



Histopath Salpingo-oophorectomy Cervical Moderate Dysplasia: A Case Report

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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Case Study

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ABSTRACT

Introduction: Cervical dysplasia is a term used to describe a condition that is on the verge of becoming malignant where aberrant cell proliferation takes place on the cervix or endocervical canals surface lining. Another name for it is cervical intraepithelial neoplasia (CIN) can occur at any age. It has a strong relationship to human papillomavirus (HPV) infection spread through sexual contact.

Case History: A case of 34 year old woman admitted in gynecology unit on date June 3, 2021, a month ago when she started experiencing pain in abdomen. It was insidious in onset, continuous type, not associated with bleeding per vaginal. Patient has previous history of five abortions. Patient underwent investigations like complete blood count, kidney function test, liver function test, radiographic investigations and colposcopy where she was found to have moderate dysplasia and chronic cervicitis. Histopathology report also indicated moderate dysplasia with chronic cervicitis.

Interventions: Primarily, the pain management is necessary for such patients. Later on all further investigations and procedures performed to confirm the diagnosis and treat the patient accordingly. The aim during the treatment is to safeguard the life and further complications.

Outcomes: Over this period of long course treatment, the patient significantly reduced the severity of infection and pain. Improved the daily activities, appetite and sleep. Progress of patient towards

her goal of recovering as early as possible.

Discussion: The patients response was quite good to treatment, however additional interventions could be used in the future for her greater improvements in disease.

Keywords: Cervical dysplasia; endocervical; human papillomavirus; cervical intraepithelial neoplasia.

1. INTRODUCTION

Cells in and around a woman's cervix that are abnormal or precancerous are referred to as cervical dysplasia [1]. Cervical dysplasia is frequently asymptomatic and is found by a standard Pap test. [2]. Depending on the appearance of the aberrant cells, cervical dysplasia can range from minor to severe [3]. Cervical dysplasia is caused by the human papillomavirus (HPV), a common infection. There are hundreds of strains of HPV, which is a sexually transmitted virus. Some are low-risk, although they can lead to genital warts [4]. Women with slightly dysplastic results are frequently referred for urgent colposcopy and biopsy [5]. The condition may revert or improve with correct care and treatment before turning malignant [6]. Cervical precancerous diseases are classified based on how abnormal the cells appear under a microscope and the severity of the cell alterations. They're divided into categories based on the aberrant cell type. Cervical precancerous alterations are extremely common [7]. Most cases of cervical dysplasia can be cured with early detection and therapy. The condition may, however, reappear. Without treatment, severe cervical dysplasia may change into cervical cancer [8].

2. CASE HISTORY: PATIENT INFORMATION

A case of 34 year old woman admitted in gynecology unit on date June 3, 2021. Patient was apparently alright a month ago when she started experiencing pain in abdomen. It was insidious in onset, continuous type. Abdominal pain was severe and not associated with bleeding per vagina. There was no current history of fever, cough and cold. Her duration of marriage was 6 years with five incidences of abortion. Patient has no any history of multiple sexual partner. Prior consent has been taken from the patient and informed the purpose of collecting detailed case history.

2.1 Medical/Surgical History

Patient has been operated for vaginal hysterectomy with bilateral sphincterotomy under

spinal and epidural anesthesia on date 4th May 2021. Patient have previous history of laparoscopic fimbrial cyst resection done in the year 2016, cervical biopsy done in year 2020. Patient was diagnosed as histopath salpingo-oophorectomy moderate dysplasia with chronic cervicitis on 7th December 2020. No any significant history of Tuberculosis/Diabetes mellitus/Hypertension/Epilepsy/Thyroid disorder. No any history of blood transfusion.

2.2 Obstetric History

Patients duration of marriage is about 6 years with obstetric score P1L1A5. P1L1-female child of 5 years.

Patient had her first abortion with spontaneous at 1.5 month, Dilatation & curettage was done before 3 years ago, second abortion with spontaneous at 1.5 months, Dilatation & curettage was done before 2 years ago, third abortion at 1.5 months with MTP pills 1 year back, fourth abortion at 1.5 months with MTP pills 1 year back, fifth abortion at 1.5 months with MTP a year ago. All the abortions are reportedly caused due to incompetent cervix.

2.3 Menstrual History

Patients Last Menstrual Period date was 1st May 2021, menstrual cycle of 28 days with duration of 2-3 days having regularity and average amount of flow. Also patient experiences dysmenorrhea during her menstrual cycle.

