American Journal of Pharmacology and Pharmacotherapeutics

Case Report

Diagnostic Dilemma Due to Discrepancy in Histopathological Report of Endometrial Fractional Curettage

Shalini Mahana[1] and Som Biswas*[2]

[1]Associate Professor& Head of Unit, Dept of Obstetrics & Gynecology
[2]Resident, Dept of Obstetrics & Gynecology

*Corresponding author e-mail: sombiswas4 @gmail.com

ABSTRACT

This is a case report of a patient with perimenopausal polymenorrhagia from a tertiary care hospital in Mumbai wherein the endometrial fractional curettage report showed Papillary Serous Carcinoma (a rare tumor) but review biopsy report revealed it to be hyperplasia with no evidence of malignancy. Patient underwent Total Abdominal Hysterectomy with Bilateral Salpingo oophorectomy HPR showed Simple hyperplasia. Thus proper clinical judgment can lead to proper diagnosis and thus proper management.

Keywords: Fractional curettage, Diagnostic dilemma, Papillary serous carcinoma, Simple hyperplasia.

INTRODUCTION

Preoperative endometrial sampling has good overall histological correlation to hysterectomised corpus specimen. This is especially so for the endometrioid and certain subtypes of the non-endometrioid endometrial cancer cells (uterine papillary serous carcinoma 67%)[1]. Papillary serous carcinoma of the endometrium is a very aggressive type of endometrial carcinoma that behaves more similar to ovarian carcinoma than to endometrial carcinoma.[2] Uterine serous carcinoma (USC) is an aggressive variant of Type 2 endometrial carcinoma, which in most cases exhibits, at least focally, a papillary architecture. Occasionally, especially in small biopsy specimens, it may be difficult to distinguish between USC and a variety of metaplastic or reactive processes[3].

CASE REPORT

A 47 years old perimenopausal patient, P3L3 with tubal ligation done 3

years back came in OPD with complaints of irregular menses since 1.5 years and pain in lower abdomen on & off since 20-25 days. She had menses for 4-5 days in a 2-3 month period. Her past menstrual period was regular. She had no other complaints. She is Parity 3 Living 3, all full term normal deliveries. Her last child birth was 18 years back.

She had no medical or surgical illness in the past. On examination her general condition was fair, her vitals were stable and she had no pallor or edema. On per abdominal and per speculum examination there were no abnormal findings. On per vaginal examination uterus was retroverted, normal sized, firm, mobile, bilateral fornices were free, non tender. Ultrasonography showed uterus 7.7 x 5.7 x 3.3 ems., ET = I5mm, hypertrophied, echogenic, central. Bilateral ovaries were normal. No free fluid in abdomen. Office endometrial biopsy taken in OPD as patient was not willing for admission for next premenstrual D&C and sent for histopathology. Histopathology was suggestive of papillary serous carcinoma of endometrium. Being a rare type of carcinoma slides were sent to TATA hospital for review. Review HPR from TATA showed hyper plastic endometrium with atypia. On CT scan findings Uterus was 9 x 5 x 4.7 cms, Appeared normal in attenuation
and enhancement. ET was 9mm. Sub millimeters size nabothian cyst was found in post wall of cervix. Both ovaries were normal No obvious lymphadenopathy and fat stranding was seen.

Third review of Histopathology was done by Professor & Head of Department of Pathology of JJ group of hospitals. HPR was s\o hyper plastic endometrium with atypia with no frank malignancy. Patient underwent Total Abdominal Hystrectomy with Bilateral Salphingo-oopherectomy under spinal & epidural anesthesia. Intra operatively uterus was normal in size to bulky, on gross examination external surface was normal, smooth & regular. Bilateral ovaries were mildly cystic. Bilateral fallopian tubes were normal. No free fluid was seen. Uterus and cervix was removed along with both ovaries. Vault was closed. Abdomen was closed in layers. On cut section uterine endometrium was unremarkable. Myometrium was unremarkable. On cervix no obvious lesion was found. Post operative course in ward was uneventful. On day 8 stitches were removed. Wound was healthy. Final histopathogy report of uterus, cervix, and both fallopian tubes showed endometrium having simple hyperplasia, normal myometrium and cervix showing chronic endocervicitis with squamous metaplasia with nabothian cyst. Right ovary had endometriosis and left ovary was normal. Patent was discharged & after 15 days patient came for follow-up. Patient had no complaints.

