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Case Report

Endometrioid Adenocarcinoma of the Endometrium: Postoperative Debulking and Pelvic/Abdominal Wall Recurrence—A Case Report

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Abstract:

This case describes a young woman with a history of endometrioid endometrial adenocarcinoma treated with robotic hysterectomy and bilateral salpingo oophorectomy with pelvic lymph nodes sampling, who later developed pelvic and abdominal wall metastases. The patient's main concerns centered on recurrence and treatment options. Initial pathology showed a low-grade endometrioid tumor confined to the endometrium with shallow myometrial invasion and negative nodes. Subsequent surveillance revealed suspicious pelvic lymph nodes and a new abdominal wall metastasis confirmed by IR biopsy (CK7+, PAX-8+, ER+, CK20−, GATA-3−, TTF-1−, WT p53). Management evolved to systemic chemotherapy with immunotherapy, with plans for radiotherapy or possible surgical intervention based on response; the takeaway is early tissue confirmation guiding multidisciplinary, multimodal therapy in recurrent gynecologic cancer.

Keywords: endometrioid adenocarcinoma; endometrium; debulking; recurrence; case report

Introduction

Endometrioid endometrial carcinoma in young women presents unique diagnostic and therapeutic challenges, including the balance between oncologic control and fertility considerations. Emerging literature underscores that a substantial proportion of cases occur in patients well below the typical age range, highlighting the need for heightened clinical suspicion and multidisciplinary evaluation [1]. This case contributes to that evolving narrative by detailing a young patient who required aggressive initial management followed by complex surveillance for recurrence, reinforcing the necessity of tailored, age-appropriate care.

A core theme across recent reports is the critical role of multidisciplinary collaboration in optimizing outcomes for young patients with gynecologic cancers. Evidence-based guidelines stress standardized pathways while allowing adaptation to individual biology and comorbidity profiles, especially in cases where obesity and metabolic disease intersect with cancer care [2]. The present case illustrates how imaging, pathology, and systemic therapies—guided by IR biopsy and tumor board input—inform a dynamic treatment plan that responds to evolving disease biology.

Advances in surgical and systemic approaches, including robot-assisted techniques and integrated chemoradiation strategies, have reshaped management paradigms for endometrial cancer. Literature documents the benefits of robot-assisted interventions, with potential reductions in perioperative morbidity and improved precision, alongside evolving recommendations for recurrence management in young patients [3]. This case reinforces the value of employing state-of-the-art surgical methods coupled with timely, tissue-confirmed recurrence assessment to enable individualized multimodal therapy while prioritizing quality of life.

Case scenario

A young, de-identified female in her early 30s with a history of diabetes mellitus and morbid obesity presented after an initial diagnosis of endometrioid endometrial adenocarcinoma. She underwent definitive surgical management in 2023, including robotic assisted total hysterectomy with bilateral salpingo-oophorectomy with lymph nodes sampling (figure 1), following preceding procedures for evaluation (laparoscopic detorsion of the right adnexa and diagnostic hysteroscopy with curettage). Her primary concerns over time centered on disease control, recurrence risk, and the

balance between systemic therapy and local control, given her comorbidities and young age.

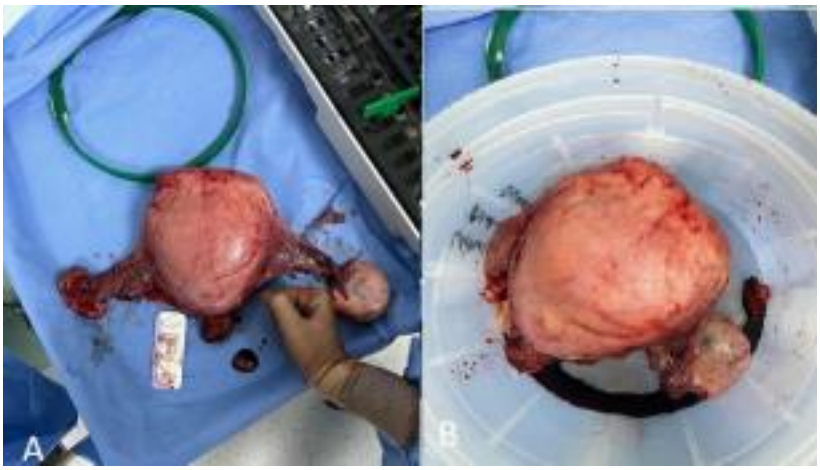

Figure 1 (A, B): showing Specimens from Robotic assisted hysterectomy with bilateral salpingo oophorectomy. A) Uterus with bilateral adnexa in situ on a sterile backdrop prior to dissection, illustrating attached ovaries/adnexa. B) Retrieved specimen set showing uterus and adnexa after removal.

