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Case Report

Unexpectedly Good Results from Advanced Invasive Cervical Cancer: Palliative Surgery

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Abstract

Presentation with a highly infiltrated malignant lesion often leads to unfavorable outcomes. This woman exhibited an advanced form of cervical cancer that had spread to the surrounding tissue, which might involve the urinary bladder. Due to the Sudan War in 2023, there was a lack of oncological therapy. In response, we implemented palliative surgery, which yielded positive results.

Keywords: Cervical cancer, palliative surgery, Sudan.

INTRODUCTION

Cervical cancer is currently ranked as the fourth most prevalent form of cancer among women globally. The annual mortality rate is around 324,000 for women, with almost 85% of these instances taking place in developing nations, primarily in Sub-Saharan Africa and Southeast Asia [1]. However, those diagnosed in the early stages of this malignancy still face a bleak outlook. Researchers have identified the correlation between certain variables, such as the tumor microenvironment, and the invasion and metastasis of cervical cancer [2, 3].

The absence of cervical screening and early detection programs in Sudan has resulted in a significant number of women receiving advanced stage diagnoses, leading to unfavorable treatment outcomes.

A CASE REPORT

A 70-year-old female patient arrived at our surgical department with an advanced, locally invasive cervical carcinoma that has spread to the upper portion of the vagina, bladder, and parametrium. Upon initial examination, the patient presented with vaginal hemorrhage, malodorous vaginal discharge, and bilateral loin pain. After an initial evaluation, focused examination, and imaging, the doctor diagnosed the patient with cervical cancer and bilateral hydronephrosis, a condition that causes obstructive uropathy and elevated levels of urea and creatinine. A urologist saw the patient and performed an urgent bilateral nephrostomy procedure. Given the circumstances in Sudan, specifically the Sudan War of 2023, there is a lack of access to chemoradiotherapy and limited transportation options. Therefore, we have decided to pursue palliative surgery. A multidisciplinary team comprising a gynecologist and a urologist carried out this procedure. The surgeon performed the surgery under general anesthesia after preparing six units of blood.

A midline laparotomy procedure was performed. The urologist recognized and moved both ureters. We performed a total abdominal hysterectomy with bilateral salpingo-oophorectomy and removal of the upper portion of the vagina.

Surgery necessitated bilateral ureteric ligation. The urologist surgically examined and separated both ureters, then reconnected them to the bladder through a procedure called bladder neocystotomy. Additionally,

the urologist placed bilateral double J catheters (see images 1-4).

There were no difficulties during the surgery or immediately after. After a span of four days, the patient had a remarkable enhancement as the levels of urea and creatinine significantly decreased. The last vaginal examination revealed the presence of a tiny vesicovaginal fistula.

Six weeks after the fistula closed and she started to regain her weight without any intervention, the patient underwent evaluation. She was satisfied, and now she is becoming more socially engaged with an amazing demeanor. We are postponing the administration of chemoradiation until the situation improves. We have included all investigations and photographs related to the operation, and recorded a brief video with her explicit agreement and approval.

DISCUSSION

Patients diagnosed with advanced invasive cervical carcinoma typically require complex care strategies. These complex processes often lead to unfavorable results. Despite the patient's advanced condition upon presentation, we anticipate better outcomes due to the patient's improved overall health and the expected further improvement following chemoradiation treatment. Surgery is crucial in the early stages of cervical cancer treatment. For this condition, the typical surgical approach is a Type III radical hysterectomy with bilateral pelvic lymph node dissection performed via an open method. Strong evidence suggests that performing radical hysterectomy for cervical cancer should not involve the laparoscopic or robotic method. Recent evidence suggests that sentinel lymph node biopsy and nerve sparing radical hysterectomy are effective treatment options for carefully chosen patients with early-stage illness. Patients with locally advanced cervical cancer have found that neoadjuvant chemotherapy (NACT) followed by radical surgery results in worse disease-free survival rates compared to definitive concomitant chemoradiation therapy [4].

Therefore, certain patients may not be candidates for lymphadenectomy. For young women with malignancies that have spread locally, it may be possible to treat them with neoadjuvant chemotherapy followed by fertility-sparing surgery. In certain cases of early SCC, it is possible to use a more cautious and personalized surgical strategy, which can lead to reduced complications and the preservation of fertility without negatively affecting the outcome [5].

A previous case reported restoring the continuity of the urinary system through ureteral reimplantation via uretero-neocystostomy and augmentation cystoplasties combined with ureteral reimplantations. In one case, ureteral reimplantation was not feasible, leading to the execution of a final cutaneous ureterostomy. In seven cases, the postoperative course proceeded without any complications. However, in one case, a urine leak necessitated a terminal cutaneous ureterostomy to bring the ureter to the surface. Patients with locally advanced cervical carcinoma can safely have ureteral resections [6].

