

# A Presentation of Rare Case of Carcinoma of the Cervix - Cervical Lymphadenopathy (Case Report)

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**Abstract**— *Lymphadenopathy of the cervical lymph nodes is referred to as cervical lymphadenopathy (the glands in the neck). Carcinoma of the cervix commonly metastasizes by direct extension or lymphatic dissemination within the pelvis. Clinical presentation of carcinoma of the cervix as cervical lymphadenopathy has not been described before. We report a case of this unusual manifestation of cervical cancer. Although cervical carcinoma recurrences have been reported in the past as lymphadenopathy, this is the first report of cervical carcinoma presenting clinically as cervical lymph adenopathy. Despite the rarity, metastasis from the cervix to the cervical lymph nodes can be understood by describing how the lymphatic system drains from the cervix.*

## I. INTRODUCTION

Cervical lymphadenopathy is not a diagnosis; it is an indication or symptom. The causes might range from inflammatory to neoplastic to degenerative. Healthy lymph nodes in the axilla, neck, and groin of adults can be palpable (feelable). Cervical nodes up to 1 cm in size may be felt in children under the age of 12, however this may not indicate a disease. Nodes may continue to be palpable if they recover from inflammation through resolution or scarring. The majority of palpable cervical lymphadenopathy in children is inflammatory or infectious. Metastatic growth from malignancies of the aerodigestive tract (most frequently squamous cell carcinomas) should be taken into consideration in those over the age of 50. Often, localised cervical lymphadenopathy won't need any more testing. A person may have a far more serious ailment, such as cancer, an autoimmune disease, or other dangerous diseases, such as infectious mononucleosis, AIDS, cat scratch disease, and others, if they exhibit symptoms including weight loss, fever, exhaustion, or night sweats. For a precise diagnosis of these disorders, additional testing, such as laboratory and imaging procedures, may be necessary. It may be necessary in some circumstances to do a node biopsy, which is normally carried out via a fine needle aspiration, core needle biopsy, or excisional biopsy.

## II. CASE REPORT

A 51-year-old woman was referred to the ENT division with a lump on the right side of her neck that had been present for two weeks. She had no prior history of dysphagia or vocal changes.

She has had all of her vaginal deliveries normally and has previously had normal cervical smears. She is a para 4. Her cycles were regular, and she denied ever experiencing post-coital or intermenstrual bleeding. She consumed 20 to 30 cigarettes daily.

She revealed after further inquiry in the clinic that she had been getting more lethargic over the previous three months and had also been unable to go to work because of excruciating back pain.

She claimed to have felt ill five years before the current event, losing a substantial amount of weight and having frequent periods. She received five units of blood after it was determined that she was anaemic. She was examined for potential colon cancer, but the results were negative. She was advised to visit a clinic for menstrual disorders but failed to do so twice.

Several cervical lymph nodes were palpable during the examination on both sides of the neck. A neck ultrasound revealed seven abnormal-looking lymph nodes in the right carotid chain in addition to two sizable supraclavicular lymph nodes.

The chest's X-ray revealed no anomalies. Squamous carcinoma cells were obtained from the lymph nodes using fine needle aspiration.

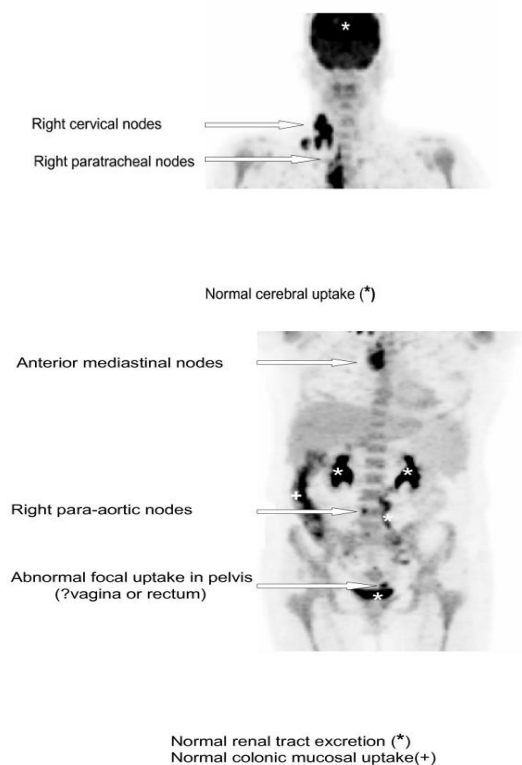
Investigations were carried out to identify a potential primary site because it was thought that the probable main tumour was a metastatic squamous cell carcinoma. The nasopharynx, larynx, and hypopharynx did not exhibit any evident primary tumours on clinical examination or endoscopy of the upper digestive tract.