2.4 Family History

Patient belongs to joint family type consisting of 6 members. Her father-in-law is the eldest member. Her husband and father-in-law both are the bread-winner of the family. There is no any significant history of cancer in the patients maternal as well as paternal side.

2.5 Personal Assessment

Patients sleeping pattern is slightly disturbed due to insidious onset of pain although the appetite is

normal. Patients dietary pattern is normal. Bowel and bladder pattern is regular. Patient is not having any bad habits like smoking, tobacco chewing and alcoholism.

Patient has maintained good interpersonal relationship with the family members and neighbors. There are no issues and conflicts within the family that will hamper her psychological status.

2.6 Physical Examination

General appearance and behavior: Moderately nourished, hygiene and grooming is maintained, dull activities.

Mental status: Patient was conscious and oriented to time, place and person, attentive but slightly irritated.

General parameter: Height is 161 cm, weight is 62 kg, BMI: 23.9kg/m², Vital signs: Temperature-97.7 ° F, pulse-70beats / min, respiration-21breath/min, blood pressure-130/90 mm/Hg

Skin conditions: Fair in color, no cyanosis, no signs of dehydration, intact skin

Eyes: Symmetrical eyebrows, pupils are equally reacting to light

Chest: Symmetrical expansion, respiratory rate was 22b/min, no fluid collection on percussion, normal breath sound, nipple erected, dark brown areola

Abdomen: On inspection no scars present, no distension, no tenderness but mild painful on palpation, bowel sound auscultated

Musculoskeletal system: Patient was having moderate body built. The range of motion was possible, able to do her daily life activities, capillary refill is 1 second and no edema

Upper and lower extremities: There was possible range of motion observed with no signs of cyanosis on nail beds.

Per-vaginal examination: Cervix firm to hard in consistency, irregular on bimanual examination, uterus retroverted and normal in size. Bilateral fornices were free and no tenderness found.

Genitalia and rectum: No any signs of hemorrhoids, hygiene is maintained.

2.7 Diagnostic Assessment

Blood investigation: In Complete Blood Count-hemoglobin is 11.9gm/dl (12-14.5gm/dl), mean corpuscular volume (MCV) is 83CubMicron (80-90cubmicron), total Red Blood Cell count is 4.41millions/cu.mm (4.5-6millions/cu.mm), total White Blood Cell count is 10300cu.mm (4000-11000cu.mm), total platelet count is 2.4 lacs/cu.mm (1.5-4cu.mm) and blood group is O⁺ve.

Peripheral smear shows RBCs Normocytic Normochromatic, platelet- adequate on smear

Hepatitis – HBsAg is Non-reactive, hepatitis – HCV is Non-reactive

Kidney function test (KFT): Urea is 22mg/dl (15-36mg/dl), creatinine is 0.7mg/dl (0.52-1.04mg/dl), sodium (Na⁺) is 147mmol/L, and potassium (k⁺) is 3.5-5.1mmol/L

Liver Function Test (LFT): SGPT is 18U/L (<35U/L), SGOT is 22U/L (14-36U/L), Normal albumin levels is 3.5-5.0g/dl and Total protein is 7.6g/dl, total bilirubin is 0.5mg/dl (0.2-1.3mg/dl), and the patients level is 4.0g/dl. Bilirubin conjugated is 0.1mh/dl and Bilirubin unconjugated is 0.4mg/dl

RBS- Glucose-plasma Random is 81mg%

Urine examination findings were normal.

Colposcopy findings are cervical erosion seen on posterior lip, mosaic pattern of blood vessels seen on green filter, aceto white areas seen at 7 O'clock position

HPV infection testing has been done i.e. Oncquest HPV DNA TEST GOR HIGH RISK + LOW RISK COMBO – Specimen type: Cervical/ vaginal exfoliative tissue specimen received in STM medium, test result was Negative for high risk + low risk combo HPV (HPV HR+LR) types. Patient sample to known Positive Control Cut-Off Ratio of less than 1.00 is NEGATIVE for HPV HR as well as LR type.

Histopathology findings shows multiple, irregular, whitish tissue pieces aggregating 1.5* 1cm, section from cervix shows hypertrophied ectocervical lining with moderate dysplasia, chronic cervicitis. Deeper tissue shows fibrocollagenous tissue with Nonspecific

Inflammatory Infiltrate and prominent blood vessels on histopathology.

