Squamous Cell Carcinoma during Pregnancy: A Case Report

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Abstract
Cervical cancer during pregnancy is relatively uncommon[1]. Prevention and screening measures for cervical cancer are paramount because the ability to identify and treat the illness at its premature stage often disrupts the process of neoplasia[2]. Marked socioeconomic and ethnic differences are evident in incidence, mortality, and survival from the disease, with the less affluent groups having a much higher impact[3]. Of particular interest, are women who are currently pregnant with cervical cancer? Cervical cancer is the most commonly diagnosed gynecological malignancy during pregnancy worldwide, though it is quite rare to occur in developed countries[1]. Here we present a case of squamous cell carcinoma of the cervix in a woman who is currently 18 weeks pregnant.

Case report
A 39-year-old Hispanic female gravida 5, para 2 was seen in consultation because of a cervical biopsy that revealed invasive squamous cell carcinoma of the cervix. The patient visited her gynecologist for symptomatic vaginal bleeding, of note she has not had a gynecological exam for the past 13 years since the birth of her last child. At the time, it was also discovered that the patient was pregnant with an 18 week old fetus confirmed via ultrasound; however the patient was not aware she was pregnant prior to this time. The patient’s biopsies confirmed the presence of invasive squamous cell carcinoma with basaloid features and foci suspicious for neuroendocrine carcinoma. There was also evidence of lymph vascular invasion. The patient was informed of her diagnosis and offered options to continue with the pregnancy to viability, with the understanding that the malignancy could continue to progress resulting in significant morbidity. Patient decided to proceed with radical hysterectomy with pregnancy in situ.

The patient has no significant past medical history, and has a past surgical history of laparoscopic cholecystectomy two years prior. She has two children, the first born vaginally, the second born via Cesarean-section. Her immunizations are not up to date, and of note, she has not received her Human Papilloma Virus (HPV) vaccine. The patient’s mother and grandmother had cervical cancer and father had prostate cancer. She smoked about 10 cigarettes every day for the past 10 years. She denies alcohol or illicit drug use.

On physical, the abdomen was distended secondary to pregnancy, uterus fundal height congruent with 18 weeks gestation and non-tender. There was a laparoscopic incisional scar secondary to cholecystectomy. Pelvic exam revealed a cervix that was markedly hypertrophic, edematous, tender, and a lesion measuring about 10 cm in size. The patient was taken to surgery and an exploratory laparotomy, modified radical hysterectomy with fetus in situ [Figure1], bilateral salpingectomy, partial vaginectomy, removal of cervical mass, and lymph node dissection was performed.

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Discussion

The patient was seen for a cervical biopsy that revealed invasive squamous cell carcinoma of the cervix stage IB2. The cancer can be seen on physical and is larger than 4 cm, with spread to nearby lymph nodes, and no distant metastasis noted. Risk factors associated with cervical cancer are high risk sexual behavior, many sexual partners, human papilloma virus infection, other sexually transmitted infections, immune compromise, smoking, family history of cervical cancer. Other risk factors are initiation of sexual activity at less than 20 years of age, being unmarried (single, divorced or widowed), older age, and older age at the first pregnancy. It is widely accepted that detection and treatment of dysplastic epithelial change can prevent the development of invasive cervical cancer. Human Papilloma Virus vaccination has sustained long-term efficacy against incident and persistent infections and in the long term should provide an answer to the cervical cancer problem. Of note, our patient had multiple risk factors as well as lack of preventative measures. Her mother and grandmother had cervical cancer, she was a daily smoker, and she lacked proper vaccinations and had not had screening in thirteen years.

When treating a pregnant patient with cervical cancer, several issues are important: histological subtype, disease stage, nodal status, gestational age, obstetrical complications and also patients’ wishes concerning continuation versus termination of pregnancy. Our patient had squamous cell carcinoma of the cervix stage IB2. Treatment options for this stage are either chemotherapy with cisplatin plus fluorouracil or radical hysterectomy with pelvic lymph node dissection. Type of treatment needs to be individualized and depends mainly on gestational age, disease stage, and histology. Extensive counseling regarding maternal and fetal risks is required.

An inter-disciplinary team approach is needed for a patient like this in order to properly achieve optimal results. Weighing the risks versus benefits in concordance with the patient’s wishes, we proceeded with modified radical hysterectomy with fetus in situ consequently terminating the pregnancy.

Conclusion

There are several issues to be taken into consideration when treating cervical cancer in pregnant women. Balance between patient’s best interests, fetus viability, and patient’s personal beliefs are essential. Multidisciplinary teams should be involved in the patients care as significant physical and emotional harm could occur. Lastly, preventative screening, vaccinations, and close follow up are essential to decreasing the morbidity and mortality of cervical cancer.

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References

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