

# A Silent Threat: A Case Report of Cervical Cancer and the Importance of Screening in Healthy Adults

**AtlantiCare**

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## History of Presenting Illness

A 36-year-old primiparous female patient, with no known medical history, arrived at the Emergency Department reporting right-sided flank pain that had persisted for 5 months, escalating to the point where she struggled to lift her leg. She also described symptoms such as nausea, vomiting, dysuria, urinary retention, and alternating diarrhea and constipation over several months, alongside irregular menstrual bleeding for a year. Despite having visited the ED previously for similar issues and receiving recommendations for follow-up care, she had been unable to pursue this due to caring for her mother, who recently had a stroke.

Her mother also had a history of cervical and breast cancer.

Of note, the patient had never undergone a gynecological examination.

On admission, her she was found to have severe anemia, and AKI secondary to BL hydronephrosis. Patient had a foley catheter placed, which drained a large amount of urine. She was transfused, and BL nephrostomy tubes were placed by IR.

## Objective

### PHYSICAL EXAM

T: 98.6, BP 182/116, HR 124, RR20, Satting 99% on room air

General: Alert and Oriented

HENT: NC, AT

Resp: Lungs CTABL

Cardio: Normal S1, S2, No MGR

Pelvic Exam: Vulva with no lesions, +Foley catheter in place, Lower vagina with no masses or lesion, + Upper Vagina filled with 7-8cm hard fixed fungating mass with sanguineous discharge, + Upper vagina and perimetrium are indurated, no apparent adnexal mass

### PERTINENT LABS

Cr 14.1, Hgb 5.8

### IMAGING

CTAP w/o Contrast: Significantly distended urinary bladder, irregular posterior bladder wall thickening contiguous with significant cervical thickening. Large 7.4cm transverse dimension of the cervix. Severe hydronephrosis. Para-Aortic retroperitoneal lymphadenopathy. BL pleural effusions.

## Assessment and Plan

The patient was evaluated via EUA w/Colposcopy with GYN attending:

A 6cm necrotic mass involving the entire cervix and upper vagina was visualized, as well as active bleeding. Parametria was shortened BL. Cone biopsies were taken for pathology at 3,6,9,12 o'clock positions.

Cystoscopy and rigid proctoscopy were completed to rule out invasion:

Cystoscopy: Bladder trigone was hyperemic but without lesions. Two 2-3 mm elevated lesions were noted at the posterior bladder wall at the midline and were biopsied by urology.

Proctoscopy: No Rectal masses were visualized.

Pathology results revealed Invasive moderately differentiated squamous cell carcinoma in each of the biopsies taken from the cervix.

The bladder wall biopsies revealed acutely inflamed urothelium with focal atypia, favoring reactive changes.

