



CLINICAL CASE: CANCER OF THE BODY OF THE UTERUS WITH THE RETURN OF THE DISEASE AFTER 12 YEARS.

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Article history:	Abstract:
<p>Received: June 1st 2022 Accepted: July 1st 2022 Published: August 6th 2022</p>	<p>The article presents a clinical case of cancer of the uterine body with the return of the disease after 12 years. The clinical picture of the disease was dominated by pain and the presence of postoperative hernia. After a thorough diagnostic examination and preliminary preparation, the patient was co-operated in the department of the oncogynecology of the Tashkent City Branch of the Republican Specialized Scientific and Practical Medical Center of Oncology and Radiology. The paper analyzes the reasons for the return of the disease after 12 years, considers options for preventing the recurrence of the disease. These data can help in the management of patients with this pathology and improve disease-free survival of patients.</p>
<p>Keywords: Cancer Of The Uterine Body, Metastasis, Incisional Hernia, Undifferentiated Carcinoma.</p>	

INTRODUCTION. Endometrial cancer is one of the most common female gynecological malignancies and can develop in normal, atrophic, or hyperplastic endometrium. About 75% of endometrial cancer is detected at stage I of the disease, when the tumor is located only inside the uterus, which in itself has a positive oncological prognosis [12]. However, it is noteworthy that there are exceptions to the general pattern of the course of endometrial tumors. Cancer of the body of the uterus is a morphologically heterogeneous tumor and is predominantly (>80%) represented by endometrioid forms of the disease, which are characterized by a favorable course with a 5-year survival rate of up to 90% [8]. The share of rare endometrial tumors accounts for only 15-20%, however, it is this group that is responsible for the largest number of relapses of the disease (50%), and the 5-year survival rate of these patients does not exceed 40% [2,7]. Since research on the problem of uterine body cancer is being conducted in all countries of the world, approaches to the diagnosis and treatment of tumors of the female genital tract are being improved every year. However, specialists can often use different terms to characterize the same neoplasm, and for a comparative analysis of clinical and morphological studies, unity of nomenclature is required. Therefore, in the 90s of the twentieth century, under the chairmanship of S. Silverberg, the International Classification of Endometrial Cancer was developed and adopted, which is still used today. According to the latest WHO classification [6], there are two groups of endometrial carcinomas: endometrioid and non-endometrioid (rare), including sero-papillary, clear cell,

mucinous, squamous, mixed and undifferentiated cancer.

CLINICAL CASE. Patient S., born in 1948, was admitted to the hospital with complaints of a hernia in the anterior abdominal wall, pain in the area of the hernia and in the lower abdomen (Pic. 1.). From the anamnesis, the patient underwent extirpation of the uterus with appendages for cancer of the uterine body of the 1st stage in 2010 in our hospital. The postoperative planned histology was a moderately differentiated endometrioid carcinoma. Subsequently, the patient received radiation therapy with total focal dose 40Gy and was in dispensary observation at the clinic of the Tashkent city branch of the Republican Specialized Scientific and Practical Medical Center of Oncology and Radiology (TashCBRSSPMCOandR). The last 2 years the patient noted the appearance of a postoperative hernia. Deterioration of well-being during the month before admission, when pain in the lower abdomen began, aggravated by physical exertion. She went to the doctor of the polyclinic of TashCBRSSPMCOandR, and she was hospitalized. On admission, she was in a state of moderate severity. The skin and visible mucous membranes are pale in color. In the lungs, vesicular breathing, no wheezing, respiratory rate 20 per minute. Heart sounds are muffled, the rhythm is correct, heart rate (HR) is 82 beats/min, blood pressure is 130/80 mm Hg. Art. The abdomen is soft, there is a postoperative hernia in the anterior abdominal wall, moderately painful on palpation. The liver and spleen are not palpable. The stool is prone to constipation. Diuresis regular, independent.



Picture 1. A view after surgical hernia in the supine position.

