Case Title: **The Case of Ms. Edith Edgard**

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Case synopsis: A 45 year old woman is referred to a gynecologist for the assessment of abnormal vaginal bleeding.

Number of pages: 12

Date of last revision: June 2009

Case objectives: As part of an adult learning experience the learners should identify what they need to know to solve this patient's case. The learning goal of this case is to facilitate the clinical reasoning skills of the learners.

The authors used published objectives from the Association of Professors of Obstetrics & Gynaecology of Canada (APOG), Association of Professors of Gynecology and Obstetrics (APGO) and Council of Residency Education of Obstetrics & Gynecology (CREOG) as guidance for writing these cases.

This case was designed for a small group interactive 2.5 hour seminar – the case may be revised as needed into 2 parts to fit a shorter time frame.

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Box 1

A 45-year-old primary school teacher is referred to you at the Chief Resident's Gynecology Clinic in your hospital.

She had been seen in the emergency room one week previously with heavy vaginal bleeding. By the time she was assessed by the doctor her bleeding had settled down and she was stable. He decided a consult by gynecology was not needed at that moment, and subsequently referred her to the outpatient clinic.

Ms. Edith Edgard tells you she has been having intermenstrual spotting for approximately 6 months. She mostly notices the blood on the toilet paper. She has not noticed any abdominal pain or changes to her bladder or bowel function. She would like to get this sorted out because she is tired of wearing panty liners everyday. The panty liners are irritating and she wonders if the blood could be coming from an itchy area "down there". She hasn't had a Pap smear in 5 years.

1. What is your differential diagnosis for vaginal bleeding in this patient?
2. What is your differential diagnosis for vulvar itching in this patient?
3. What further information for her history would be helpful?

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Box 2

Ms. Edgard states that her first period was at the age of 16. She had a long history of irregular periods throughout her adolescence and was eventually placed on the pill to resolve these problems. She continues to have irregular cycles. On average the frequency is every 2 months and the bleeding lasts anywhere from 10 days to 2 weeks. She denies any significant pelvic pain with her periods. She also denies any pre-menstrual symptoms although occasionally she gets some lower abdominal pain in the "middle" of her cycle. Her last menstrual period was 10 days ago.

Five years ago she had a Dilation and curettage (D & C) for a heavy period. She was told the result of the D & C was abnormal but can't remember exactly what was wrong with it. She is a Gravida 1 Parity 1. She developed gestational diabetes in her pregnancy. She had trouble getting pregnant (it took 5 years of trying) and is currently not taking anything for birth control.

She is an asthmatic and uses ventolin prn. She is also on synthroid for hypothyroidism. She is otherwise healthy. She has had an appendectomy and C-Section. She smokes ½ pack per day. A recent mammogram done was normal.

You ask your secretary (dare to dream Arnold!) to track down the result of her D & C and you ask the patient to change for the examination.

1. How does this information change your differential diagnosis?
2. What are the important components of a focused physical examination for this patient?

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Box 3

Examination reveals: Height 150 cm Weight 90 kg. Blood pressure 145/80 Heart rate 80, Respiratory rate 14 and temperature 36.8 degrees C. She has some excessive hair growth on her face and abdomen. Breast exam is normal, and no discharge from the breasts is noted. Chest is clear. Heart sounds are normal. Abdominal exam: soft, non-tender, no masses. Previous pfannensteil and appendectomy incision are noted. Vulvar exam: The anatomy of the vulvar is normal. The skin of the lower labia majora and perineum is diffusely red. Inspection of the vagina is normal. The pH of the vaginal discharge is 4.5. The cervix is normal and there is thick yellow cervical mucus noted in the os. This is gently wiped off and a Pap smear is obtained. You inspect the cervix after the application of acetic acid and the exam is satisfactory and negative. There is no blood in the vagina. Bimanual reveals a small, mobile anteverted uterus. There are no adnexal masses.

1. What is the most likely diagnosis for her vaginal bleeding at this point?
2. What is your next step in management?

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Box 4

You decide to do an endometrial biopsy. Unfortunately you are unable to advance the pipelle beyond 2 cm. You make some general recommendations to the patient regarding skin care and vulvar hygiene as you think the external vulvar rash is an irritant dermatitis secondary to the constant use of synthetic panty liners. You arrange for a transvaginal ultrasound in the interim. The secretary gives you the report from the last D&C, which says: "simple endometrial hyperplasia without cytological atypia". (See figure 1)

At the end of the day you are reviewing your patients with Dr. French, the attending gynecologist who is supervising your clinic.

