

Misdiagnosis in Endometrial Cancer: A Case Report

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Abstract

Introduction: Early diagnosis of endometrial cancer in younger female patients has good prognosis and better survival because of lower stage and lower grade. Endometrial cancer should be diagnosed early at lower stage because of signs and symptoms of patients. We report on a usual case of endometrial cancer that was miss diagnosed because she insisted on the protection of her hymen and virginity.

Case Presentation: We report a usual case of endometrial cancer that was miss-diagnosed because the patient insisted on the protection of her hymen and virginity. A 32-year-old virgin female did not permit a general gynecologist for endometrial biopsy or curettage, to protect her hymen and virginity; the patient had stage IV endometrial cancer.

Conclusions: In conclusion, patients with persistent signs and symptoms should be considered for endometrial cancer especially patients with high risk factors: nulliparity, late menopause, obesity, diabetes mellitus, unopposed estrogen therapy, tamoxifen therapy, atypical endometrial hyperplasia, Lynch II syndrome, etc. However, the most important issue for patients with persistent symptoms and risk factors for endometrial cancer in highly religious countries is obtaining a document for the gynecologist that endorses patient virginity.

Keywords: Obesity, Abnormal Uterine Bleeding, Endometrial Cancer

1. Introduction

Endometrial cancer is the most common cancer in female genitourinary system with a mean age of about 60 (1), however 20-25% of patients are pre-menopausal and approximately 5% of patients are younger than 40 years old (2).

Early diagnosis of endometrial cancer in younger females has good prognosis and better survival because of lower stage and lower grade (3). Endometrial cancer should be diagnosed early at a lower stage because of signs and symptoms of the patients (4).

Here we report on a usual case of endometrial cancer that was miss diagnosed because she insisted on the protection of her hymen and virginity.

2. Case Presentation

A 32-year-old virgin female was referred to the gynecologic oncology department of Tehran Medical University in Yas hospital, with chief complaint (C.C.) of abnormal uterine bleeding (AUB), on December 2015.

The patient had AUB for the past one year and she had visited a general gynecologist during the past year, because of suspicion of myoma. She was treated with cyclic medroxyprogesterone acetate and contraceptive pill.

The patient did not permit the general gynecologist to perform endometrial biopsy or curettage to protect her hymen and virginity.

Laboratory work showed normal complete blood count (CBC) and sedimentation rate of 8 mm/hour.

The patient was obese with body mass index (BMI) of 38, but she lost 40 kilograms of her weight during the past year and her BMI at referral was 24.2.

In the follow-up of the patient during the past year only increase of endometrial thickening was reported in multiple sonography with no ovarian mass, yet the last sonography reported 16 mm endometrial thickening with myoma 49 × 43, with solid-cystic mass (77 × 50 mm) in the right ovary (Figure 1).

Because of this sonography result, the patient underwent diagnostic surgery due to ovarian mass and myoma.

During surgery, a frozen section of the mass was prepared, and pathology reported ovarian cyst and mass of uterus (suspicious of myoma); both of them were endometrioid adenocarcinoma then right salpingo-oophorectomy with left cystectomy was done and surgery was stopped because the patient did not know she had cancer and permanent pathology should confirm frozen pathology. Permanent pathology confirmed that both the cyst and mass were endometrioid adenocarcinoma and

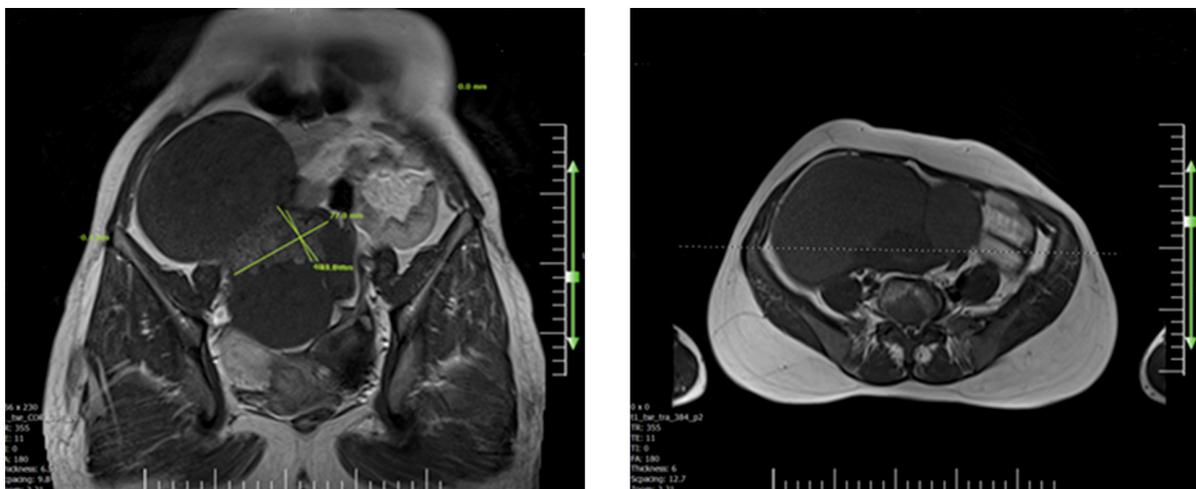


Figure 1. Myoma 49 × 43, With Solid-Cystic Mass (77 × 50 mm) in the Right Ovary

the patient was then referred to our center (Figure 2).

