

Invasive cervical cancer and pregnancy: a case study

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2 **Invasive cervical cancer and pregnancy:**
3 **a case study**
4 **Maternity ward of the Abderrahim Mother and Child Hospital**
5 **Harouchi Ibn Rochd University Hospital, Casablanca.**
6
7

8 **Introduction**

9 The diagnosis of cervical cancer is relatively rare during pregnancy, but it
10 is the most frequently detected cancer in pregnant women. Its incidence
11 varies between one and ten per 10,000 pregnancies, depending on the
12 population [1], [2], [3]. The majority of cases occur in women in their
13 thirties who have had multiple births (four to five, according to studies)
14 [1], [2].

15 In addition, approximately 30% of patients with cervical cancer are of
16 childbearing age at the time of diagnosis, and 1 to 3% of cervical cancers
17 are discovered during pregnancy [4]. Pregnancy provides an opportunity
18 to screen a population that sometimes receives little or no gynecological
19 care, thanks to repeated clinical examinations and cervical smears,
20 which are part of routine prenatal care.

21 **Clinical observation**

22 This is a 36-year-old woman with no history of disease, V G/ IIIP , 3
23 children by caesarean section , 2 spontaneous miscarriages ,admitted to
24 the maternity ward of HAROUCHI hospital for cervical lesion during an
25 unmonitored pregnancy at 39 weeks of amenorrhea . On admission, the
26 patient was conscious, with BP: 12/06, HR: 76 bpm, BU: negative, TV:
27 cervix dilated to 2 cm with speculum examination revealing: ulcerative
28 budding lesion of the cervix, membrane ruptured for 7 hours, with clear
29 fluid, high presentation, fetal heart sound detected at 137 bpm. Obstetric
30 ultrasound revealed a progressing monofetal pregnancy, positive
31 cardiac activity , cephalic presentation, fundal placenta, biometrics
32 corresponding to term. ERCF: no abnormalities. The patient underwent a

prophylactic cesarean section, giving birth to a female newborn, birth weight: 3750g, APGAR 10/10. A cervical biopsy was performed, . Pathological examination revealed a well-differentiated squamous cell carcinoma of the cervix. Pelvic MRI revealed: tumor thickening of the endocervix invading the vaginal fornix and parametrium, crossed by the isthmocele, right primary iliac lymph node measuring 12.5 mm in short axis, classifying the examination as T4N1MX.

Discussion

Cervical cancer is one of the most commonly diagnosed cancers during pregnancy, along with breast cancer, malignant hematological disorders, and melanoma. Its incidence is estimated at 1/10,000 pregnancies [5]. According to a recent Swedish study, 1.2% of invasive cervical cancers are discovered during pregnancy [6].

Zemlickis et al. [7] showed that cervical cancers diagnosed during pregnancy were significantly more often in the early stages: 69–83% in stage I versus 42% in the non-pregnant group, 11–23% in stage II versus 35%, 3–8% in stage III versus 21%, and 0–3% in stage IV versus 2%.

It is therefore important to systematically screen women during their first prenatal consultation. In 1995, Baldauf et al. [8] conducted a case-control study which showed that there was no significant difference in concordance between cytology and colposcopy with direct biopsy, regardless of whether or not the woman was pregnant.

The distribution of histological types is identical between pregnant and non-pregnant women: 95% squamous cell carcinomas and 5% adenocarcinomas [9].

Pregnancy does not alter the prognosis or progression of cervical cancer in the early stages (stage IB being the most common): in 1992, Hopkins et al. [10] published a case-control study comparing the five-year survival rate for stage IB squamous cell cervical cancer in pregnant women versus non-pregnant women, finding no significant difference. Lee et al.

[11] in a retrospective Korean multicenter study , published in January 2008, compared the prognosis of cervical cancer between pregnant and non-pregnant patients using matching. For stage IB, they observed no significant differences in resection margins, parametrial invasion, lymphatic and vascular emboli, treatment modalities, or five-year survival.

The management of cervical cancer is now well codified [12]. The combination of pregnancy and cervical cancer requires multidisciplinary management involving obstetricians, oncologists, cancer surgeons, and pediatricians. Analysis of the literature reveals mainly reported cases or small series. A set of guidelines has been developed by the French National College of Gynecologists and Obstetricians (CNGOF) concerning the management of pre-invasive lesions during pregnancy [13]. With regard to invasive cervical tumors diagnosed during pregnancy (from FIGO stage IB onwards), Morice et al. published national recommendations [14] validated by three French learned societies: the French Society of Gynecological Oncology (SFOG), the French Society of Pelvic Surgery (SFCP), and the CNGOF. We wanted to take stock of our practices with reference to these recommendations.

Conclusion

In women who have not been closely monitored or who have not been screened for more than two years, a Pap smear should be performed at the beginning of pregnancy to screen for cervical abnormalities and to raise patients' awareness of the importance of this screening. For dysplastic lesions in the absence of proven invasion on colposcopy, treatment can be deferred until after delivery, under close supervision. For invasive lesions, the assessment must be supplemented by MRI to determine the size of the lesion as accurately as possible. Management will depend on the term, the stage of the lesion, and lymph node involvement, if this information can be obtained (laparoscopic pelvic lymphadenectomy up to 20-24 weeks of gestation for tumors smaller than 4 cm). The couple must be informed that pregnancy itself does not alter the prognosis of the tumor. If the couple's decision is to continue with the

1 pregnancy and treatment must be deferred until fetal maturity, the risks
2 associated with the delay must be assessed based on the time required
3 and the prognostic factors of the tumor. The treatment is decided
4 collectively by the oncologist, surgical oncologist, obstetrician,
5 neonatologists, and the couple.

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