The known squamous cell carcinoma was found to have spread when computerised tomography (CT) of the neck, chest, and abdomen indicated significant mediastinal and para-aortic lymphadenopathy. There was evidence of bilateral collecting system enlargement, and proximal ureter enlargement suggested a pelvic blockage.

A Positron Emission Tomography-CT (PET-CT) scan was performed which showed markedly increased uptake in the right cervical lymph nodes, as well as in the right paratracheal, anterior mediastinal, lower para-aortic, and bilateral iliac lymph nodes with an obturator node showing a photopaenic centre. In addition, there was a focal area of increased uptake in the pelvis, suggesting a lesion within the rectal wall or in the vaginal vault

The PET scan revealed that the uptake in the pelvis may represent a primary gynaecological issue rather than a second malignancy in the rectum given the histology of squamous carcinoma. However, a study of the histology was advised with a possible differential diagnosis of lymphoma to be taken into consideration due to the disease's spread, which was quite rare for cervical carcinoma. It was determined by histology

that the cervical lymph node's cancer cells were of squamous origin.



The gynecologic oncology team was then contacted about our patient. The uterus was anteverted, mobile, and bulky upon examination, roughly the size of a 14-week pregnancy, with no palpable adnexal masses. Her cervix was visible to the naked eye as being normal, and a smear was taken and reported.

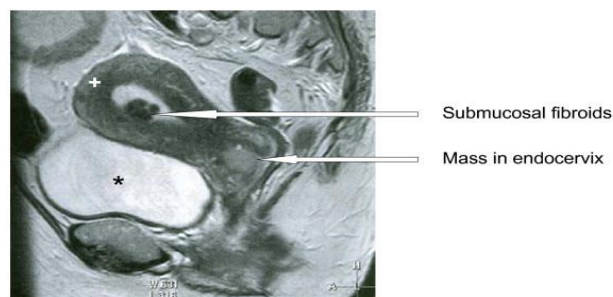
A highly abnormal cervix, diffusely infiltrated by an intermediate to high T2 signal intensity mass measuring approximately 3 4 3.5 cm, was discovered after abdominal and pelvic MRI was performed. The mass was located in the stroma and the endocervical canal, and it is thought to have begun with an anterior parametrial invasion. The rectum was free of disease, and there was no convincing evidence to suggest bladder involvement. Within the myometrium, there were several small intramural fibroids and a submucosal fibroid in the anterior body of the uterus.

There was extensive lymphadenopathy along both lateral walls of the pelvis, the common iliac region, and the para-aortic region, but no evidence of inguinal lymphadenopathy. Bilateral hydronephrosis was noted. No bone deposits were seen. In summary, MRI reported an appearance consistent with FIGO stage 3b cervical cancer with extensive lymphadenopathy and hydronephrosis.

A pre-examination routine blood test under anesthesia showed that she was anemic with her hemoglobin level of 6 g/dl. She was transfused with 4 units of blood. Her liver function tests and renal function tests were normal, and her serology showed that she was HIV-negative.

She underwent examination under anesthesia, cervical biopsy, and cervical and endometrial curettage. Examination under anesthesia showed that the cervix was bulky with intact surface epithelium. There was no parauterine involvement and the rectum and bladder were clean. Hysteroscopy showed a pedicled fibroid on the anterior wall of the uterus. A large biopsy of the anterior and posterior lip of the cervix was performed to identify a poorly differentiated squamous cell carcinoma of the anterior lip of the cervix. Cervical curettage was positive for squamous cell carcinoma, and endometrial curettage revealed proliferative endometrium.

With the emergence of metastatic squamous cell carcinoma of the cervix, palliative chemotherapy with carboplatin and paclitaxel was initiated. She reportedly responded well to treatment, with a reduction in the size of her neck nodules.



Uterine fundus (+)

Bladder (\*)

### III. CONCLUSIONS

Although recurrence of cervical cancer manifesting as lymphadenopathy has been previously reported, this is the first time the clinical manifestation of cervical cancer has been reported as cervical lymphadenopathy.

Metastasis to cervical lymph nodes is rare, but this can be explained by delineating lymphatic drainage from the neck. The prognosis for such patients is usually poor and treatment is mainly palliative.

Although our patient's treatment was unchanged, this case report highlights the unusual presentation of cervical cancer and the investigative methods needed to make a definitive diagnosis.

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