After the patient referred to our center because of the sonography and pathology report, we suspected high stage endometrial cancer, thus the patient underwent chest computed tomography (CT) (5). In the chest CT scan, six small nodules (up to 4 mm) suspicious for metastasis with mild bilateral pleural effusion was reported.

In Abdominal magnetic resonance imaging (MRI) (6, 7), para-aortic and pelvic lymphadenopathy suspicious for metastasis with omental thickening was reported.

One week after the first surgery, the patient underwent a second surgery with vertical incision, total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAH & BSO) and pelvic with para-aortic lymph node dissection, as well as omentectomy.

As for the pathology report, the patient was at stage IV of endometrial cancer. She underwent six cycles of chemotherapy with Taxol and Carboplatin together with radiotherapy.

Her general condition is currently good and she has been followed-up by our center, however we know her survival prognosis is poor.

3. Discussion

Endometrial cancer is the most common cancer in female genitourinary system with a mean age of about 60 (1), however 20-25% of patients are pre-menopausal and approximately 5% of patients are younger than 40 years old (2); 70% of endometrial cancers are localized when diagnosed (8) because of the signs and symptoms of this cancer (4).

Nevertheless, here we reported on a usual case of endometrial cancer, which was miss diagnosed because of cultural issues with strong religious beliefs pursuing virgin patients to insist on protecting their hymen before engagement.

In conclusion, patients with persistent signs and symptoms should be considered for endometrial cancer especially patients with high risk factors, such as nulliparity, late menopause, obesity, diabetes mellitus, unopposed estrogen therapy, tamoxifen therapy, atypical endometrial hyperplasia, Lynch II syndrome, etc.

Patients with major risks factors, such as our patient who was obese, should not undergo drug therapy before pathology evaluations rule out endometrial cancer.

Further evaluations should be considered for patients with alerting sonography results and risk factors; such evaluations include CT scan for metastasis (5), MRI with 84% accuracy (6) and about 90% positive predictive value (7) for endometrial cancer.

However, the most important issue for patients with persistent symptom and risk factors for endometrial cancer in highly religious countries is interaction between gynecologists and the coroner to provide a document that endorses patient virginity for medical procedures like biopsy or curettage, so that the patient can provide consent for the required procedures.

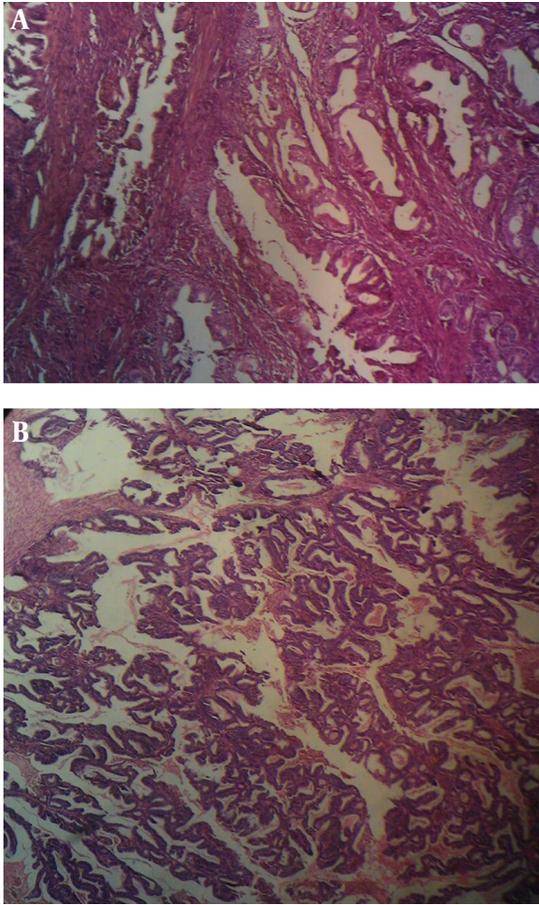


Figure 2. A, Uterus Endometrioid Adenocarcinoma; B, Ovarian Endometrioid Adenocarcinoma

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