



ORIGINAL RESEARCH PAPER

Radiodiagnosis

ENDOMETRIAL ADENOCARCINOMA PRESENTING AS HEMATOMETRA IN A POSTMENOPAUSAL WOMAN

KEY WORDS: Endometrial carcinoma, Post menopausal, Hematometra

Dr. Harshvardhan Singh Rathore	Resident, Department of Radiodiagnosis, Dr. D.Y. Patil Medical College, Navi Mumbai
Dr. Sarafaraz Shaikh	Consultant, Department of Radiodiagnosis, Dr. D.Y. Patil Medical College, Navi Mumbai
Dr. Pratik Patil	Associate Professor, Department of Radiodiagnosis, Dr. D.Y. Patil Medical College, Navi Mumbai
Dr. Om Tavri	Professor emeritus, Department of Radiodiagnosis, Dr. D.Y. Patil Medical College, Navi Mumbai
Dr. Madanmanmohan	Head of Department, Department of Radiodiagnosis, Dr. D.Y. Patil Medical College, Navi Mumbai

ABSTRACT Endometrial carcinoma (EC) is one of the most common malignancy in females. The peak incidence of it is around 6th – 7th decade, though 12% of cases may present in pre-menopausal women. The most common presentation of endometrial carcinoma in post menopausal women is vaginal bleeding. However in case of complete cervical stenosis, this sign may be missing. In such cases, patient usually presents with pelvic or abdominal pain while ultrasonography might reveal the presence of enlarged intrauterine fluid collection with a thickened endometrial lining. We here present the case of a 65-year-old Indian patient who presented with lower abdominal pain since 3 months.

INTRODUCTION

In well-developed countries, Carcinoma Endometrium is the most common cancer of the female reproductive organs. The mean age of presentation is around 65 years. In India, the incidence is around 4.3 per 1,00,000 women. In >80% cases, patients usually present with abnormal vaginal bleeding . It rarely presents with haematometra. Haematometra is a condition caused by an obstruction or stenosis of the lower part of female genital tract, which results in an accumulation of blood in the endometrial cavity. The cases reported by John W. Brickenridge in AJR (in Feb, 1982) mentioned that postmenopausal uterine fluid collection seen in an ultrasound suggested carcinoma involving the endometrium in 94% of cases.

The common causes of hematometra are congenital malformations like imperforate hymen, cervical stenosis from surgery like Manchester's operation or cone surgery and malignant conditions like Ca cervix or Ca endometrium

Risk factors for developing EC are nulliparity, obesity, unopposed estrogen intake, , diabetes mellitus, PCOD, Lynch syndrome, and tamoxifen therapy. Definitive diagnosis of EC is generally made by biopsy or dilatation and curettage.

Histologically, it is divided into two subtypes. The most common is the endometrioid adenocarcinoma (type I) that accounts for almost 90% of the tumors. They are associated with estrogen excess and obesity. These tumors often arise in a background of endometrial hyperplasia, occur in the early postmenopausal period, generally are low grade, and have a good prognosis.

Type II ECs include the clear-cell, serous papillary subtypes and carcinosarcomas. They have no association with estrogen excess or atypical hyperplasia, generally occur in older women, carry a worse prognosis, and spread like ovarian cancer.

EC can spread by direct infiltration , lymphatic, transtubal peritoneal seeding or hematogenous routes. Locally, EC

initially invades the myometrium and then the endocervix. After transserosal spread, direct invasion of the parametrium, bladder, or bowel may occur.

CASE HISTORY

A 65-year-old post menopausal female patient presented to OPD for diffuse lower abdominal pain on and off since 3 months associated with vaginal discharge . Owing to her symptoms , patient was referred for USG which revealed bulky uterus with 49cc sized anechoic collection in the endometrial cavity with obliteration of endocervical canal. Patient was then advised MRI Pelvis for further evaluation , which revealed a well defined fluid intensity collection measuring approximately 4.2 x 4.2 x 4.1 cm (AP x TR x CC) was noted in the uterine cavity.

Thus , possibility of Ca endometrium was considered and patient was advised pathological and biopsy correlation for confirmation of diagnosis.

PAP smear was positive for epithelial malignancy.

Fluid for cytology showed atypical cells which suggested epithelial malignancy.

Owing to above findings of malignancy , patient was advised Wertheim's hysterectomy to avoid further complications. Intraoperative no spread was noted into vagina, bilateral ovaries, fallopian tubes, parametrium and obturator lymph nodes

The specimen of uterus was sent for histopathology.

