

# Ten Best Readings Relating to Endometrial Cancer

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**Alvarez Secord A, Havrilesky LJ, Bae-Jump V, et al. The role of multi-modality adjuvant chemotherapy and radiation in women with advanced stage endometrial cancer. *Gynecol Oncol.* 2007;107(2):285-291.**

Combined adjuvant chemotherapy and radiation was associated with improved survival in patients with advanced-stage disease compared with either modality alone.

**Ushijima K, Yahata H, Yoshikawa H, et al. Multi-center phase II study of fertility-sparing treatment with medroxyprogesterone acetate for endometrial carcinoma and atypical hyperplasia in young women. *J Clin Oncol.* 2007;25(19):2798-2803.**

The efficacy of fertility-sparing treatment with a high-dose of medroxyprogesterone acetate for endometrial carcinoma and atypical hyperplasia was proven by this prospective trial. Even in responders, however, close follow-up is required because of the substantial rate of recurrence.

**Goldberg H, Miller RC, Abdah-Bortnyak R, et al. Outcome after combined modality treatment for uterine papillary serous carcinoma: a study by the Rare Cancer Network (RCN). *Gynecol Oncol.* 2008;108(2):298-305. Epub 2007 Dec 21.**

Uterine papillary serous carcinoma harbors a moderate prognosis, with age, stage and histology as significant prognosticators. Conservative surgery followed by adjuvant chemotherapy and pelvic radiotherapy can be suggested as an appropriate treatment approach for patients treated with curative intent.

**Mariani A, Dowdy SC, Cliby WA, et al. Prospective assessment of lymphatic dissemination in endometrial cancer: a paradigm shift in surgical staging. *Gynecol Oncol.* 2008;109(1):11-18. Epub 2008 Mar 4.**

The high rate of lymphatic metastasis above the inferior mesenteric artery indicates the need for systematic pelvic and para-aortic lymphadenectomy (vs sampling) up to the renal vessels. The latter should include consideration of excision of the gonadal veins. Conversely, lymphadenectomy does not benefit patients with grade 1 and 2 endometrioid lesions with myometrial invasion  $\leq 50\%$  and primary tumor diameter  $\leq 2$  cm.

**Abu-Rustum NR, Iasonos A, Zhou Q, et al. Is there a therapeutic impact to regional lymphadenectomy in the surgical treatment of endometrial carcinoma? *Am J Obstet Gynecol.* 2008;198(4):457.e1-5; discussion 457.e5-6.**

This study emphasizes the importance of lymph node dissection in endometrial cancer. Lymph node dissection is essential for accurate surgical staging, which remains the most important prognostic factor. In addition to well-known clinicopathologic risk factors for survival, the removal of 10 or more regional lymph nodes was associated with improved overall survival in lower-stage, older patients who received no adjuvant therapy or brachytherapy only.

**Frumovitz M, Singh DK, Meyer L, et al. Predictors of final histology in patients with endometrial cancer. *Gynecol Oncol.* 2004;95(3):463-468.**

A clinically significant number of patients will have more advanced disease than predicted by preoperative or intraoperative prognostic factors. These predictors should not be relied on in the staging of endometrial cancer.

**Schmeler KM, Lu KH. Gynecologic cancers associated with Lynch syndrome/HNPCC. *Clin Transl Oncol.* 2008;10(6):313-317.**

Women with Lynch syndrome have a 40% to 60% risk of endometrial cancer and a 12% risk of ovarian cancer. Special screening and risk-reducing guidelines are presented.

**Maxwell GL, Tian C, Risinger JI, et al. Racial disparities in recurrence among patients with early-stage endometrial cancer: is recurrence increased in black patients who receive estrogen replacement therapy? *Cancer.* 2008;113(6):1431-1437.**

The findings of the current study suggested that recurrence-free survival may be shorter among black women with stage I endometrial cancer, even in a clinical trial setting in which patients received similar treatment and follow-up. This increased risk of recurrence appeared to be most evident in black women with endometrial cancer who maintained ERT after primary treatment.

**Palomba S, Falbo A, Mocciaro R, et al. Laparoscopic treatment for endometrial cancer: a meta-**

**analysis of randomized controlled trials (RCTs). *Gynecol Oncol.* 2008 Oct 28. Epub ahead of print.** Although limited by few RCTs with short-term follow-up, this group's data suggest that a laparoscopic approach should be considered as an effective and safe procedure for patients with early-stage endometrial cancer as well as laparotomy. Notwithstanding the longer operative time, advantages of the laparoscopy over traditional laparotomy include reduced intraoperative blood loss and postoperative complications.

**Bogges JF, Gehrig PA, Cantrell L, et al. A comparative study of 3 surgical methods for hysterectomy with staging for endometrial cancer: robotic assistance, laparoscopy, laparotomy. *Am J Obstet Gynecol.* 2008;199(4):360.e1-9.**

Robotic-assisted hysterectomy with staging is feasible and preferable over the laparotomy technique and may be preferable over the traditional laparoscopy technique in women with endometrial cancer. Further study is necessary to determine long-term oncologic outcomes.