

# World Journal of *Clinical Cases*

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## Contents

Thrice Monthly Volume 10 Number 21 July 26, 2022

## OPINION REVIEW

- 7187 Effects of glucocorticoids on leukocytes: Genomic and non-genomic mechanisms  
*Jia WY, Zhang JJ*

## MINIREVIEWS

- 7195 Apheresis: A cell-based therapeutic tool for the inflammatory bowel disease  
*Yasmin F, Najeeb H, Naeem U, Moeed A, Koritala T, Surani S*
- 7209 *Helicobacter pylori* infection and small intestinal bacterial overgrowth—more than what meets the eye  
*Dharan M, Wozny D*
- 7215 Anatomy of the anterolateral ligament of the knee joint  
*Park JG, Han SB, Rhim HC, Jeon OH, Jang KM*

## ORIGINAL ARTICLE

## Clinical and Translational Research

- 7224 Molecular mechanisms of Biyu decoction as treatment for psoriasis: A network pharmacology and molecular docking study  
*Wang Z, Zhang HM, Guo YR, Li LL*
- 7242 Expression of hepatocyte nuclear factor 4 alpha, wingless-related integration site, and  $\beta$ -catenin in clinical gastric cancer  
*Hu Q, Li LL, Peng Z, Yi P*

## Case Control Study

- 7256 Improved Pittsburgh Sleep Quality Index scores on first postoperative night achieved by propofol anesthesia in patients undergoing ambulatory gynecologic surgery  
*Hu CH, Chou WY*
- 7265 Efficacy of Guhong injection *versus* Butylphthalide injection for mild ischemic stroke: A multicenter controlled study  
*Zhang WW, Xin J, Zhang GY, Zhai QJ, Zhang HM, Wu CS*

## Retrospective Study

- 7275 Clinical values of Barcelona Clinic Liver Cancer subgroup and up-to-7 criteria in intermediate stage hepatocellular carcinoma with transcatheter arterial chemoembolization  
*Lee SW, Peng YC, Lien HC, Ko CW, Tung CF, Chang CS*
- 7285 Intervention effect of encouraging mental and programmed nursing of patients in interventional operating room on their compliance and bad moods  
*Chi RB, Cai YY, Mao HP*

- 7293** Preoperative neoadjuvant chemotherapy in patients with breast cancer evaluated using strain ultrasonic elastography  
*Pan HY, Zhang Q, Wu WJ, Li X*
- 7302** Risk factors for delayed intracranial hemorrhage secondary to ventriculoperitoneal shunt: A retrospective study  
*Chen JC, Duan SX, Xue ZB, Yang SY, Li Y, Lai RL, Tan DH*
- 7314** Sequential treatment of severe pneumonia with respiratory failure and its influence on respiratory mechanical parameters and hemodynamics  
*Niu BY, Wang G, Li B, Zhen GS, Weng YB*
- 7324** Effects of alendronate sodium combined with InterTan on osteoporotic femoral intertrochanteric fractures and fracture recurrence  
*Wang KM, Wei SP, Yin XY, Meng QJ, Kong YM*
- 7333** Correlation of magnetic resonance imaging quantitative parameters and apparent diffusion coefficient value with pathological breast cancer  
*Wang Z, Ren GY, Yin Q, Wang Q*
- 7341** Risk factors for delirium after surgery for craniocerebral injury in the neurosurgical intensive care unit  
*Chen RY, Zhong CH, Chen W, Lin M, Feng CF, Chen CN*

**Observational Study**

- 7348** Effect of osteoarthritic knee flexion deformity correction by total knee arthroplasty on sagittal spinopelvic alignment in Indian population  
*Puthiyapura LK, Jain M, Tripathy SK, Puliappadamb HM*
- 7356** Imaging characteristics of orbital peripheral nerve sheath tumors: Analysis of 34 cases  
*Dai M, Wang T, Wang JM, Fang LP, Zhao Y, Thakur A, Wang D*

**Randomized Controlled Trial**

- 7365** Comparison of involved-field intensity-modulated radiotherapy combined with S-1 *vs* radiotherapy alone for elderly patients with esophageal cancer  
*Liu LH, Yan MH, Di YP, Fu ZG, Zhang XD, Li HQ*

**Randomized Clinical Trial**

- 7376** Dexmedetomidine in pediatric unilateral internal inguinal ring ligation  
*Liu G, Zhang L, Wang HS, Lin Y, Jin HQ, Wang XD, Qiao WN, Zhang YT, Sun JQ, Liu ZN*

**META-ANALYSIS**

- 7386** Impact of cancer on mortality rates in patients with sepsis: A meta-analysis and meta-regression of current studies  
*Xiang MJ, Chen GL*

