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LETTER TO THE EDITOR

Cervical Cancer in HIV Seropositive Patients

Cervical cancer is the second most common malignancy in women worldwide, second only to breast cancer and it remains a leading cause of cancer-related death for women in developing countries.[1] The incidence of invasive cervical cancer has declined steadily in developed countries over the past few decades; however, it continues to rise in many developing countries.[2] Apart from the well known association of cervical cancer with Human papilloma virus (HPV), cervical cancer has been associated with Human Immunodeficiency virus (HIV), and it is classified as Acquired immunodeficiency syndrome (AIDS) defining disease since 1993 (CDC).[3] Two thirds of the World Health Organization (WHO) estimated 40 million people in the world with Human Immunodeficiency Virus (HIV) live in Africa.[3] One is yet to see if the HIV pandemic will have any effect on the epidemiological trend, natural history of cervical cancer, response to standard treatment and overall survival. Described below is recent experience with 3 cervical cancer patients with HIV infection.

Case 1
A 30 years old para^{3+3} woman presented with 8 months history of post-coital bleeding and mass in her vagina; 4 months afterwards, she developed discharge per vagina, suprapubic pain, swelling of her left lower limb, and pain in the left hip joint. She married twice, both husbands have many wives and with multiple sexual partners. On examination, the significant findings were shotty inguinal lymphadenopathies, lymphoedema and a bulky exophytic cervical mass with contact bleeding. Results of investigations showed seroreactivity to HIV-1 antibodies, a pelvic mass with secondary pressure effect on the left ureter on IVU, and ultrasound revealed a bulky cervical mass with infiltration of the lower aspect of the urinary bladder. She was staged IVA and the histopathology revealed poorly differentiated carcinoma. She had external beam radiation therapy after which she absconded from clinic without receiving any chemotherapy or antiretroviral drugs for about 4 months only to present with multiple lumps in the left supraclavicular region and left chest wall (overlying the 9th, and 10th ribs posteriorly and the 3rd and 4th ribs anteriorly above the left breast). Abdominal ultrasound revealed paraaortic lymphadenopathy and secondaries in the liver and multiple intraabdominal masses. At this presentation, there was no local relapse of the disease. Patient opted for traditional herbal medication and died of progressive disease after 2 months.

Case 2
A 32 years old para^{4+1} woman presented with the history of 12 months of post-coital bleeding, 10 months of intermenstrual bleeding, and 1 month of lower abdominal pain and discharge per vaginam and 2 weeks history of unprovoked vaginal bleeding. She was married once and her first coitus was at age of 16 years. She denied any history of multiple sexual partners. On examination, she was found to have a tennis ball-size solitary lump in the axillary tail of the right breast attached to the underlying ribs, not mobile and tender. Both breasts were clinically normal. Abdominal examination revealed a suprapubic mass. There was no abnormality detected on examination of the other systems. Had haemostatic dose of radiation, 1200 cGy in 4 fractions over 4 days which stopped the profuse vaginal bleeding. Post haemostatic dose vaginal examination revealed a residual growth on the cervix with involvement of the parametria and extension to the pelvic side walls especially on the right. The results of investigations revealed Seroreactivity to HIV-1 antibodies; ultrasound revealed a large solid cervical mass without involvement of surrounding organs, FNAB result of the right axillary lump confirmed metastasis, and chest x-ray showed a soft tissue mass on the lateral wall of the chest on the right with erosion of the underlying ribs. She was staged IVB and histopathology of cervix revealed poorly differentiated carcinoma. She had additional external beam radiation therapy to the pelvis, and was scheduled to receive palliative radiotherapy to the right chest wall. Patient was placed on antiretroviral drugs. She was confirmed dead 8 weeks afterwards.

Case 3
A 30 years old para^{5+1} woman presented with 12 months history of unprovoked vaginal bleeding, dragging sensation in the vagina and protrusion of a mass from the vagina on micturiction. There was occasional vaginal discharge when there is no bleeding. There was associated lower abdominal pain, lower abdominal mass and low back ache. She married twice and her first coitus was at the age of 15 years. Examination under anaesthesia by the referring gynaecologist revealed a bulky haemorrhagic friable mass in the vagina down to the vestibule with an anterior and posterior lip separated by a slit, continuous with the uterus which was bulky and the margins flushed with vaginal walls. There was extension to the pelvic side walls. Histopathology of the incisional biopsy revealed Squamous cell carcinoma (large cell keratinizing), poorly differentiated. She was clinically staged FIGO IIIB. Investigation results showed seroreactivity to HIV-1 antibodies, ultrasound revealed hour glass appearance of the uterus due to bulky cervix. She had external beam radiation therapy and was placed on antiretroviral drugs but developed full blown Acquired Immunodeficiency Syndrome (AIDS) and died after few weeks.

Some evidence suggests that HIV-infected women with cervical cancer are more likely to have advanced

disease at presentation and to have a higher recurrence rate than non-HIV-infected women.[4] Furthermore, cervical intraepithelial neoplasia occurs more frequently in women with HIV infection.[5-7] With the presence of HIV infection (HIV-1) in patients with carcinoma of the cervix, the pattern of presentation of cervical cancer seems to be evolving to presentation at younger age, locally advanced and metastatic disease, shorter duration of symptoms and poor differentiation of tumour with metastasis to unusual sites. HIV screening should be done in patients presenting at a very young age with poorly differentiated cervical cancer, advanced disease and metastasis to unusual sites.

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