Advanced Cancer Of The Cervix Coexisting With Multiple Fibroids In A Nulliparous 47 Year Old Woman

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Summary:
A case of a 47 year old nulliparous woman with advanced cervical cancer coexisting with uterine fibroid is presented. The nulliparity and the presence of Fibroids presented diagnostic challenges especially because epidemiologically the factors present are not commonly associated. Diagnosis was assisted by a thorough examination under anaesthesia, then clinical staging with histological confirmation and subsequent referral for radiotherapy.

Key words: cervical cancer, nulliparity, uterine fibroid

Introduction:
Cervical cancer has a very long history, it took nearly 150 years from Rigoni Stein's observation that 'cancer of the uterus' might be related to sexual lifestyle, before human papilloma virus got established as a cause of cervical cancer in the 1980s [1]. Within this period, several studies corroborated the association of sexual lifestyle, multiparity and other epidemiological factors with cervical cancer [1,2]. Nulliparity and low parity have been associated with Uterine Fibroids but not cervical cancer[3].

We present a case which highlights the need not to rely heavily on epidemiological factors in the aetiology of cervical cancer. Highlighting uncommon presentations in a disease like cervical cancer which has a great percentage of the burden[4] of gynaecological diseases in this environment will help increase treatment coverage.

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Case report
Mrs. A.Y is a 47 year old restaurateur who has been in the care of the Unit on account of infertility and has actually had myomectomy about 16 years previously. She was nulliparous and the last menstrual period was difficult to determine as at the time of presentation because it had been quite irregular for over a year. The abnormal vaginal bleeding was of insidious onset, and has gradually increased in the quantity of flow, there is associated post-coital bleeding. No history of abnormal vaginal discharge.

There was a history of an abdominal swelling, which was noticed at about the same time the irregular vaginal bleeding started and has progressively increased in size, no associated pain.
There was a similar history of abdominal swelling about 16years prior to this presentation when she was diagnosed as having uterine fibroids and she had abdominal myomectomy done.

Examination findings at presentation in the clinic showed that she was not in any obvious distress but was mildly pale. The pulse rate was 108beats per minute and blood pressure 130/80mmhg. The abdomen was distended in the suprapubic region with a midline infraumbilical scar. There was an 18week size mass that was not tender, not attached to the skin above or the structures below and mobile from side to side.

The pelvic examination by the attending registrar revealed a normal vulva and vagina that was smeared with blood.

A hard mass was felt on the cervix around the 5 '0' clock to 11 '0' clock position, which bled on contact. However, speculum examination then confirmed the mass might be originating from the uterine cavity while bimanual examination did not clearly showed the mass moved with Cervix to confirm the abdominal mass to be uterine origin because movement was limited.

A diagnosis of recurrent Multiple Uterine Fibroids with a cervical component was made to rule out Endometrial Cancer and Cancer of the Cervix.

Management:
Mrs. A. Y was ordered to do a packed cell volume

which came out to be 27% while her chest x-ray, electrolyte and urea and intravenous urogram came out normal. The ultrasound however confirmed multiple Uterine Fibroids of varying sizes. A plan for total abdominal hysterectomy preceded by an examination under anaesthesia and endometrial biopsy were made. Mrs. A. Y presented for surgery 2 weeks afterwards and at examination under anaesthesia the cervical mass was seen to be rather craggy and indeed the parametria on both sides were indurated. Cystoscopy could not be done because it was then not available while the endometrial biopsy and punch biopsy of the cervical mass now seen to be stand alone were taken and sent for histology. At this stage our diagnosis was shifted more towards cercal cancer and clinical staging of the disease was done which suggested a minimum stage 3 disease. The total abdominal hysterectomy was then suspended and further management was deferred until results of histology were released.

Histology results revealed large cell non-keratinising variant of squamous cell cervical cancer for the cervical biopsy while that of that of the endometrium was said to be normal proliferative phase.

Mrs. A. Y was then referred to the Radiotherapy Centre for further management.

Discussion:

Cervical cancer is the fourth most common cancer affecting women after breast, colorectal and lung cancers and commonest gynecological cancer, the world over. About 528000 new cases are detected yearly and 266,000 deaths arise from cervical cancer in 2012 alone, with approximately 86% occurring in the low/middle income countries which Nigeria belongs[4]. A study in North-central Nigeria found that the frequency of the disease increases parity with the highest frequency in grand-multiparous women, 79.9% while those with two parous experiences and below constituting 5.4%[5]. Though cancer of the cervix has been described in nulliparous women, including nuns and celibates, it is however, rare and may present diagnostic difficulties[6,7,8].

In Mrs. A. Y's case, she presented with abnormal vaginal bleeding with a recurrence of uterine fibroid, she was a nulliparous woman and still desirous of a child at 47 years of age. She had myomectomy done 16years prior to presentation, she did not have pap smear done and indeed has never had pap smear done before. This is a reflection of the low uptake of screening in Nigeria[9,10].

Human papilloma virus (HPV), which is a sexually transmitted disease, is very ubiquitous and its presence makes other risk factors insignificant in pre-invasive as well as invasive cervical cancer. However. just like Pap smear, Mrs. A. Y has never done serology or polymerase chain reaction (PCR) test for HPV in the past. Indeed screening for HPV is not common in this environment yet because of non availability and when it becomes available, it may not be accessed for one reason or the other[7].

The Nulliparity and indeed the recurrent Uterine Fibroids presented a diagnostic difficulty and almost lead to a near miss in Mrs. A. Y. Naturally, endometrial cancer associated with Nulliparity was higher in our differentials for this case and not until the thorough EUA did we clearly realize what we were about to miss an advance cancer of the cervix. The initial treatment option of TAH was based on the fact that recurrent multiple fibroid which was thought to be symptomatic close to menopause was confirmed on ultrasound and another repeat myomectomy may not serve the patient much benefit because of her advanced age which makes childbearing remote. Alternative reproductive option of adoption was going to be suggested to the patient.

The technical challenges that the presence of the multiple fibroid will cause was left for the radiotherapy team to deal with. Clearly however, surgical radical hysterectomy for advanced disease as in Mrs. A. Y has very poor result and thus our reason to refer her for radiotherapy.

Conclusion

Cervical cancer is very common in this environment in multiparous but not in nulliparous women. Screening services now need to be improved upon more than ever before to reduce the incidence of this disease. The epidemiological indices should not be unduly emphasized while assessing women with or without suspected cervical cancer. Human papilloma virus (HPV) infection is now the single most important variable when assessing women with cervical cancer[7] and indeed Mrs. A. Y's husband was found to have another wife, but we are not sure if this is contributory to the illness in anyway. An awareness campaign as well as making HPV screening and vaccination available for all sexually active females from teenage age need now be put in place as part of the preventive programme in our environment. This is because increasing number of cases of cervical cancer is now been diagnosed in women of low or no parity in our enviroment[6,7].

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