CASE REPORT

Laparoscopic Management of Suspected Vault Recurrence Following Staging Surgery of Endometrial Cancer

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Abstract

Background: Postoperative issues with the vaginal vault after hysterectomy for benign or malignant conditions are not common. However, these include vault hematoma, granuloma, keloid, incisional hernia, vascular formation, and recurrence of pelvic malignancy at the vault.

Case description: A 47-year-old woman with a history of breast cancer surgery under tamoxifen developed endometrial carcinoma stage 1 for which she underwent staging laparoscopy 1 year ago. She presented with a vaginal cuff tumor of 3 cm detected vaginally 3 months later which was suspicious of recurrence. Laparoscopic management was done and circumferential excision of vaginal cuff margin and repair was done. The final pathology report revealed infection and granulation tissue in the excised margin.

Conclusion: Management of vaginal cuff complications following hysterectomy can be feasible by minimally invasive surgery regardless of indication of primary surgery.

Keywords: Endometrial cancer, Laparoscopic management, Vault recurrence.

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Background

Postoperative issues with the vaginal vault after hysterectomy are not very common. These complications include vault hematoma, granuloma, keloid, incisional hernia, vascular formation, fistula, prolapse of the oviduct, and recurrence of pelvic malignancy at the vault.[1] Out of these, vaginal vault granulation is a commonly observed benign sequela of hysterectomy. Regarding the recurrence of pelvic malignancy, approximately 6–13% of all patients with endometrial cancer will develop the recurrent disease and most of these are located at the vaginal vault.[2] Indications for surgical treatment depend on resectability, site and size of the tumor, and performance status of the patient. Both these conditions have a common initial presentation with vaginal bleeding, discharge, and fleshy growth in the vaginal cuff. Here, we present a case of a woman who was suspected to have vaginal cuff recurrence following staging laparoscopy done for endometrial cancer.

Case Description

A 47-year-old woman with right breast infiltrative ductal carcinoma had surgical treatment in 2015 at Chang Gung Memorial Hospital, Linkou, Taiwan and was under regular follow-up. She was under tamoxifen with yearly surveillance of her endometrial thickness. Three years later, she had abnormal endometrial thickness which on hysteroscopic biopsy was proven to be endometrial cancer. So, she underwent staging laparoscopy with total hysterectomy and adnexal removal in January 2019. Histopathology revealed The International Federation of Gynecology and Obstetrics (FIGO) stage 1a grade I endometrial cancer.

Three months later, she presented with a vaginal discharge of 2 weeks duration. On vaginal exam using a colposcopy, there was a cuff lesion with the appearance of ulcer or granulation tissue, over a nodule of 3 cm, which was angry red, velvety, and bled on touch (Fig. 1). Vaginal biopsy showed acute on chronic inflammation and magnetic resonance imaging (MRI) of the abdomen revealed

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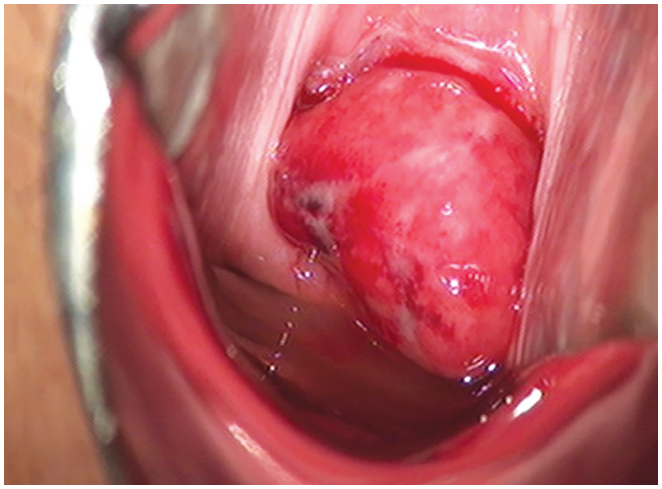

Fig. 1: Colposcopy shows red, velvety vaginal cuff with some swelling which bled on touch

