CASE PRESENTATION

DR. NISHITHA
2nd YEAR PG
DEPARTMENT OF OBSTETRICS
AND GYNECOLOGY

NAME :- XYZ

AGE/SEX :-62years / Female

ADDRESS :- Nalagonda

OCCUPATION :- House wife

CHIEF COMPLAINT :-

Postmenopausal bleeding since 9 months

HISTORY OF PRESENT ILLNESS :-

- Patient was asymptomatic 9 months back then she developed bleeding per vagina , frequency and amount increased progresively

- She used 2 pads a day
- No h/o passage of clots
- No h/o pain abdomen

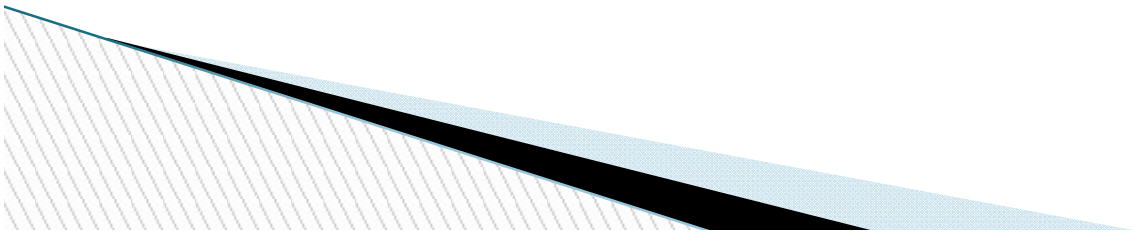
- No h/o constipation
- No h/o back ache
- No h/o abdominal lump
- No h/o fever
- No h/o cough

MENSURAL HISTORY :-

Attained menopause :- 15 years back

Age of menarche :- 13years

Previous menstrual cycle :- 4days/30days, regular, normal flow, without pain.



MARITAL HISTORY :-

50 years of married life

Non consanguinous

No usage of any oral contraceptive pills

OBSTETRICS HISTORY :-

Para(4) , Live (4),

1st pregnancy :- male child of 47 years
2nd pregnancy :- male child of 44 years
3rd pregnancy :- female child of 40 years
4th pregnancy :- female child of38 years
LCB :- 38 years

All normal vaginal deliveries at home.

Tubectomised 38 years back.

PAST HISTORY :-

No h/o hypertension

No h/o diabetes mellitus

No h/o tuberculosis

No h/o asthama

No h/o epilepsy

No h/o thyroid disorders

No h/o heart disease

No h/o any blood or its products transfusions

FAMILY HISTORY :-

No h/o any similar complaints in the family

PERSONAL HISTORY :-

Bowel and bladder habits :- Regular

Diet :- mixed

Sleep :- adequate

Appetite :- normal

No h/o any addictions

No h/o loss of weight

GENERAL EXAMINATION

Patient is conscious, coherent, cooperative

Moderately built and moderately nourished

Pallor – present
No icterus
No clubbing
No cyanosis
No generalised lymphadenopathy
No pedal edema

General condition :- fair

Temperature :- aftebrile

Pulse rate :- 86 beats per minute

Blood pressure :- 110/70 mm of Hg in right arm in supine position

CVS :- S1 S2 normal, no murmurs

Lungs :- bilateral air entry present, normal vesicular breath sounds, no additional sounds

Thyroid
Breast — Normal
Spine

GYNECOLOGICAL EXAMINATION :-

Inspection :-

- Abdomen scaphoid in shape
- Tubectomy scar of 3*2cm size present , well healed
- No sinuses
- No visible pulsations
- Hernial orifices normal
- All quadrents moving equally with respiration

PALPATION :-

- Abdomen soft
- No organomegaly
- No areas of tenderness

PURCUSSION :-

Overall abdomen is resonant

AUSCULTATION :-

Bowel sounds present

LOCAL EXAMINATION :-

- Mons pubis – sparse hair is distributed
- Labia majora – atropic changes are present

PER SPECULUM EXAMINATION :-

- Cervix hypertrophoid
- Circumoral erosion present
- An irregular growth of2*3cm size is seen on posterior lip of cervix at 7 o clock position
- Bleeds on touch
- Vagina :- healthy

