

An Innovative Treatment Strategy for Primary Cervical Diffuse Large B-Cell Lymphoma is Hysteroscopic Resection Followed by Adjuvant Radiotherapy

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Abstract

Female genital tract involvement can occur as a subsequent symptom of disseminated lymphomas or leukaemia, although primary extranodal lymphoma sites are extremely rare. Primary lymphomas of the female genital tract can develop in the vulva, vagina, adnexa, uterine corpus, or uterine cervix. Primary malignant lymphomas make up only 0.008% of cervical tumours. The presenting symptoms are vague and can sometimes be associated with much more widespread conditions affecting the female genital tract. Typically, cervical cytology is negative. Deep cervical biopsy is necessary for preoperative diagnosis. Regarding the best course of action, there is no agreement to date. Surgery, chemotherapy, and radiotherapy are all utilised in various combinations. We present the first instance of a primary cervical diffuse large B-cell lymphoma treated by an immediate hysteroscopic excision that has been documented in the literature adjuvant radiotherapy is then given. The pertinent literature was examined. In the future, our cautious approach needs to be supported, especially for women who want children and for people with low performance status. Our patient is still free of disease 24 months after being diagnosed.

Keywords: Cervical cancer • Lymphoma • Conservative treatment • Minimally invasive approach

Introduction

Although seldom the initial site of so-called extranodal lymphomas, the female genital tract may be affected as a subsequent manifestation of disseminated lymphomas or leukaemia. The uterine corpus, uterine cervix, vulva, vagina, or adnexa can be affected by primary lymphomas of the female genital system. Non-Hodgkin lymphomas (NHL) incidence rates roughly doubled in the United States from the early 1970s to the early 21st century. NHLs currently make up around 4% of all new cancer diagnoses, with extranodal NHLs making up about one-third of NHL diagnoses. Only 0.12-0.6% of extranodal NHLs are derived from the cervix, while approximately 0.5-1.5% are on the other hand, primary malignant lymphomas account for only about 0.008% of all cervical cancers. Early on, it is rather simple to classify it as a primary Cervical lymphoma is distinct from advanced disease caused by widespread lymphadenopathy or even bone marrow involvement since the disease is restricted to the uterine cervix in cervical lymphoma [1].

Only I E lymphomas are included because they meet the strictest definition of primary extranodal NHL, which is "lymphoma appearing only in extra-nodal locations, with no apparent lymphadenopathy on imaging". (Ann Arbor staging). The location with the largest area of involvement is referred to as the principal site when the disease affects contiguous sites (for example, the cervix and the uterine corpus or the cervix and upper vagina). Fox et al. proposed the following criteria for the diagnosis of primary ovarian lymphomas: tumour that was limited to local lymph nodes or nearby organs at the time of

diagnosis; absence of bone marrow involvement; absence of malignant cells in peripheral blood; existence of any distant extraovarian disease. must happen at least a few months after the ovarian lesions first show. These might be used on any other part of the female genital canal with ease [2].

An 83-year-old woman who had been experiencing sudden, heavy vaginal bleeding without any other symptoms came to our emergency room. The woman had only hypertension and dyslipidemia in her prior medical history and was in good general health (ECOG Performance Status 0). She had two vaginal spontaneous births and a spontaneous menopause, according to her obstetric-gynecologic history, and since she was 51 years old, no additional abnormal vaginal bleeding has been reported. Two years ago, a Pap test was conducted, and the results were negative. Her vital signs were all within the normal range at the time of presentation (blood pressure 130/70 mmHg, heart rate 90 bpm, and oxygen saturation 96%). No aberrant abdominal findings, palpable cervical, axillary, or inguinal lymphadenopathy, or hepatosplenomegaly were found during the physical examination [3]. The difficulty of a complete pelvic examination was related to the retropubic position of the cervix, which was actively bleeding. The cervix appeared dilated by an exophytic bulky lesion partially protruding from external cervical orifice. Transvaginal echography revealed a bulky hypoechoic formation of the cervix of approximately 43 × 23.5 mm and color score 3. Corpus uteri seemed regular, with a thin endometrium (2.4 mm), and the ovaries were atrophic. During the exam the bleeding worsened, so an urgent hysteroscopy was performed to control the bleeding and obtain at least a biopsy of the mass. The procedure was carried on under general anesthesia without intubation. Hysteroscopy revealed the presence of an endocervical lesion of about 4 cm with a whitish appearance, fibrous consistency and accentuated vascularization [4].

