definitive treatment. Regular follow up with endometrial biopsy is required for those who have undergone conservative hormonal and hysteroscopic endometrial ablation. No follow up is required for hysterectomized patients.
Keywords: Carcinoma, Endometrial, Endometrial Ablation, Hormonal Therapy, Hysterectomy

INTRODUCTION

Endometrial carcinoma is a disease of postmenopausal woman and is uncommon in young woman [1, 2]. Based on clinicopathologic and molecular genetic features, endometrial carcinoma can be broadly divided into two major categories, referred to as type I and type II. Endometrioid carcinoma is the most common form of endometrial carcinoma, accounting for more than three fourths of all cases. Carcinoma in young are bettter differentiated, lowgrade and has good prognosis in early stages hence, diagnosis as early as possible is essential.

CASE REPORT

A 32 year old woman presented to our outpatient department with complaints of bleeding on and off since 2 months and excessive bleeding since 15 days. Her previous menstrual cycles were irregular 6-8 days of bleeding per every 20-25 days. There was no history of dysmenorrhia or white discharge. Her obstetric history revealed that she has four live children and was tubectomized. Past history was nil significant. On examination except for mild pallor there was no other abnormality. Vitals were stable. Patient was subjected to routine investigations which revealed slightly low hemoglobin, other parameters were normal. Ultrasound pelvis was non-contributory and findings revealed only increased thickness of endometrium. As she has completed her family total abdominal hysterectomy (TAH) and bilateral salpingo oophorectomy(BSO) was done and specimen was sent for histopathological examination (HPE). Postopertively patient was stable.

Gross

We received a TAH and BSO specimen. Uterus and cervix measuring 10 x 7 x 6 cms. Cut section of uterus showed increased endometrial thickness of 1.5 cm and myometrial thickness of 2.5 cm (Fig. 1). Right ovary measuring 4 x 3 x 1 cms, cut section showed solid and cystic areas. Left ovary measuring 3 x 3 x 1 cms, cut section showed cystic and solid areas. Both the tubes measured 5cms.

Fig. 1: Cutsection of uterus showing thickened endometrium

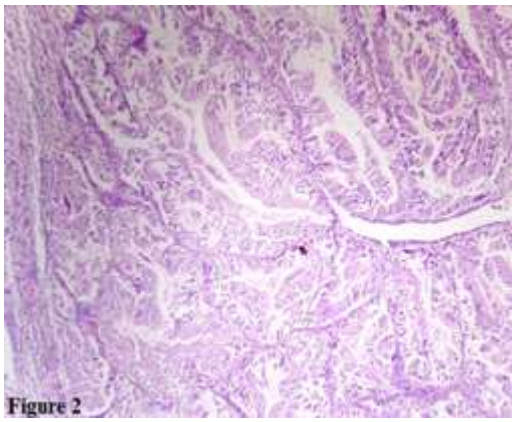

Fig. 2: Photomicrograph showing glandular arrangement of the tumor tissue (Low-Power View)

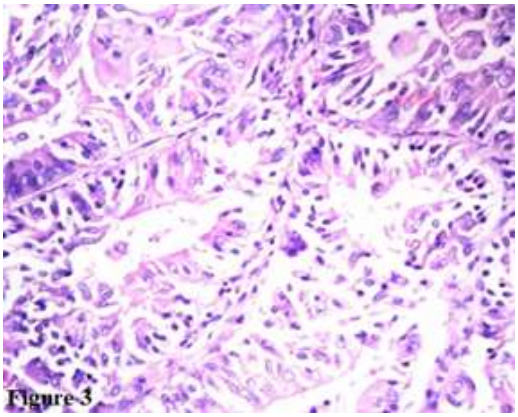

Fig. 3: Photomicrograph showing tumor cells with High Nuclear cytoplasmic ratio, Vesicluar nuclei and prominent nucleoli

Microscopy

Sections from cervix showed features of chronic non specific cervicitis with nabothian cyst. Sections from endometrium showed features of well differentiated endometrioid carcinoma with less than one third extension in to the myometrium. Section from both the ovaries showed ovarian stroma, corpora albicantia and follicular cysts. Tubes were nil particular.

DISCUSSION

Endometrial carcinoma is a disease of older woman, typically arising in the sixth and seventh decades of life. In woman younger than 45 years of age, endometrial carcinoma is uncommon, constituting less than 10% of patients [3]. Endometrial carcinomas in young are less aggressive and better differentiated than old age [1, 3]. Endometrioid sub type, which is catregorized as type 1 is more common in young. Obesity and hyper estrogenic state are the main risk factors for endometrial cancer in young woman [4, 5]. Most studies reported that the majority of patients had a history of anovulation, infertility, ovarian dysfunction, nulliparity and obesity but in our case except for the obesity there was no other abnormality. Among young patients, lean woman seem to have a more advanced stage compared to those who are obese. Although most of these patients have an identifiable source of excess estrogen, a small subset the pathogenesis is related to mismatch repair abnormality and Lynch syndrome. Vaginal bleeding is the most common symptom in case of endometrial carcinoma. Investigations in evaluating endometrial carcinoma include complete blood picture, biochemical, ultrasonography, magnetic resonance imaging, hysteroscopy and endometrial biopsy. In our case, Histopathological examination was valuable in giving the diagnosis. Confirmation and staging is done by thorough correlation between radiological and histopathological examination. Although hysterectomy represents the standard treatment for endometrial cancer, it is often not accepted when the patient is young and desires a pregnancy in the future [1, 6]. In such cases hormonal therapy alone or combined with hysteroscopic ablation are identified as the most used and effective conservative treatments [6]. In our case as patient has completed her family hysterectomy was definitive treatment.

CONCLUSION

Endometrial carcinomas though common in menopausal age, it can also occur young woman hence, detailed investigations are to be done even in young patients to rule out carcinoma. Generally carcinomas in young are less aggressive, better differentiated and has good clinical outcome when detected early. Conservative hormonal therapy is given for young patients who want to conceive but for patients who finished their family, hysterectomy is the the definitive treatment. No follow up is required for hysterectomized patients but regular follow up with endometrial biopsy is required for those who have undergone conservative hormonal and hysteroscopic endometrial ablation.

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