DISCUSSION

Papillary or Serous carcinoma of endometrium is very rare (<1%). It is to be treated as an ovarian malignancy. It is a disease of poor prognosis requiring extensive surgery & even chemotherapy or radiotherapy. Failure to diagnose endometrial carcinoma preoperatively can lead to inadequate staging and potentially suboptimal treatment.[4] Clinical & CT co-relation is a must. Luckily, we sought second opinion instead of rushing into surgery. An endometrial thickness>8 mm is more likely than that of 8 mm or less to be indicated with endometrial biopsy in premenopausal uterine bleeding[5]. Endometrial biopsy is an accurate diagnostic procedure for the detection of high-grade endometrial lesions in premenopausal women. It showed Hyperplasia of Endometrium with Atypia,

which comes under the classification of pre-malignant endometrial hypeiplasia for which a simple Hysterectomy suffices. Note that the histopathology report of hysterectomised specimen did not even reveal atypia. A Rare Diagnosis Is Rarely Correct. Co - relate investigations with clinical findings & other investigations. Current World Health Organization classification of endometrial hyperplasia is problematic because of poor diagnostic reproducibility Review of slides may delay surgery but can change the course of therapy. Second and even third opinion is advisable. The histologic feature associated with the most diagnostic disagreement was cytologic atypia ($P<0.0001$). Architectural crowding, architectural complexity, or the presence of a polyp were all associated with diagnostic disagreement ($P<0.0001$). High diagnostic disagreement in endometrial hyperplasia is related to both sample adequacy and interpretation of histologic features present. Although obtaining additional tissue may increase diagnostic reproducibility, differences in interpretation of key histologic features like cytologic atypia remain major factors contributing to diagnostic disagreement.[6] In today's litigation charged environment, mistakes in diagnosis and hence management are fraught with risk.

CONCLUSION

Avoid misdiagnosis. Psychologically also patients suffer when wrongly diagnosed with cancer.

ACKNOWLEDGEMENT

We, the authors do not have any source of financial support, gifts, technical assistance and advice for the work being published.

REFERENCES

1. Sany O, Singh K, Jha S. Correlation between preoperative endometrial sampling and final endometrial cancer histology. *Eur J Gynaecol Oncol*. 2012; 33(2):142-4.
2. Benito V, Lubrano A, Arencibia O, Alvarez EE, León L, Medina N, Falcón JM, Falcón O. Pure papillary serous tumors of the endometrium: a clinicopathological analysis of 61 cases from a single institution. *Int J Gynecol Cancer*. 2009 Nov; 19(8):1364-9.
3. McCluggage WG, McBride HA. Papillary syncytial metaplasia associated with endometrial breakdown exhibits an immunophenotype that overlaps with uterine serous carcinoma. *Int J Gynecol Pathol*. 2012 May; 31(3):206-10.
4. Antonsen SL, Ulrich L, Høgdall C. Patients with atypical hyperplasia of the endometrium should be treated in oncological centers. *Gynecol Oncol*. 2012 Apr; 125(1):124-8. *Epub* 2011 Dec 20.
5. Ozdemir S, Celik C, Gezginç K, Kıreşi D, Esen H. Evaluation of endometrial thickness with trans vaginal ultrasonography and histopathology in premenopausal women with abnormal vaginal bleeding. *Arch Gynecol Obstet*. 2010 Oct; 282(4):395-9. *Epub* 2009 Nov 17.
6. Allison KH, Reed SD, Voigt LF, Jordan CD, Newton KM, Garcia RL. Diagnosing endometrial hyperplasia: why is it so difficult to agree? *Am J Surg Pathol*. 2008 May;32(5):691-8.