

First Presentation and Diagnosis of a Rare Advanced Gynaecological Cancer in Emergency Department: A Case Report

Abstract

A case of rare endometrial carcinosarcoma with locoregional spread and sigmoid fistula presenting for the very first time at a hospital emergency department (ED). A 56-year-old female presented with abdominal pain, diarrhea, fever, and pancytopenia, which was diagnosed as advanced gynaecological cancer following assessment, imaging, and tissue biopsy. Increased pressure on the ED owing to coronavirus disease 2019 pandemic may cause the first presentation of gynae-oncology cases to ED physician. A full return of all primary care services may reduce such pressure, improve early detection of gynaecological malignancies, allow early multidisciplinary team care, and result in better patient experience in the long run.

Keywords: *Carcinosarcoma, colo-endometrial fistula, CT/MRI scan, emergency department, pancytopenia, point of care ultrasound (POCUS)*

Introduction

Beyond the usual norm, a rare and advanced endometrial tumor with atypical presentations greeted our emergency department (ED), but detected and appropriately flagged up for multidisciplinary care.

Case Report

Noontime priority call for Ms. X, 56 years old, with insidious onset disabling suprapubic pain, diarrhea and high-grade fever (40.1°C) for a couple of days. There was associated dyspnea, no chest pain, and no urinary tract symptoms. She also reported irregular menstrual periods, dark brown vaginal discharge, anorexia, steady activity decline, and unexplained weight loss for 3 months. There was no hematochezia and no melaena. Ms. X reported a lower abdomen distension not particularly concerning to her before presentation. She had not been able to access any other healthcare provider services for these symptoms before presentation. Past medical history was significant for only controlled asthma. Previously, she was active and independent, a nonsmoker, and had no alcohol misuse. There was no family history of cancer.

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On assessment, she was febrile, pale, hypotensive, tachypnoeic, and tachycardic. Her chest was clinically clear, and her abdomen had a tender, firm, irregular, and fixed suprapubic mass of pelvis origin. Point of care ultrasound (POCUS) revealed no free fluid, empty uterorectal pouch, normal sonographic appearance of liver, spleen, kidneys, ovaries, and an ill-defined bulky uterus, necessitating further imaging modalities. Blood results showed severe pancytopenia. Provisional diagnosis was pancytopenia, sepsis of unknown focus, and gynaecological malignancy. She had full sepsis six bundle delivery, adequate analgesia, antipyretic, and blood product transfusion. Computed tomography (CT) scan [Figure 1] reported a locally advanced endometrial malignancy. Gynae-Oncologist and hematologist referrals were made. Pelvic magnetic resonance imaging (MRI) [Figure 2] revealed a complete myometrial tumor, which invaded through the cervix into the vagina and sigmoid with a colo-endometrial fistula. Follow-up histology confirmed endometrial carcinosarcoma and a swift multidisciplinary team (MDT) process was commenced. MDT outcome was an inoperable advanced endometrial cancer (The endometrial cancer has spread to inguinal lymph nodes, the upper abdomen, the omentum, or to organs away from the uterus, such as the lungs, liver, or

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Figure 1: CT scan demonstrating advanced uterine tumor

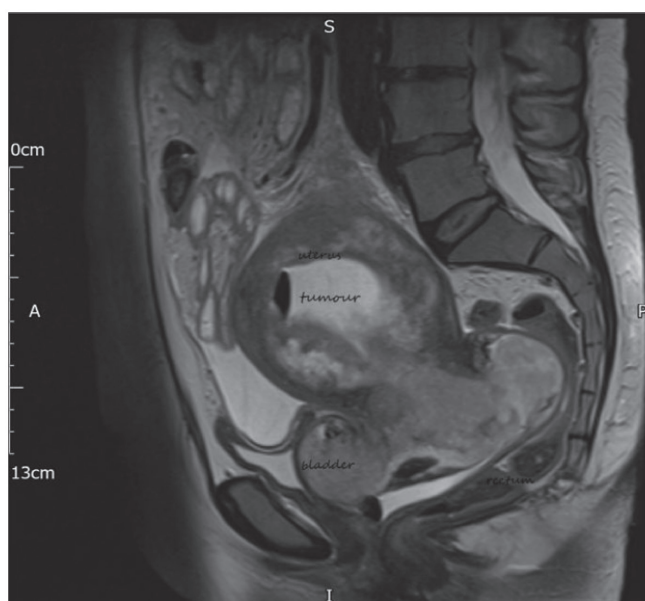


Figure 2: MRI scan demonstrating colo-endometrial fistula

bones, patient prognosis 3–6 months) with consideration for palliative interval chemoradiotherapy for symptoms control after optimization. She, unfortunately, succumbed to the illness having only received two cycles of paclitaxel and carboplatin chemotherapy and no radiotherapy session.

Discussion

Gynaecological emergencies met in ED are mostly bleeding or infection-related.^[1] Most gynaecological neoplasm utilizes the primary care and clinics as the first portal of call.^[2] Probably owing to COVID-19 pandemic^[3] and a resultant drastic shift to remote consultations, ED becomes the easiest means of first in-person consultation. On rare occasions, the first diagnosis of gynaecological cancers could await the unprepared emergency physician; a vast majority ending with subsequent MDT care.^[4]

New gynae-oncology cases could be very challenging to both the ED clinician and the patient. Among the reasons, being that a busy ED may not present an ideal environment for in-depth evaluation and breaking bad news.^[5,6] Pain has remained the most consistent reason for ED visits in cancer patients.^[7] POCUS could pick vast range of visceral abnormalities in trained ED doctors, whereas CT/MRI remained important tools for diagnosis, disease staging, and direction of management.^[8-10] At 45.5 years median age, spectrums of cases encountered in ED were least for endometrial and highest for cervical cancers.^[11] Identified risk factors in some series^[1,6] were postradiation, tamoxifen exposure, exogenous estrogen, obesity, and null parity. None of these risk factors were inherent in Ms. X who presented atypically with sepsis and pancytopenia.

It is expected that a steady decline in performance score could occur with disease progression, dwindling quality of life.^[6] A research piece^[11] noted daytime as the commonest visit hours and such patients use ED at higher rates via treat-and-release patterns. Progressive tumor vascular invasion may occur with resultant hemorrhage.^[12] Bleeding from gynaecological cancers may pose a challenge in management, especially in developing countries where prompt hemostasis with external beam radiotherapy is not readily available.^[12-14] Tissue histology for the index case confirmed endometrial carcinosarcoma. A high index of suspicion is key as such cancer is very rare, vastly malignant, highly invasive, notoriously recurrent, and carries meager prognosis with no clear-cut treatment modalities. Late encounters lead to the poorer delineation of exact tumor origin since spread becomes inevitable, curative treatment if near impossible, and prognostic outcomes are usually poor.

Conclusion

Beyond the trauma calls and cardiac arrest bleeps that characterize a typical ED, gynaecological malignancies might slip in. Meticulous history, examination, and institution of relevant investigative modalities could help identify such patients and direct compassionate multidisciplinary care plan. Return of full primary care functionality may further help in early identification, timely specialist referral, probably improving survival rate from cancers, and ultimately leading to sustainable health in the populace.

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