## CASE REPORT

- 7397** Updated clinical and glycomic features of mannosyl-oligosaccharide glucosidase deficiency: Two case reports  
*Abuduxikuer K, Wang L, Zou L, Cao CY, Yu L, Guo HM, Liang XM, Wang JS, Chen L*
- 7409** Solitary necrotic nodules of the liver with "ring"-like calcification: A case report  
*Bao JP, Tian H, Wang HC, Wang CC, Li B*
- 7415** Corticosteroid-induced bradycardia in multiple sclerosis and maturity-onset diabetes of the young due to hepatocyte nuclear factor 4- $\alpha$  mutation: A case report  
*Sohn SY, Kim SY, Joo IS*
- 7422** Essential thrombocythemia with non-ST-segment elevation myocardial infarction as the first manifestation: A case report  
*Wang ZM, Chen WH, Wu YM, Wang LQ, Ye FL, Yin RL*
- 7429** Extranasopharyngeal angiofibroma in children: A case report  
*Yan YY, Lai C, Wu L, Fu Y*
- 7438** Deep Sylvian fissure meningiomas: A case report  
*Wang A, Zhang X, Sun KK, Li C, Song ZM, Sun T, Wang F*
- 7445** Acute pulmonary embolism originating from upper limb venous thrombosis following breast cancer surgery: Two case reports  
*Duan Y, Wang GL, Guo X, Yang LL, Tian FG*
- 7451** Managing spondylitis tuberculosis in a patient with underlying diabetes and hypothyroidism: A case report  
*Novita BD, Muliono AC, Wijaya S, Theodora I, Tjahjono Y, Supit VD, Willianto VM*
- 7459** Ovarian mucinous tumor with mural nodules of anaplastic carcinoma: Three case reports  
*Wang XJ, Wang CY, Xi YF, Bu P, Wang P*
- 7467** Transcatheter arterial infusion chemotherapy and embolization for primary lacrimal sac squamous cell carcinoma: A case report  
*Sun MH, Yi WD, Shen L, Zhou L, Lu JX*
- 7474** Programmed cell death-1 inhibitor combination treatment for recurrent proficient mismatch repair/microsatellite-stable type endometrial cancer: A case report  
*Zhai CY, Yin LX, Han WD*
- 7483** Novel compound heterozygous mutation of *SLC12A3* in Gitelman syndrome co-existent with hyperthyroidism: A case report and literature review  
*Qin YZ, Liu YM, Wang Y, You C, Li LN, Zhou XY, Lv WM, Hong SH, Xiao LX*
- 7495** Successful treatment of hyperglycemia with liraglutide in a hospitalized 27-year-old patient with schizophrenia: A case report  
*Zhang L, Yu WJ, Zhu H, Li HF, Qiao J*

- 7502** Refractory lymphoma treated with chimeric antigen receptor T cells combined with programmed cell death-1 inhibitor: A case report  
*Zhang CJ, Zhang JY, Li LJ, Xu NW*
- 7509** Median arcuate ligament syndrome with retroperitoneal haemorrhage: A case report  
*Lu XC, Pei JG, Xie GH, Li YY, Han HM*
- 7517** Novel frameshift mutation in the *AHDC1* gene in a Chinese global developmental delay patient: A case report  
*Lin SZ, Xie HY, Qu YL, Gao W, Wang WQ, Li JY, Feng XC, Jin CQ*
- 7523** Selective nerve block for the treatment of neuralgia in Kummell's disease: A case report  
*Zhang X, Li ZX, Yin LJ, Chen H*
- 7531** Traditional Chinese medicine manipulative reduction combined with percutaneous vertebroplasty for treating type III Kummell's disease: A case report  
*Hao SS, Zhang RJ, Dong SL, Li HK, Liu S, Li RF, Ren HH, Zhang LY*
- 7539** Differential diagnosis and treatment of foot drop caused by an extraneural ganglion cyst above the knee: A case report  
*Won KH, Kang EY*
- 7545** Effect of hydrogen intervention on refractory wounds after radiotherapy: A case report  
*Zhao PX, Luo RL, Dang Z, Wang YB, Zhang XJ, Liu ZY, Wen XH, Liu MY, Zhang MZ, Adzavon YM, Ma XM*
- 7553** Chronic urticaria associated with lung adenocarcinoma — a paraneoplastic manifestation: A case report and literature review  
*Jiménez LF, Castellón EA, Marengo JD, Mejía JM, Rojas CA, Jiménez FT, Coronell L, Osorio-Llanes E, Mendoza-Torres E*
- 7565** Spinal giant cell-rich osteosarcoma-diagnostic dilemma and treatment strategy: A case report  
*Tseng CS, Wong CE, Huang CC, Hsu HH, Lee JS, Lee PH*
- 7571** Primary clear cell sarcoma of soft tissue in the posterior cervical spine invading the medulla oblongata: A case report  
*Liu CC, Huang WP, Gao JB*
- 7577** *Pseudomonas aeruginosa*-related effusive-constrictive pericarditis diagnosed with echocardiography: A case report  
*Chen JL, Mei DE, Yu CG, Zhao ZY*
- 7585** Maternal peripartum bacteremia caused by intrauterine infection with *Comamonas kerstersii*: A case report  
*Qu H, Zhao YH, Zhu WM, Liu L, Zhu M*
- 7592** Considerations of single-lung ventilation in neonatal thoracoscopic surgery with cardiac arrest caused by bilateral pneumothorax: A case report  
*Zhang X, Song HC, Wang KL, Ren YY*

- 7599** Rare primary rectal mucosa-associated lymphoid tissue lymphoma with curative resection by endoscopic submucosal dissection: A case report and review of literature

*Tao Y, Nan Q, Lei Z, Miao YL, Niu JK*

- 7609** Differences in examination results of small anastomotic fistula after radical gastrectomy with afterward treatments: A case report

*Lu CY, Liu YL, Liu KJ, Xu S, Yao HL, Li L, Guo ZS*

### **LETTER TO THE EDITOR**

- 7617** Baseline differences may impact on relationship between dietary tryptophan and risk of obesity and type 2 diabetes

*Ren XH, Ye YW, He LP*

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## Programmed cell death-1 inhibitor combination treatment for recurrent proficient mismatch repair/ microsatellite-stable type endometrial cancer: A case report

Chong-Ya Zhai, Lu-Xi Yin, Wei-Dong Han

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### Abstract

#### BACKGROUND

Endometrial cancer (EC) is one of the most common cancers of the female reproductive tract, and the incidence is increasing rapidly. Immunotherapy using programmed cell death-1 (PD-1) inhibitors is an emerging research topic and treatment strategy for refractory gynecological malignancies. However, clinical management of EC with checkpoint inhibitors requires improvement. Herein, we discuss a case of refractory proficient mismatch repair (pMMR)/microsatellite-stable (MSS) EC treated with a combination of PD-1 and angiogenesis inhibitors and offer a review of the pathophysiology and clinical outcomes based on previous studies.