PER VAGINAL EXAMINATION :-

- Mass – firm to hard in consistency
- Uterus is retroverted , bulky , mobile

Fornices free , non tender

- Bleeds on touch

PER RECTAL EXAMINATION :-

- Rectal mucosa intact
- Parametrium is free

SUMMARY :-

XYZ of 62 years old with para4 live4 came with complaint of post menopausal bleeding on per speculum cervix is hypertrophoid with circumoral erossion and a mass of 2*3cm size is present on posterior lip of cervix, which bleeds on touch

PROVISIONAL DIAGNOSIS :- Carcinoma cervix stage IB1.

DIFFERENTIAL DIAGNOSIS :-

- Oestrogen replacement therapy
- Endometrial polyp
- Endometrial hyperplasia
- Endometrial cancer

INVESTIGATIONS :-

BLOOD GROUPING AND TYPING :- 0 positive

COMPLETE BLOOD PICTURE :-
Hemoglobin :- 9.7gm%
Total count :- 7,700/cumm
Platelet count :- 2.43lakhs/cumm

COMPLETE URINE EXAMINATION :- NORMAL

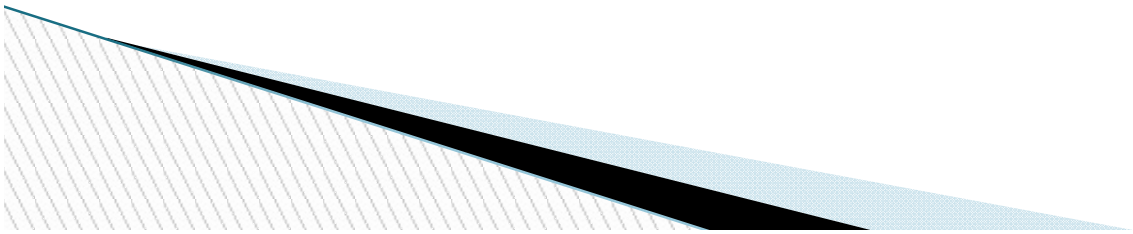
CLOTTING TIME :- 3min 30sec
BLEEDING TIME :- 2min

RANDOM BLOOD SUGARS :- 104mg/dl

LIVER FUNCTION TEST :- Normal

RENAL FUNCTION TEST :- Normal

LDH :- Normal



HIV, HbsAg, VDRL :- non reactive
Chest Xray :- normal
ECG :- Normal
THYROID PROFILE :- Normal

ULTASONOGRAPHY of abdomen and pelvis :- bulky uterus of 10.2*4.9*5.8cm .
bulky cervix
endometrial thickness :- 4mm

MRI PELVIS :-
Mass lesion of 2.10*1.96*3.64cm across the posterior lip of cervix extending upto the anterior lip, posteriorly reaching upto its serosal surface.
suggestive of cervical carcinoma
Stage IB1 - (FIGO staging system)

TREATMENT GIVEN :-

- Antibiotics are given for 1 week to control infection
- Pap smear and cervical biopsy is taken and sent for HPE

HISTOPATHOLOGICAL REPORT

CERVICAL BIOPSY :-

Show features of small cell non keratinising squamous cell carcinoma with foci of inflamation

Advice to corelate clinnically.

Type III radical hysterectomy was done

INTERA OPERATIVE FINDINGS

- Uterus bulky
- Right ovary cystic of 3*2cm
- Cervical growth present on posterior lip of 2*3cm size
- Uterus along with both ovaries and tubes sent for HPE
- Right and left pelvic lymphnodes are sent for Histopathological examination

POST OPERATIVE PERIOD :-

Was uneventful

Sutures are removed on 7th post operative day and patient was discharged on 9th post op day

Patient came for followup and wound was healthy

HISTOPATHOLOGICAL REPORT

SPECIMENS :-

- Uterus with both ovaries and tubes
- Left and right pelvic lymphnodes

DIAGNOSIS :-

Well differentiated squamous cell carcinoma cervix

Regional lymphnodes show reactive follicular hyperplasia

THANK YOU