Endometrial Cancer

Endometrial Cancer

1. Incidence

Endometrial cancer usually arises in post-menopausal woman. It is the most common gynecological cancer in developed countries.

Incidence increases between the ages of 40 and 55.

2. Risk factors

- obesity
- amoxifen therapy
- oestrogen therapy unopposed by progestogens
- PCOS
- early menerche and late menopause
- post menopausal woman with atrophic endometrium
- diabetes and hypertension
- Family history of colorectal cancer, endometrial cancer, breast cancer (HNPCC)

3. Clinical features

• perimenopausal irregular vaginal bleeding (intermenstrual bleeding, abnormal uterine bleeding) and post menopausal bleeding (80%), abnormal vaginal discharge.

• pelvic or lower abdominal pain and pressure symptoms and lately, symptoms of metastasis.

4. Investigations

• Ultrasound (transvaginal ultrasound is preferable) examination to detect endometrial thickness and any metastasis should be done first. In postmenopausal women, endometrial thickness should be < 5 mm.

• endometrial sampling by Pipelle, MVA (manual vacuum aspiration) at OPD.

• Hysteroscopy and biopsy if available.

• Pelvic MRI is necessary to detect myometrial invasion, cervical involvement and adnexal extension.

• CT scan is good for assessing retroperitoneal lymph nodes.

• CXR is needed to detect metastasis and preoperative assessment.

FIGO Staging

I: Tumor confined to the corpus uteri

IA: No or less than half myometrial invasion

IB: Invasion equal to or more than half of the myometrium

II: Tumor invades cervical stroma, but does not extend beyond the uterus

III: Local and/or regional spread of the tumor

IIIA: Tumor invades the serosa of the corpus uteri and/or adnexae

IIIB: Vaginal involvement and/or parametrial involvement

IIIC: Metastases to pelvic and/or para-aortic lymph nodes

IIIC 1: Positive pelvic nodes

IIIC 2: Positive para-aortic nodes with or without positive pelvic lymph nodes

IV: Tumor invades bladder and/or bowel mucosa, and/or distant metastasis

IVA: Tumor invasion of bladder and/or bowel mucosa

IVB: Distant metastasis, including intra-abdominal metastases and/or inguinal nodes

5. MANAGEMENT

- Surgery is the main stay of treatment.
- Staging is surgicopathological.
- Staging laparotomy to explore the pelvic and whole abdomen and pelvic and para aortic lymph nodes.
- Standard surgery is total hysterectomy +/- bilateral salpingo-ophorectomy for low risk and modified radical hysterectomy in advanced stage with lymphadnectomy.
- Cut section of dissected uterus to detect the myometrial involvement and intrauterine lesion.
- Ovarian preservation can be considered in younger patients (< 45 years, Grade 1 endometrial cancer, with < 50% myometrial invasion)
- Staging omentectomy should be considered in serous high risk serous papillary uterine carcinoma.

Adjuvant Therapy

Post operated RT is necessary in moderate and high risk patients.

- Stage IB, grade 3
- Type 2 (serous papillary, clear cell) with any myometrial invasion
- grade 3, >60 years with any myometrial invasion
- >50% myometrial invasion, grade 1/2, >60 years
- stage II (any grade)

• Multimodality management should be considered for advanced carcinoma.

• Radiotherapy should be considered for patients who are not fit for surgery.

Follow Up

Refer to Gyne-onco centre if suspicious of recurrence

History and physical examination and vaginal examination

Other investigations as required

3 to 4 monthly for first 2 years

6 monthly for further 3 years

Then annually

References

1. Obstetrics and Gynaecology An evidence-based Text book for MRCOG

2. Obstetrics and Gynaecology Myanmar management guidelines, 2024