



BMH Med. J. 2026;13(1):29-33. **Case Report**

A Rare Case Report of Adenocarcinoma Endometrium

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Abstract

Endometrial adenocarcinoma in young age are very unusual tumors especially in women less than 40 years. Rarely cases have been reported under 30 years. A conservative treatment including preservation of fertility for early stage is possible if a complete pre-therapeutic assessment is achieved and a rigorous follow-up during and after the treatment is pursued. We herein present a rare case of young unmarried woman who presented with heavy menstrual bleeding and was found to have adenocarcinoma endometrium.

Keywords: adenocarcinoma endometrium, Heavy menstrual bleeding

Case Report

A young unmarried woman presented with heavy menstrual bleeding. She had history of fatigue and exertional dyspnea. No history of loss of weight or appetite. No history of mass per abdomen, urinary or bowel symptoms. She had multiple episodes of heavy bleeding on and off for the past 5-6 years. She was evaluated, medically managed with hematinics and iron supplements. History of 1 unit packed red blood cells transfusion. No history of any surgeries in the past. She attained menarche at the age of 12 years. Since then she had regular cycles but with menorrhagia in some.

On examination, her vitals and general examination findings were normal, except for pallor. Per abdomen no mass was palpable. Per speculum revealed normal cervix and vagina. Bimanual pelvic examination showed a normal sized uterus, retroverted, mobile, with fornices and pouch of Douglas free and non tender. Per rectal examination was normal. Laboratory blood investigations gave a picture of microcytic hypochromic anemia with an Hb 5.9g/dL, for which blood transfusion was given.

Ultrasonography of pelvis showed bilateral polycystic ovarian morphology and thickened endometrium of 18mm. Due to a long standing history of heavy menstrual bleeding and a thickened endometrium, pipelle aspiration was done. Moderate amount of curettings obtained and sent for histopathology. Report came as Endometrial Carcinoma endometriod type, grade 2. A subsequent magnetic resonance imaging Pelvis showed retroverted uterus, mildly thickened endometrium - 12mm with heterogenous enhancement. No myometrial invasion. No cervical or vaginal extension. No pelvic / para-aortic lymph node. Endometrial carcinoma stage IA.

Computed Tomography of thorax shows no significant abnormality. She was adviced definitive treatment which is total hysterectomy with bilateral salpingo-oophorectomy. Owing to her young age and unmarried status, patient and relatives were not willing for hysterectomy. Hence fertility preservation was recommended and medical management followed. She was given progestin therapy for 3 months and is under follow up.

