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SUMMARY

This case highlights successful conservative outpatient management of early endometrial cancer in a surgically unfit elderly woman, in the form of combined therapy with high dose local progestogen and hysteroscopic surgery over a period of 2 years. There was no disease progression whereas, histological regression of the disease was noted.

BACKGROUND

- Definitive management is surgical for stage 1 endometrial cancers.¹
- Short term conservative management of early endometrial cancer is considered safe and is offered to carefully selected women who wish to preserve their fertility. ^(2,3,4)
- Limited literature on the use of progestogens as primary treatment, correct dosage, length of treatment and long-term outcome is unclear.^{2,3}
- Limited data studying relapse, regression, progression rate with progestogens in older women. ^(2,3)
- Management for patients unfit for surgery: hormonal/ radiotherapy/ vaginal hysterectomy.⁽³⁾
- Combined conservative management with myosure resection and double Mirena coil insertion could be a novel therapeutic option for older surgically unfit patients.

CASE DETAILS

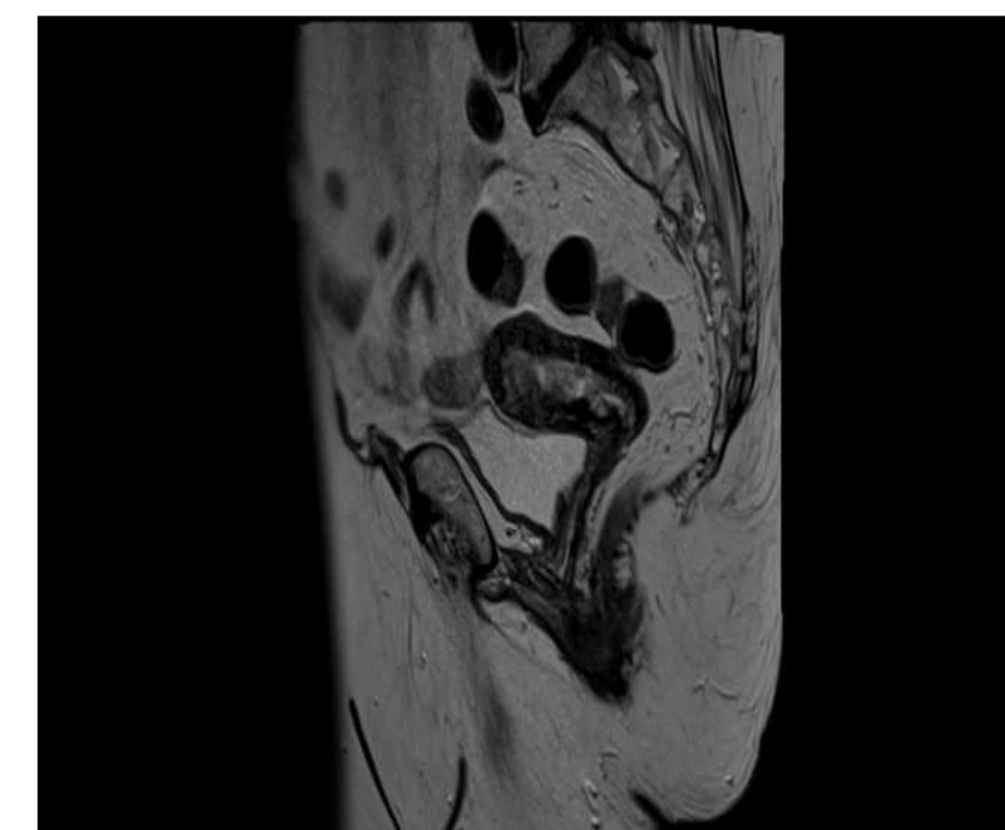
- 92 years old woman with 2 months history of postmenopausal bleeding reported no other symptoms.
- History of right mastectomy for carcinoma breast at age 82. No HRT or tamoxifen.
- Significant medical history of hypertension, Bowens disease, depression, chronic kidney disease, hip arthritis, postural dizziness and was on regular medication for these.
- On examination: BMI 33, inflamed vulva, minimal vaginal discharge, lower vaginal tract atrophic.
- Pipelle biopsy confirmed stage 1 endometroid adenocarcinoma, grade 1.
- MRI showed >50% myometrial invasion and abnormal endometrial cavity.
- Chest x-ray, ECG, routine blood investigation done followed by MDT meeting.
- Management options: hysterectomy or radiotherapy (brachytherapy) or conservative management with hormone therapy.³ Patient counselled about the 20% mortality risk with general anaesthesia. And opted for conservative management.
- Plan: Outpatient hysteroscopic resection and double Mirena coil insertion. Local progesterone better than oral progesterone, less systemic side effects like vascular thromboembolism, headaches in frail patients.^(3,4) Controlled Primary hysteroscopic resection not a standard treatment but cytoreduction of the tumor followed by local progesterone reports better outcome. No RCT for use of this therapy. ^(4,5,6)
- Follow up plan: every 3-4 months. Repeat ultrasonography at 3 months and repeat procedure at 4 months.
- 1st outpatient hysteroscopy and myosure: stage 1 endometrial adenocarcinoma grade 2.
- Patient received 7 procedures of mirena (x2) insertion and myosure resection. Procedures were spaced between 3-4 months.

