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An Approach to Managing Pelvic Organ Prolapse in Gynecologic Cancer Survivors: A Case Report

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Abstract

Uterine malignancy, which coexists with pelvic organ prolapse (POP) still, has no standardized treatment protocol which has been established yet. The first objective of this present case was to highlight the management of endometrial polyp and myomas causing postmenopausal bleeding in association with POP. Another aim of this case was to determine how to add prophylactic bilateral salpingo-oophorectomy (BSO) to vaginal hysterectomy due to the strong family history related to the patients' mother with ovarian cancer.

Keywords: Gynecologic oncology; Pelvic organ prolapse; vaginal hysterectomy

Introduction

POP is a common health problem in the women both in premenopausal and postmenopausal periods. Prolapse of intraabdominal organs from vagina can be detected at any level of pelvic floor. Gynecologic oncologic diseases can coexist with POP such as endometrial cancers, postmenopausal endometrial polyps, endometrial hyperplasias, myomas, adnexal masses and cervical precancerous conditions [1]. This present case provides an approach to managing mild POP coexisting with postmenopausal endometrial polyp in which endometrial cancer was not excluded clearly, two critical located myomas causing postmenopausal bleeding, and performing BSO vaginally although anatomical and technical difficulties.

Case

A 62-year-old woman in menopausal period with active sex life, gravida 5, para 5 was admitted to the hospital with bleeding for six months and bulging mass from vagina for two years. In her family history there was a strong family risk because of her mother related to ovarian cancer. She has not

undergone any operation in the past, except tissue samplings from lung masses which were reported as benign. Her medical history has been including hypertension. Transvaginal ultrasound demonstrated the uterus 90 × 70 × 60 mm in size with two myomas fundus located 50 mm in diameter and cervix located 40 mm in diameter, and a single endometrial polyp 25 mm in diameter was detected at the same time. Endometrial tissue sampling was performed before the operation which was reported as benign endocervical tissues. As a result of pathological evaluation before the operation, endometrium cancer has not been excluded yet and made confusion because of absence of endometrial tissue in the report which was given by pathologists after probe curettage. The single polyp 25 mm in diameter still has been detected by transvaginal ultrasound after probe curettage, so it can be defined as insufficient material due to the cervical stenosis in the postmenopausal patient. All tumor markers were negative. The patient diagnosed with Stage 2 POP according to the Pelvic Organ Quantification System (POP-Q) including anterior vaginal wall prolapse with paravaginal defect, posterior vaginal wall prolapse with rectocele and desensus uteri with elongatio colli. We managed this case by vaginal way including hysterectomy, prophylactic BSO, colposuspension and vaginal remodeling with no posterior repair in addition to protect from postoperative de novo dyspareunia. The uterus was measured 160 × 80 × 70 mm in size, myomas were measured 50 mm and 40 mm in diameter and cervix was measured 100 mm in length just before the frozen section evaluation. The size of uterus can be measured in different values when compared with preoperative examination by ultrasound and postoperative examination by surgeons and pathologists related to the position of the patient and situation of intraabdominal organs. The frozen section was reported as benign. Postoperative examination was performed in the third month after the operation. Objective cure defined as Stage 0 according to POP-Q and subjective cure defined as negative response to all questions on Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6). Three different secondary acquisitions were obtained such as no complication, no symptom and high quality of sex life according to Female Sexual Function Index (FSFI).

Discussion

Uterine malignancy coexists with POP is a rare health problem although isolated POP is common, a range of 0.2%-1.2% risk of detecting uterine malignancy after POP operations [1]. Can it be related to insufficient examination of pelvic floor before cancer surgery? Is there a classic idea that suggests performing cancer surgery by abdominally because of anatomical and technical difficulties in cases with mild or severe prolapse of pelvic floor? This present case is asking these questions to the gynecologic oncology as a title “*why don't we give us a chance for performing nearly all surgeries including oncology by vaginally?*” The patients diagnosed with POP, in cases who complain of postmenopausal bleeding probe curettage should be performed for excluding endometrial cancer or precancerous conditions which coexist with POP [2]. POP can be described as bulging of intraabdominal organs to the vaginal walls at any level of pelvic floor, which effects to quality of life including quality of sex life which makes serious social problem. Bulging of urethra described as urethrocele, bulging of bladder described as cystocele, bulging of rectum described as rectocele, bulging of uterus described as uterine prolapse. Prolapse of pelvic floor staged according to POP-Q including mild and severe defects. The patients with POP complain of bulging mass, urinary symptoms including incontinence which makes another serious social problem like decreased quality of sex life, bleeding, chronic pelvic pain, constipation, sexual dysfunction. POP has been increasing in the past two decades and 20% of women in the United States were affected by pelvic floor disorders , and accounting for over 200.000 surgeries on pelvic floor performed in every year [3-5]. Cancer surgery can be performed by laparotomy, laparoscopy, laparoscopy assisted vaginally, robotic or vaginally. Vaginal hysterectomy is effective and reliable surgical treatment in patients with POP. On the other hand, abdominal surgery provides surgical staging exactly, which is one of the main determinant factor of treatment and prognosis of endometrial cancer. However, patients who diagnosed with endometrial cancer, especially with Stage 1 and Stage 2A diseases, coexist with prolapse of pelvic floor, can be operated with vaginal hysterectomy with BSO including peritoneal cytologic sampling by vaginal way with vaginal remodeling cosmetically and functionally [1,2]. There is no consensus related to the surgery of advanced stage endometrium cancer in patients with POP, this subject is still controversial [6]. Endometrial polyps can coexist with uterine malignancy; especially in postmenopausal period causing bleeding can be detected with endometrial cancers. Benign myomas can turn into leiomyosarcomas especially in postmenopausal period with complain of bleeding, diagnosis of malignancy in myoma can be certain after removing of myoma or uterus. Vaginal hysterectomy can be performed even in benign myomas causing symptom in postmenopausal period. Vaginal way is the best way for all surgeries [7-10]. Only a good plan before the operation, and to be good at pelvic floor anatomy is required, then it is possible to do vaginal hysterectomy, BSO, colposuspension and vaginal remodeling even in complicated cases with severe or mild POP (**Figures 1-5**). Except BRCA Mutations there is no clear predictor factor of ovarian cancer,

prophylactic BSO can be added if there is strong family history independently of BRCA Mutations even in mild prolapse cases [11,12].



Figure 1: Preoperative POP-Q examination.



Figure 2: Vaginal hysterectomy in addition with BSO, colposuspension, vaginal remodeling.



Figure 3: Postoperative evaluation of uterus.



Figure 4: Postoperative POP-Q examination (Just after the operation).



Figure 5: Postoperative POP-Q examination (Three months after the operation).

Conclusion

In fact, pelvic floor disorders (PFDs) are prevalent in gynecologic oncology, if we add literal POP-Q examination before the cancer surgery in routine, this is an important area and future studies are urgently needed.

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