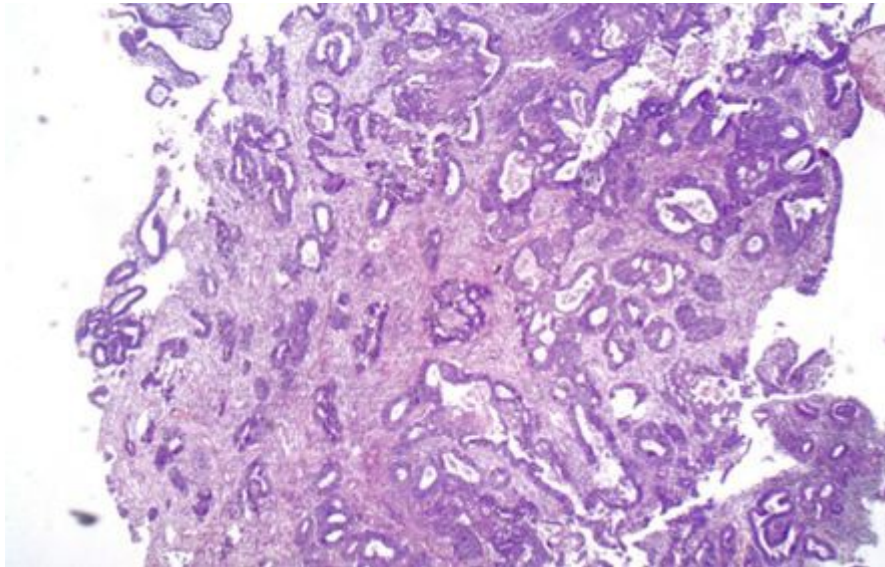


Figure 1: Microscopy (low power) section showing neoplasm

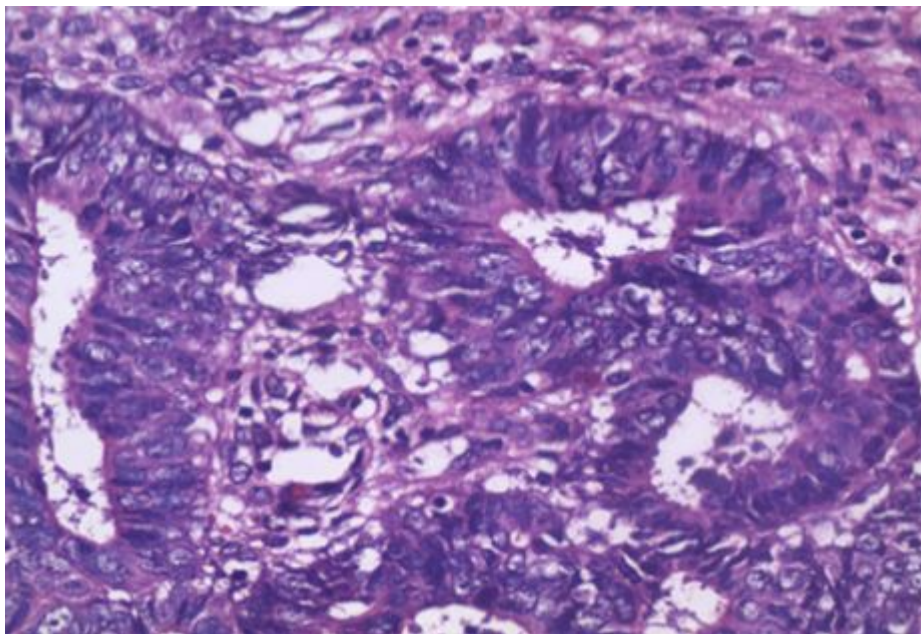


Figure 2: Microscopy (high power) section showing pleomorphic vesicular nucleus

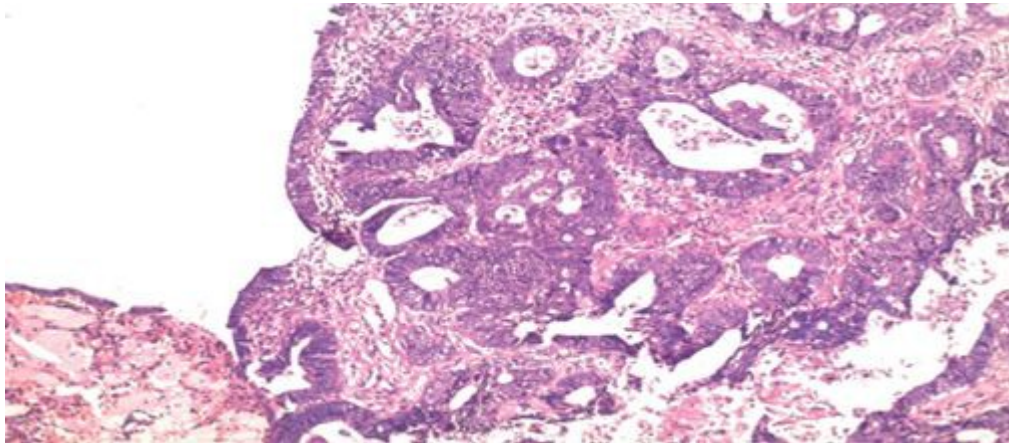


Figure 3: Microscopy (low power) section Cribriform pattern of closely packed glands

Discussion

Endometrial carcinoma is the third most common gynecological cancer in developing countries. It is primarily seen in post menopausal women around 6th to 7th decade. However, in 2%-14% of cases, it occurs in young women (less than 40), most of whom wish to preserve their fertility [1-4]. The most reported risk factors of endometrial cancer are anovular cycles associated with polycystic ovarian syndrome, hypertension, diabetes, obesity, the sole use of estrogens and drugs like tamoxifen [5].