The gaps in the data were filled in using linear interpolation. This was notably true for cannabis use on a regular basis. During this time, 59 EMCDDA data points on daily cannabis consumption were accessible for these 14 nations. The 129 datapoints in this dataset were added using linear interpolation (further details provided in Results section). For Sweden, there were no statistics on the THC concentration of cannabis resin. However, it was found that the ratio of the THC content of the herb to the resin in the neighbouring country of Norway was essentially constant at therefore this ratio was used to estimate the THC content of Swedish cannabis resin using information on the THC content of the herb. In Poland, no information was available on the THC content of cannabis

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Date of Submission: 02 July, 2022, Manuscript No. rrms-22-76043; **Editor Assigned:** 05 July, 2022, PreQC No. P-76043; **Reviewed:** 19 July, 2022, QC No. Q-76043; **Revised:** 25 July, 2022, Manuscript No. R-76043; **Published:** 02 August, 2022, DOI: 10.37421/2952-8127.2022.6.83.

resin. Resin from neighbouring Germany to herb THC content ratio was utilised to extrapolate the known Polish plant THC concentrations to the resin THC content in Poland. For Croatia in 2018 and 2019, and The Netherlands in 2010, the dataset was completed by the latest observation carried forward or backward because geospatial analytical tools do not accept missing data. For this dataset, multiple imputation techniques were inappropriate since they cannot be used with panel or spatial multivariable regression methods [5].

Discussion

Due to a dearth of examined cases, as is frequently the case with rare disorders, the therapeutic approach is not consistent. What we know about lymphoma therapy is derived from our extensive understanding of nodal NHL therapy. Chemotherapy is the mainstay of treatment in most reported cases; radiotherapy may also be used in conjunction with chemotherapy. In cases where a precise preoperative diagnosis is not feasible, surgery is typically done carefully. Typically, a radical operation consists of bilateral salpingo-oophorectomy and hysterectomy. Conization or trachelectomy are occasionally used as a more cautious strategy. We were unable to locate any additional cases of cervical lymphoma treated with hysteroscopic excision in the published literature. Only a few cases of severe bleeding brought on by cervical lymphoma have been documented [5-10].

Conclusion

Data offer significant evidence demonstrating that various metrics of cannabis use, notably daily usage, are strongly linked with all seven of the chromosomal diseases evaluated in inverse probability weighted and causal inferential models. These results support decades of in vitro laboratory research, many recent epidemiological series from Hawaii, Colorado, Australia, Canada, and the United States, as well as a previous, less complex analysis of the same dataset. As previously mentioned, the field is open for genotoxic and epigenotoxic mechanistic studies to look into the epigenetic mechanisms of chromosomal mis-segregation and mitotic spindle dysfunction, cannabinoid-induced chromosomal scission, and the gross disorders of meiosis I that result in an increase in whole genome doubling events and are a part of the testicular cancer oncobiogenesis pathway and cellular pathology of epigenomic aging with emergency hysterectomy or uterine artery embolization. To quickly achieve hemostasis and get a biopsy of the tumour, we mostly used a hysteroscopic technique. However, during the treatment, we discovered a cleavage plan that made it theoretically possible to remove the entire mass after a partial decrease in the lesion and hemostasis that enabled a greater visualisation. At the time of diagnosis, 15% of women are over 80 and should not be eligible for chemotherapy, while 30% of women are under 40 and probably want to get pregnant. Given this, it's critical to learn more using a conservative and non-invasive manner.

Acknowledgement

None.

Conflict of Interest

None.

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How to cite this article: Carlucci, Guglielmo. "An Innovative Treatment Strategy for Primary Cervical Diffuse Large B-Cell Lymphoma is Hysteroscopic Resection Followed by Adjuvant Radiotherapy." *Res Rep Med Sci* 6 (2022): 83.