#### CASE SUMMARY

A 62-year-old woman diagnosed with invasive or metastatic EC in 2015 was treated with six courses of chemotherapy and refused further radiotherapy. Four years later, she developed chest pain, and lung biopsy indicated thyroid transcription factor-1 (-), Napsin A (-), estrogen receptor (+), progesterone receptor (+), anaplastic lymphoma kinase (D5F3) (-), and receptor tyrosine kinase (D4D6) (-) metastatic EC. Genetic testing results showed low tumor mutation burden, pMMR, PD ligand 1 (-), MSS, and HLA-class 1 heterogeneous disease. The patient was started on toripalimab combined with nab-paclitaxel for seven cycles (every 3 wk), but this regimen was terminated because of an intolerable chemotherapy adverse event. The disease progressed in 2020, and the patient's treatment was switched from nab-paclitaxel to anlotinib, while immunotherapy using toripalimab was continued. The patient achieved a major partial response with well-tolerated toxicities, and treatment is ongoing.



## CONCLUSION

Molecular testing is advised for clinical classifications of EC owing to its high heterogeneity. In this case, the patient had pMMR/MSS EC and achieved a positive outcome with combination PD-1 inhibitor treatment. These results warrant further clinical exploration.

**Key Words:** Refractory endometrial cancer; Proficient mismatch repair; Microsatellite-stable; Immunotherapy; Case report

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**Core Tip:** Endometrial cancer (EC) with proficient mismatch repair/microsatellite-stable (pMMR/MSS)-type hardly responds to immune checkpoint therapy. This case reported a satisfactory outcome with well-tolerated toxicities using toripalimab combined with anlotinib treatment in an EC patient with pMMR/MSS-type. Although need further clinical evidence, programmed cell death-1 inhibitor combined anti-angiogenesis therapy may present an option for EC patients with pMMR/MSS-type after multi-line treatment.

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## INTRODUCTION

Endometrial cancer (EC) is one of the most common gynecological malignancies in women, with 382069 newly confirmed cases reported in 2018 and an occurrence rate that increases annually by an estimated 1% to 2% worldwide[1]. The prognosis of advanced EC is poor. Even though the 5-year survival rate for stage I EC is as high as 95%, the 5-year survival rate for metastatic EC is approximately 17%[2]. Immunotherapies, such as programmed cell death-1 (PD-1) inhibitors, block PD-1 and PD ligand 1 (PD-L1) activities on the cell surface to prevent immune escape and are currently being used to treat refractory gynecological malignancies, but the clinical application of immunotherapy for EC patients remains exploratory. Data from the Keynote-158 and GARNET trials demonstrate that immunotherapy alone offers promising results for patients with mismatch repair-deficient (dMMR)/microsatellite instability-high (MSI-H) advanced EC, with overall response rates (ORRs) of 57.1% and 56%, respectively[3]. However, the objective response rate of patients with proficient mismatch repair/microsatellite-stable (pMMR/MSS) malignancies was only 10%[3]. This article presents a case study and preliminary discussion of PD-1 inhibitor immunotherapy combined with chemotherapy or anti-angiogenesis targeted therapy for a patient with pMMR/MSS recurrent EC. We further elaborate the molecular classification, choice of treatment regimen, and therapeutic efficacy.

## CASE PRESENTATION

### Chief complaints

A 67-year-old female presented to our hospital with complaint of 5 years and 7 mo after endometrial carcinoma hysterectomy and a dull chest pain for 1 wk.

### History of present illness

In November 2013, a female patient experienced “uterine cavity abnormality for 2 d” and went to an outpatient center, where she underwent total hysterectomy + bilateral salpingo-oophorectomy + pelvic lymphadenectomy on November 18, 2013. The postoperative pathology indicated Grade I endometrioid adenocarcinoma with squamous differentiation and superficial muscular infiltration, and all 16 Lymph nodes were negative. The patient underwent regular check-ups thereafter. On April 20, 2015, the patient was diagnosed with lung metastases by enhanced chest computed tomography (CT) scans, which suggested multiple nodules in both lungs. Four days later, the patient underwent lower right lung wedge resection with pleuroscopy + lung repair. Postoperative pathology showed adenocarcinoma infiltration or metastasis (0.6 cm × 0.5 cm). Three cycles of paclitaxel + nedaplatin chemotherapy were

administered before the patient presented with disease progression, after which treatment was switched to three cycles of epirubicin + cisplatin chemotherapy. After chemotherapy, additional radiotherapy was recommended by the physician but refused by the patient. In June 2019, the patient visited our hospital due to a dull chest pain.

### History of past illness

The patient had a ten-year history of hypertension and diabetes but had no history of trauma or surgery.

