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Carcinoma of the cervix co-existing with multiple pregnancy: a case report

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Summary

A case of a 38-year-old grandmultipara (Gravida 9, Para 7⁺¹, all alive) woman with squamous cell carcinoma of the cervix co-existing with multiple pregnancy is presented. She had therapeutic termination of pregnancy with oxytocin at a gestational age of 18 weeks. This was followed by intracavitary and then extracavitary radiotherapy. The need to consider the possibility of carcinoma of cervix in bleeding disorders of early pregnancy and the importance of a thorough evaluation of such patients is emphasized.

Keywords: Carcinoma, cervix, twin pregnancy, radiotherapy, Nigeria.

Résumé

Un cas de grand multiple paragravida⁹ et para⁷⁺¹ chez une femme de 38 ans ayant des cellules carcinome squameux du cervix co-existant avec plusieurs grossesses a été évalué. Un avortement terminal d'une grossesse de 18 semaines a été exécuté à l'aide de l'oxitocine. Ceci était suivi par une radiothérapie intracavitaire et ensuite extracavitaire. Ainsi, il faut considérer le besoin de la possibilité du carcinome du cervix aux désordres de saignement pendant le début de la grossesse et l'importance d'une évaluation complète d'un tel patient doit être bien adressée.

Introduction

The cervix is the commonest site for female genital cancer in sub-Saharan Africa [1]. Though the precise aetiology of cervical carcinoma is unknown, various epidemiological studies have stressed the predisposing effects of early exposure to sexual intercourse, multiple sexual partners, multiparity, low socioeconomic class, infections by herpes simplex virus and more recently Human Papilloma virus types 16 and 18 [2]. It has been estimated that 2% of all women over the age of 40 years will develop cervical cancer. The average age at diagnosis is 45 years. Since majority of our women in tropical Africa bear their children rather early with many of them having already completed their families by the middle thirties, carcinoma of the cervix co-existing with pregnancy is rarely seen in this environment. More rare is its coexistence with multiple pregnancies. This communication is intended to highlight the diagnostic and

management difficulties that may be experienced in the rare presence of cervical cancer co-existing with multiple pregnancy.

Case Report

A 38-year-old grand-multipara (Gravida 9, Para 7⁺¹, all alive) woman presented at the gynaecologic clinic of the University College Hospital (UCH), Ibadan on account of histologically confirmed moderately differentiated large cell keratinizing squamous cell carcinoma of the uterine cervix. She gave a 4-month history of post coital bleeding, offensive watery vaginal discharge and amenorrhea of about four months duration. A pelvic ultrasonography confirmed twin pregnancy. Both twins were alive and of a gestational age of 18 weeks.

On examination, she looked healthy although mildly pale. There was no significant weight loss and her state of hydration was satisfactory. A chest examination revealed clear lung fields, and an abdominal examination revealed a gravid uterus with the symphysiofundal measurement compatible with 26 weeks intrauterine gestation. A vaginal examination revealed an offensive watery vaginal discharge associated with a fungating mass involving the anterior lip of cervix but sparing the vaginal walls and parametria. There was contact bleeding. A diagnosis of cervical carcinoma (Stage 1b) was made. She was counselled to have immediate termination of the pregnancy and later radiotherapy to treat the condition. She consented to the plan of management. Her packed cell volume was 29 percent and the plasma electrolytes and urea were within normal limits.

A week later, the cervix was ripened with an intracervical Foley's catheter and labour was induced with Oxytocin the following day. A set of twins (male and female) was expelled ten hours after commencement of the induction. The blood loss was 200 ml and the immediate post-abortion period was uneventful. She subsequently had two courses of intracavitary radiotherapy (Caesium ¹³⁷) two weeks apart. These were followed by a course of extracavitary radiation. Six weeks after therapy, she was seen in the outpatient gynaecological clinic with minimal clinically detectable cervical tumour.

Discussion

While it is generally acknowledged that carcinoma of the cervix is the most common gynaecological malignancy in tropical Africa, it is rarely found in pregnancy. Its incidence in pregnancy is thought to be about 1 in 2500 [2]. Invasive carcinoma of the cervix in pregnancy is found more

frequently in areas where routine cytological examination is done. The incidence may be as high as 1 in 350 pregnancies depending upon the population sampled [3]. In the non-pregnant patients, the principal symptom is bleeding per vagina. However, in the gravid patient the diagnosis is frequently missed because the bleeding is assumed to be related to the pregnancy rather than to cancer. Therefore, the possibility of cancer must be kept in mind in bleeding disorders of early pregnancy and the patient should be adequately examined. During normal pregnancy, hypertrophy and hyperplasia of the squamous and glandular elements of the cervix are usually obvious on biopsy. However, intraepithelial as well as invasive carcinoma may also be present and gestational changes should not be allowed to confuse the diagnosis [4].

The presence of multiple pregnancy could even confuse the picture further as bleeding is more commonly associated with multiple pregnancy than in singleton pregnancy due to the larger surface area of the placenta [3]. Radiotherapy can be used in treating invasive cancers of the cervix discovered during pregnancy. The choice of Foley's catheter ripening of the cervix and subsequent oxytocin infusion in this patient to evacuate the uterus is based on its proven efficacy for this purpose [6]. Alternative methods to evacuate the uterus at this gestational age include agents such as prostaglandin pessary, laminaria tent and the use of intra-amniotic injection of hypertonic solution. In the first trimester of pregnancy, irradiation may be carried out with the expectation of spontaneous abortion. In the second trimester, some authors have suggested interruption of the pregnancy by hysterectomy or rather by induction of labour [5,1] as was successfully done in this patient prior to radiotherapy. In the third trimester, the decision must be made whether to allow the pregnancy to proceed to viability (28 – 32 week gestation) and perform a caesarian section before instituting radiotherapy or terminate the pregnancy forthwith. Radical surgery may be chosen in all 3 trimesters for Stages I and

2^A lesions because it simultaneously eliminates the pregnancy and the cancer. Radical hysterectomy (Wertheim's surgery) as an alternative treatment choice for such cases is however commonly associated with a number of major complications such as severe haemorrhage, ureteric injury and pelvic lymphocyst formation. The decision to treat this patient with radiotherapy was based on its availability in our hospital and also because the outcome of treatment following radical surgery or radiotherapy are similar thus supporting this choice treatment.

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