SAS Journal of Medicine
Abbreviated Key Title: SAS J Med
ISSN 2454-5112
Journal homepage: https://saspublishers.com

OPEN ACCESS

Clinical Oncology

Cervical Cancer in Primiparous in the Third Trimester: Diagnosis and Treatment: A Case Report and Review of the Literature

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DOI: 10.36347/sasjm.2022.v08i08.014 | **Received:** 26.07.2022 | **Accepted:** 24.08.2022 | **Published:** 30.08.2022

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Abstract **Case Report**

The occurrence of cancer during pregnancy is a delicate event for the obstetrician and the oncologist, because many diagnostic and therapeutic procedures usually used are inapplicable during pregnancy. The discovery of cervical cancer during 3rd trimester pregnancy is a rare but not exceptional event. The difficulty of the question lies in balancing maternal and fetal well-being: How to obtain effective treatment for cervical cancer without compromising pregnancy? The low frequency of this situation did not allow the performance of randomized studies. We report a case of a primiparous patient in her 3rd trimester of pregnancy in who stage IIB FIGO cervical cancer was discovered.

Keywords: Cervical cancer, Third trimester, chemotherapy, fertility preservation, pregnancy, surgery.

INTRODUCTION

The results of Pap tests performed during routine screenings at the beginning of prenatal care are abnormal in 8– 12% of cases [1], its estimated incidence is of 1–10 per 10,000 pregnancies [2]. Cervical cancer is the second neoplasia diagnosed during pregnancy or postpartum [3].

The rarity of the condition makes large trials or randomized studies impossible, and guidelines up to now are based on small case series and expert opinions [4].

Consequently, individualized therapy is strongly recommended and the treatment decision should be made collaboratively with a multi-disciplinary team consisting of obstetricians, gynecologists, oncologists, pediatricians, and psychologists [5]. Pregnancy is an opportunity to screen a population that is sometimes poorly followed in gynecology, by taking a cervivo-vaginal smear in the prenatal consultation

CASE REPORT

We report the case of a 28-year-old patient with no particular history. G2 P0, (spontaneous abortion of the 1st trimester and a current pregnancy of 25 WA). 1st sexual intercourse at the age of 27, no multiple partners. Without toxic habits. In whom a suspicious cervix process was discovered during a pregnancy monitoring consultation using a pelvic ultrasound. a bleeding cervix on contact with vaginal examination.

Biopsies were performed and confirmed the presence of a poorly differentiated and infiltrating invasive adenocarcinoma. An extension assessment based on an abdominal MRI and a pelvic MRI was performed. Tumor classified 2B according to FIGO.

The patient's file was staffed in onco-gynecology RCP. The decision was to start chemotherapy based on Cisplatin monotherapy. Then plan a caesarean at 35 weeks. During the caesarean section, evaluate the characteristics of the tumor and decide on the postoperative course.

The patient then received neoadjuvant chemotherapy with two doses of Cisplatin monotherapy at a dose of 25mg/m2 for 3 days. Post-chemotherapy follow-ups were normal except for nausea at the end of each course.

A caesarean section was performed at 35 SA followed by an ACHE with transposition of the ovaries. New born weighing 3100 g in good general condition.

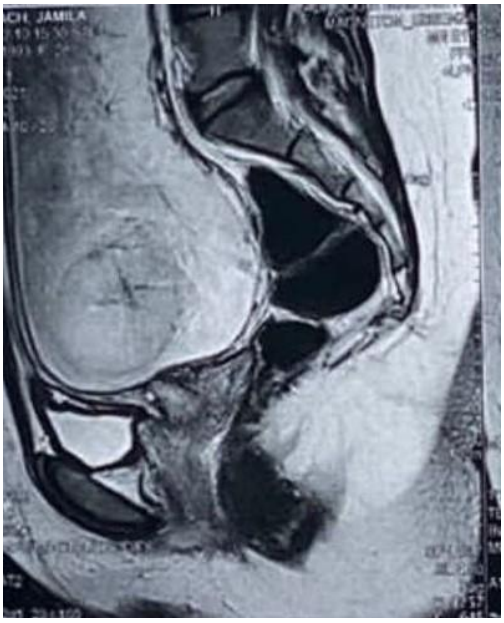

Figure 1: Pelvic MRI showing Adenosquamous cervical neoplasia Stage IIb. 25th week of gestation

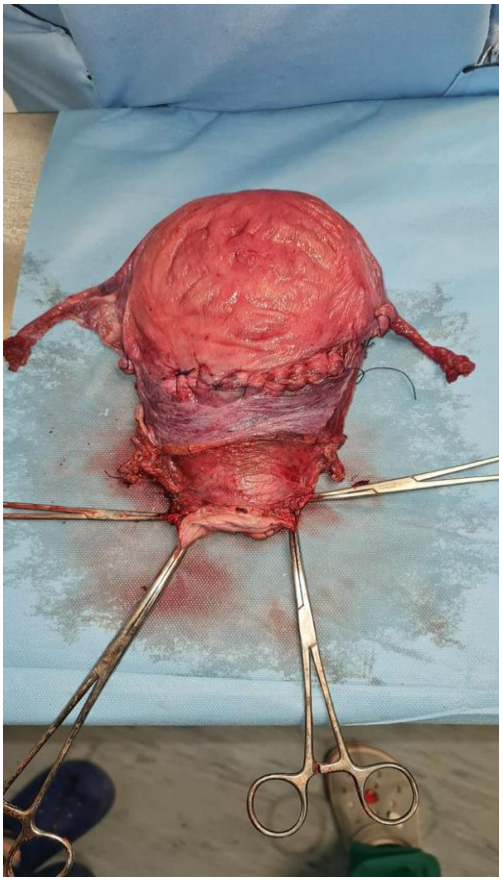

Figure 2: Surgical specimen of a total adeno-colpo-hysterectomy of the patient

DISCUSSION

Management in the third trimester and modality of delivery:

Although several different vaccines are routinely administered to pregnant women, few are licensed for use during pregnancy [6].

During third trimester, the incidence of invasive neoplasia is rare, as the diagnosis is generally obtained during first or second trimester.

The diagnostic work-up and follow-up of previous lesions are very difficult because of the size of the cervix and the edema of the vaginal walls. Staging lymphadenectomy is difficult to perform due to the size of the uterus. In general, the best strategy at this time appears to be “wait and see” [7, 8].

In Stage Ia2 and Ib1, tumors smaller than 2 cm, one option is to delay treatment until fetal maturity and then to decide with a neonatologist the timing of delivery. An alternative option in selected cases is the administration of NACT. For advanced stages, NACT is the only strategy to preserve pregnancy and achieve fetal maturity [5, 8].

Time of delivery must be evaluated with obstetricians as the reach of fetal maturity is the main issue. In case of NACT administration, a 3-week interval after the last cycle of chemotherapy is preferred to avoid infection and hematologic complications in both mother and child [9].

Vaginal delivery is indicated only in case of SILs and frequently vaginal delivery can lead to a complete clearing of the cervical lesions. In case of invasive tumor, a cesarean section is suggested to avoid scar recurrence in the site of episiotomy and a longitudinal uterine incision is recommended to prevent abdominal implants. Radical hysterectomy could be performed at the time of cesarean section, but because of the risk of blood loss, it is possible to delay the procedure a few weeks later [10].

ACKNOWLEDGMENT

We thank our statistic department of Hematological and oncological center for providing us with patients’ Data.

DISCLOSURES

The authors have declared no conflict of interest.

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