Endometrial cancer: an update

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Endometrial cancer is the most common cancer increasing in post-menopausal women and lung.

Who gets the disease?
The majority of women developing endometrial cancer have risk factors which increase chronic estrogen exposure. This is attributed to the increase in this disease.

Risk factors for endometrial cancer
- Post-menopause/Increasing age
- Obesity
- Early menarche and late menopause
- Polycystic ovarian syndrome
- Low parity, family history
- Lynch syndrome
- Diabetes
- Estrogen-secreting tumours
- Hypertension
- Breast cancer
- Hormone replacement therapy
- Tamoxifen
- Previous pelvic radiotherapy
- Unopposed oestrogen
- High fat/High carbohydrate diet

Pathology of endometrial cancer
The majority of women will have Type 1 tumours (80 to 90%), which are estrogen-dependent adenocarcinomas, generally of good prognosis. Type 2 tumours are more aggressive and have a much higher risk of presenting with metastatic disease at presentation and of subsequent relapse. These tumours are generally of clear cell or serous papillary type.

In those women who are diagnosed with endometrial hyperplasia, rather than a frank malignancy, the risk of developing a subsequent endometrial cancer must be considered. Simple or complex hyperplasias have a relatively low risk of malignancy (1 to 3%) and hormonal therapy with progestogens may be appropriate. Those women with complex hyperplasia with atypia however have a 30 to 40% chance of a concurrent carcinoma at the time of presentation.

Treatment of endometrial cancer
The majority of women with endometrial cancer will present with Stage 1 disease, i.e. disease confined to the uterus. In these patients total hysterectomy with bilateral salpingoophorectomy is the treatment of choice. This can be performed both abdominally and via a laparoscopic approach, although most cancer centres within the UK now favours the latter as recovery time after surgery is much improved.

The use of staging MRI prior to surgery enables invasion of the myometrium, cervical or ovarian involvement and enlarged lymph nodes to be identified, which together with the grade of pathology at diagnosis, will influence the decision as to whether a pelvic and or para aortic lymphadenectomy should be performed. The role of lymphadenectomy has been much debated over the last few years with conflicting data from around the world. In general, however, the consensus is that with Grade 1 early stage tumours there is probably no role for lymphadenectomy, while in high-risk patients it may help plan adjuvant therapy.

Adjuvant therapy
In those women with early stage, low-grade disease no adjuvant therapy is required, including hormonal manipulation, which was given in the past. In high-risk patients with deep involvement of the myometrium and/or cervical involvement, adjuvant therapy consisting of radiotherapy (brachytherapy + external beam) is the treatment of choice. Those women with nodal involvement or distant disease at the time of presentation will be offered chemotherapy, often followed by radiotherapy to help local control. Although progestogens may have a role in metastatic disease, many high-risk tumours are receptor negative and are therefore unlikely to respond to this form of treatment.
Survival

The overall survival of women with endometrial cancer is approximately 80%. If we are to make improvements in survival rates then early presentation and diagnosis of women must be improved together with careful individualisation of patient treatment plans depending on the tumour type, stage and grade.

For further information about our services please contact our GP Liaison Team on +44 (0)20 7460 5973.