



Villoglandular Papillary Adenocarcinoma of the Cervix

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Editorial

Cervical cancer encompasses several histologic types, of which Squamous Cell Carcinoma (SCC) is the most common (70 percent). The incidence of invasive cervical adenocarcinoma and its variants has become more common over the past few decades. Currently, this cell type accounts for 10% to 25% of all invasive cervical cancers diagnosed in the United States [1,2]. Most cervical adenocarcinomas are HPV related cancers. HPV 16 is the most common HPV type, with HPV 18 nearly as common and HPV 45 occurring less often [3,4]. They are treated the same at most institutions as the knowledge on the treatment of cervical cancer comes from studies in which the majority of the patients had SCC. Very few studies report separate outcomes for adenocarcinoma, and no prospective study has focused on the treatment of adenocarcinoma as the sole histology. As a result, our understanding of the natural history and optimal management of adenocarcinoma of the cervix is limited.

Villoglandular Papillary Adenocarcinoma (VGPA) of the uterine cervix was described for the first time by Young and Scully in 1989 [5]. VGPA is an uncommon variant of well-differentiated endocervical adenocarcinoma [5]. It usually affects young women with an average age in the mid-30s, who often have a history of oral contraceptive use. It is distinguished from the common types of adenocarcinoma by its generally good long-term prognosis [6,7], as it infrequently involves lymph nodes [8]. VGPA were superficially infiltrative tumors with exophytic architecture, but these tumors were cytologically low-grade lesions, with a low number of mitosis, minimal cytologic atypia, and minimal vascular space invasion. Because of the young age of patients and the favorable prognosis, conservative surgery such as cone biopsy is adopted by many physicians when the tumor is low grade and superficial, without vascular space invasion or involvement of the resection margins [6,9].

Conservative management is possible in some cases. Superficial well-differentiated villoglandular adenocarcinomas have a favorable prognosis. Pathologists must be cautious in making VGPA diagnosis. The entire tumor must be seen before making a diagnosis of well-differentiated villoglandular adenocarcinoma, and no higher grade patterns should be present. Nuclei must be grade 1 throughout. Tumors with a villoglandular pattern but with higher-grade areas, areas of deep stromal invasion, or even with other types of differentiation have been described. Such tumors can behave aggressively [8,10]. Thus, it does not seem prudent to make this diagnosis based on a small biopsy specimen.

In our report of 28 cases of VGPA of the cervix [11], the largest series in the literature, we investigated the clinicopathologic features, the management, and the outcome of VGPA of the uterine cervix.

The median age of the patients was 38 years with a range of 26 to 65 years. Sixteen of the 21 patients presented with abnormal bleeding, and 5 patients had an abnormal Papanicolaou (Pap) test result. Nineteen patients had International Federation of Gynecology and Obstetrics stage IB disease, and 5 patients had stage IIB disease. Two of 24 patients, where the lymph node status was known, had positive nodes. Twenty patients underwent different types of radical surgery with or without pelvic radiotherapy, and 8 patients received platinum-based chemotherapy and pelvic radiotherapy with no surgery. The follow-up ranged from 5 to 168 months with a median of 35 months. Twenty one patients were alive with no evidence of recurrent disease, 5 patients have died because of the disease recurrence, and 2 patients were lost to follow-up. The overall and disease-free 5-year survival for these patients was 82% and 75%, respectively.

The overall prognosis of VGPA is excellent compared to the common forms of cervical cancer, but the prognosis is related to stage and pathology. A large multicenter prospective study is warranted to define the best treatment for the disease and to clarify more fully the prognostic factors other than FIGO stage; and even then, local variations of treatment modalities will make.

OPEN ACCESS

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Received Date: 03 Jul 2017

Accepted Date: 18 Jul 2017

Published Date: 25 Jul 2017

Citation:

Lataifeh I. Villoglandular Papillary Adenocarcinoma of the Cervix. Clin Case Rep Int. 2017; 1: 1013.

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