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A rare path in a common symptom: A case report on serous carcinoma of the cervix

Reimalyn Doton Agustin[1], Ana Victoria Vallido Dy Echo[1]

Abstract:

Although commonly seen in the ovary, fallopian tube, peritoneum, and endometrium, the serous carcinoma histology is considered a rare subtype when seen in the cervix. The prevalence of cervical adenocarcinoma, including serous carcinoma, varies between 5% and 15% of all cervical malignancies. A thorough literature study revealed only 113 cases of serous carcinoma of the cervix, highlighting its infrequency relative to other cervical cancer variants. As a subtype of adenocarcinoma, serous carcinoma of the cervix has aggressive characteristics and usually unfavorable prognosis, more so its clinicopathological characteristics are relatively unclear because of its rarity and limited number of cases and reviews seen in literature. This is a case of a 44-year-old G3P3 with a primary complaint of heavy vaginal bleeding. The diagnosis of serous carcinoma of the cervix was made by histopathological evaluation, confirmed by immunostaining. With physical examination and diagnostic imaging confirming an early stage disease, the patient successfully underwent primary surgical management.

Keywords:

Cervical cancer, poorly differentiated carcinoma, radical hysterectomy, serous carcinoma

Introduction

Serous carcinoma of the uterine cervix (USCC) is an extremely rare type of cervical cancer, representing <1% of cervical cancer cases.[1] The 2014 World Health Organization (WHO) Classification and the International Endocervical Adenocarcinoma Criteria and Classification (IECC) recognize the serous carcinoma as a histological subtype of cervical adenocarcinoma, defined by the morphological features of intricate papillary and/or micropapillary formations with severe nuclear abnormalities.[2] However, the 2020 WHO classification and 2018 IECC do not recognize SCUC as a distinct diagnostic entity. The absence of HPV and atypical p53 expression suggest metastases or direct extension of serous carcinoma from the fallopian tube, ovary, endometrium, or peritoneum.[3]

Serous carcinoma of the cervix shares histological similarities with the serous carcinomas of the ovary, fallopian tube, peritoneum, and endometrium but has distinct clinicopathological features and prognosis, providing a unique challenge to the clinician.[4] Thus, there is a need to explore the clinical consequences of serous-like morphological features in cervical adenocarcinomas, specifically its implications in the management and prognosis.[4]

This case report presents a patient with serous carcinoma of the cervix. The course and management of the patient are discussed, along with a comprehensive literature review of the etiology, pathogenesis, clinical features, diagnosis, treatment options, and prognosis of diagnosed cases of serous carcinoma of the cervix. The challenges in diagnosing and managing this rare condition and potential areas for future research to improve the patient outcomes are also highlighted.

[1]Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, University of the Philippines-Philippine General Hospital, Manila, Philippines

Address for correspondence:
Dr. Reimalyn Doton Agustin, Lot 3 Block 21 Mt. Elgon St., Cresta Verde Subdivision, Brgy. Sta. Monica, Novaliches, Quezon City, Philippines.
E-mail: rdagustin2@up.edu.ph

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Case Protocol

This is the case of a 44-year-old G3P3 (3002) who presented with heavy vaginal bleeding. The patient is married and a homemaker. She finished elementary level education. She has no vices. Her past medical and family medical histories were unremarkable. She had her menarche at 13 years old, with a regular menstrual cycle usually lasting for 5 days ever since, using approximately 5 pads per day, with no reported dysmenorrhea. Her first coitus was at 18 years old, with 1 nonpromiscuous sexual partner. All her pregnancies were delivered vaginally. Three years ago, she used oral contraceptive pills for 5 years. Her last pap smear was 14 years ago, with normal results reported.

Five years before this consult, the patient was diagnosed with colon cancer with mucinous adenocarcinoma with signet ring cell carcinoma component, poorly differentiated, stage III. She underwent transverse colectomy surgery followed by eight cycles of capecitabine and oxaliplatin chemotherapy. For the past 4 years and 1 month, the patient has been under surveillance, with the most recent tests, including normal carcinoembryonic antigen (CEA) levels, imaging, and colonoscopy, indicating no current signs of disease.

Four months before consult, the patient experienced heavy vaginal bleeding, using approximately 1 diaper per day. She consulted an obstetrician-gynecologist, who detected a cervical mass during pelvic examination. A cervical punch biopsy was done, which showed the [Figure 1] presence of poorly differentiated adenocarcinoma, with recommendation for immunohistochemical staining with CEA, P16, P40, CK7, CK20, and CDX2 markers. She was then referred to the gynecologic oncology service of a tertiary government hospital.

Evaluation by the gynecologic oncology service revealed the following findings: Systemic physical examination showed normal examination. Specifically, there were no enlarged supraclavicular lymph nodes, no breast masses or abdominal masses appreciated. On pelvic examination, the patient had normal external genitalia and a smooth vagina. The cervix measured 3 cm × 3 cm, with a palpable friable mass measuring 2 cm × 1 cm on the anterior lip. The uterus appeared small, with no palpable masses or tenderness in the adnexal regions. On rectovaginal examination, the sphincter tone was good, and the rectal vault was intact. Bilateral parametria were smooth, pliable, and unremarkable.

The immunohistochemistry stains yielded the following results: P40 [Figure 2], CK20 [Figure 3], CDX2 [Figure 4], and CEA [Figure 5] were negative, while P16 [Figure 6] and CK7 [Figure 7] showed positive, diffuse staining in the cells of interest. Initial diagnosis was poorly differentiated carcinoma, and the possibility of metastatic colorectal adenocarcinoma was deemed less likely.

