

# Undiagnosed Cervical Cancer After Total Abdominal Hysterectomy In North Central Nigeria-Case Report

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## Abstract

Back ground: Total abdominal hysterectomy (TAH) is a commonly performed surgical procedure by many doctors in the developing world, for reasons ranging from mild benign to severe malignant conditions. This is because they are often confronted with cases where treatment has to be offered to their patients either due to lack of facilities and / or personnel for appropriate diagnosis or pressure and anxiety from clients and relatives, resulting in cases of undiagnosed cervical malignancy. Many of which could have been treated differently if properly diagnosed. Objective: This study was to evaluate the uterine specimen obtained after TAH and bilateral salpingo-oophorectomy (BSO) for undiagnosed cervical bleeding for unexpected histology. Design/ methods: This was a retrospective study design. The case of a 58-year old woman with post coital bleeding who was anxious to have hysterectomy for fear of cervical cancer was analyzed after surgery with the histology report of the surgical (TAH/BSO) specimen .Result: She had TAH/BSO with excision of a cuff of the vagina. The histology of the specimen showed evidence of early locally invasive cancer of the cervix. The surgical margins were microscopically disease free. She was referred for radiotherapy at a regional centre in Nigeria (Ibadan) where she had teletherapy and two years of out- patient follow-up showed no recurrence or complications. Conclusion: Cases of invasive cervical cancer usually present late in this part of the world with surgical treatment not considered an option. We present a case of undiagnosed early cervical cancer in a postmenopausal woman who had successful TAH/BSO and postoperative radiotherapy. Preventive screening measures coupled with accurate diagnosis, and the improvement in manpower and facilities have been known to give better results. This is a reminder to all doctors and gynecologists of the need for cervical screening, in our hospitals.

## INTRODUCTION

Although diagnosis is the key to effective and satisfactory treatment of cervical cancer, many doctors in the developing countries are often confronted with cases where treatment has to be offered to their patients either due to pressure from clients/or relations or the lack of resources and facilities/personnel for appropriate diagnosis and management. Worldwide, the American cancer society (ASC) estimated in 2010 that cervical cancer cases was 555, 095, with an associated 309, 808 deaths<sup>1</sup>. Among women globally, cervical cancer is second only to breast and lung cancers with regard to mortality<sup>2</sup>, but the most common in developing countries including Nigeria<sup>3,4,5</sup> and comprises approximately 12% of all cancers in women<sup>3,4</sup>.

Invasive cervical cancer cases are sometimes inappropriately managed by hysterectomy which may involve removal of the tubes and ovaries including the Para-aortic nodes depending on the age, parity and clinical indications, with the patient referred afterwards. Such procedures are performed

unknowingly for management of benign uterine disease in the presence of undiagnosed cervical carcinoma or knowingly for undiagnosed carcinoma and retrospective staging according to FIGO criteria sometimes, accomplished on the basis of the pathology report as well as the result of post-hysterectomy evaluation<sup>6</sup>. Most recently, in 2009 unlike the staging of other gynecological cancers, the FIGO staging of cervical cancer is clinical and does not rely on surgeons pathological findings. This gives uniformity of staging for all patients worldwide and is important because cervical cancer is most prevalent in countries where surgical and diagnostic processes are limited. The clinical assessment may be supplemented by other investigations of lymph nodes, examination under anesthesia, cystoscopy, sigmoidoscopy and intravenous urography, but these are optional and no longer mandatory under the new revised FIGO staging system<sup>7</sup>. Although, hysterectomy for incidental cervical cancer has been proven to be inadequate treatment resulting in a reduced survival rate with risk of recurrence as high as 60% after total hysterectomy alone for invasive

disease even when it is entirely limited to the cervix (stage 1)<sup>6</sup>.

### **CASE REPORT**

A 55 year old para 1<sup>+0</sup> who was three years postmenopausal and a primary school teacher, presented at the gynecological clinic of a private hospital in Makurdi town, in North Central Nigeria with, occasional postcoital bleeding of more than two years duration. She started noticing abnormal vagina discharge about two months before presentation which was watery to yellowish and inoffensive in odour. She had been experiencing superficial dyspareunia since onset of menopause but there was no associated abdominal discomfort or urinary symptoms. There was no vaginal or vulva itching and no history of chronic cough or weight loss. She had two previous laparotomies for infertility eight years apart, the last of which was 23 years before presentation. She attained menarche at 13 years and had regular 28 day menstrual cycles. She was not diabetic or hypertensive.