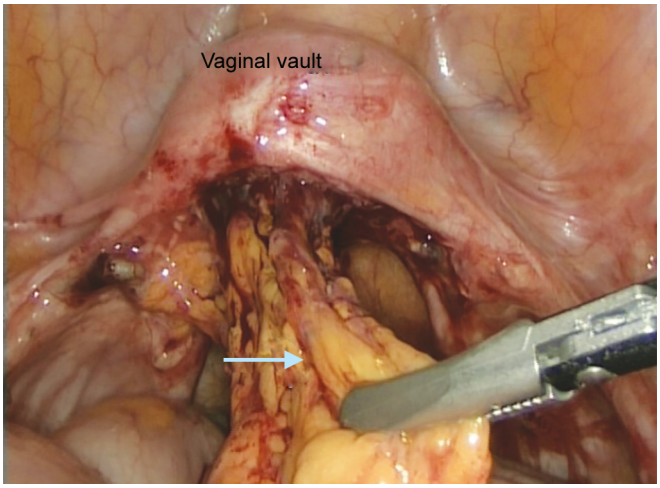

Fig. 2: Vaginal vault with the loop of omentum adhered (arrow)

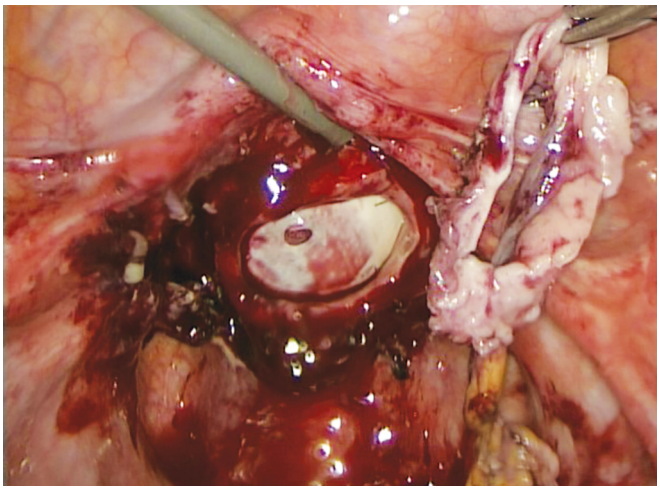

Fig. 3: Excised margin with remaining vaginal cuff ready for repair

nodularity at the tip of the vaginal stump, with focal M-shape folding. Its impression was postoperative change with superficial recurrence cannot be completely excluded. Following this four-port laparoscopy with 10 mm primary port at umbilicus was done. Intraoperatively, adhesiolysis was done for the loop of omentum adhered to the vault (Fig. 2). The assistant inserted gauze on sponge forceps in the vagina to push it through the vagina to show margins of the vault. Dissection was done all around the mass to excise the unhealthy cuff and get a good healthy cuff margin (Fig. 3) for better repair and healing. Once excised, the specimen is retrieved vaginally and sent for a frozen section which revealed granulation tissue with inflammation which was confirmed later. Closure of vaginal cuff with 1-0 suture (absorbable) in double-layer was done. Intraperitoneal drain was inserted to reduce the risk of infection and coverage with postoperative antibiotics for 1 week was given. She had an uneventful postoperative period and was discharged on 3rd day. Her follow-up till 6 months post-surgery was uneventful with healed vaginal cuff.

Discussion

Vaginal vault recurrence after hysterectomy for gynecologic malignancies is a well-recognized problem, and this has led to protocols for adjuvant therapy to prevent their occurrence.[3]

Women often do not seek gynecologic care, particularly after hysterectomy. Additionally, women with a history of gynecologic malignancy may be followed by various primary care physicians, and oncologic surveillance may be focused more on distal than the local disease. The vaginal vault may be the first site of recurrence of genital tract neoplasms. Once vault recurrence is diagnosed, treatment is planned after the completion of a metastatic workup. The standard treatment is radiotherapy (RT) which is effective for local control and the effect has been documented in prospective studies. Surgical treatment has also been advocated in isolated vault recurrence.

However, signs and symptoms of vault recurrence frequently mimic extensive vault granulation. This is a common postoperative complication after total hysterectomy for benign or malignant lesions but little reports have been published. Most of the time small granulation over the cuff is self-limiting and can be treated by chemical coagulation, such as, silver nitrate or thermal coagulation. A large lesion as described in this case report needs excision.

The proper recognition and differentiation between granulation tissue and possible recurrent malignant tissue are most important in patients who have been operated upon for malignant disease of the female pelvis. A biopsy of apparent granulation tissue in such patients is, therefore, necessary before treatment is instituted.

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