During laboratory and instrumental examination:
 In the general blood test: hemoglobin 101 g/l, hematocrit 34.2%, erythrocytes $4.0 \times 10^{12}/l$, leukocytes $6.1 \times 10^9/l$, leukocyte formula unchanged, ESR 23 mm/h (accelerated). Biochemical blood test and coagulogram are within normal limits. General analysis of urine without pathology. X-ray of the chest organs: fresh focal and infiltrative shadows in the lungs were not detected. The pulmonary pattern is moderately enhanced by the vascular and interstitial components. The roots of the lungs are compacted, heavy. Electrocardiography: sinus rhythm, heart rate 74 beats/min, left ventricular hypertrophy, deviation of the electrical axis to the left. Ischemic changes in the ST segment were not detected. Echocardiography: left ventricular myocardial hypertrophy: left ventricular myocardial mass 160g, without signs of outflow tract stenosis. The maximum pressure gradient across the aortic valve is within normal limits. Local violations of contractility were not revealed. The contractile function of the myocardium is satisfactory; the ejection fraction is 59% (normal > 57%). Diastolic function of the myocardium is not disturbed. Moderate sclerosis of the aortic valve cusps, minimal regurgitation under the cusps. Doppler of the veins of the lower extremities: no signs of thrombosis. Ultrasound examination of internal organs revealed signs of diffuse changes in the parenchyma of the kidneys and liver, kidney cysts. MSCT Conclusion: a hernia of the anterior abdominal wall, formations in the hernial sac with possible invasion into the intestinal loops. Esophagogastroduodenoscopy: the mucosa of the gastric areas accessible to inspection is moderately, unevenly hyperemic. The mucosa of the visible parts of the duodenum is moderately hyperemic. Conclusion: gastroduodenitis. Irrigography: dolichocolon. Chronic colitis. Revision of ready-made

histological blocks: undifferentiated carcinoma. IHC studies: mutant p53: +, bcl-2:++.

The patient was diagnosed with: Primary: Cancer corporis uteri pT1NxM0 Stage I, II clinical group. Condition after combined treatment (condition after surgery + condition after radiation therapy from 2010 in the conditions of TashCBRSSPMCOandR) Relapse of the disease? (February 2022). Concomitant pathology: Hypertension III degree, stage II, risk 3. Left ventricular hypertrophy. Hernia of the anterior abdominal wall. Gastroduodenitis. Chronic colitis

The patient was examined by a cardiologist, gastroenterologist, angiosurgeon and anesthetist, no contraindication to surgical treatment was identified. The patient's condition was discussed at a council with the participation of oncogynecologists, radiologists and chemotherapists. Taking into account the patient's complaints, the results of laboratory and instrumental studies, the genital status is recommended as the first stage of treatment, surgery in the amount of: "Laparotomy, revision. Removal of the tumor. Hernia excision with autoplasty". The patient in stationary conditions received preoperative preparation, there was infusion management of cardiotropic, general strengthening, anticoagulant and antioxidant drugs. Received drugs to improve blood rheology.

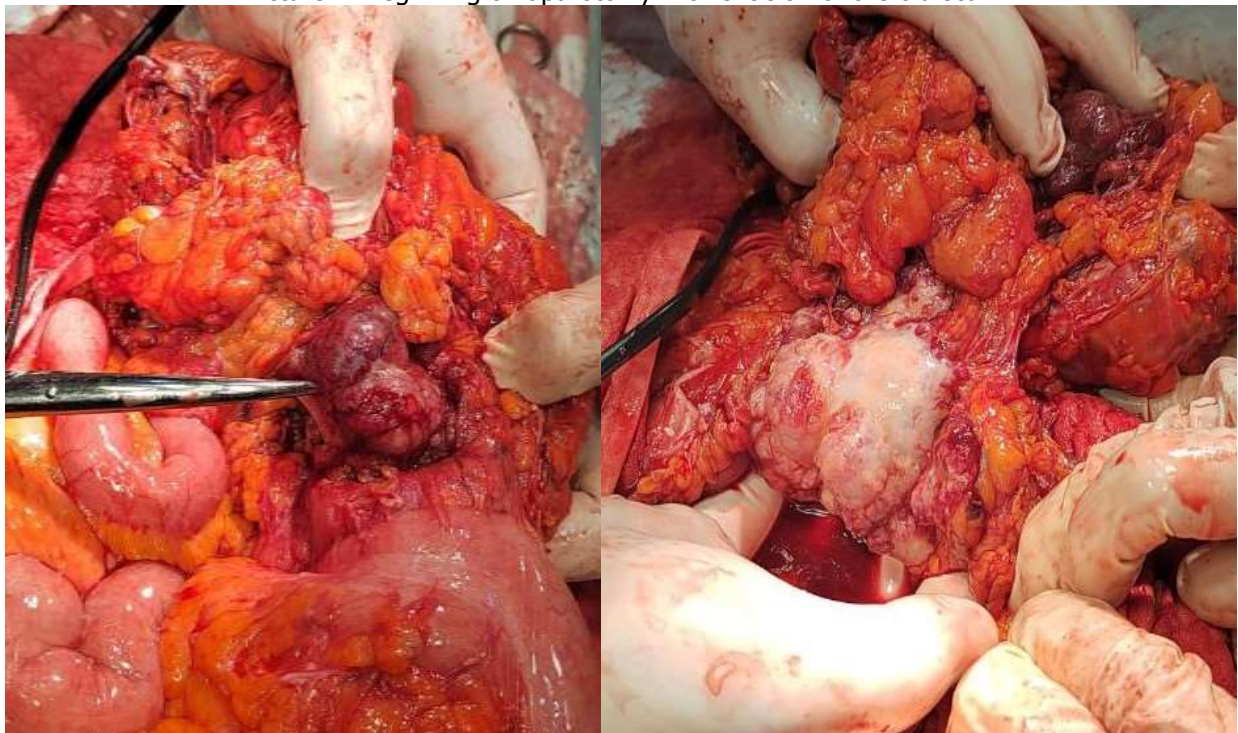
On February 18, 2022, the patient underwent an operation above the indicated volume under combined anesthesia (Pic 2.). During the revision, it was found that the contents of the hernial sac were represented by a greater omentum, loops of the small and large intestines and space-occupying formations of a metastatic nature, a whitish hue, a dense consistency, 5x6.5x5.5 cm in size (Pic. 3,4). The same tumors were found in the mesentery of the intestine, up to 1.5 cm in diameter (Pic.5). An omentectomy was performed and