### Physical examination

The patient's height and weight were 156 cm and 58 kg, respectively, with a body mass index of 23.8 kg/m<sup>2</sup>. No enlargement of lymph node was found in the superficial lymph nodes. Breath sounds were low in both lungs. Heart auscultation revealed a regular rhythm, normal heart sounds without murmur. Two surgical scars can be seen in the chest and abdomen. The abdomen was soft without tenderness, and the liver and spleen were not palpable under the ribs. There was no percussion pain in the liver area. Shifting dullness was negative, and bowel sounds were normal.

### Laboratory examinations

The patient underwent a tumor marker exam to find that the levels of carcinoembryonic antigen (CEA), carbohydrate antigen 125 (CA125), carbohydrate antigen 19-9 (CA19-9) were all within normal limits. None of the other laboratory values were considered clinically significant. Lung biopsy confirmed thyroid transcription factor-1 (TTF-1) (-), Napsin A (-), estrogen receptor (ER) (+), progesterone receptor (PR) (+), anaplastic lymphoma kinase (ALK, D5F3) (-), and receptor tyrosine kinase (ROS1, D4D6) (-) metastatic endometrial carcinoma (Figure 1). Genomic sequencing results demonstrated polymerase-epsilon (POLE) (-) tumor pathology, mouse double minute 4 (MDM4) amplification, v-Akt murine thymoma viral oncogene homolog 1 (AKT1) missense mutation, CTNNB1 missense mutation, TP53 (-), 2.09 Muts/Mb [tumor mutation burden-low (TMB-L)], pMMR, PD-L1 (-), MSS, and heterozygous HLA-1 (Table 1).

### Imaging examinations

Enhanced chest CT showed multiple nodules and mass shadows in both lungs after the right lung operation, suggesting metastasis (Figure 2A).

## FINAL DIAGNOSIS

The patient was diagnosed with endometrial cancer with lung metastases (Stage IV; MSS).

## TREATMENT

The patient was given seven cycles of albumin-bound paclitaxel + toripalimab; specifically, 240 mg toripalimab *via* intravenous drip infusion every 3 wk + 200 mg albumin-bound paclitaxel *via* intravenous drip infusion on Days 1 and 8 between July 5 and November 29, 2019. On June 26, 2019, baseline chest CT results showed that the sizes of the three target lung lesions were 47.4 mm, 50.1 mm, and 48.4 mm. On November 28, 2019, these tumors had shrunk to 28.9 mm, 37.2 mm, and 32.0 mm, respectively, after 6 cycles of treatments. The sum of the maximum diameter of the target lesions was reduced from 145.9 mm to 98.1 mm with a reduction rate of 32.8%, which meets the RECIST definition for partial response (PR). Unfortunately, treatment was discontinued because of the neurotoxicity of albumin-bound paclitaxel, and the patient refused to continue using a PD-1 inhibitor for immunotherapy. Progression-free survival (PFS1) lasted 9.7 mo, and the patient had regular follow-ups afterward. On April 16, 2020, a follow-up chest CT check suggested disease progression. According to the results of Keynote-146, pembrolizumab combined with lenvatinib has an ORR rate of 36.8% in patients with pMMR/MSS advanced EC. Accordingly, we believed that the patient might benefit from China's own PD-1 checkpoint inhibitor combined with an antiangiogenic medication. The patient was administered anlotinib, 12 mg orally for two weeks, stopped for one week combined with toripalimab, 240 mg intravenous drip every 3 wk starting on April 17, 2020, until present (August 28, 2021). The patient's diagnosis and treatment timeline are shown in Figure 2.

## OUTCOME AND FOLLOW-UP

On April 16, 2020, chest CT results showed that the sizes of the target lung lesions were 57.6 mm, 56.9 mm, and 51.2 mm and had rapidly reduced to 37.4 mm, 39.5 mm, and 27.8 mm, respectively, on June 30,

**Table 1 Genetic testing of blood and tissue samples**

Tests	Results
Next generation sequencing	
PD-L1 expression	Negative
Mismatch repair	pMMR
Tumor mutation burden	2.09 Muts/Mb
MicroSatellite Instability	MSS
Human leukocyte antigen typing	Heterogeneous
Tumor neoantigens	6
POLE	Negative
TP53	Negative
Predictive/prognostic biomarkers	
MDM4	4 amplifications
AKT1	83.05% p. Glu17 Lys mutation
CTNNB1	37.06% p. Ser37Ala mutation

PD-L1: Programmed cell death-Ligand 1; POLE: Polymerase epsilon; TP: Tumor protein; MDM: Murine double minute; AKT: V-Akt murine thymoma viral oncogene homolog; CTNNB: Catenin beta; pMMR: Proficient mismatch repair; Mb: Mega byte; MSS: Microsatellite-stable.