Younger patients with endometrial carcinoma tend to have a history of estrogen use or hormone-related disorders such ovarian dysfunction, chronic anovulation, infertility, obesity and polycystic ovary [6]. Clinical features include abnormal uterine bleeding, intermenstrual bleeding, frequent menstruation, long periods of amenorrhea and heavy bleeding. On clinical examination, enlarged uterus, bleeding / discharge per vaginum or pyometra is seen in advanced cases. Ultrasonogram determines the extend of disease, ascites, myometrial invasion, pelvic/para aortic lymphadenopathy, extension to cervix, ovarian / liver metastasis and MRI is good at assessing the size and extend of tumor, depth of myometrial invasion, parametrial extension and nodal metastasis. But USG, MRI and sonosalpingography are not pathognomic. In a meta-analysis comparing the utility of CT, USG and MRI, the range of sensitivity reported the most for contrast-enhanced MRI. [7]. The final diagnosis is established by histopathological examination of tissue based on nuclear grade and mitotic activity, lymphovascular invasion, intratumoral heterogeneity and metaplasia.

The most important prognostic factors of endometrial adenocarcinomas are the histological grade, the cancer stage and the myometrial invasion. Fortunately, 70% of the endometrial adenocarcinomas in young women are at Stage I and 90% of them are Grade 1 carcinomas, which have a good prognosis and offer other therapeutic possibilities instead of the standard radical treatment.

Management

Definitive treatment is after a staging laparotomy. Fertility preserving treatment is usually done in young women, desirous to conceive. Criteria includes well differentiated grade 1 endometrioid adenocarcinoma on sampling. In all cases, MRI is mandatory to exclude myometrial invasion. There should be absence of suspicious or metastatic disease on imaging and no contraindication to medical therapy or pregnancy. Continuous progestin based therapy is given. The dose of progestogen is 600 mg of medroxyprogesterone acetate per day, taken in 200 mg amounts three times a day [8]. Other drugs include Megestrol and Levonogestrel-Intrauterine Device (LNG-IUD).

In addition, weight management and lifestyle modification counselling is also given. The duration of the treatment varies from 3 to 9 months [9,10]. A duration of six months seems to be an acceptable compromise [7]. Repeat endometrial evaluation is done every 3-6 months. Patient is referred to fertility treatment if there is response. The risks and benefits of ovarian preservation in young women with low grade, early stage endometrial carcinoma undergoing definitive treatment require individualization [11-13]. The safety of ovarian preservation in young women with endometrial carcinoma has been studied via the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) database [12]. Women failing conservative treatment due to either disease progression or lack of regression should undergo definitive treatment consisting of hysterectomy, bilateral salpingo oophorectomy and/or lymphadenectomy. Definitive surgery should be considered if no evidence of disease regression is observed within 6-9 months of treatment initiation, as the likelihood of success with further treatment is low. Even if conservative treatment is initially successful with biopsy-proven regression of disease, 40.6% of responders will recur, even despite the use of maintenance therapy [14,15]. Therefore, once women who have been successfully treated with progestins have completed childbearing, should undergo definitive surgery.

Summary

Heavy menstrual bleeding is a very common entity we come across in daily OPDs. And we tend to offer conservative management especially if patient is in younger age group. However at times, thinking out of the box is required. Here tuberculosis and malignancy were kept as differentials. Pipelle aspiration in an unmarried woman changed the entire course of disease and saved life of this young woman.

Hence, we can conclude that a conservative treatment for endometrial carcinoma at Stage IA with a low histological grade is possible if a complete pre-therapeutic assessment is achieved and if a rigorous follow-up during and after the treatment is pursued, achieving a complete response rate of 75%.

A recurrence rate of 25% is seen after a temporary response. However, no consensus has been drawn concerning the ideal treatment, its dose or its duration, even though medroxyprogesterone and megestrol acetate are the most used and the best explored. Furthermore, it should be kept in mind that every delay in implementing radical treatment can increase the rate of recurrence or the development of metastasis, which will systematically worsen the prognosis. Radical treatment should be indicated as soon as the desire to carry a pregnancy to term is fulfilled.

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