Physical examination revealed an anxious, elderly looking, moderately nourished woman, who was not in any obvious distress. She was not pale, anicteric, afebrile and had no peripheral lymphadenopathy or oedema. The chest was clinically clear, pulse rate was 80beats/minute and blood pressure was 120/70mmHg with normal heart sounds and no cardiac abnormality. There was a midline sub umbilical scar with the liver, spleen and kidneys not palpably enlarged. The pelvic examination showed atrophic external genitalia. The vagina walls were smooth and healthy with no obvious stress incontinence or prolapse noted. The cervix was flush with a small circumferential area of ulceration around the external os which bled easily on touch. The uterus was normal size and anteverted. There was no pelvic organ tenderness and the adnexae were free. Rectal examination did not yield any additional finding. A clinical impression of chronic cervicitis to rule out early cervical cancer (stage 1) was made.

The laboratory investigations showed a packed cell volume of 0.31, white cell count  $3.6 \times 10^9/l$  with normal differentials, urine analysis and microscopy was normal and the culture yielded no growth after 24 hours incubation. Her blood group was O Rhesus positive and the genotype was AA. Abdomino-pelvic ultrasound scan showed normal organs and a plain chest x-ray was normal. She was counseled for a direct/cone biopsy of the abnormal lesion on the cervix and an option for TAH and bilateral salpingo-oophorectomy (BSO) however, she preferred the latter. She was admitted into the gynecological ward a week later and she had TAH

with excision of the vagina cuff and BSO on 11<sup>th</sup> March, 2009 under general anaesthesia. She was discharged home with no complications on the seventh postoperative day. The histology report revealed an essentially normal uterine tissue with sections of the cervical tissue showing a nonkeratinized stratified squamous cell epithelium with invasion of the endocervical stroma confirming the diagnosis of early invasive squamous carcinoma of the cervix. The surgical margins were free of cancer. She remained healthy two months after surgery but was referred to University College Hospital, Ibadan for possible radiotherapy. She had three sessions of teletherapy and routine follow-up in the out-patient clinic showed no sign of relapse or complications.

### **DISCUSSION**

Mrs. F.D. had TAH, BSO and vaginectomy (excision of a cuff of the upper vagina) for undiagnosed cervical cancer stage I.

Further adjuvant treatment for invasive cervical cancer after hysterectomy is usually dependent on the extent of surgery, age, and parity, the time lapse after surgery, residual disease at surgery and the recurrence of new disease. Such treatment may include upper vaginectomy as well as radiotherapy as was done here, as the main modality of treatment in most cases, but in a few selected cases radical reoperation consisting of radical parametrectomy, Pelvic lymphadenectomy and chemotherapy with platinum based agents may be required for optimum results. However, the low socio-economic status coupled with the paucity of radiotherapy facilities and manpower associated with the lack of an effective cytological screening policy and treatment of pre-invasive cervical lesions in the third world countries has greatly hampered effective management and reduction of cervical cancer cases unlike the developed countries<sup>3</sup>.

Although this patient presented with symptoms of vagina discharge, postcoital bleeding and a clinical lesion in which cervical carcinoma could not be ruled out, definitive cytological diagnosis could not be done before hysterectomy due to lack of trained manpower (histologist) and facilities and the anxiety and morbid fear of cancer by the patient. In view of the estimated increase of cases of cervical cancer worldwide with most of them (80%) in the third world, the incidental pathological finding of cancer in specimens is likely to increase in the presence of increasing hysterectomy procedures without a corresponding increase in trained manpower, facilities and proper policy formulation on

cervical cancer screening seen in most third world countries.

In conclusion, invasive cervical cancer found after hysterectomy may be treated safely and effectively with postoperative radiotherapy as was seen in this patient although, patients with known residual disease after surgery do poorly after radiotherapy or reoperation<sup>8</sup>. It is therefore, recommended that routine follow-up and cytological examination of the vault be strictly instituted in all cases of post hysterectomy diagnosis of both carcinoma-in-situ CIN) and invasive disease while attempts are intensified to institutionalize national cytological cervical cancer screening and awareness programs including, liquid based cytology which is simple, effective and eliminates inadequate smears<sup>9</sup>. This is likely to reduce and even eliminate cases of post-hysterectomy incidental diagnosis of cervical cancer especially in the developing world.

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