Additional immunohistochemistry studies, including p53, Napsin A, estrogen receptor (ER), and Chromogranin, were recommended. The findings indicated strong, diffuse nuclear staining for p53 in over 80% of tumor cells (indicating mutant-type staining) [Figure 8] and moderate to strong, focal nuclear staining for ER in tumor cells. Napsin A and Chromogranin tests were negative. These immunological and histomorphological characteristics were consistent with serous carcinoma [Figures 5,9-11].

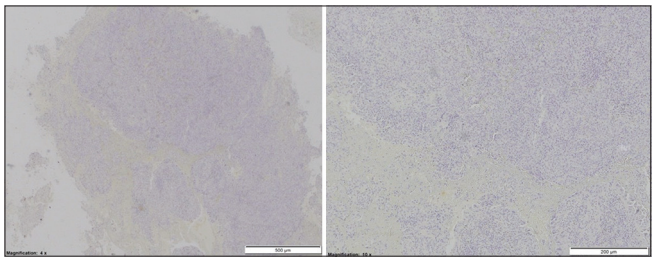

Figure 1: Malignant cells show no staining for CDX2

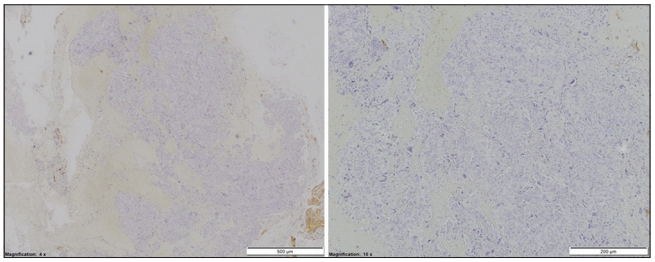

Figure 2: Malignant cells show no staining for CEA

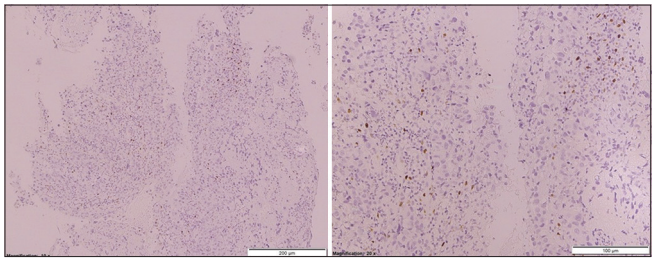

Figure 3: Malignant cells show no staining for estrogen receptor

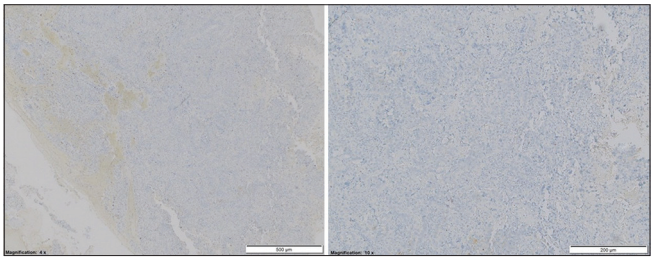

Figure 4: Malignant cells show no staining for chromogranin

On transvaginal ultrasound, the cervix measured 2.1 cm × 2.8 cm × 3.4 cm, with a mixed stromal echotexture and a clearly defined endocervical canal. An unevenly contoured, hypoechoic exophytic mass was seen near the lower portion of the anterior cervical lip. The dimensions of this mass are 2.7 cm × 2.4 cm × 1.5 cm, yielding an estimated volume of 5.1 cc. The superior edge was positioned 1.6 cm inferior to the left internal os, indicating that the lesion was restricted to the ectocervical area without direct involvement of the uterine cavity or upper endocervical canal.

Power Doppler imaging of the cervical mass showed moderate branching vascularity (color score = 3) [Figure 12]. On the transabdominal scan, the spleen appeared enlarged, measuring 16.0 cm × 4.8 cm with homogeneous parenchyma. Other areas examined had essentially unremarkable findings. The ultrasound revealed a cervical mass indicating malignancy, with <2/3 stromal invasion, a secretory phase in the endometrium,

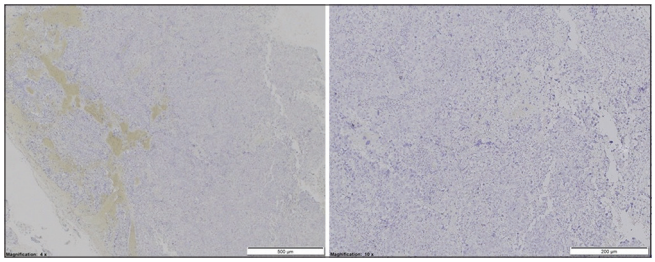

Figure 5: Malignant cells show no staining for Napsin A

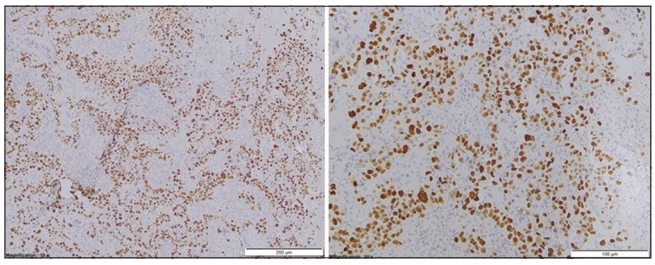

Figure 6: Malignant cells show strong, diffuse, nuclear staining for p53 in more than 80% of tumor cells (mutant-type staining)

normal ovaries, a corpus luteum on the left, and splenomegaly.

