# Case Report: Small Cell Cervical Cancer in Pregnancy

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**ABSTRACT**

Neuroendocrine cervical cancers are rare, the reported incidence was 0.06 per 10,000 women and were even less commonly seen during pregnancy. Most neuroendocrine tumours are aggressive with lymphovascular metastasis and overall prognosis are poor. To date, not many cases have been reported. We report a case of late presentation of bleeding cervical cancer in pregnancy. A 34 years old Malay lady, gravida 7 para 6, no comorbidity had multiple visits to district hospital with the complaint of persistent per vaginal bleeding. She had required multiple blood transfusions due to symptomatic anaemia. She was noted to have cervical mass and had an early referral to Gynaecology Oncologist but defaulted. She only presented herself at 33 weeks of gestational due to premature contraction. Clinical assessment revealed exophytic cauliflower like growth involving the whole circumference of the cervix measuring about 8 cm x 7 cm, fornices, vaginal walls, both parametrium and pelvic side walls were free. The impression was cervical cancer stage 1B2 clinically with premature contraction. An emergency classical Caesarean section followed by Wertheim's hysterectomy and pelvic nodes dissection was performed. A live baby boy with a birth weight of 1.82 kg was delivered and the baby was admitted to NICU for observation. She was discharged well day 6 postoperatively. Histopathological examination revealed a huge fungating mass with irregular surface protruding from cervical canal measuring 105 x 95 x 62 mm arising from the endocervical tissue. It was a high grade neuroendocrine carcinoma, features consistent with cervical small cell carcinoma with extensive lymphovascular permeation, closed surgical margin with pelvic lymph nodes metastases. Unfortunately, the patient and her husband had refused adjuvant therapy despite being counselled on the risk of recurrent and distant metastasis. To date, there is no established guideline to specifically address its management. The management of small cell carcinoma and the impact of surgery, chemotherapy and radiotherapy to the survival rate have only been studied in a small number of patients. As such, managing such a case especially in a pregnant lady whom presented in labour without proper tissue diagnosis posed a great dilemma for Gynaecology Oncologist. In conclusion, recognition of cervical cancer in pregnancy preoperatively is important for operative planning and subsequent adjuvant therapy postoperatively. Furthermore, patient's counselling is of paramount importance particularly when patient is pregnant.



# Broad Ligament Leiomyoma: Diagnostic Dilemma and Surgical Challenge

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**ABSTRACT**

Leiomyoma are the most common benign tumors of the uterus, present in almost 30% of all women in the reproductive age group. The commonest site being the uterus. Extra-uterine leiomyoma is rare to come by with cervical fibroids accounting for 1-2 % and broad ligament accounting for less than 1 % of cases. Pre-operatively, it poses a great challenge to diagnose broad ligament fibroids, as it is difficult to differentiate between an adnexal or uterine pathology. Here, we report a case of a rapidly growing broad ligament fibroid and illustrate the importance of accurate pre-operative diagnosis and the surgical challenge in removing the fibroid while preserving the uterus and vital organs. A 28-year-old, Para 1 with secondary subfertility for 9 years presented to us with complaints of severe dysmenorrhea and a mass per abdomen for 1-month duration. There was a pelvic mass of 18 weeks' size, which was mobile and able to get below. Ultrasound showed a uterus measuring 8 x 4.5 cm with a right solid adnexal mass measuring 10 x 8.5 cm. However, within 2 months the mass grew to 28 weeks' size with restricted mobility. This prompted for a CT scan in view of the nature and rapid enlargement of the mass. CT scan reported a huge heterogeneously enhancing pelvic mass likely ovarian in origin, measuring 20.4 x 9.6 x 27.8 cm. However, a differential diagnosis of a broad ligament fibroid was made based on clinical and radiological findings. An Exploratory laparotomy was performed, which revealed a huge solid multi-lobulated right broad ligament leiomyoma arising from the broad ligament distorting the whole pelvic anatomy. The challenge was to remove the mass without injuring the uterus, bladder and the ureter while preserving the blood supply to the ovary, fallopian tube and uterus. After 2 hours of careful meticulous dissection, the mass was removed as a whole and the uterus was preserved. She had an uneventful recovery. Diagnosing and managing a broad ligament fibroid is always a challenge. It may present as a mass per abdomen with pressure symptoms, menstrual irregularities or fertility issues. Ultrasound and CT scan may be helpful in shedding a clue to the diagnosis but is not diagnostic. Surgery is technically challenging due to its close proximity to the ureters and vascular blood supply to the uterus and ovary. Hence, meticulous dissection is required to prevent morbidity and complications.