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Case Report

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Young Nulliparous Female with Continous Vaginal Bleeding: A Case of Atypical Endometrial Hyperplasia

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Abstract

Mrs. XYZ 32 years of age, nulliparous presented in the OPD with complaint of continuous vaginal bleeding for 1 month. She had had Dx D & C twice previously for the same complaint one year ago. The two H/P reports showed Adenocarcinoma of the Uterus and repeat D & C one month later showed Secretory endometrium.

Dilatation and curettage was done again on19. 03 2018 which showed Atypical Endometrial Hyperplasia (AEH). The couple was counseled and they opted for definitive treatment. TAH & BSO was done on 03.04 2018. Cut section showed thickened endometrium with no myometrium invasion.

Conclusion: In patients with irregular or continuous bleeding P/V should be evaluated for AEH or Endometrial carcinoma.

Case Report

Mrs, XYZ aged 32, nulliparous, married for 12 years presented in the Gynae OPD , Ghurki Trust Teaching Hospital, Lahore on 18 03. 2018.

She presented with the C/O continuous vaginal bleeding for 3 months. She had no H/O dysmenorrhea, dysparunea or post coital bleeding. She had an H/O a similar episode of continuous vaginal bleeding for 3 months approximately 1 year ago. Her diagnostic curettage was done, but bleeding did not abate and a repeat D & C was performed a month later. Her H/P reports showed endometrial carcinoma and Secretory endometrium respectively.

Patient was alright 1 ½ year back when she had regular menstrual cycle 6-7/2 months with average flow, soaking 1-2 pads/ day with no H/o dysmenorrhoea or dysparunea, intermenstrual and post coital bleeding then she developed continuous p/v bleeding for 3 months initially soaking 3-4 pads/ day followed by spotting p/v, intermittently

Patient remained alright for 1 year with menstrual cycle of 6-7 every 2 months. She presented again with continuous p/v bleeding for 3 months. Her pelvic USG & MRI showed anteverted uterus 7.6x4.1x5.5 cm with abnormal soft tissue in endometrial cavity measuring 2.1x3.2x5.3 cm for which her diagnostic D & C was done on 19th March 2018, which report showed complex hyperplasia with severe atypia, the couple was counseled and the patient was admitted for Total Abdominal Hysterectomy + Bilateral Salpingoopherectomy.

Gynaecological History

Menstrual cycle 6-7/2 months with average flow, soaking 1-2 pads/ day with no H/o dysmenorrhoea or dysparunea, intermenstrual and post coital bleeding then she developed continuous p/v bleeding for 3 months initially soaking 3-4 pads/ day following p/v spotting.

Contraception was never practiced H/o ovulation induction multiple times cervical smear did not show any abnormality.

Past Medical History

No H/o breast lump, diabetes mellitus, hypertension, chronic illness or hospitalization

Surgical History

Diagnostic D&C was done twice within the last one year. No H/o any allergy or blood transfusion.

Transfusion History

No H/o any blood or blood product transfusion.

Personal and socioeconomic history

The patient belonged to middle socioeconomic class. She did not have any drug allergies. No H/O use of any habit forming substance

Family History

H/o hypertension and diabetes but no H/o breast, ovarian, endometrial or colon cancer in the family

Examination

Height:	157 cm
Weight:	97 kg
Vitals:	130/90
Pulse:	80 bpm
Temperature:	98.6oF
Respiratory Rate:	16 bpm
Pallor:	Negative
Jaundice:	Negative
Thyroid:	Not enlarged
Lymph Nodes:	Not palpable
CVS:	S1+S2+0
Respiration:	Normal vesicular breathing with no added sound
CNS:	No abnormality

Abdominal Examination

Abdomen flabby, soft non tender
No mass palpable
No viscera palpable

Speculum Examination

Cervix normal looking
Bleeding positive from the external os

Bimanual Examination

Uterus normal in size anteverted, mobile
Fornices clear; No tenderness

Investigations

Blood Group:	A +ve
Hemoglobin:	11.8gm/dl
Blood sugar random:	100mg/dl
HbsAg:	Negative
Anti HCV:	Negative
Platelets:	452x109/ ml