A contrast-enhanced computed tomography scan of the chest and abdomen was performed. Significant observations included cervical prominence [Figure 13] and incidentally noted splenomegaly, with a splenic index measuring 1498. The spleen displayed homogeneous parenchymal density and enhancement characteristics.

Tumor marker results showed normal levels, with CA 125 at 18.0 U/mL and CEA at 2.68 ng/mL.

The preoperative diagnosis was serous carcinoma of the cervix, HPV-associated, stage IB2; splenomegaly from chronic iron-deficiency anemia; mucinous adenocarcinoma with signet ring cell carcinoma component, poorly differentiated, of the colon, stage III; Status posttransverse colectomy surgery; status post 8 of capecitabine and oxaliplatin chemotherapy; no evidence of disease for 4 years and 3 months. The splenomegaly was attributed to iron deficiency anemia from chronic blood loss, with work up showing normal direct total iron-binding capacity (dTIBC) of 70.4 umol/L, low serum iron at 4.7 umol/L, and normal ferritin at 42.7 ng/mL. The patient is being managed with internal medicine and hematology service.

The patient then underwent exploratory laparotomy, radical hysterectomy (RH) with bilateral salpingo-oophorectomy, bilateral pelvic lymph node dissection, and para-aortic lymph node sampling.

Internal examination under anesthesia revealed: normal external genitalia, smooth vagina, cervi × 3.0 cm × 3.0 cm, with a 2.0 cm × 2.0 cm exophytic mass at the anterior cervical lip, corpus small, no adnexal masses, bilateral parametria smooth and pliable.

Upon exploratory laparotomy, there were no ascites. The liver, subdiaphragmatic surfaces, peritoneum, gallbladder, stomach, omentum, spleen, kidneys,

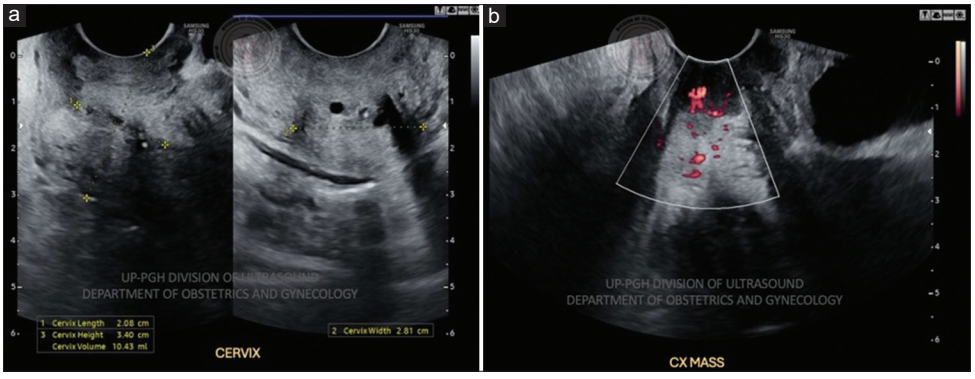

Figure 7: Transvaginal ultrasound: (a) There is an irregular, hypoechoic, exophytic mass measuring 2.7 cm × 2.4 cm × 1.5 cm (volume: 5.1 cc) at the lower third of the anterior cervical lip. (b) Power Doppler of the cervical mass shows moderate branching vascularity (Color score = 3)

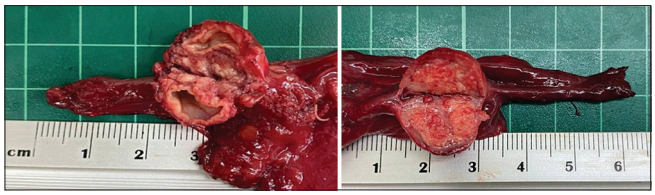

Figure 8: Gross pathology of the left (left photograph) and right (right photograph) adnexae: Grossly normal bilateral ovaries and fallopian tubes

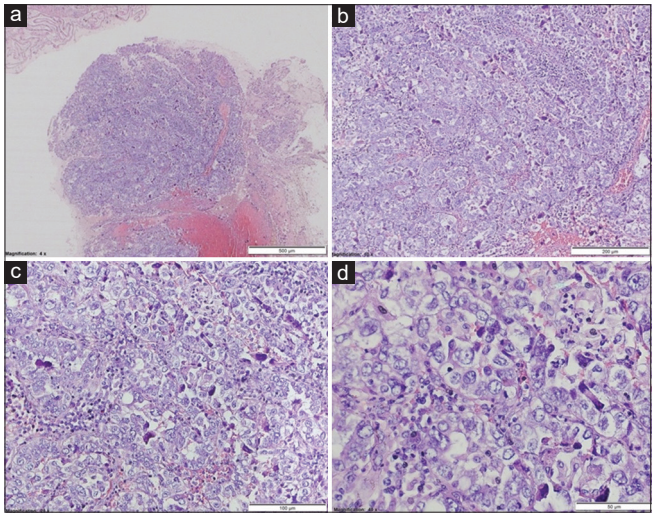

Figure 10: (a) Histopathological examination of the cervical punch biopsy revealed a high-grade, poorly differentiated malignant neoplasm. (b) The tumor shows a solid architecture arranged in sheets with lymphoplasmacytic infiltrates in between slit-like spaces. (c) The tumor cells are polygonal, with significant nuclear atypia, significant nuclear pleomorphism with large, bizarre and multinucleated forms. (d) Malignant cells show prominent, eosinophilic nucleoli can be seen with a high mitotic index (>X mitotic figures per 10 high power fields)

