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Editorial

ENDOMETRIAL CARCINOMA

Carcinoma of the endometrium is essentially a disease of women in the perimenopausal age or later. Its incidence has been on the rise partly due to increased longevity, acceptance of the small family norm, and widespread use of oestrogenic drugs. In U.S.A., endometrial cancer is fast emerging as the leading cancer of the genital tract. According to the estimate of the American Cancer Society, about 38,000 new cases of endometrial cancer are reported annually but only 3,200 women die of it annually in the U.S.A. This high cure rate is possibly because many of them are detected early and are often of a low histologic grade of malignancy, wherein a simple panhysterectomy can cure the patient. In India, the picture is somewhat different. Cancer cervix still accounts for the majority of gynaecological cancers. Vyas and Desai reviewing the gynaecological malignancies at the Tata Memorial Hospital, Bombay, reported that cancer cervix accounts for 86% of cases, Ovary—8%, Uterus—3%, Vulva and Vagina—2.5% and other sites 0.5% respectively.

The key to early diagnosis is a greater degree of awareness on the part of the clinician, so that an adequate histologic sample of the endometrium is evaluated in all women at 'high-risk'. The high risk factors to be considered in women with abnormal bleeding are age exceeding 40 years, Obesity, Abnormal Carbohydrate Tolerance, Hypertension, Infertility and anovulation, Estrogen therapy, Post-Irradi-

ation bleeding or suspicion of accompanying ovarian neoplasm.

Amongst the various screening diagnostic procedures evaluated for sampling the endometrium in our efforts at early detection of the disease, four examination methods deserve a mention (1) Endometrial Jet Washing. (2) Use of Nylon Endometrial brushes. (3) Hysteroscopic examinations coupled with selective endometrial biopsies and (4) Endometrial curettages preferably fractional.

The general concensus of opinion is that histologic examinations are superior to cytologic examinations, because it allows the proper diagnosis not only of the cancer but also its hyperplastic precursors. Effective treatment of atypical endometrial hyperplasia can prevent this cancer from ever developing.

A fractional dilatation and curettage after a thorough clinical examination under anaesthesia is necessary for proper staging of the disease. The information which one must obtain is the depth of the endometrial cavity, presence of disease in the endocervix, grade of the tumour, and clinical evidence of disease in the parametrium, adnexae, bladder and rectum. Intravenous pyelogram, cystoscopy and proctosigmoidoscopy may be further utilised if indicated.

Staging of the disease is important to decide on the line of treatment to be adopted to give the best results and prognosis. Unlike most grading classifications in

other neoplasms, the FIGO (1970) classification is based on the architecture of the tumour rather than the cytologic characteristics of the tumour cell types.

FIGO staging of Endometrial Cancer.

Stage—I: The carcinoma is confined to the Corpus.

Subdivision according to the size of the uterus.

Stage—Ia: The uterine cavity sounds to 8.0 cms or less.

Stage—Ib: The uterine cavity sound to more than 8.0 cms.

Subdivision according to histology.

G-1: Highly differentiated adenomatous carcinoma.

G-2: Differentiated adenomatous carcinomas with partly solid areas.

G-3: Predominantly solid or indifferently differentiated carcinoma.

Stage—II: The carcinoma has involved the corpus and cervix.

Stage—III: The carcinoma has extended outside the uterus, but not outside the true pelvis.

Stage—IV: Involvement of bladder, rectum or presence of distant metastasis.

In Western countries, the majority of the patients seen at oncologic clinics are seen in the earlier stages when the disease is restricted to the uterus. However in India, patients seek medical help when the disease is far advanced. Vyas and Desai reported 58% of their cases were in stage—I, 12% in stage II, 5% in stage III and 25% in stage IV.

The most important modality of treatment continues to be Total Abdominal Hysterectomy with bilateral salpingo-oophorectomy. The use of more extensive surgery or adjuvant radiotherapy probably does not materially alter the prognosis of stage I disease. But radiotherapy does benefit women with deep myometrial penetration and extension to the cervix.

The addition of high dosage progestagen therapy to standard therapy or radiotherapy to more advanced cases of endometrial cancer can yield further benefits with the virtual absence of undesirable side effects

A summary guide-line for treatment plans for endometrial cancer are outlined below

Experiences at the Tata Memorial Hospital, Bombay reveal that radiotherapy prior to surgery, uniformly improves the 5 year cure rates. A comparison of treatment modalities of stage I Endometrial cancer reveal that Total Abdominal Hysterectomy with Bilateral Salpingo-oophorectomy gave a 5 year cure rate of 47%, Radiotherapy gave, a comparable 5 year cure rate of 49%. But the best results of 71% were obtained in cases treated with pre-operative irradiation followed by surgery. Their overall cure rates were also better when combined radiotherapy and surgery were employed, and the recurrence rates in the genital tract were the lowest with this form of therapy.

In conclusion, it may be stated that a concerted effort must be launched to screen perimenopausal women in the high risk category for endometrial cancer to enable the establishment of an early diagnosis amenable to therapy and yielding satisfactory results.

A note of caution should be sounded against the indiscriminate use of synthetic estrogens for replacement therapy in cases of premature ovarian failure, ovarian agenesis, or for the control of menopausal symptoms. Use of natural conjugated oestrogens in a cyclic manner with addition of intermittent progestogens is a more rational approach.

Attempts to diagnose and treat precursors of endometrial carcinoma should be emphasised.

Explanations for cases of treatment failures should be sought to improve methods of evaluation and treatment. Studies implemented to assess the importance of occult nodal spread of the disease in the pelvis and para-aortic nodes. Significance of cancer cells in peritoneal washings scrutinised, and methods to determine specific progesterone receptor proteins established. Data obtained from such studies will throw light on future methods of management of the disease.

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