Abdominopelvic TVS

Uterus normal in size, anteverted
Endometrial thickness: 29 mm
No adenxal pathology

MRI Pelvis

Abnormal soft tissue is noted filling endometrial cavity measuring 2.1x3.2x5.3 cm
No evidence of pelvic lymphadenopathy

Procedure

Total abdominal hysterectomy + bilateral salpingoopherectomy

Operative Findings

After aseptic measures abdomen was opened by low transverse incision. Uterus 8 weeks size. Both ovaries normal looking. Under surface of diaphragm was smooth. Para-aortic lymph nodes were not palpable.

Uterus and ovaries were removed by clamping, cutting and ligating all pedicles. Vault was closed and an abdominal drain was placed. After securing hemostasis, counting instruments and sponges, abdomen was closed in reverse order.

Cut section revealed thickened endometrium with no invasion of myometrium. Sample sent for histopathology.

Postoperative Period

During the postoperative period the patient remained stable. Stitches were removed on the 7th post operative day and the patient was discharged. She was advised follow up with histopathology report in the outpatient department.

Histopathology

Complex hyperplasia with severe atypia and chronic cervicitis.

Discussion

Endometrial hyperplasia is defined as histologically abnormal overgrowth of the endometrial glands and can be a precursor to cancer. Sustained stimulation by estrogen that is not opposed by progesterone can lead to an increased number of endometrial glands.

Endometrial hyperplasia is suspected when measurement revealed that the endometrial thickness is greater than 4 mm in a patient with postmenopausal bleeding or greater than 8 mm in a patient with premenopausal abnormal uterine bleeding.

Endometrial hyperplasia, particularly with atypia, is a significant concern clinically because it can be a precursor and marker of concurrent endometrial cancer [1]. Endometrial hyperplasia with atypia progresses to endometrial carcinoma in around 39% of the cases. This usually progresses to well differentiated adenocarcinoma of endometrium [2-5].

If the family is complete or the patient is postmenopausal. The treatment of choice is total abdominal hysterectomy with bilateral salpingoopherectomy with selective lymphadenectomy. On the contrary, ovarian preservation can be considered for AEH patients, especially for premenopausal women, and lymphadenectomy is unnecessary [6, 7].

The final diagnosis is determined on the histopathology of resected uterus. The difficulty in the differential diagnosis of AEH and well-differentiated endometrioid EC may result in enforced secondary surgery or overtreatment.

In patients with atypical endometrial hyperplasia, the detection of endometrial cancer before hysterectomy can decrease the risk of suboptimal treatment. The accuracy of endometrial sampling for the diagnosis of concurrent endometrial carcinoma is much lower than that for atypical endometrial hyperplasia. Therefore, concurrent endometrial carcinoma should be suspected and surgical intervention should be considered in young or obese patients who present with atypical endometrial hyperplasia. It is clear that D&C alone does not completely exclude endometrial CA [8].

However, if the patient wants to retain her fertility a short course of progestigen therapy followed by repeat evaluation is recommended [9-11].

This patient had recurring episodes of heavy vaginal bleeding. She was obese and nulliparous and had had diagnostic D & C thrice. Two out of three reports showed atypia and endometrial CA while one report showed secretory endometrium. This report however

does not merit consideration as the procedure was done just a few days after the initial report revealing endometrial carcinoma.

In view of her history and explanation of the risk of endometrial CA, the couple opted for surgical intervention. Hence, TAH with BSO was carried out. No lymph node was palpable so lymphadenectomy was not done.

Acknowledgement

Endometrial hyperplasia is suspected when measurement revealed that the endometrial thickness was greater than 4 mm in a patient with postmenopausal bleeding or greater than 8 mm in a patient with premenopausal abnormal uterine bleeding.

The risk factors for endometrial hyperplasia are similar to those for type 1 endometrial cancers, which are estrogen dependent endometrioid adenocarcinomas and are associated with a favorable prognosis

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