

Hysteroscopy as a Tool for Identification of Uterine Endocervical Lesion

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A 65-year-old menopausal woman consulted regarding 3-week duration of vaginal spotting, for which transvaginal ultrasound (TVS) was done and showed an 8.2-mm thickened endometrium with dilated cavity and suspicious endocervical lesion [Figure 1]. The following day, hysteroscopy was performed which revealed a proliferative phase endometrium and papillary outgrowth at the endocervical canal, for which a biopsy was obtained [Figure 2]. Histopathological report showed atypical complex hyperplasia, suggestive of endometrioid carcinoma. Two weeks later, she underwent laparoscopic staging surgery (total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic lymph node dissection, Para-aortic lymph nodes dissection, peritoneal cytology). Final pathology account was well-differentiated endometrioid adenocarcinoma in atypical complex hyperplasia, T1aN1 and metastatic adenocarcinoma on the right pelvic nodes.

Minimally invasive surgery in the treatment of early-stage endometrial cancer has become standard of care with benefits that include shorter hospital stay and improved quality of life in the postoperative period. Moreover, a preoperative method for determination of cancer spread has the advantage in operative planning, in selecting women for minimally invasive surgery, and in ensuring that any extensive surgery is performed only for women considered at high risk for extrauterine cancer invasion.

The presence of cervical involvement in patients with endometrial cancer has a greater risk of extrauterine spread such as nodal metastasis and serosal invasion.^[1] Both TVS and hysteroscopy are very observer-dependent techniques, where in diagnostic errors may be accounted for, and the ability to recognize and differentiate between normal and pathologic anatomy is part of the technical skill.

TVS is simplest, low cost, least invasive, and easily accessible and has been advocated as a routine modality of choice for gynecologic diagnosis before any plan for treatment is initiated. Invasion of the cervix by TVS is diagnosed when the neoplastic tissue distended the cervix and showed ill-defined borders with the cervical stroma, irregular and heterogenous endometrial echogenicity overcoming a dilated internal cervical ostium, or disruption of the normal endocervical image with irregular or inhomogenous echogenicity, discrete hypoechogenicity or increased echogenicity.^[2-4] However, in this case, only a “suspicious” endocervical lesion was noted.

Office hysteroscopy is a minimally invasive diagnostic procedure that is now considered as the “gold standard” in the diagnosis of malignant endometrial pathology because it provides direct panoramic visualization of the uterine cavity and the cervical canal, provides precise clinical evaluation

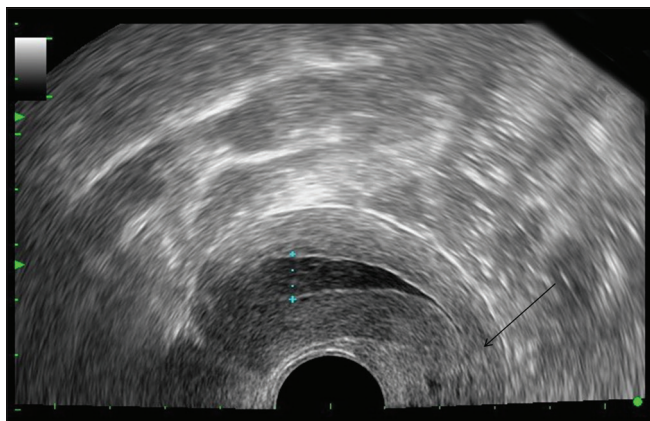


Figure 1: Transvaginal ultrasound showing thickened endometrium and suspicious endocervical lesion (black arrow)



Figure 2: Hysteroscopy image showing papillary outgrowth at the endocervix (black arrow)

of lesions and abnormalities, and permits the option of taking biopsy samples. Major hysteroscopic features of the malignancy spreading into the cervix are presence of exophytic lesions that originate from the cervical walls, irregularities in the cervical surface and contours of isthmus, and increased and accentuated vascularization of the cervical mucosa,^[5] which were clearly demonstrated in this case image.

Most authors agree that a hysteroscopic examination, performed with modern instrumentation at low intracavitary pressure, is virtually devoid of any risk of intraperitoneal spillage and therefore is still considered a first-line modality in the diagnostic and therapeutic workup of endometrial carcinoma.^[5] Therefore, preoperative detection of possible cervical spread or its absence in uterine cancer is best done by hysteroscopy, and it is the most practically useful tool for making individualized management plans to decrease morbidity and avoid overtreatment in low-risk patients. Cost-efficiency is always an important factor when making a choice, and it is likewise prudent to consider the quality of life after treatment, especially in cancer patients.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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