

INTRODUCTION

Cancer cervix is important Gynaecological malignancy during pregnancy with incidence of 0.1 -12/10000 pregnancies. Management of Ca cervix is challenging during pregnancy due to involvement of genital organs & hormonal fluctuations which contribute to acceleration of disease

OBJECTIVES

The objectives are to review the clinical presentation, discuss diagnostic and ethical challenges, evaluate treatment modalities and prognosis for mother & foetus.

CASE OPERATION PROCEDURE

31yr old G3P2L1, presented at 38wks 5days period of gestation. C/O leaking PV, past 6hrs & bleeding, O/E PA –uterus term, cephalic, 2 contractions lasting for 30secs in 10 mins, P/S exam friable growth of 4*4cms occupying the cervix, Investigations normal, Obstetric Growth scan showed single intra uterine pregnancy, cephalic presentation AFI 11.7

estimated fetal weight 2.6kgs, single loop of cord around the neck, Cervical biopsy showed poorly differentiated non keratinizing squamous cell carcinoma NOS clinically 1b3. underwent LSCS Discharged in stable condition advised to follow up for chemoradiation



Fig 1: Shows proliferative growth occupying whole of the cervix



Fig 2: MRI abdomen and pelvis showing cervical lesion

DISCUSSION

Hormonal changes can mask the symptoms of cervical cancer, resulted in detection rate of 70%, risk of mistaking cancer symptoms for normal or benign condition leading to delayed diagnosis. Pregnant & postpartum women vigilant. Treatment depends on gestational age. Pelvic examination and cytology are useful & safe. 1st trimester align with FIGO stage including termination, 2nd /3rd trimester if fetal maturity or EDD is near, delaying ca treatment until after the baby.

CONCLUSION

Clinical and imaging features often fail to diagnose leiomyosarcoma, with histopathology remaining the gold standard. Due to its rapid growth and metastasis, early detection and treatment are crucial. Future research should aim to improve preoperative diagnostic methods.

REFERENCES

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