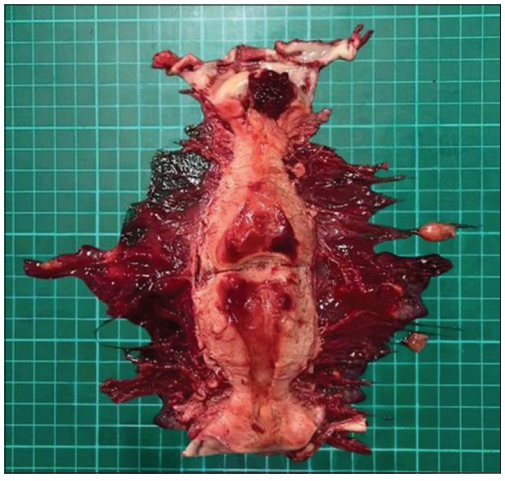

Figure 12: Cut section of the uterus: The endometrium is thin measuring 0.2 cm

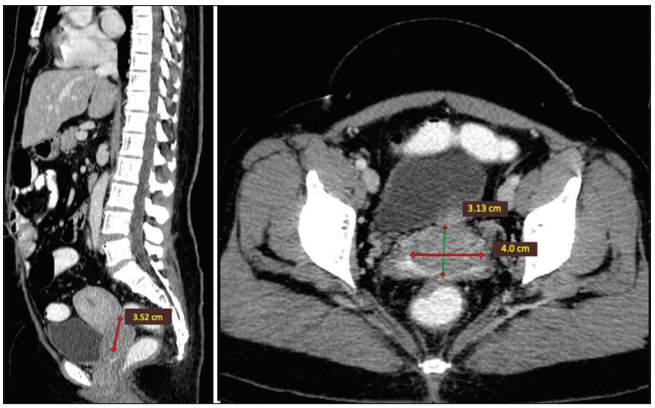

Figure 9: Abdominopelvic computed tomography scan with contrast: Hypodense, distinct mass measuring 3.13 cm × 4.0 cm × 3.52 cm

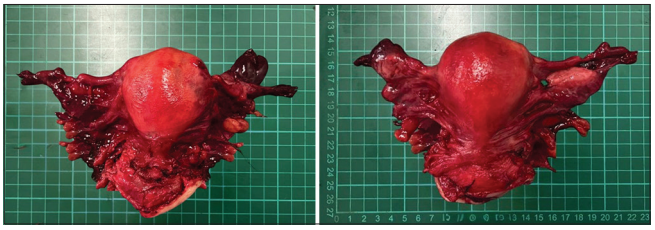

Figure 11: Gross pathology of the uterus: Smooth, tan serosal surface with regular contour, measuring 11.0 cm × 6.0 cm × 5.0 cm. The left parametrium measured 4.0 cm × 4.0 cm, while the right parametrium measured 4.0 cm × 4.0 cm, both grossly free of tumor

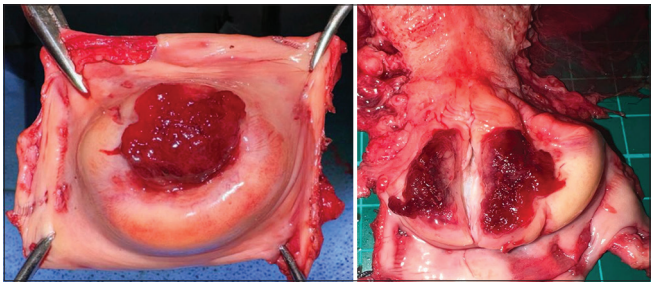

Figure 13: Gross pathology of the cervix: The cervix measures 4.0 cm × 3.0 cm × 3.0 cm, with a 2.0 cm × 2.0 cm friable area at the anterior cervical lip. On cut section of the a 2.0 cm × 2.0 cm friable area at the anterior cervical lip, there is a middle cervical stromal invasion

appendix, and bowels appeared grossly normal. The spleen was smooth but slightly enlarged. There were no palpable pelvic or paraaortic lymph nodes. The prevesical, para-vesical, prerectal, and pararectal spaces were easily accessed and were free of tumor. The uterus [Figure 14] had a smooth, tan serosal surface with a regular contour, measuring 11.0 cm × 6.0 cm × 5.0 cm. The uterine cavity measured 9.0 cm, 3.0 cm, of which was the endocervical canal. The cervix measured 4.0 cm × 3.0 cm × 3.0 cm, with a 2.0 cm × 2.0 cm friable mass noted at the anterior cervical lip, showing invasion up to the middle third of the cervical stroma [Figure 15]. The myometrium measured 1.0 cm anteriorly and posteriorly, with a thin endometrium measuring 0.2 cm [Figure 16]. The vaginal cuff measured 2.0 cm circumferentially. Both the left and right parametrium measured 4.0 cm × 4.0 cm and appeared grossly tumor-free. The left and right ovaries and fallopian tubes were also grossly normal [Figure 17]. Bilateral pelvic and paraaortic lymph nodes harvested during the procedure did not show signs of malignancy. The estimated total blood loss was 1000 mL, with 1 unit of packed red blood cells transfused intraoperatively.