He asks you:

- "Describe your technique for obtaining your endometrial sample – are there any techniques that might help to obtain a sample in a difficult scenario?"
- "If you had done her first D&C 5 years ago, what type of follow-up would you have arranged? What is her risk of developing endometrial cancer?
- "Given that you were unable to perform the biopsy what is the sensitivity and specificity of endometrial ultrasound for detecting endometrial hyperplasia or cancer?"

1. Outline what type of skin care recommendations you would give to this patient.
2. Address Dr. French's questions.

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Box 5

You review the ultrasound result with Dr. French prior to the patient's next visit. The ultrasound report reads, "Exam findings include an 8cm uterus and an endometrial echo that is uniform and measures 1mm".

Dr. French asks you:

- What are you going to recommend to the patient with regards to the ultrasound results?"

1. Address Dr. French's question.

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Box 6

The patient returns for follow-up appointment one month later. Ms. Edgard reports that she is still having a small amount of daily vaginal bleeding. In the interim the results of the Pap smear have come back and the report is normal. You decide to recommend a hysteroscopy and fractional D&C.

The patient asks you:

- “What is a hysteroscopy? Is it necessary? Why not just do the D & C like last time?”
- “What are the chances that this is cancer?”
- “Wouldn’t the Pap smear have picked up something abnormal inside the uterus?”

1. Address the patient’s questions.

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Box 7

You perform the hysteroscopy and D&C. The cervix requires dilation, first with lacrimal probes, and then with Pratt dilators. The endo cervix appears normal. The uterine cavity is well visualized. Both cornua and tubal ostium are seen. The lining of the uterus is pale and thin with patchy areas of erythema and one polyp is noted. Curettage of the endometrial cavity is performed. The pathology report is returned one week later. The endometrial biopsy is reported as "well-differentiated endometrial adenocarcinoma".
See figure2: histology of endometrium.

You review the result with your attending who asks,

- "How is endometrial cancer staged?
- "What is her stage?
- "What is your recommended treatment for this patient?"

You arrange to have Ms. Edgar return to your office accompanied by her husband and daughter to discuss the results.

They have several questions:

- "How did she get this cancer, was it because I was on the pill in my 20's?"
- "Do I need any more investigations?"
- "What is the likelihood of curing this cancer?"

1. Address the above questions.

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Box 8

The patient consents to a total abdominal hysterectomy and bilateral salpingoophorectomy. At the time of the surgery, you perform a vertical midline laparotomy and obtain pelvic washings.

- Dr. French asks you to explain to Kevin (the 3rd year medical student who will be cutting your sutures), why you are doing pelvic washings.

Exploratory laparotomy reveals a 7 cm uterus of normal shape and size with healthy appearing tubes and ovaries. On palpation you note a slightly enlarged left pelvic lymph node located between the bifurcation of the common iliac arteries. You perform a total abdominal hysterectomy and bilateral salpingoophorectomy.

Dr. French, who has been chatting amicably with the anaesthesiologist, asks:

- "Do you want to do anything more before we close?"

You tell Dr. French that you would like to excise the enlarged left pelvic node. He asks you,

- "What are the chances of pelvic node involvement in a Stage 1 endometrial cancer?"

1. Address Dr. French's questions.

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Box 9

The final pathology is reported as:

"Grade 2 endometrial adenocarcinoma invading the endometrium but not the outer half. The tumour extends into the cervical glands but does not invade the cervical stroma. The ovaries, and washings are negative. Single left pelvic node is reported as negative for tumour."

See fig 3 for gross and histology of uterus.

You review the results with Dr. French who asks:

- "What is her Federation of International Gyne-oncologists (FIGO) stage?"
- "Does she need any further treatment at this point?"

1. Address Dr. French's questions.

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Box 10

You see Ms. Edgard in your clinic 2 weeks after surgery to discuss the results. Ms. Edgard has been on the Internet and has read that some women need radiation treatment for their cancer. She has also started to have hot flushes which she finds uncomfortable.

