She died three years and seven months after initial diagnosis; four months after stopping all treatment.

Discussion

Ovarian cyst is the second most common palpable pelvic mass. It is not considered suspicious in premenopausal women, but this is not the case with postmenopausal women [2]. It can develop under the influence of elevated levels of oestrogen. Surgery is the treatment of choice and clinical correlation is always advised [3].

The small area of possible pneumonia demonstrated pre-operatively, with a statistical 10-15% chance of being benign [4] was not investigated pre-operatively as adverse effects from possible rupture of the potentially malignant cyst, with seeding into the abdominal cavity, was the greater risk. Early detection of lung cancer is sometimes an incidental finding on chest radiograph when a patient is being investigated for another medical condition [2].

The greatest risk for this patient in undergoing any invasive procedure was due to the necessary manipulation of her anti-coagulant therapy. Thinner blood, with International Normalisation Ratio of between 2.4 and 4.2 was her optimum norm, due to her cardiac condition; this had to be reduced to be in the region of 1 before an invasive procedure could take place. Thicker blood for this patient carried an increased risk both of stroke and of clotting at her prosthetic mitral valve. Thoracotomy, as a biopsy procedure, offers a greater risk than most biopsy procedures.

The pathology report positive for endometrial malignancy was unexpected; no evidence of malignancy had been seen macroscopically during surgery. Ovarian pathology, not endometrial pathology, had been suspected.

Although bronchoscopy as a diagnostic procedure has a fairly low success rate, with sensitivity of biopsy, cytobrushings and washings being 0.74, 0.59 and 0.48 respectively [5] it is usually done before thoracotomy, being the lesser invasive of the two procedures. In this case, sampling was difficult due to narrowing and blockage of the bronchial lumen, caused by extrinsic pressure exerted by the mass. Thoracotomy and fine-needle aspiration were both possible diagnostic procedures which could have been carried out as the next step in diagnosis [5].

Despite being more costly and invasive, the cardiothoracic surgeon performed a thoracotomy since a lobectomy or pneumonectomy might have been indicated depending on the frozen section results during the procedure and the chest would already be open. It was also necessary to view the lesion and local lymph nodes directly. Surgical resection would have been carried out if the disease had been localized to the lung [6]. The positive pericardial lymph node ruled out the possibility of lobectomy or pneumonectomy, as surgery is not indicated unless the mass is localized.

The oncologist decided to treat the lung lesion as a second primary carcinoma, although the frozen section done during thoracotomy had shown evidence of metastatic endometrial carcinoma, because no evidence of invasion outside the chest had been found and the patient was in good physical condition; both being major factors in the decision to treat with radical intent. Subsequent recurrences of tumour growth indicated the change to terminal disease; chemotherapy was then given as palliation [7] to prolong life.

The maternal history of endometrial carcinoma in this patient is significant. An hereditary predisposition to malignancy, coupled with a six-fold [8] additional risk of the same malignancy by the transdermal application of oestrogen-only hormone replacement therapy greatly increased the risk of developing a malignancy. Unopposed oestrogen has a highly carcinogenic effect [8] in hormone-dependant tissue. In contrast, progesterone therapy has successfully treated endometrial carcinoma in pre-menopausal women [9].

Concluding remarks

By following standard procedure, this patient was able to receive treatment for the incidental malignant findings far earlier than would otherwise have been expected. The author is of the opinion that this case report highlights the importance of detailed history-taking.

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References

1. Kao, M.S., Management of Recurrent Endometrial Carcinoma. *Chang Gung Medical Journal*., 2004, September, 27(9)., 640.
2. Stuurman, M.E. Effective *Medical Imaging: A signs and symptoms approach*. Baltimore: Williams and Wilkins, 1993: 233 - 235; 285 - 287.
3. Sanders, R.C. *Clinical Sonography. A PRACTICAL GUIDE*. Boston: Little, Brown and Co. Boston. 2nd ed, 1991: 60.
4. Schreiber G. and McCrory D.C. *Summary of Published Evidence: Performance Characteristics of Different Modalities for Diagnosis of Suspected Lung Cancer*. 2003, Chest. 123:115S - 128S. American College of Chest Physicians. [online]. Available from: http://www.chestjournal.org/cgi/content/abstract/123/1_suppl/115S [Accessed 04 March 2006]
5. Kuhns, R.E., Thornbery, J.R., Fryback, D.G. *Decision Making In Imaging*. Chicago: Year Book Medical Publishers, 1989: 108; 112.
6. Khan, F.M., Potish, R.A. *Treatment Planning In Radiation Oncology*. USA. Williams and Wilkins, 1998: 567 - 586
7. Humber, C., Tierney, J., Symonds, P., Collingwood, M., Kirwan, J., Williams, C., Green, J. *Chemotherapy for advanced, recurrent or metastatic endometrial carcinoma*. 2006; [online]. Available from: http://www.cochrane.org/reviews/en/ab003915.html. [Accessed 04 March 2006].
8. Lee, J.R. *Natural Progesterone. The multiple roles of a remarkable hormone*. England: John Carter Publishing, 2002: 97; 101.
9. Kim. B., Holschneider, C., Ghosh, K., Nieberg, R., Montz, F. *Progestin alone as primary treatment of endometrial carcinoma in premenopausal women*, 1996. [online]. California, University of California-Los Angeles School of Medicine. Available from: http:/www3.interscience.wiley.com/cgi-bin/abstract/73502317/ABSTRACT?CRETRY=1&SRETRY=0 [Accessed 05 March 2006].

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HPCSA ANNOUNCES AMNESTY ON PENALTY RESTORATION FEES

In a move to further boost health care capacity in South Africa, the Health Professions Council of South Africa (HPCSA) has agreed to a once-off waiver of penalties for those practitioners, both local and abroad, who failed to pay their annual registration fees on time, or who allowed their registration to lapse without informing Council.

The amnesty period will start on 1 February 2007 and expire on 30 April 2007. It applies to those practitioners - living locally and abroad - whose registrations have lapsed and who have not practiced for up to two years, as well as those practitioners who have been resident and practicing in other countries.

"We are offering this blanket waiver of penalties to encourage health professionals to be restored back onto the register, particularly those working abroad who have expressed a desire to come back to South Africa, but who have found the restoration penalties very high," said Adv. Mkhize. He added that some professionals who left South Africa during the apartheid era had been unable to regularize their registration issues before leaving.

"This is a further effort by the HPCSA to boost human resource capacity and so broaden access to health care for our country's population," said Mkhize. "We do, however, expect all health care practitioners who take advantage of this amnesty period to render professional services to any public sector institution of their choice. We expect them to work for 100 hours in service to public health within six months of their restoration. This may include working in the public service or with health non-governmental organizations. They will be required to submit evidence of their public health service within six months, failing which they will need to pay full restoration fees applicable at that time," said the Registrar.

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