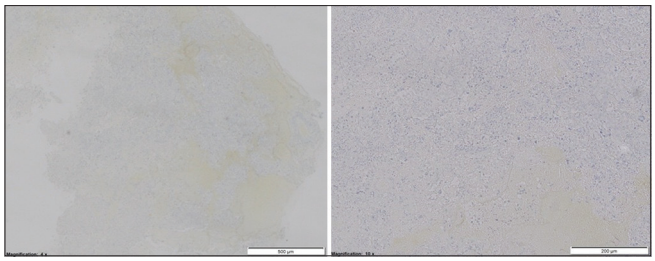

Figure 14: Malignant cells show no staining with p40

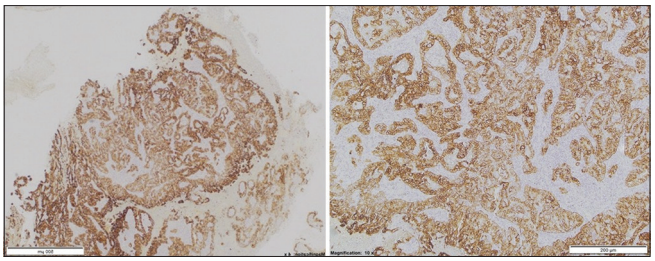

Figure 15: Malignant cells show strong, diffuse membranous staining with CK7

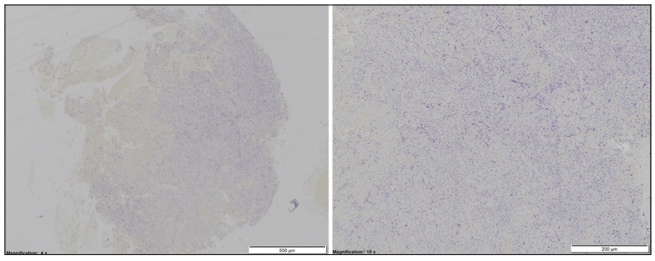

Figure 16: Malignant cells show no staining for CK20

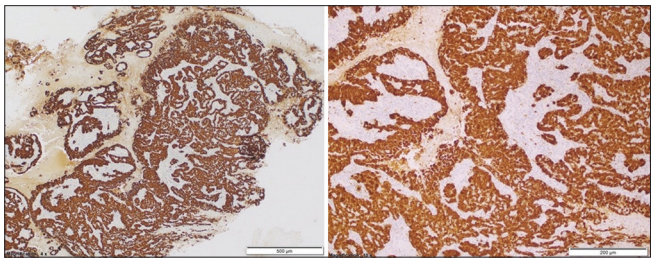

Figure 17: Malignant cells show strong, diffuse and nuclear staining with p16

The procedure was well tolerated by the patient, with no intraoperative complications and no residual tumor identified. The intraoperative stage was maintained.

The final histopathological evaluation of the specimen revealed poorly differentiated carcinoma, which was morphologically compatible with serous carcinoma of the cervix at the left superior to right superior quadrant (10 o'clock–3 o'clock). The tumor measured 2.5 cm in the greatest dimension with 1 mm stromal invasion. No lymphatic or vascular invasion was identified. The margins were negative for invasive carcinoma, high-grade squamous intraepithelial lesion, or adenocarcinoma *in situ* [Figure 18]. There were no parametrial, vaginal cuff, or lymph node invasions. Other findings were low-grade squamous intraepithelial lesion (at 12 o'clock position of the cervix) and secretory phase endometrium. No diagnostic abnormalities were recognized in the bilateral fallopian tubes and ovaries.

The immunohistochemistry stains showed the following results [Figure 19]: ER, Napsin A, and Chromogranin were negative, while p53 abnormal expression (mutated) and overexpression (strong, diffuse nuclear expression in >90% of cells). These immune-histomorphologic characteristics supported diagnosis of serous carcinoma.

There was no adjuvant treatment initiated in the case. The patient is being monitored every 3 months by doing physical examination, including pelvic examination.

Case Discussion

Incidence and history

Serous carcinoma of the cervix is very rare, with its true incidence unknown due to the scarce number of cases reported in local and international journals. A literature review done by Jonska-Gmyrek *et al*. in 2018 showed a total of 113 cases of USCC.[2] In 1990, Young and Scully initially identified serous carcinoma of the cervix as a subtype of cervical cancer.[5] In 1992, Gilks and Clement conducted a detailed analysis of this subtype of tumor, highlighting its aggressive characteristics.[6] By 2020, Kitade *et al*. analyzed USCC and found it rare and unique, potentially treatable without lymph node metastases or peritoneal spread. Four patients with RH and one stage IVB patient remained relapse-free after platinum-based chemotherapy and bevacizumab treatment.[4]

Interestingly, in the 2020 WHO Classification of Cervical Cancer, the serous carcinoma entity was removed from the classification. The majority of reported cases seem to involve either adenocarcinomas linked to human papillomavirus (HPV) that show serous-like features, spread to the endometrium, or are identified as serous carcinomas originating from the tubes or ovaries, as indicated by several studies.[7,8] Conversely, a number of more recent investigations have shed light on the pathological characteristics and clinical importance of cervical carcinomas exhibiting micropapillary formations. These particular carcinomas are frequently connected with HPV-associated adenocarcinomas and are considered to have negative prognostic outcomes. As of now, it remains unclear whether cervical carcinomas with micropapillary patterns constitute a unique biological category, and the molecular mechanisms underlying their development remain unidentified. Furthermore, as our understanding of the variety in the morphology of gastric type adenocarcinomas of the cervix expands, there have been instances documenting the identification of serous-like papillary sections within some of these cases.