She asks:

- ☐ "How can you be sure that the cancer has not spread?"
- ☐ "Do I have a better chance of cure if I have radiation therapy?"
- ☐ "What are the side effects of radiation therapy?"

1. Address the patient's questions.

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Box 11

Epilogue:
The patient was referred for further management to the regional cancer agency. Dr. Jones a gyne-oncologist saw Mrs. Smith. With her stage, and the absence of a complete node dissection, it was discussed that her node status remains unknown. She was offered a laparoscopic pelvic lymphadenectomy and agreed to proceed with the procedure which she underwent 2 weeks later. The final pathology from the pelvic lymph nodes was all negative for carcinoma and thus no further therapy was pursued.

At her post-op visit with Dr. Jones, Mrs. Smith again complains of severe hot flushes that are interrupting her sleep.

 She asks “Can I take something for the hot flushes? I’ve tried various herbal supplements but nothing seems to be working and I can’t think straight because I am so tired”

1. Address the patient’s questions.
2. Are hormones absolutely contra-indicated in her situation?

END OF CASE

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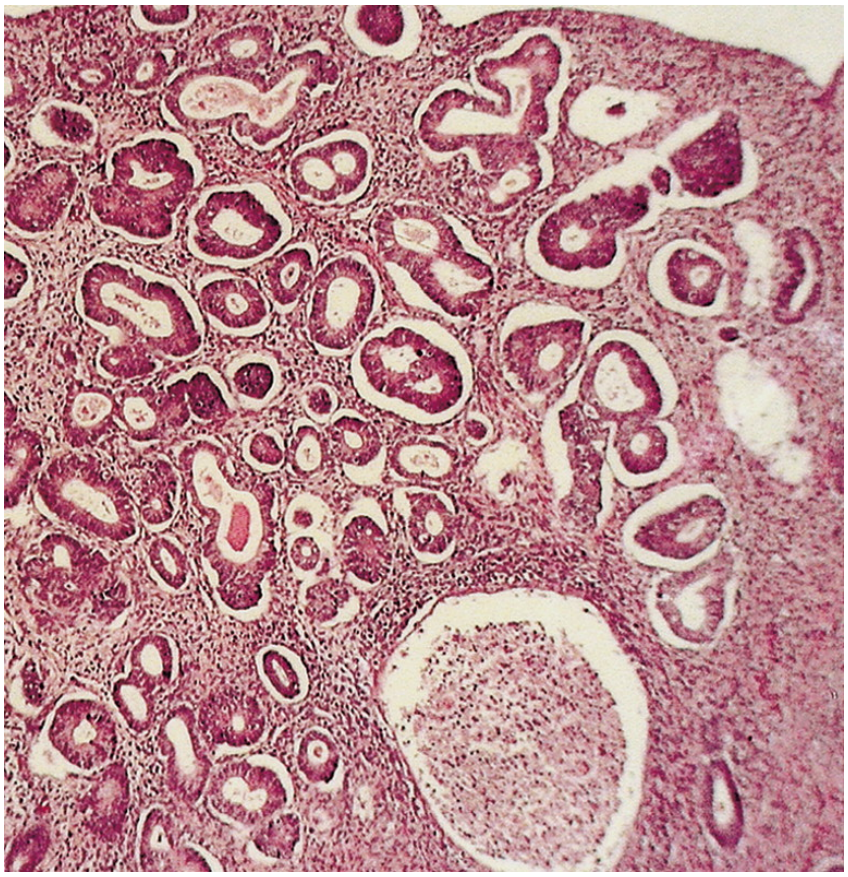
Figure 1 Endometrial hyperplasia without atypia



Accessed on July 16, 2009 at http://radiographics.rsnajnls.org/content/vol23/issue1/images/large/g03ja02c8c.jpeg

