CASE REPORT

Pregnancy With Carcinoma Cervix

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Introduction

Invasive cervical cancer is relatively uncommon during pregnancy. Depending on the patient population studied, estimated incidence ranges from 1 in 1,000 to 1 in 100,000 pregnancies [1]. Pregnancy provides a good opportunity to the obstetrician to screen the patient for cervical neoplasia. We report a case of pregnancy with carcinoma cervix.

Case report

A 26-year-old lady presented to our emergency department on April 6, 2008, referred from a rural hospital as threatened abortion, with bleeding per vagina and pain abdomen, carrying 5 months' pregnancy. She had been bleeding per vagina from the April 5 and gave history of occasional spotting. She also gave history of post-coital bleeding over a period of 8–9 months. She had two previous successful pregnancy outcomes; both times she had delivered vaginally and both her children were fine and healthy. Her last childbirth was 6 years back. She never had any complications in her previous pregnancies. After her last pregnancy, she was

using oral contraceptives, and this pregnancy resulted from improper intake of oral contraceptives.

On admission, we examined the patient and found she was pale, her pulse was 120/min, and blood pressure was 130/90 mm Hg. Uterus was 20 weeks' size on abdominal examination, and she could perceive fetal movements. On Doppler examination, the fetal heart rate was 140/min and regular. On per speculum examination of cervix, a bleeding mass could be seen on the anterior lip of cervix. On gentle per vaginal examination, the mass was hard and irregular, and cervix was tubular with parous os. Provisional diagnosis of pregnancy with carcinoma cervix was made.

We did blood requisition and blood transfusion, gave her antibiotics, catheterized the patient, and gave vaginal packing with Botroclot. Next day, we got a whole abdomen ultrasonography done which showed an 18-week-sized single live fetus, without any congenital anomaly of approximate weight 220 grams. The scan also showed bulky and irregular cervix, but rest of the organs were normal. We went for pre-operative investigations, which were found to be normal after three units of blood transfusion (Haemoglobin 10 gram percent). The patient was taken for Examination Under Anaesthesia and cervical biopsy on the April 9. She was clinically diagnosed to be a case of carcinoma cervix stage I b₂. Biopsy report came on the April 19 which showed moderately differentiated infiltrating squamous cell carcinoma of cervix. Proper counseling was done to the patient party, and the patient herself was informed regarding the severity of the disease and management of the case and with informed consent,

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she was taken up for operation on the April 26, 2008, under general anesthesia.

Abdomen was opened by low transverse incision, with muscle cutting Maylard incision. Low transverse incision was given on the uterus and fetus, and placenta was expelled (Fig. 1). Immediately uterus was inverted, and two circumscribing knots were placed at the lower pole of uterus with No1 Vicryl (Fig. 2) to control bleeding. This step abolished the need for any oxytocics as bleeding was almost nil. Following this, we proceeded for radical hysterectomy with bilateral hypogastric artery ligation and bilateral external iliac lymph node dissection. Haemostasis was secured, and abdomen was closed in layers. Total approximate blood loss during entire operation was 300 ml. *What was remarkable was the control of blood loss following inversion of uterus and the ease with which the planes could be dissected compared to a non-pregnant radical hysterectomy.* Time taken for the operation was 80 min. Postoperative period was uneventful. Two weeks' after operation, patient was started on brachytherapy.

Fig. 1 Intraoperative step

Fig. 2 Fetus seen in situ

Discussion

Cervical carcinoma remains the most common malignancy diagnosed during pregnancy. Among the patients with this disease, approximately 1–3 % are pregnant at the time of diagnosis. Thus, for the oncologist, pregnancy associated with cervical carcinoma is more common. Average age of pregnant women with cervical carcinoma is 31 years.

In selected cases of early-stage cervical cancer, surgical management of cervical cancer is safe during pregnancy [2]. For early stage I squamous cell carcinoma of cervix, planned delay in therapy is safe. Non-invasive cervical carcinoma can be safely deferred until the post-partum period provided that careful colposcopic evaluation is performed in addition to cytology. However, early treatment is advisable in stages I b₂ and II a. Concerns regarding safety of surgery for cervical carcinoma in pregnant patients have been raised. Although increased operative time, blood loss, and fistulae formation have been reported, recent studies have not demonstrated any increase in blood transfusion requirements or major complications [3]. Therefore, in stage I b or stage II, a carcinoma cervix with pregnancy radical hysterectomy with bilateral pelvic and para-aortic lymphadenectomy can be performed in any trimester of pregnancy. If fetus is viable, then a classical cesarian section is carried out, followed by radical hysterectomy with bilateral pelvic and para-aortic lymphadenectomy. With non-viable fetus, a hysterotomy can be performed if necessary to improve surgical exposure.

Patients with more advanced disease are treated with radiation therapy. Prior to fetal viability, whole pelvic irradiation is initiated and the patient usually undergoes a spontaneous abortion 2–3 weeks after initiation of therapy. If spontaneous abortion has not occurred by the time the external radiation is completed, a dilatation and curettage (or rarely a hysterotomy) is required to empty the uterus. A delay of several weeks is required for involution of uterus to occur prior to brachytherapy. Patients with advanced disease (II b or greater) with viable fetus are delivered by classical cesarean section, and external radiation therapy is initiated. Standard brachytherapy is added at the completion of external radiation.

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