Uterine cancer

Surgical management of endometrial cancer

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Hysterectomy for benign disease

- Too many unnecessary hysterectomy for no reason or harmless benign process

- For bleeding some without pre-op evaluation

Do not do hysterectomy without checking endometrium

- In presence of Premenopausal irregular bleeding

1 in 70 will have Endo. Ca.

- in presence of postmenopausal bleeding

1 in 10 will have Endo. Ca

- Be careful morcellating!!!!!

- Do not Use laparoscopy for TAH if you do not have benign endometrial tissue sample
- **Do not use Marcelation if you are not sure of presence of benign process**

Endometrial cancer Prognostic factors

- Increase incidence but most with early stage and good prognosis surgery alone
- Difficult to Identify early stage pts. who are H-risk for recurrence

- Tumor molecular profiling &
  Biomarker p53 & L1CAM
  Investigational

Endometrial cancer prognostic risk factors

- Grade
- LVSI
- Age
- Stage including MI
- Histologic type

  type I (70%): Metabolic Syndrome

  Type II

Endometrial carcinoma

- Endometrioid adenocarcinoma &
  Adenosquamous carcinoma: 80%

Endometrial carcinoma type II histology

- Serous carcinomas. 10%
- Clear cell carcinoma. 4%
- Mixed histology
- Others

❖ **?!! Poorly diff. endometrioid (G3)**

Endometrial cancer Management

- TAH
- TAH,BSO
- Radical hysterectomy
- Primary radiation therapy ICS or Ext RT
- Post op radiation
- Hormone therapy

Endometrial cancer treatment

- Conservative hormone therapy

RR; +/- 50%in carcinoma group rate of pregnancy:35%

Endometrial cancer treatment

- TAH ,BSO
- Vaginal brachytherapy In most patients

Endometrial cancer surgical staging

- Has been pushed for in name of help in:

  1- prognosis

  2- to identify pts For:

  Chemotherapy or

  Radiotherapy

- Without any strong data's to support it!?

  without significant effect on OS or PFS!

Endometrial cancer
Surgical treatment

- Standard:

  Total extrafascial Hysterectomy & BSO

  Meaning removing Cx too!!!
- Lymph nodes assessment & removal of suspicious nodes
- Gross examination of abdominal cavity
- Biopsy of suspicious areas
- ?!!Omental biopsy

Endometrial carcinomas surgical treatment

- Minimally invasive surgery

vs open surgery

Endometrial cancer
Peritoneal cytology

- Without association of other risk factors

- With association of other risk factors

Endometrial cancer treatment

- Preserving ovaries

Ovarian removal in early stage endometrial cancer

- Presence of micro metastasis
- Decrease circulating estrogen production as promoter of proliferation of metastatic cells

(Theoretical!?)

Endometrial cancer ovarian preservation

- Young patients (<50yrs. Of age)
  - -no adverse effect on survival
  - -but better OS
  - -help vasomotor symptoms
  - -less bone density loss
  - -decreased risk of CVD
  - -more fertility options
- Without Lynch Syndrome

Endometrial cancer

- Pelvic lymph nodes dissection
- paraaortic lymph nodes
  sampling or dissection

Endometrial cancer Paraaortic lymph nodes

- Lymphatic drainage: from pelvis to Paraaortic region
- Difficult procedure in these patients
- Vena cava injuries
- Hi-risk pts. Of +pelvic nodal will receive systemic therapy
- No significant risk of isolated +PA nodes

Endometrial cancer
Pelvic lymph nodes removal

- In pts. with G3, MI>50%.

  G3+MI.50%. & Type II Histology
- UK (MRC-ASTEC) study: 1408 pts.2009

  (IM-risk & HR)

  No OS benefit
- Second Italian study: 514pts. 2008

  No OS or DFS benefit

Endometrial cancer lymphedema

- Mayo clinic criteria.

  Nodal disease in o.8% LR

  in 10.7% HR

- Rate of lymphedema 10-11%

Endometrial cancer
Pelvic lymph nodes removal

- No OS or PFS or DFS
- Surgical complications
- In hand of most providers inadequate nodes removal

Why do it?!!!

Endometrial cancer
Surgical treatment

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Endometrioid carcinoma of Endometrium

- Sentinel node dissection

- Stage IA G3


Abyaneh
from Widow