

# Conservative Management of Endometrial Cancer Permitting Subsequent Triplet Pregnancy: A Case Report

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Grade 1 endometrial adenocarcinoma was diagnosed by endometrial biopsy after suspicious ultrasonographic findings in 28-year-old infertile women. After high dose progesterone therapy follow up endometrial biopsy was normal. The patient subsequently underwent ovulation induction cycles and triplet pregnancy had achieved. In carefully chosen cases, conservative management of infertile patients with endometrial cancer may be a viable option permitting subsequent successful pregnancies.  
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Patients with endometrioid carcinoma range in age from the second to the eighth decade, with a mean age of 59 years. Most women are postmenopausal, as the disease is relatively uncommon in young women. Only 1-8% of endometrial carcinomas occur in women under 40 years. A small number of cases have been reported in women under the age of 30 years, the youngest being 15 years. In most series, the majority of patients have had clinical evidence of polycystic ovary disease (irregular menses, infertility, obesity, or hirsutism) but in some reports patients lack these features. Rarely endometrioid carcinoma occur during pregnancy.<sup>1</sup>

In young women, the tumor is generally low grade and minimally invasive. For stage Ia grade I tumors, the standard treatment is total hysterectomy; the survival rate is 94%.<sup>2</sup> Kistner has described the use of progestins to treat atypical hyperplasia of the endometrium, but it is not first line therapy for frankly malignant lesions.<sup>3</sup> Randall et al has reported that, 16 of 17 women under 40 years of age with atypical endometrial hyperplasia and 9 of 12 women under 40 years of age with well differentiated adenocarcinoma appeared to respond to progestin treatment. Twenty-five women attempted to become pregnant, and five delivered healthy, full-term infants.<sup>4</sup> Here, we report a case of successful management followed by triplet pregnancy.

## Case Report

A 28-year-old nulligravid woman whose menarche was at the age of 16 and married at the age of 20. The patient reported cycle so irregular (2-3 cycles per year) that she received clomiphene citrate (250 mg/day) for 4 months and SSK Aegean Maternity and Women's Health Teaching Hospital, İzmir, Turkey

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HMG for 5 months in order to conceive. After two years with failure of conception, patient came with vaginal bleeding and transvaginal ultrasound revealed semisolid structures within the endometrial cavity. Computerized tomography of whole abdomen also confirmed situation as hypodense lesion in uterine corpus. The histopathologic examination of endometrial biopsy revealed a well differentiated adenocarcinoma (endometrioid type grade 1). Then she underwent hysteroscopy as an oncologic decision and hysteroscopic excision of polypoid structures on the anterior and right wall of uterine corpus were reported as fibrous connective tissue. After fully informing the patient about the possible therapeutic options, a conservative management was decided and medroxyprogesterone acetate was prescribed, 10 mg/day for 20 days in a cyclic manner and endometrial sampling after 3 months showed proliferative endometrium.

Since ovulation induction cycles with clomiphene citrate was unsuccessful, patient underwent ovulation induction with rFSH (Puregon Organon laboratories, Inc.) and metformin. She became pregnant at the end of 3 cycles and ultrasound revealed triplet pregnancy.

Patient was hospitalized due to risk of premature labor at 20 gestational week. Tocolysis with nifedipine was started and prophylactic cerclage was performed. After 1 month of discharge, patient was hospitalized again and tocolysis with ritodrine started. Patient was followed either as hospitalized or as outpatient and underwent cesarean at 32 weeks of gestation after betamethasone treatment. Triplet was trichorionic and triamniotic and their birth weights were 2100 gr, 1800 gr, 1600 gr respectively. Neonates were transferred to neonatal intensive care unit. Maternal blood pressure was elevated mildly and angiotensinogen inhibitor was started and patient was discharged two days later. Patient is still taking 10 mg medroxyprogesterone acetate 20 days of each month.

## Conclusion

Endometrial cancer is one of the leading carcinomas of the female genital tract. Although most commonly seen in fifth

decade, up to 8% of endometrial cancer seen under 40 years of age.<sup>1</sup> Total abdominal hysterectomy and bilateral salpingo-oophorectomy is the essential treatment for stage I grade I endometrial cancer. Terada KY et al reported that among 135 stage I endometrial carcinoma patients treated with total abdominal hysterectomy and bilateral salpingo-oophorectomy, 16 (12%) of them had to undergo postoperative radiotherapy.<sup>5</sup>

But patients with young age and desire to preserve fertility force to modify even change the treatment modalities. High dose medroxyprogesterone acetate is used as a hormonal therapy for low grade endometrial cancer. Wang CB and et al described the usage of tamoxifen and GnRHa for the one persistent case to the initial medroxyprogesterone acetate treatment.<sup>6</sup>

While preferring conservative treatment special attention should be taken account because persistent disease or even carcinomas with metastases can be seen. Mitsushita and et al reported persistent endometrial carcinoma after term pregnancy following conservative treatment with medroxyprogesterone acetate<sup>7</sup> Kaku T. and et al also reported that among 12 women with endometrium adenocarcinoma 9 of them respond medroxyprogesterone but later 2 of have relapsed and one of them had metastases to the left obturator lymph node.<sup>8</sup>

So as result, for whom we choose conservative treatment and when we substitute hysterectomy to conservative treat-

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