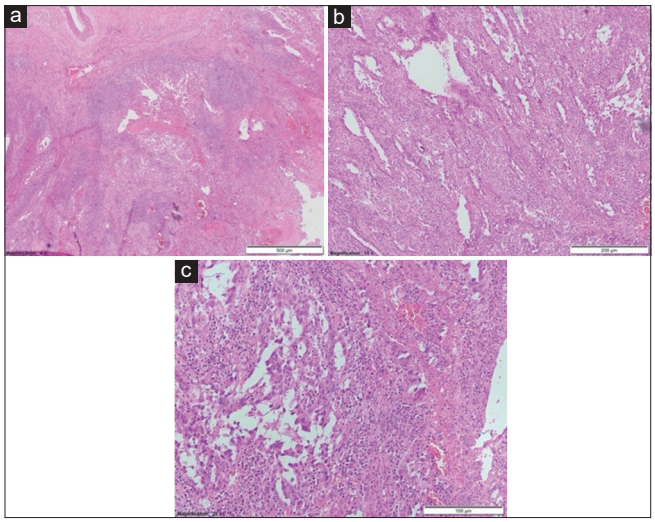

Figure 18: (a) Histopathological examination of the lower uterine segment and cervix revealed a high-grade, malignant neoplasm that has diffusely infiltrated the surrounding stroma. (b) The tumor exhibits glandular architecture arranged in sheets with lymphoplasmacytic infiltrates in between slit-like spaces. (c) High power field shows moderate to severe nuclear atypia, significant nuclear pleomorphism and tufting with cellular budding

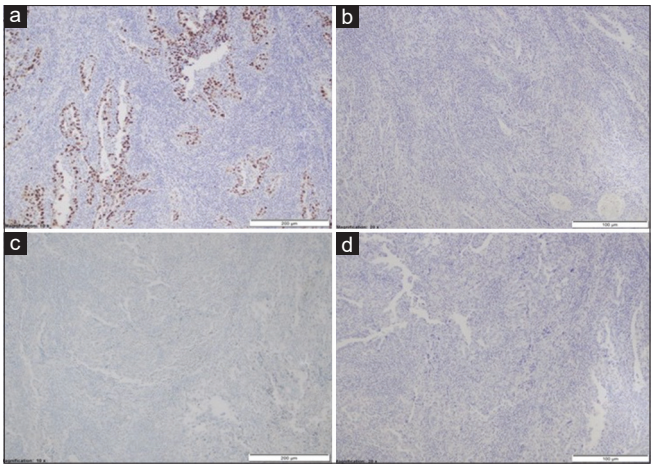

Figure 19: Immunohistochemistry stain of the hysterectomy specimen: (a) p53 - Abnormal expression (mutated). Overexpression (strong, diffuse nuclear expression in greater than 90% of cells). (b) Estrogen receptor - Negative (c) Chromogranin - Negative (d) Napsin A - Negative

Locally, a literature search of interesting case reports over the past 10 years, this present case is seemingly the only written reported case of serous carcinoma of the cervix at a tertiary training hospital in the Philippines.

Clinical characteristics

Akhter and Begum highlighted some common risk factors associated with carcinoma of the cervix in general, such as multiparity, early marriage, early age of first intercourse, and having high-risk male partners. These factors contribute significantly to the development and progression of cervical cancer.[9] In a study by Kitade *et al*. in 2020, 3 out of the 5 patients are more than 50 years old and were diagnosed early (1B1).[4] According to Jonska-Gmyrek *et al*., there are two peaks where serous carcinoma of the cervix is common: one before 40 years of age and the second, after the age of 54 years.[2] Interestingly, the index patient does not fall within the two peaks and our patient is diagnosed early in her disease. While detailed information on serous carcinoma risk factors may require further investigation due to its rarity and complexity compared to other types of cervical cancer, one must understand the common risk factors associated with cervical malignancies.

The index patient did not have the usual risk factors associated with cervical cancer. However, she is predisposed to the condition due to her age, socioeconomic condition, menopausal status, screening frequency, vaccination history, and immune status.

Histopathological and immunohistochemical features

Microscopic features of the serous carcinoma of the cervix are similar to the ovarian, fallopian tube, peritoneal, and endometrial fallopian tube serous carcinoma. It appears as slit-like lumina with a complicated papillary architecture. Neoplastic cells exhibited pleomorphic nuclei with several mitotic figures in the high-power field.[5,6] Accordingly, according to the 2014 WHO classification, serous carcinoma of the cervix displays a complex architecture with cellular budding and frequent psammoma body formation; glandular areas may also be seen. Nuclear atypia is generally high grade.[3] In the index case, histopathological examination of the lower uterine segment and cervix revealed a high-grade, malignant neoplasm that has diffusely infiltrated the surrounding stroma. The tumor exhibits glandular architecture arranged in sheets with lymphoplasmacytic infiltrates in between slit-like spaces, and on high-power field shows moderate-to-severe nuclear atypia, significant nuclear pleomorphism and tufting with cellular budding.