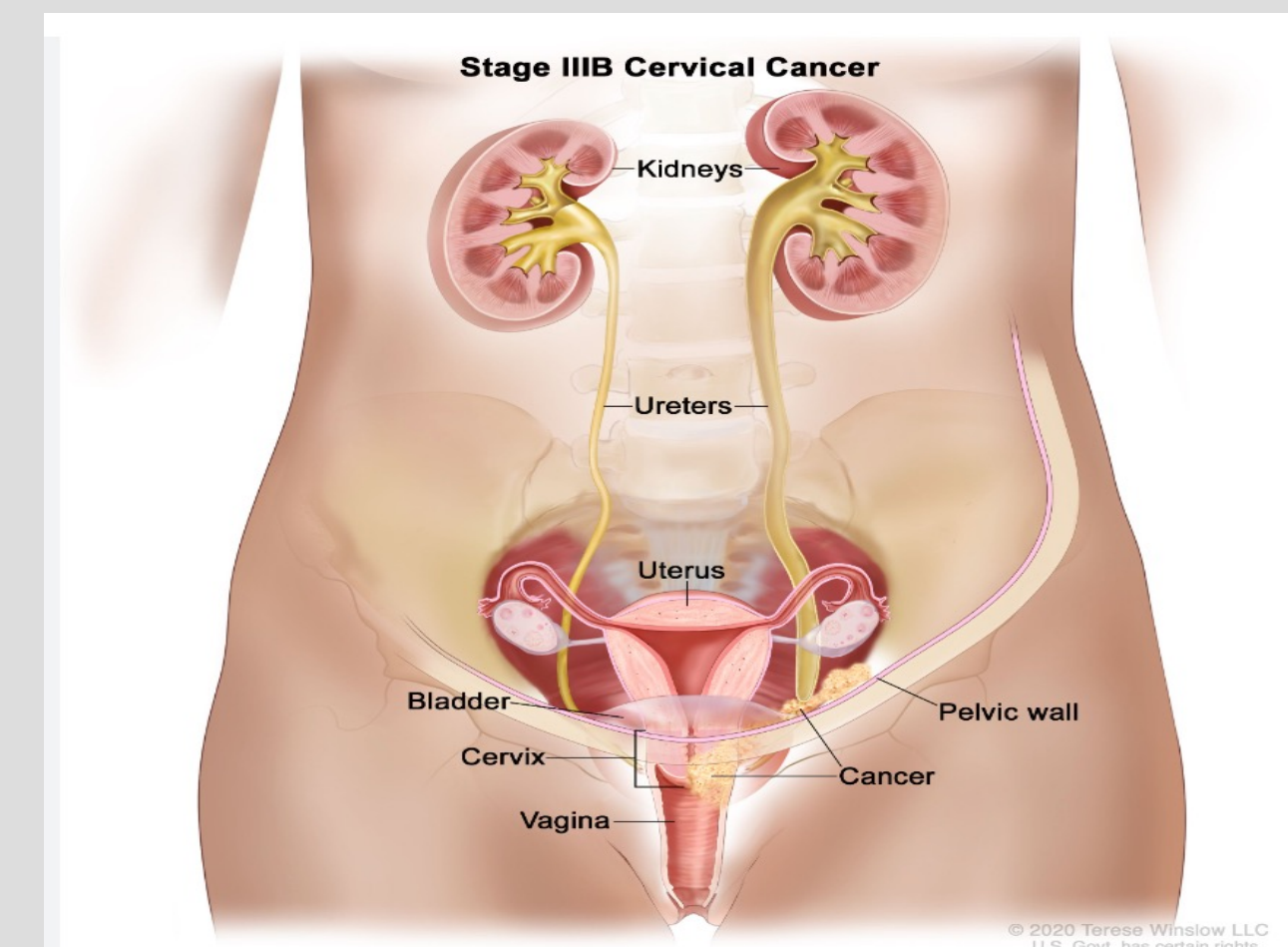
During the hospitalization, her creatinine improved s/p ureteral stent placement, foley catheterization, and IV fluid. She received multiple packed red blood cell transfusions, and her anemia improved as well. Once her acute presentation was stabilized, she was discharged with instructions to follow up with Oncology, Gyn-Onc, Radiation Onc, Gyn, and Urology.

## Conclusion

Based on the International Federation of Gynecology and Obstetrics (FIGO) cervical cancer staging system, the patient had stage IIIB or IIIC cervical cancer. Due to her subsequent finding of para-aortic lymph node metastasis, she does have stage IIIC cancer.

She was initiated on chemoradiation therapy as an outpatient. Overall outcome to be determined...

### DIAGRAM ILLUSTRATION OF INVASIVE CERVICAL CANCER



## Discussion

Cancer of the uterine cervix is the third most common gynecologic cancer diagnosis and cause of death among gynecologic cancers in the United States. Each year, about 11,500 new cases of cervical cancer are diagnosed, and about 4,000 women die of this cancer, according to the CDC. Since 1999 the incidence has trended down, probably due to increased awareness, screening and early detection leading to effective/curative interventions in the US and other resource rich countries.

Human papillomavirus (HPV) is central to the development of cervical neoplasia and can be detected in 99.7 percent of cervical cancers.

Routine HPV vaccination is recommended at 11 to 12 years. It can be administered starting at 9 years of age. For adolescents and adults aged 13 to 26 years who have not been previously vaccinated or who have not completed the vaccine series, catch-up vaccination is recommended. Ages 15 and older will require a 3 dose series of vaccination rather than 2 doses.

Screening is recommended for non pregnant women regardless of sexual activity from the ages of 21-65, at least every 3 years, or every 5 years with HPV co-testing for women 25 and older.

The most common histologic types of cervical cancer are squamous cell (70%) and adenocarcinoma (25%). The most common presenting symptoms are heavy/irregular menstrual bleeding and post coital bleeding.

Differentials of benign tumor-like lesions that may mimic cervical cancer include Nabothian cysts, mesonephric cysts, cervical ectropion, ulcers associated with sexually transmitted infections, reactive glandular changes from inflammation, and endometriosis. In general, the diagnosis of cervical cancer can be made on physical examination. If detected, further evaluation with biopsy and imaging may be required for staging.

As classified by FIGO, there are four stages of cervical cancer, stratified by the dimensions of the lesion and the extent of involvement with other surrounding and distant tissue sites. The treatment of cervical cancer is largely determined by staging.