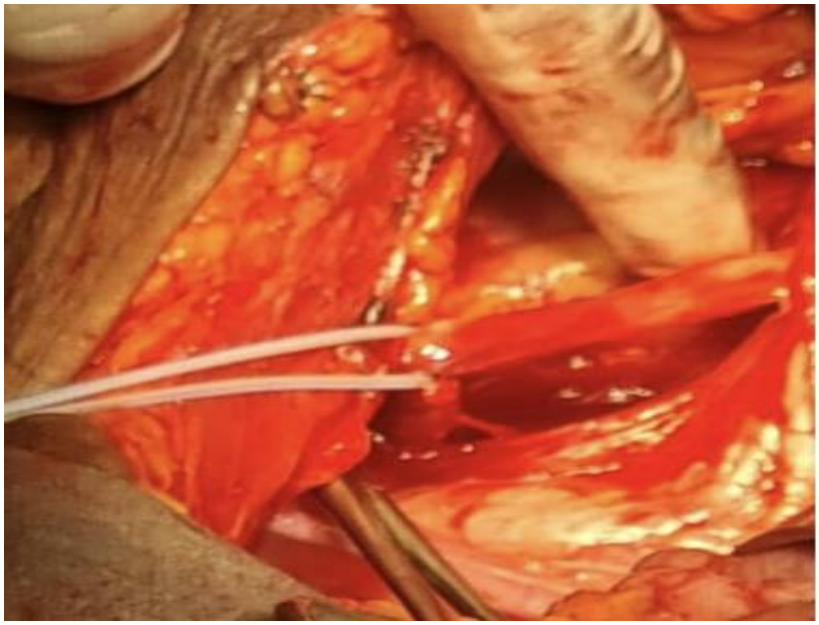

Image 1: Identification of both ureters before hysterectomy

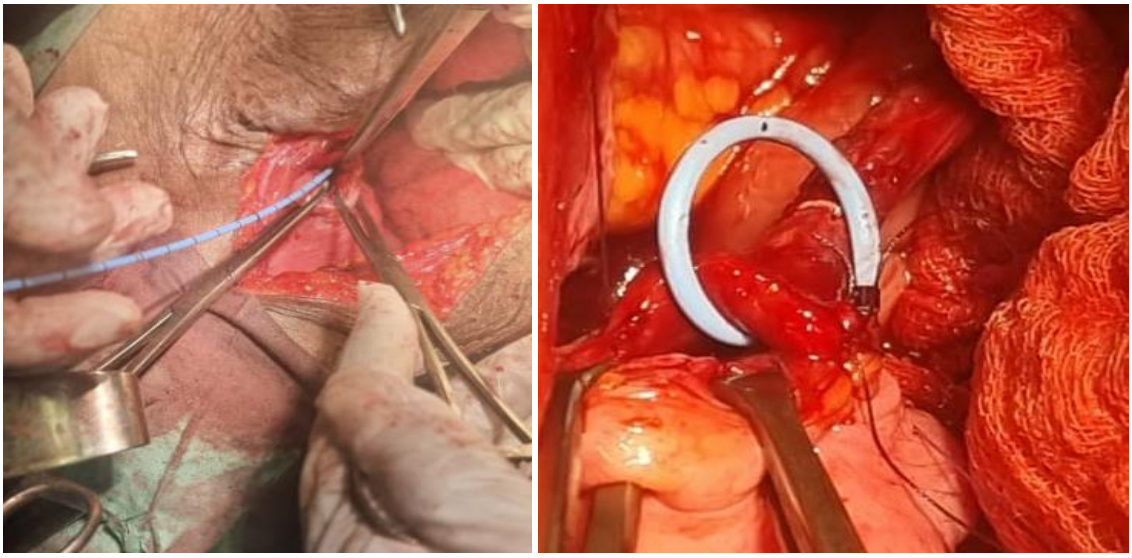

Image 2: Insertion of double J stent

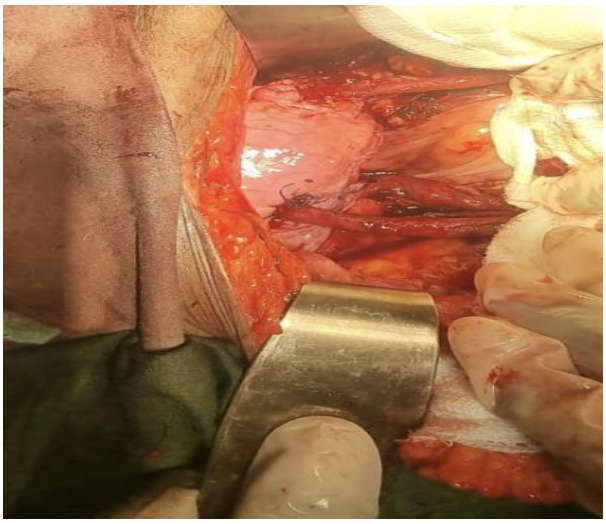

Image 3: Bilateral ureteric reimplantation in the urinary bladder

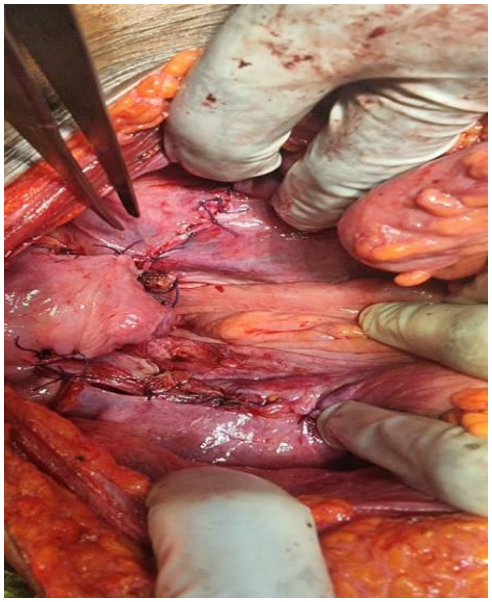

Image 4: Final view

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