all macroscopic visible tumors were removed, the operation was completed by excision of the hernia and autoplasty. The postoperative period was uneventful; the sutures were removed on the 9th-10th day. The patient was discharged in a satisfactory condition.

Postoperative planned histology: undifferentiated carcinoma, metastatic lesion of the omentum. Biopsies from the mesentery of the intestines: similar tumor cells of a metastatic nature. In the future, the patient was recommended adjuvant courses of polychemotherapy.



Picture 2. Beginning of laparotomy with excision of the old scar.



Picture 3 and 4. Detection of a metastatic tumor inside the hernial sac.



Picture 5. Metastatic eruption in the mesentery of the small intestine.

Thus, when comparing the clinical picture, these instrumental methods of research, histological examination, the following diagnosis was made. Main: Cancer corporis uteri pT1N0M1 IV stage II clinical group. Condition after combined treatment (state after surgery + condition after radiation therapy from 2010 in the conditions of TashCBRSSPMCOandR). Relapse of the disease, metastatic lesion of the greater omentum, carcinomatosis. (February 2022) Condition after optimal cytoreduction (02/18/2022). Concomitant pathology: Hypertension III degree, II stage, risk 3. Hypertrophy of the left ventricle. Gastroduodenitis. Chronic colitis.

CONCLUSION. Assessing retrospectively the clinical picture, the data of laboratory and instrumental methods of examination of the patient, it is possible to emphasize the peculiarity of the course of cancer of the uterine body of a non-endometrioid nature. However, from our point of view, such a late recurrence (after 12 years) of this pathology can be explained by the low expression of apoptosis inhibitor genes (the mutant p53, bcl-2 gene). Undifferentiated endometrial carcinoma has no glandular, squamous, or sarcomatous differentiation in conventional slides. Most contain epithelial antigens that are immunologically detectable. Some may contain argyrophilic cells or neurosecretory granules detectable immunohistochemically or by electron microscopy [9,13]. According to J.P. Geisler et al. [3], only the FIGO stage and overexpression of the p53 protein are the only independent prognostic

significant factors for this tumor. Studies by M. Miyazaki [5] demonstrate a similar picture of undifferentiated cancer in relation to p53. M.K. Heatley [4] found a high apoptosis index among rare endometrial tumors, however, the highest rates were characteristic only of undifferentiated endometrial carcinomas. Undifferentiated carcinoma, like sero-papillary and clear cell carcinoma, is a high-risk neoplasm - a 5-year survival rate does not exceed 58% [1,10,11]. Thus, undifferentiated endometrial cancer is characterized by the following features: 1. microscopically there are no signs of glandular, squamous or sarcomatous differentiation, 2. the neoplasm is characterized by overexpression of p53, a high apoptosis index in relation to other rare forms of cancer of the uterine body, 3. the tumor is characterized by an extremely unfavorable course, prognostic factors are the stage of the disease, overexpression of p53. The most informative diagnostic method is the modern "Pipelle" biopsy with obligatory immunohistochemical examination for the mutant p53 and bcl-2 genes. When rare (non-endometrioid) forms of endometrial cancer are detected, more aggressive treatment methods should be prescribed, with the addition of preoperative brachytherapy stacks and postoperative adjuvant courses of polychemotherapy. Also, in the volume of surgical intervention, add the removal of the greater omentum - omentectomy.



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