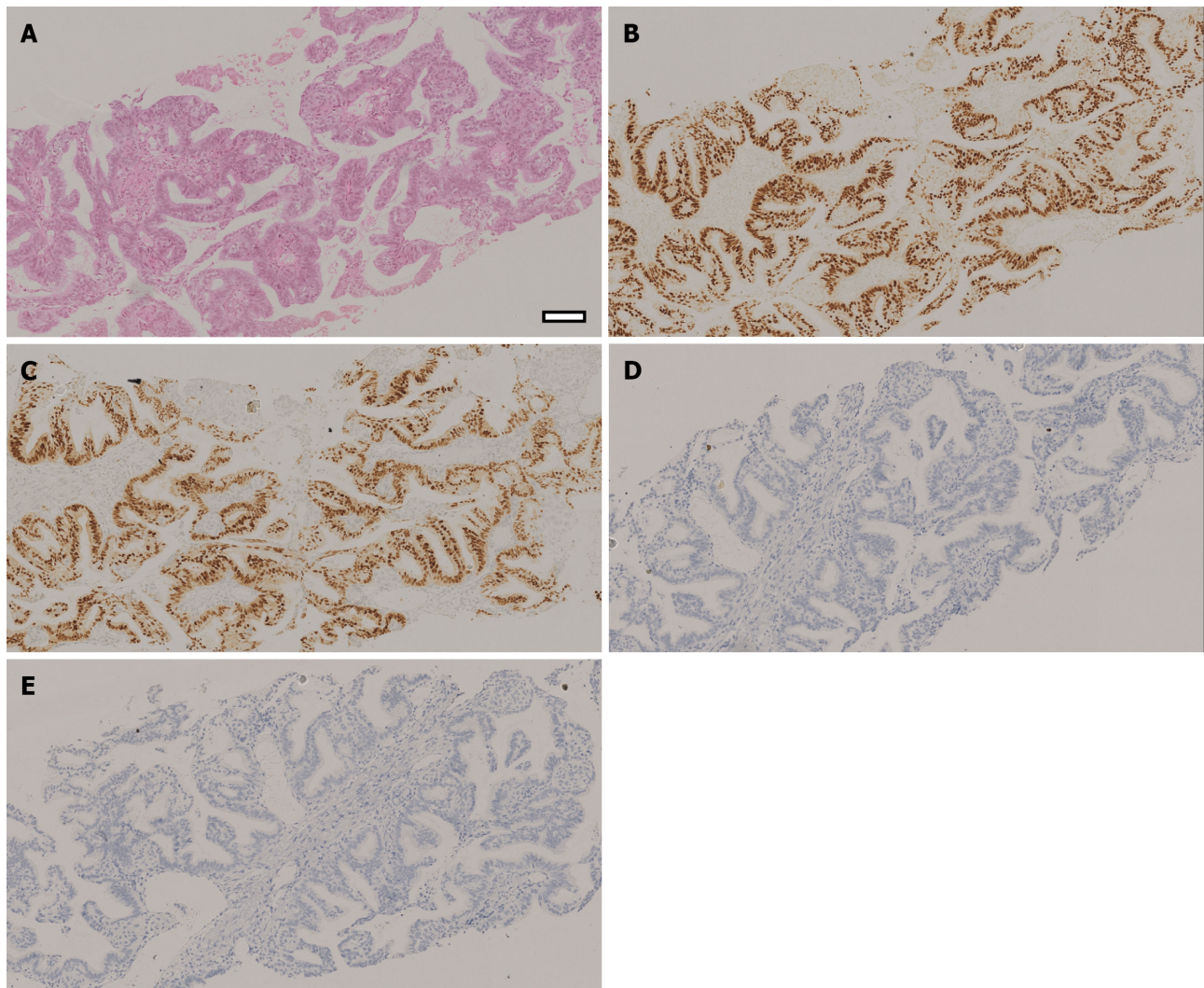
2020. After 2 cycles of treatment, the sum of the maximum diameter of the target lesions decreased from 165.7 mm to 104.7 mm with a reduction rate of 36.8%, which meets PR. Regular examination showed that massive necrosis was clearly observed (Figure 3) and the therapeutic effect was long-lasting (Figure 4). The treatment is ongoing, and PFS2 has lasted more than 16 mo. During treatment, the patient developed anlotinib-related common terminology criteria for adverse events (CTCAE) grade 1 gingival bleeding, CTCAE grade 2 joint dull pain, and perineal skin ulceration, which were improved after short-term withdrawal and management of symptoms.

## DISCUSSION

EC exhibits high heterogeneity in its molecular, biological, and pathological aspects. Endocrine therapy and chemotherapy are the primary treatment strategies for advanced, recurrent, and metastatic EC. However, the ORRs are not high, and the median PFS remains at approximately 1 year[4]. Traditional pathological classifications divide EC into types I and II. Type I EC is estrogen-dependent and accounts for 60% to 70% of all EC cases[5]. Type I primarily includes endometrioid adenocarcinoma and some rare types, such as the one we reported, in which the patient had endometrioid adenocarcinoma with squamous cells. This type of EC has a fairly good prognosis. Type II EC is hormone-independent and highly invasive and usually has a poor prognosis. However, the traditional pathological classification has certain limitations. For example, certain high-grade (G3) endometrioid and serous carcinomas are hard to distinguish morphologically. Traditional classifications have certain shortcomings when used as clinical risk predictions: Estrogen levels are positively correlated with the mortality risk of type I and II EC; the prognosis of patients with the same type could be very different, while molecular tests of the two types can show overlapping results. In 2013, The Cancer Genome Atlas of the United States proposed a molecular classification of EC based on whole-genome sequencing analysis. EC is divided into four types: Hypermutation of DNA polymerase E (POLE), MSI, low copy number/MSS, and high copy number[6]. In this case, genetic testing results based on a high-throughput sequencing platform indicated POLE (-), CTNNB1 missense mutations, TP53 (-), TMB-L, and MSS; thus, the patient belonged to the low copy number/MSS category.