Immediately after the 2023 surgery, pathology showed a low-grade endometrioid carcinoma (NOS) confined to the endometrium with shallow myometrial invasion (about 0.3 cm, ~20% of myometrial thickness), no serosal involvement, and no lymphovascular invasion. All margins were negative, and regional lymph nodes were negative (0/7). Adenomyosis was present with focal carcinoma involvement. Over the ensuing years, routine surveillance imaging did not reveal overt metastasis until 2025, when CT CAP suggested a mild left pelvic sidewall lymph node enlargement (~1 cm), raising concern for recurrence. A subsequent PET-CT in July 2025 showed an intensely hypermetabolic left pelvic sidewall lymph node and a new anterior deep subcutaneous pelvic lesion, both highly suspicious for metastatic disease, with no distant FDG avid sites identified (Figure 2). An IR-guided biopsy of the abdominal wall lesion in July 2025 confirmed metastatic adenocarcinoma with an immunoprofile compatible with gynecologic origin (CK7+, PAX-8+, ER+, CK20−, GATA-3−, TTF-1−, wild-type p53).

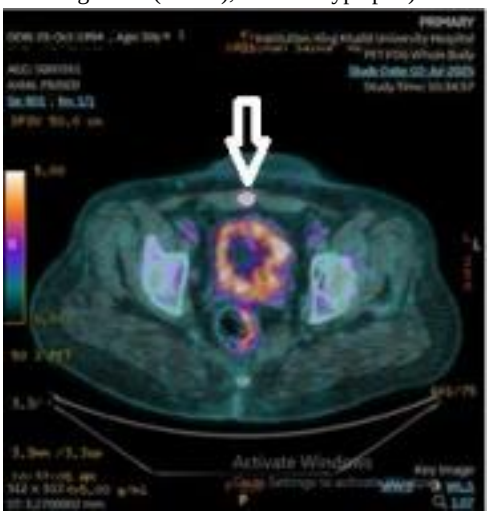

Figure 2: Axial FDG-PET/CT showing a focally hypermetabolic lesion in the left rectus abdominis muscle, consistent with active disease involvement.

Diagnostic workup included integrated physical examination, imaging, and pathology. The initial workup relied on pelvic MRI and cross-sectional imaging to stage disease, with final surgical pathology documenting confined, low-grade endometrioid cancer and no nodal disease. The 2025 surveillance era featured multimodal imaging (CT CAP, contrast-enhanced CT, PET-CT) that demonstrated pelvic and abdominal wall metastases. The IR biopsy provided tissue confirmation, enabling definitive assignment to gynecologic lineage and guiding systemic interventions. Diagnostic challenges included distinguishing recurrent disease from post treatment changes and determining optimal local versus systemic therapy in a young patient with significant comorbidity.

Initial management (2023) involved surgical cytoreduction with Robotic asissted hysterectomy with bilateral salpingo-oophorectomy, resulting in a pathologic stage dominated by a low-grade tumor with shallow myometrial invasion and negative nodes. After a period of disease control, the 2025 recurrence was managed with multidisciplinary planning. The patient received systemic therapy—carboplatin and paclitaxel—with immunotherapy added, as discussed by the tumor board. An IR-guided biopsy in July 2025 established metastatic gynecologic adenocarcinoma, guiding subsequent systemic therapy and consideration of radiation or surgical options. The plan anticipated six cycles of chemotherapy with mid-cycle reassessment, followed by reevaluation for potential radiotherapy or surgical intervention based on response.

Post-therapy imaging after four cycles demonstrated a mixed response: a stable/enlarged left pelvic sidewall node persisted, while a metastatic right rectus muscle lesion regressed, and pulmonary nodules remained stable

without new lesions (Figure 3). The current plan is to continue chemotherapy with immunotherapy and to repeat imaging after three additional cycles to guide decisions about local control strategies (radiation or possible surgical debulking). Throughout, the patient's tolerability of therapy has been monitored, with emphasis on balancing efficacy against treatment-related morbidity in the context of obesity and diabetes. Ongoing multidisciplinary follow-up and serial imaging remain essential to assess response and refine the treatment plan.