3. THERAPEUTIC INTERVENTION

General measures: To check the vital sign (Temperature pulse respiration and Blood Pressure), to watch for abdominal pain and prevention of complications like bleeding per vagina. Health management includes a healthy diet and a good diversional therapy.

3.1 Pharmacological Management

Majorly includes antibiotics like injection Gentamycin 80mg 12 hourly, injection CTAX 1gm and injection metronidazole 100ml to prevent the infection, some antispasmodics CALPOSE 10mg to relieve muscle spasm and non-steroidal anti-inflammatory suppository like ZONAC suppository for treating post-operative pain and inflammation and antacid injection PAN 40mg IV 12 hourly.

3.2 Surgical Management

Vaginal hysterectomy done on date June 4,2021 after taking consent patient shifted to operation theatre and induced under spinal and epidural anesthesia. Then patient prepared and draped in normal sterile fashion in dorsal lithotomy position was given. Bilateral sphincterotomy done with anal dilatation. Hemostasis achieved and confirmed. Sterile dressing done. Patient withstood the condition well and shifted to recovery room. There are no any evidences of conservative management like cryotherapy or laser therapy. As such hysterectomy is the usual treatment for early stage cervical dysplasia. Depending on the womans age and the stage of dysplasia, removal of the ovaries and fallopian tubes may also be recommended. To avoid the recurrence and spread of HPV infection physician suggested for non-descent vaginal hysterectomy along with removal of ovaries.

However, patient made aware of risk of under treatment of cancers, need for long-term surveillance tests and risk for future dysplasia of reproductive system.

3.3 Nursing Management

1. **Acute pain related to surgical intervention secondary to vaginal hysterectomy**

Goal: To reduce the pain level

Intervention

Assess the level of pain, intensity and site, provide non-pharmacological measures like extra comfort devices, diversional therapy and administer analgesics as per physician order.

2. **Risk of infection related to prolong hospitalization**

Goal: To reduce the chances of infection

Intervention

Use clean and aseptic technique while handling patient, instruct patient to have proper perineal care and instruct patient to have daily mouth care.

3. **Disturbed sleeping pattern related to pain and interruption on vital sign monitoring**

Goal: To improve sleeping pattern

Intervention

Identify presence of related sleep disturbance factors, recommend restriction on caffeine, assess patients usual sleep pattern and provide calm and quite environment.

4. **Knowledge deficits related to disease information perception limitations**

Goal: To improve patients knowledge regarding disease

Intervention

Assess Assessing the patients aptitude and readiness to learn, as well as the patients personal context and meaning of sickness, including perceived lifestyle changes, and financial concerns, by focusing on problem solving and decision making, give information to enhance self-efficacy, self-regulation, and self-management, and evaluate learning outcomes using client verbalization.

4. DISCUSSION

India and Southeast Asian countries have a high burden of cervical cancer due to low to moderate living standards, a high incidence of HPV (more

than 10% in women over 30 years), and a lack of screening [9]. FISH (fluorescent in situ hybridization) technique is becoming more widely acknowledged as a useful method for evaluating cervical dysplasia [10]. The standard of care for cervical dysplasia is not a hysterectomy. Recurrent cervical dysplasia, on the other hand, can be treated with hysterectomy [11]. Cervical cancer remains a leading cause of morbidity and mortality worldwide, with an estimated incidence of 470,000 [12]. The relationship between reproductive variables (parity, age at first birth, number of induced and spontaneous abortions) and cancer risk has been analyzed using data from an integrated series of case-control studies conducted in northern Italy between 1983 and 1992. The study has found that cervical cancer was directly associated with the number of spontaneous abortions [13].

5. CONCLUSION

Regular screening is important to detect and treat early precancerous changes and prevent cervical dysplasia. Patient was been advised to come for follow up after 15 days being discharge from hospital for regular check-ups, checking treatment was successful and all the precancerous cells has been removed or not, as specimen had been sent for histopath after vaginal hysterectomy and no vaginal swab was taken. Historically, the most popular screening procedure was the Pap smear test [14]. Periodical cytological screening would go a long way in the early detection of various cervical lesions and help in reducing the incidence of cervical cancer [15]. A single lifetime screening, especially in rural populations with an emphasis on high-risk groups of women, is the most feasible approach to detect the disease in its pre-invasive stage in developing countries like India, where resource constraints and a shortage of cytology workforce are major issues [16].

CONSENT

Prior consent has been taken from the patient and informed the purpose of collecting detailed case history.

ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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