Immunotherapy is currently being used to treat refractory gynecological malignant cancers. In 2019, pembrolizumab was included in the NCCN Clinical Practice Guidelines to treat patients with MSI-H/dMMR-type recurrent or metastatic endometrial cancer who failed previous treatments[7]. However, MSI-H/dMMR-type endometrial cancer only accounts for 25% to 30% of the cases, while the rest are pMMR/MSS-type endometrial cancer, which hardly responds to immune checkpoint inhibitor monotherapy[7]. In this case, the patient had endometrial carcinoma with TMB-L, PD-L1 (-), and MSS, suggesting limited effects of immunotherapy. MDM4 amplification also indicated high potential for drug resistance and disease hyperprogression[8]. However, with heterozygous HLA-A1, we decided to





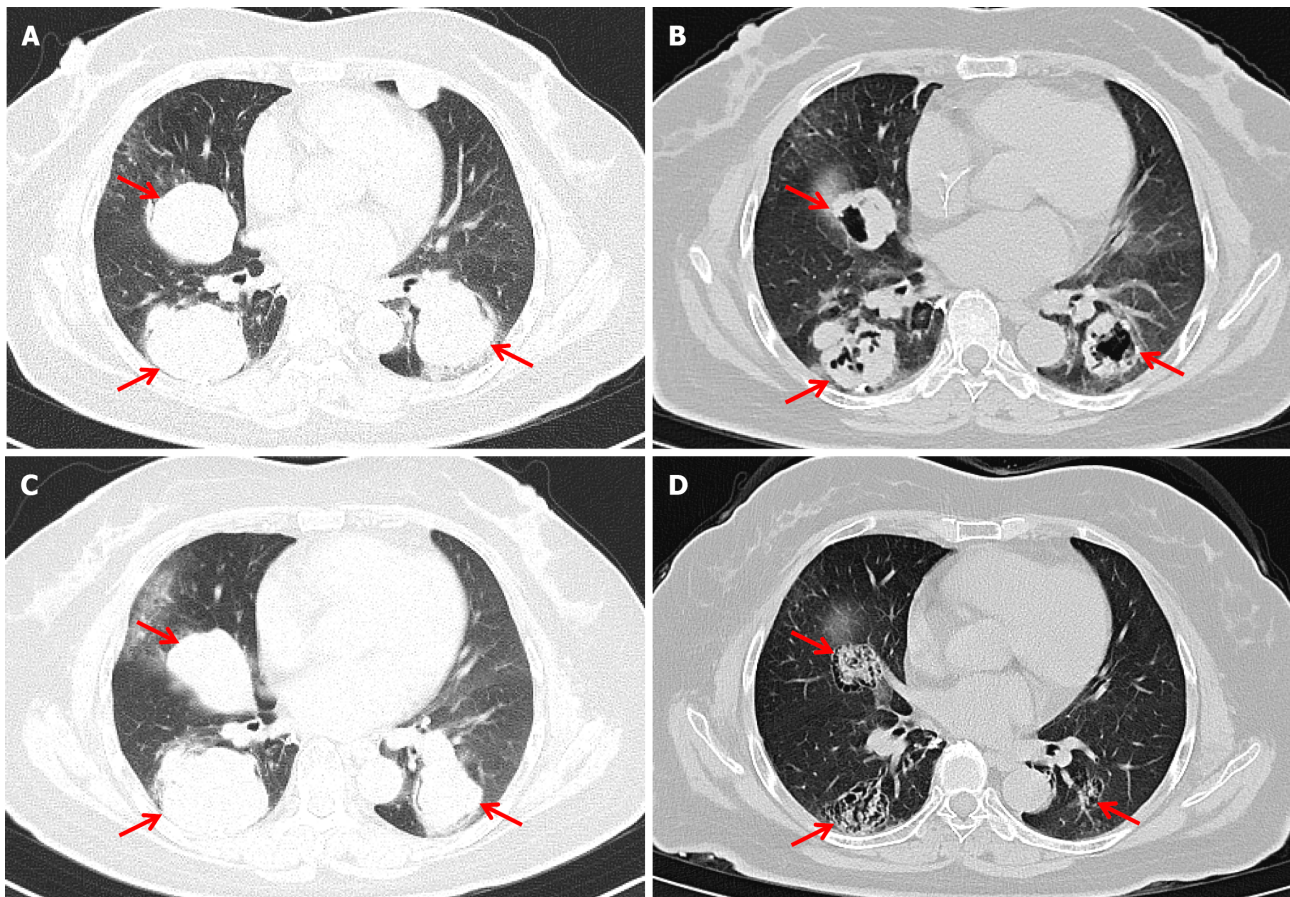
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**Figure 1** Pathological examination of pulmonary biopsy of the patient. The Hematoxylin-eosin staining and immunohistochemistry staining results indicated that the endometrioid adenocarcinoma had metastasized to the lung. A: A hematoxylin and eosin-stained slide showed the glands are arranged back-to-back and crowded, with complex branches. Parts of them form papillary structures into the glandular lumen, with only a small amount of stroma. The glandular epithelium is stratified with no polar orientation. The nuclei tend to be round. The nuclear to cytoplasmic ratio was increased, the chromatin were vacuolated, and nucleoli could be seen; B: Estrogen receptor staining showing diffuse estrogen receptor expression; C: Progesterone receptor staining showing diffuse nuclear progesterone receptor expression; D: Thyroid transcription factor-1 (TTF-1) immunohistochemistry showing negative TTF-1 staining in the nucleus; E: Napsin A immunohistochemistry showing negative Napsin A staining in the cytoplasm. Original magnification: 100 ×; scale bar: 100 μm.

administer a PD-1 inhibitor. After sufficient communication with the patient and her family, we decided to use albumin-bound paclitaxel combined with toripalimab. Toripalimab is a recombinant humanized anti-PD-1 monoclonal antibody developed by Shanghai Junshi Bioscience Co., Ltd. (Shanghai, China). It binds to PD-1 on the surface of T cells and blocks its binding to the ligands PD-L1 and PD-L2 on tumor cells, therefore reversing the immunosuppression of the PD-1 signaling pathway and activating T cell functions to inhibit tumor growth[9]. After the patient was treated with chemotherapy combined with PD-1 monoclonal antibody, satisfactory results were achieved, and the patient achieved PR. However, we had to discontinue treatment due to peripheral neurotoxicity caused by chemotherapy.