OUTCOME

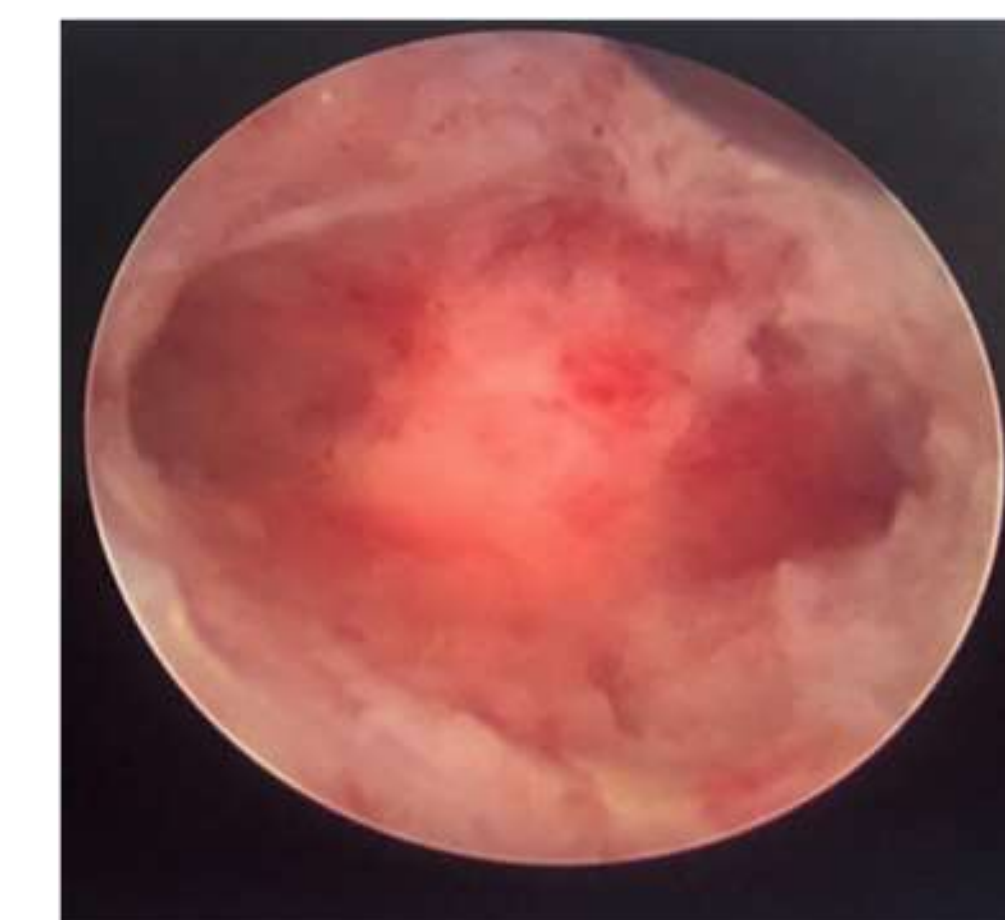
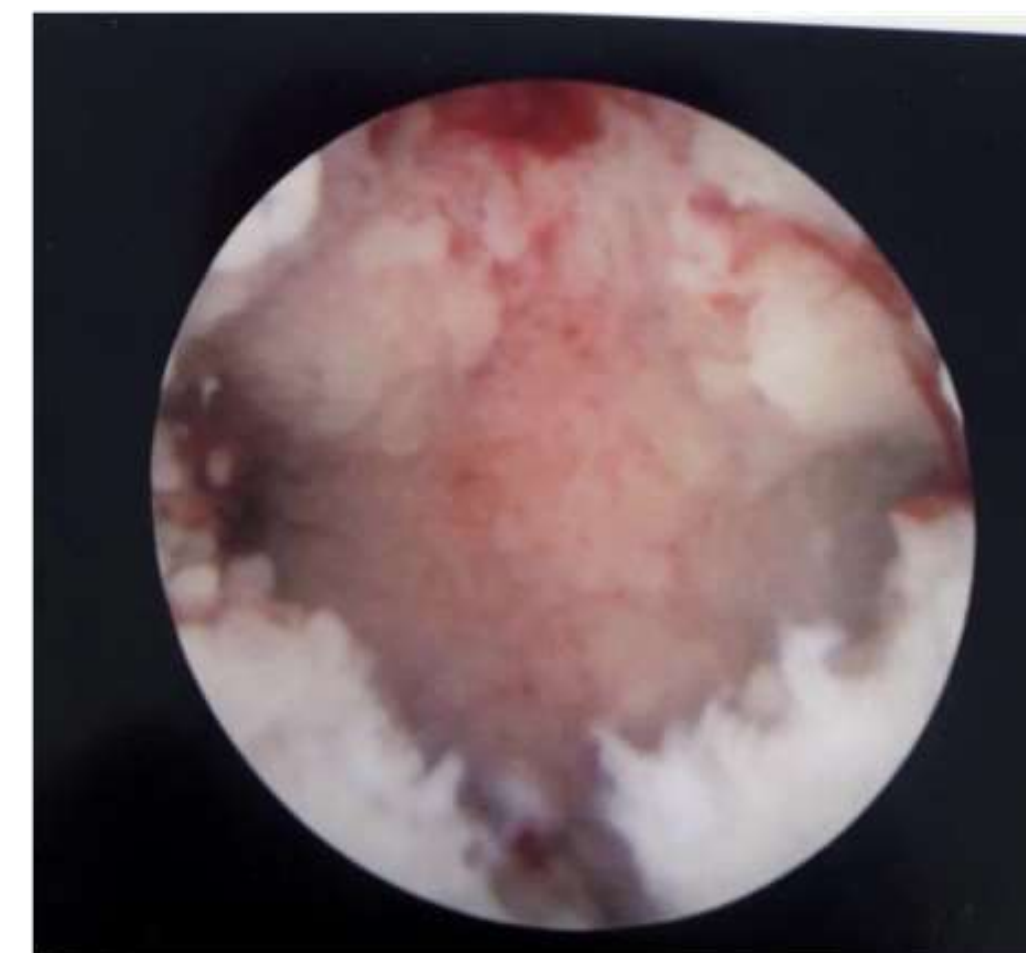
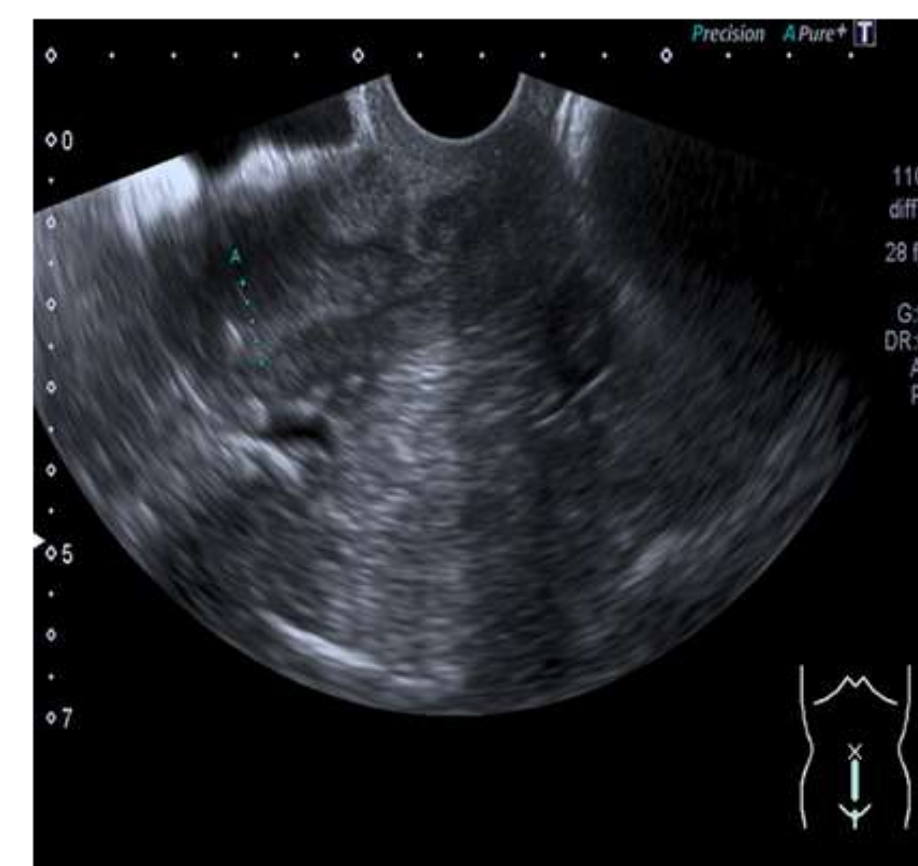
- No disease progression in 2 years.
- Histopathological disease regression from endometrial adenocarcinoma grade 2 to grade 1 with focal grade 2.
- Disease regression noted on ultrasound and hysteroscopy.
- Ultrasound at the end of 6 procedures showed: no obvious hyperplasia, Endometrial thickness 4.2mm

TAKE HOME MESSAGE

- Safe and effective treatment. ^(4,5,6)
- Good compliance with treatment and follow up.⁽⁶⁾
- Delay definitive treatment for “high risk patients”. Impact on COVID19 on cancer pathways.⁽⁷⁾
- Good to evaluate the endometrial status, extension, tumor staging.⁽⁸⁾
- MyosureLITE used extensively, safe to obtain sample.⁽⁸⁾
- Less spillage and peritoneal contamination with cancer cells if pressure <70 mmhg, less duration of operation. Overall prognosis does not change.^(9,10)
- Large multicentric, Randomized Controlled trials needed to study safety and efficacy of this novel combined therapy.^(5,6)



MRI and TVS showing endometrial cancer at diagnosis



Hysteroscopic view of uterine cavity after 2,4,6 procedures

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- MDT: MULTIDISCIPLINARY TEAM, MRI=MAGNETIC RESONANCE IMAGING,TVS=TRANSVAGINAL ULTRASOUND