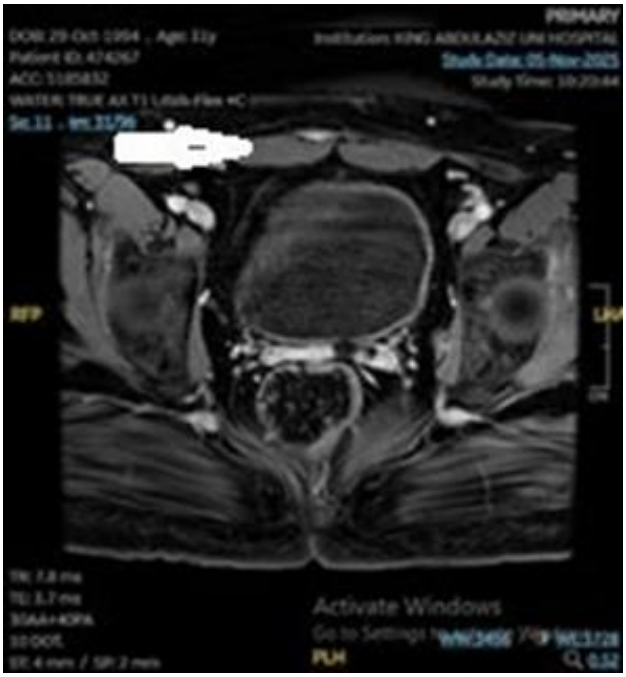

Figure 3: Axial post-contrast T1 MRI showing marked reduction in the left rectus muscle lesion, indicating good response to chemotherapy.

Discussion

This case underscores the complexities of managing recurrent endometrioid adenocarcinoma in a young patient and highlights the indispensable role of a comprehensive, multidisciplinary approach. The management strategy, which integrated precise surgical pathology, vigilant radiologic surveillance, and adaptable systemic therapy, reflects evolving best practices for young patients with this malignancy [4]. While standardized guidelines provide a framework, this case exemplifies the necessity of tailoring adjuvant strategies to individual biology and comorbidity profiles, particularly when obesity and metabolic disease intersect with oncologic care [5].

A critical consideration emerging from this case is the potential for iatrogenic tumor seeding, which may underlie the development of the abdominal wall metastasis. Despite the use of a surgical bag for specimen extraction via a mini-laparotomy during the initial robotic procedure, the occurrence of this subcutaneous recurrence suggests the possibility of bag micro-perforation or contamination during extraction. This incident serves as a vital reminder that meticulous technique is paramount, even when containment systems are employed. It underscores the need for extreme caution during specimen morcellation and retrieval, including ensuring the integrity of the containment bag, minimizing tissue manipulation, and possibly considering a larger incision to facilitate safer extraction. In cases with a high risk of occult advanced disease or fragile tumors, an initial laparotomy may provide a more controlled environment for specimen removal, potentially mitigating this risk compared to a minimally invasive approach.

The literature on endometrial cancer in young women continues to emphasize the need for individualized care plans that balance oncologic control with quality-of-life preservation [6,7]. Robotic-assisted surgery is well-documented for its benefits in precision and reduced perioperative morbidity [3]. However, this case illustrates that recurrence in non-traditional sites, such as the abdominal wall, remains a significant concern and may reflect unique metastatic patterns or iatrogenic spread. The definitive tissue confirmation of recurrence via IR biopsy was pivotal, enabling precise histologic diagnosis and guiding the integration of immunotherapy with conventional chemotherapy, aligning with multidisciplinary guidelines that advocate for tissue-based treatment personalization in recurrent disease [8,9].

The rationale for the dynamic management plan was to achieve optimal disease control while preserving the patient's quality of life. The progression from initial surgical cytoreduction to systemic therapy with carboplatin/paclitaxel and immunotherapy, followed by planned reassessment for local modalities, reflects a logical, response-driven strategy. This approach highlights the importance of early tissue diagnosis to guide therapy and the value of tumor board consensus in navigating the complex interplay among treatment efficacy, toxicity, and patient-specific factors.

The key takeaway is the critical importance of both timely tissue confirmation and scrupulous surgical technique in the management of gynecologic cancers. While multidisciplinary collaboration drives adaptive, patient-centered strategies that can optimize outcomes, surgeons must also remain vigilant against iatrogenic risks. This case reinforces that preventing recurrence is as crucial as treating it and that every procedural step, from incision planning to specimen extraction, must be optimized for oncologic safety.

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