Vascular endothelial growth factor receptor (VEGFR) activation leads to angiogenesis, which plays a key role in EC growth and metastasis[10]. Patients with high VEGFR expression often have poor prognosis[10]. Moreover, blocking the vascular endothelial growth factor (VEGF) pathway combined with anti-PD-1 monoclonal antibody therapy could have synergistic effects[11]. With the success of Keynote-146, the FDA approved lenvatinib combined with pembrolizumab as a second-line treatment of EC with systemic treatment failure, with no effective surgery or radiotherapy, and not the MSI-H/dMMR-type[12] of EC. Anlotinib is a small molecule multitarget tyrosine kinase inhibitor that can inhibit kinases such as VEGFR, PDGFR, FGFR, and c-Kit and thus has antiangiogenesis and tumor growth inhibition activities[13]. Studies have shown that anlotinib can inhibit PD-L1 expression by vascular endothelial cells, improve the immune component of the tumor microenvironment, and induce and enhance antitumor CD8<sup>+</sup> T lymphocyte infiltration, all of which provide a better tumor microenvi-





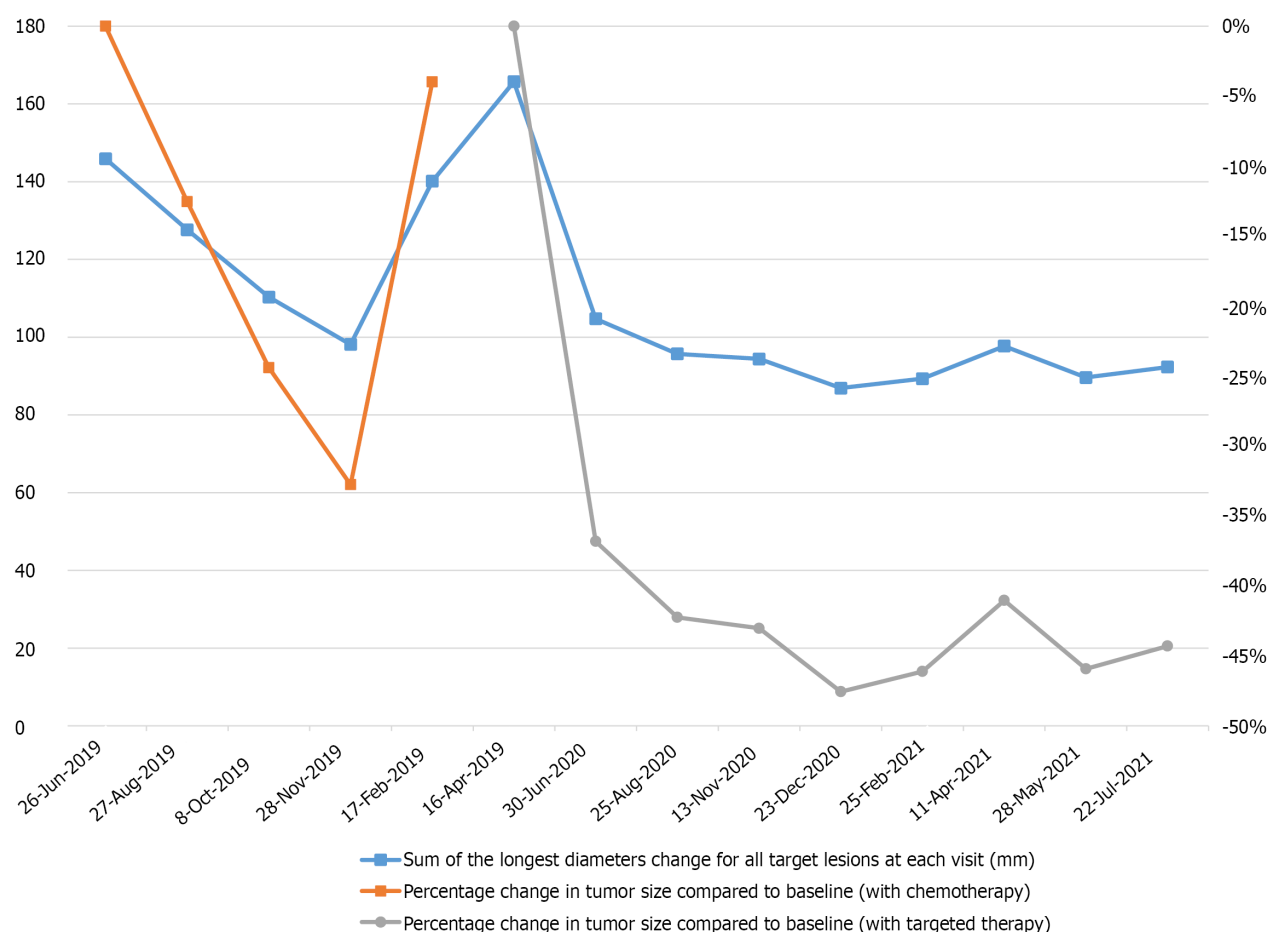
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**Figure 2** Computed tomography images scans showing changes in lung tumors after combined programmed cell death receptor-1 inhibitor therapy. Chest computed tomography images showing multiple metastases in bilateral lungs. The three metastases with the largest diameters were selected as target lesions (red arrow). A: The sizes of target lesions before PD-1 inhibitor combination treatment were 47.4 mm, 50.1 mm, and 48.4 mm (6/26/2019); B: The target lesions had regressed in size to 28.9 mm, 37.2 mm, and 32.0 mm after chemotherapy combined with immunotherapy (11/28/2019); C: The target lesions were 57.6 mm, 56.9 mm, and 51.2 mm after 4.4 mo discontinuing treatment (4/16/2020); D: Target lesions had regressed in size to 26.8 mm, 35.8 mm, and 24.3 mm after immunotherapy combined with anti-angiogenesis therapy and massive necrosis was clearly observed (12/23/2020).