Immunohistochemistry serves as a valuable tool in confirming the diagnosis of serous carcinoma of the cervix. Previous studies have noted that serous carcinomas from various origins, including serous carcinoma of the cervix, often exhibit expression of p53, p16, and CA125; WT-1, PAX8, and ER on the other hand, are positive in cases of serous carcinoma of tuboovarian/peritoneal origin.[3,4] CEA is sometimes positive in cervical but rarely in ovarian and endometrial cancer. Strongly positive p16 staining is associated with the presence of high-risk HPV.[10]

In the index case, intense, diffuse nuclear staining of p53 was observed in over 80% of tumor cells, as well as strong positive staining of p16. In addition, the malignant cells did not stain with ER. Although p53 was positive, tumor cells did not stain for CEA and CDX2; hence, metastatic disease from the colon is unlikely.

Although the frequency of HPV in all cervical carcinomas is known to range from 63% to 94%, there is less information on the frequency of HPV in cervical serous carcinoma. Togami *et al*. identified HPV DNA in 4 out of 12 cases (33%) of cervical serous carcinoma, while Pirog *et al*. detected it in 6 out of 24 cases (25%) of cervical carcinoma.[11,12] Kitade *et al*. investigated the high-risk HPV status of five cervical serous carcinoma in humans, and all of them were found to be negative.[4] This indicates that while HPV infection may play a role in some cases of cervical serous carcinoma, there are likely other factors contributing to the development of this type of cancer. Furthermore, cancers with similar morphology to serous carcinomas, such as endocervical carcinomas, are HPV-positive, hence reducing the number of HPV-positive serous cancers. Further research is needed to understand the relationship between HPV and cervical serous carcinoma fully.

Management

Early detection and treatment of cervical serous carcinoma is crucial in improving the patient outcomes and survival rates. Due to its aggressive nature and high potential for metastasis, early intervention can help prevent the spread of the cancer to other parts of the body. In a comprehensive literature review by Jonska-Gmyrek *et al*., early stage cancer (IA1, IA2, IB1, and IIA), is managed by RH, including bilateral oophorectomy, parts of the uterosacral and cardinal ligaments and the upper end (up to 2 cm) of the vagina, with bilateral pelvic or, sometimes, paraaortic lymphadenectomy.[2] Although the serous carcinoma is considered an aggressive disease, when diagnosed and treated as an early stage disease, prognosis is still good with the 5-year survival rate of 91%.

In the index case, given that patient was diagnosis to have an early stage disease stage 1B2 – Primary surgical therapy was opted. This was based on different literature suggesting that for early stage serous carcinoma of the cervix, surgical interventions such as RH, often followed by adjuvant therapy in the form of pelvic external-beam radiation (EBRT) with brachytherapy and chemotherapy in those with large tumor or deep stromal infiltration or lymphovascular space invasion. According to Togami *et al*., individuals with less advanced disease benefitted from aggressive surgery.[13] Another study showed that patients with stage I disease showed a better prognosis after radical surgery.[11] In the index case, there was no adjuvant therapy and patient is being monitored every 3 months through pelvic examination. Furthermore, ideally, the use of biomarkers and imaging tests are essential for future therapy planning and the monitoring of disease progression or recurrence. This comprehensive technique allows enhanced evaluation of possible tumor attributes, therapeutic response, and likelihood of recurrence, therefore enhancing the patient outcomes.

For the cases with advanced stage, combination of treatments were typically employed. This may involve neoadjuvant chemotherapy to shrink the tumor before surgery, followed by radical surgery if feasible. In addition, radiation therapy and targeted therapies may be utilized to address any residual cancer cells and prevent recurrence. Patients with lymph node metastases should undergo multimodal therapy since some cases have shown extended survival rates despite the presence of metastasis in the pelvic and para-aortic lymph nodes.

Prognosis

Although having a histopathological diagnosis of serous carcinoma of the cervix may signal a more aggressive type of malignancy, it should not be considered independently from other parameters, such as stage, tumor size, depth of invasion, and presence of lymph node metastases. The inconsistency in histopathological definitions and criteria might result in discrepancies in forecasting tumor behavior, hence reducing its independent prognostic significance.[14,15] For example, clinical stage and lymph node status are crucial in cervical cancer outcomes, especially in patients who have undergone surgical treatment.[14] The combination of tumor size and lymph node size shows superior diagnostic efficacy in forecasting lymph node metastases in early stage cervical cancer.[16] As reflected in the cases reported in the literature, cervical serous carcinoma has the potential to be curable for as long as it has not spread to the lymph nodes. On the other hand, if lymph node metastasis has occurred, this is strongly linked to an unfavorable prognosis.

In one study, the projected prognosis difference between HPV-associated and HPV-independent tumors is typically consistent with the clinical outcomes of cervical carcinomas with serous-like characteristics, although this may not be conclusive in all population. Nevertheless, these suggest that the disease-free survival for these cases is lower than that of conventional HPV-associated tumors. It is also emphasized that follow-up care and monitoring are crucial in assessing the effectiveness of treatment and detecting any signs of recurrence early on. Regular check-ups and imaging tests can ensure that appropriate interventions are implemented promptly. Patient outcomes may also be impacted by the type of treatment received and individual response to therapy. Therefore, personalized treatment plans based on the specific characteristics of each case are essential for optimizing the outcomes and minimizing the risk of mortality.