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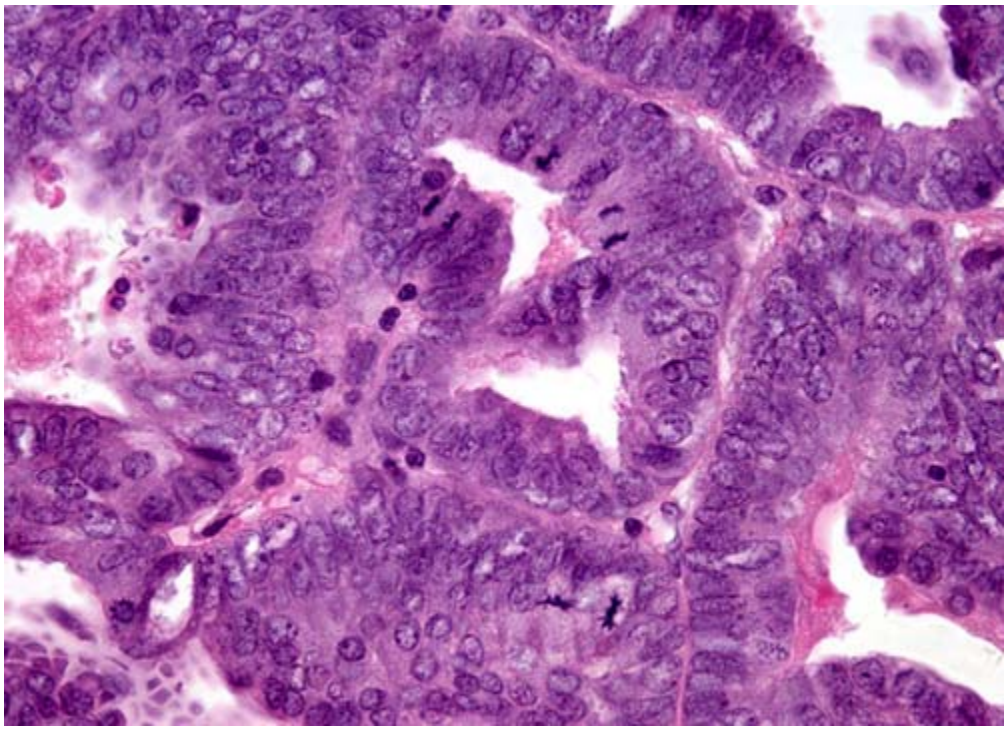
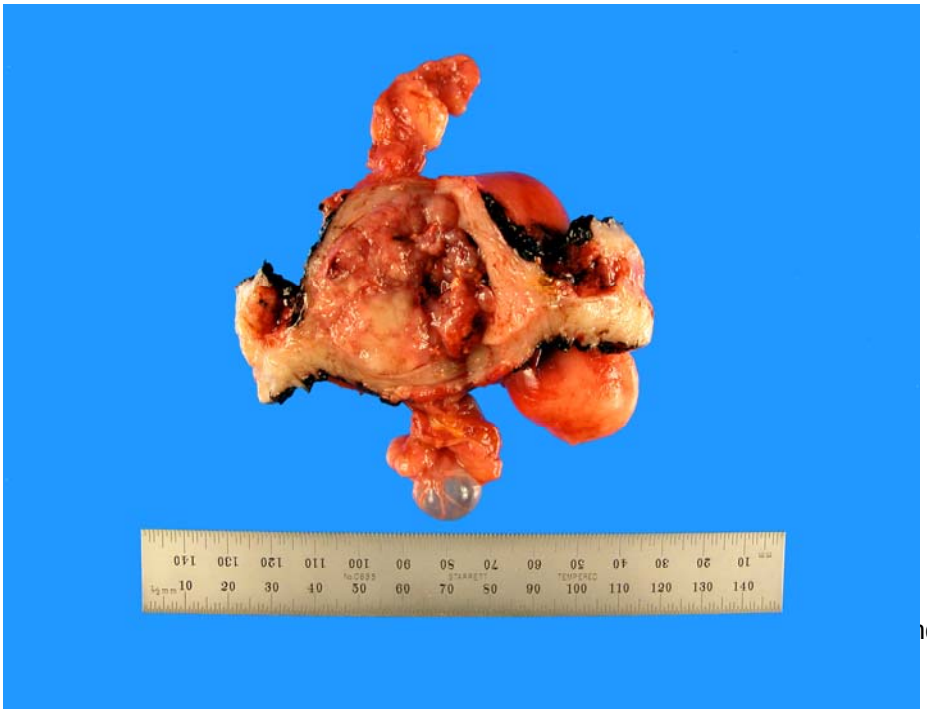
Figure 2 Endometrial cancer



Accessed on July 16, 2009 at http://www.microscopyu.com/staticgallery/pathology/images/adenocarcinomaofendometrium40x05.jpg

Figure 3 Gross specimen with endometrial cancer



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