onment for immunotherapy[13]. Considering the severe adverse reactions of chemotherapy, the patient was switched to anlotinib + toripalimab. This combination also reduces the possibility of tumor hyperprogression from using immunotherapy alone. Furthermore, anlotinib compensates for the slow onset of the immune checkpoint inhibitor, and the CT scan showed PR after two treatment cycles. PR status remained, and PFS has reached more than 16 mo to date. This successful result also demonstrates the feasibility of using China's own checkpoint inhibitors with antiangiogenesis for treating patients with pMMR/MSS EC. Compared with imported medications, the significant economic advantage of domestic drugs can also reduce some of the financial burden on patients.

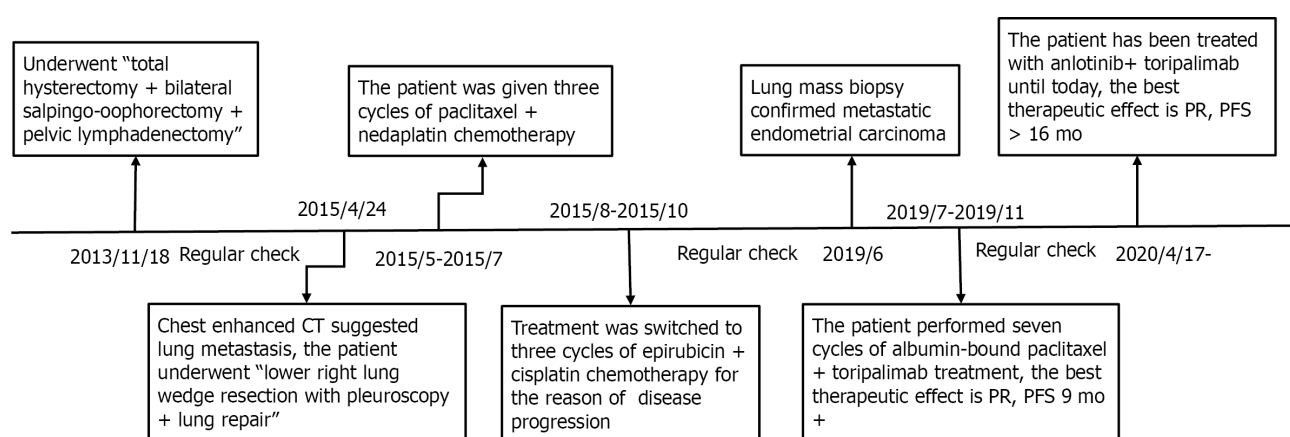
Although the combination of pembrolizumab and lenvatinib has remarkable therapeutic effects, this combination has a fairly high incidence of adverse events, with 97% experiencing treatment-related adverse events (TRAEs), among which 66.9% are grade 3 and above[14]. It is necessary to pay close attention to adverse events in clinical applications so that responses can be made for the best treatment results. In this case, the patient only experienced CTCAE grade 1 gingival bleeding, CTCAE grade 2 joint pain, and perineal skin ulceration, which were improved after short-term drug withdrawal and management of symptoms. In our previous study of advanced lung cancer, five patients were treated with anlotinib and toripalimab[15]. Three cases of CTCAE grade 1 pneumonitis and one case of CTCAE grade 2 asthenia and low appetite were reported. All adverse events were controlled through dose adjustment, medication suspension, and supportive treatment. Our previous study and this case both suggest that the combination of anlotinib with toripalimab presents safety advantages compared with other antitumor treatments.

In summary, EC is highly heterogeneous and requires molecular classification in clinical applications. For patients with pMMR/MSS EC, this case demonstrated satisfactory results using China's own PD-1 inhibitor, toripalimab, and combined anti-angiogenesis treatment. Thus, these important findings deserve further clinical exploration.



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**Figure 3** Sum of all longest diameters for all target lesions recorded at each visit and its percentage change from baseline during programmed cell death receptor-1 inhibitor with chemotherapy or targeted therapy.



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**Figure 4** Timeline of diagnosis and treatment for mismatch repair proficient / microsatellite stability/human leukocyte antigen-1 heterozygous endometrial carcinoma.

## CONCLUSION

In summary, EC is highly heterogeneous and requires molecular classification in clinical applications. For patients with pMMR/MSS EC, this case demonstrated satisfactory results using China's own PD-1 inhibitor, toripalimab, and combined anti-angiogenesis treatment. Thus, these important findings deserve further clinical exploration.

## FOOTNOTES

**Author contributions:** Zhai CY participated in clinical treatment and prepared the manuscript; Yin LX sorted out the materials and checked the manuscript; Han WD is the doctor in charge of the case.

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