Immunohistochemical assessment showed :

- ESTROGEN RECEPTOR - Positive(90%)
- PROGESTERONE RECEPTOR- Positive (90%)
- No overexpresion of p53 was noted

Thus our final diagnosis was "**Endometrioid Adenocarcinoma moderately differentiated FIGO Grade II of the endometrium**"

DISCUSSION:

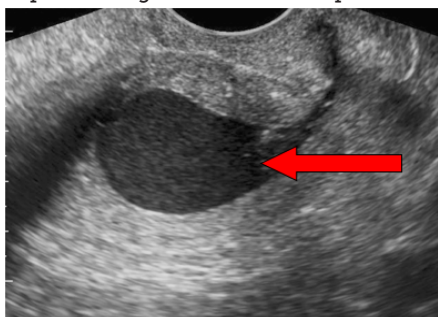
In postmenopausal women, the most common sign, which helps to diagnose endometrial cancer, is the presence of vaginal bleeding. However, this symptom might not be present in cases with cervical stenosis due to aging, previous genital infections or personal history of irradiation. If this occurs, an important delay of diagnosis occur.

The aim of this case report is to highlight the unusual presentation of Ca endometrium in postmenopausal women as well as to share our experience with a very huge haematometra which turned out to be serous adenocarcinoma endometrium stage IIA.

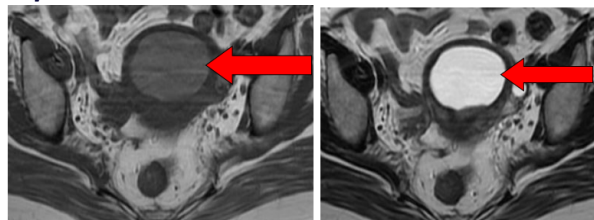
This case proved that every haematometra that occurs in postmenopausal women has a high possibility to turn out to be carcinoma endometrium

CONCLUSION-

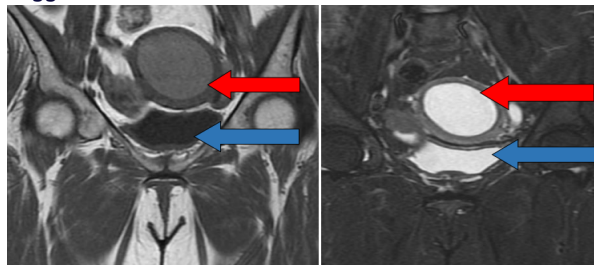
Diagnosis of endometrial cancer should always be taken into consideration in postmenopausal women presenting with hematometra. Following it , an endometrial sampling should be performed in order to diagnosis and to establish further management . Imaging plays an important role in the diagnosis and staging. Currently, MRI imaging is the most commonly used modality for preoperative staging, along with PET/CT to evaluate distant metastases In our case, performing a radical surgical approach consisting of Wertheim's hysterectomy, pelvic and para-aortic lymph node dissection provided a good outcome of the patient.



USG (Sagittal view) showing bulky uterus with anechoic collection (Red arrow) in the endometrial cavity without any extension into cervical canal.

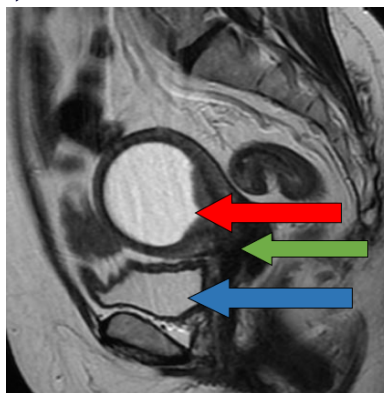


MRI pelvis (Plain)T1 and T2 W axial image showing bulky uterus with a well defined fluid intensity collection (red arrow) measuring approximately 4.2 x 4.2 x 4.1 cm (AP x TR x CC) in the uterine cavity. This finding was suggestive of hematometra



MRI pelvis (Plain) T1 W coronal and T2W Coronal STIR image showing a well defined fluid intensity collection in the uterine cavity without any extension into lower

endocervical canal. Urinary bladder seen separately (Blue arrow)



MRI pelvis (Plain) sagittal T2 image showing bulky uterus with a well defined fluid intensity collection (red arrow) in the uterine cavity without any extension in to cervix (Green arrow). Urinary bladder seen anteriorly (Blue arrow)

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