Summary, Conclusion and Recommendation

The case presented is a 44-year-old G3P3 (3002) diagnosed with serous carcinoma of the cervix, stage 1B2, confirmed by immunostaining results of a positive p53 and p16. Given that the patient had early stage disease, primary surgical treatment in the form of RH with bilateral salpingo-oophorectomy, and complete surgical staging was done. With the early stage presentation of this case, good clinical outcomes and prognosis are expected.

Serous carcinoma of the cervix is an often questioned disease entity, with unique clinical features. Further research is needed to explore the optimal treatment strategies and long-term monitoring protocols for this rare type of cancer.

Although seemingly an aggressive type of cancer, the diagnosis of such condition at an early stage allows surgical intervention and may still be associated with the good clinical outcome. Preventive cervical cancer screening programs are essential for the early identification and improved prognosis of all cervical cancer types, including rare variants such as serous carcinoma of the cervix. The use of different screening techniques, including HPV testing, in conjunction with conventional Pap smears, has shown beneficial in detecting precancerous lesions and early stage malignancies, thereby enhancing treatment results. Furthermore, community education and outreach are essential for mitigating inequities and enhancing the cervical cancer outcomes worldwide.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Authorship contributions

Reimalyn Agustin, MD – Involved in conceptualization, resources, writing – original draft, review and editing and visualization.

Ana Victoria V. Dy Echo, MD, MHPEd - Involved in conceptualization, resources, review and editing of the draft and supervision.

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Conflicts of interest

There are no conflicts of interest.

References

1. Lakshmi IS, Anunayi J, Sreedhar VV, Khan MA, Sarigama M. Primary papillary serous carcinoma of cervix: A rare variant of cervical malignancy. Indian J Mednodent Allied Sci 2014;2:101-4.
2. Jonska-Gmyrek J, Zolciak-Siwinska A, Gmyrek L, Michalski W, Poniatowska G, Fuksiewicz M, *et al*. Serous carcinoma of the uterine cervix, an extremely rare aggressive entity: A literature review. Gynecol Obstet Invest 2018;83:220-6.
3. Herrera Gómez RG, Hastir D, Liapi A, Dolcan A, Herrera FG, Mathevet P, *et al*. So-called serous carcinoma of the uterine cervix with BRCA2 mutation: Case report and review of the literature. Case Rep Oncol 2021;14:1792-8.
4. Kitade S, Ariyoshi K, Taguchi K, Maenohara S, Tomita Y, Sonoda K, *et al*. Serous carcinoma of the uterine cervix: Clinicopathological features differing from serous carcinomas of other female organs. J Obstet Gynaecol Res 2020;46:153-60.
5. Young RH, Scully RE. Invasive adenocarcinoma and related tumors of the uterine cervix. Semin Diagn Pathol 1990;7:205-27.
6. Gilks CB, Clement PB. Papillary serous adenocarcinoma of the uterine cervix: A report of three cases. Modern pathol 1992;5:426-31.
7. Wong RW, Ng JH, Han KC, Leung YP, Shek CM, Cheung KN, *et al*. Cervical carcinomas with serous-like papillary and micropapillary components: Illustrating the heterogeneity of primary cervical carcinomas. Mod Pathol 2021;34:207-21.
8. Choi CK, Tse KY, Ip PP, Shek CM, Cheung KN, Choi CK. Cervical carcinomas with serous-like papillary and micropapillary components: Illustrating the heterogeneity of primary cervical carcinomas. Mod Pathol 2021;34:207-21.
9. Akhter H, Begum F. Risk factors of carcinoma cervix. Int J Reprod Contracept Obstet Gynecol 2023;12:1257-62.
10. De Wispelaere N, Rico SD, Bauer M, Luebke AM, Kluth M, Büscheck F, *et al*. High prevalence of p16 staining in malignant tumors. PLoS One 2022;17:e0262877.
11. Togami S, Kasamatsu T, Sasajima Y, Onda T, Ishikawa M, Ikeda S, *et al*. Serous adenocarcinoma of the uterine cervix: A clinicopathological study of 12 cases and a review of the literature. Gynecol Obstet Invest 2012;73:26-31.
12. Pirog EC, Lloveras B, Molijn A, Tous S, Guimera N, Alejo M, *et al*. HPV prevalence and genotypes in different histological subtypes of cervical adenocarcinoma, a worldwide analysis of 760 cases. Mod Pathol 2014;27:1559-67.
13. Togami S, Sasajima Y, Kasamatsu T, Oda-Otomo R, Okada S, Ishikawa M, *et al*. Immunophenotype and human papillomavirus status of serous adenocarcinoma of the uterine cervix. Pathol Oncol Res 2015;21:487-94.
14. Singh N, Arif S. Histopathologic parameters of prognosis in cervical cancer – A review. Int J Gynecol Cancer 2004;14:741-50.
15. Vinh-Hung V, Bourgain C, Vlastos G, Cserni G, De Ridder M, Storme G, *et al*. Prognostic value of histopathology and trends in cervical cancer: A SEER population study.BMC Cancer 2007;7:1-13.
16. Kang S, Kim YS, Choi HJ, Kim MH, Cho KS. Additional value of combined evaluation of tumor size with lymph node size in the detection of lymph node metastases in early-stage cervical cancer patients. J Comput Assist Tomogr 2013;37:572-6.