Gynaecological Oncology News

News on Endometrial Cancer

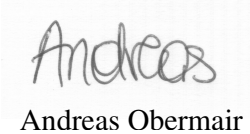
Dear Colleagues,
Thank you very much for the encouraging and positive feed back I have received over the last year for the previous three editions of The Gynaecological Oncology News. The newsletter is an easy way to keep contact between referring doctors, specialists and GPs and my practice. This time I would like to update you about recent findings from research on endometrial cancer (http://www.obermair.info/publications.shtml).

Incidence of endometrial cancer in Australia: Endometrial cancer is on the rise in Australia due partly to ageing population, increasing prevalence of overweight, obesity and diabetes among the female population. In Queensland the incidence of endometrial cancer increased 1% per year in the last few years. Currently, we see some 250 patients diagnosed every year with endometrial cancer in Queensland. I cannot stress enough the importance of vigilance by GPs in ensuring that the main symptom of this cancer, *postmenopausal vaginal bleeding*, is promptly investigated.
Endometrial cancer is now the most common gynaecological cancer, as its incidence has overtaken that of ovarian cancer in recent years. Due to early detection and treatment, its prognosis is relatively good. Delay of diagnosis will likely result in disease progression and jeopardise outcomes.

Investigations of Postmenopausal Bleeding: Endometrial sampling using the Pipelle endometrial biopsy device is used world-wide in the investigation of postmenopausal bleeding or for screening of women at high risk for endometrial cancer (gene mutations). It is a minimally invasive alternative for dilatation and curettage (D&C) or hysteroscopy and can be done in your surgery. The use of this technique saves the patients the inconvenience of a general anaesthetic without reducing accuracy.
The Pipelle endometrial biopsy device is a thin catheter, which is inserted through the cervical os and advanced into the uterine cavity until gentle resistance is felt. The inner piston of the device is then withdrawn to create a suction and the endometrial sample is obtained by moving the Pipelle up and down within the uterine cavity by approximately 2-3cm. The Pipelle is then withdrawn and the endometrial sample expelled into a specimen container (formalin). In women 80+ years, the chance of cervical stenosis is significant, resulting in the impossibility to pass the Pipelle device through the cervical os. Some patients will experience period-like pain during the procedure.
Its accuracy is very high. In a meta-analysis including almost 8,000 women, the detection rate for endometrial carcinoma by this device was higher in postmenopausal women (99.6%) compared with premenopausal women (91%). In cases of a negative Pipelle but recurrent abnormal uterine bleeding, I would still recommend a hysteroscopy and D&C.

ASTEC Trial - Lymph node dissection in Endometrial Cancer: A new landmark clinical trial from the U.K. (ASTEC trial) has been presented at the conference of the European Society of Gynaecological Oncology (paper still unpublished) late last year. Patients were randomised to receive a full pelvic node dissection versus only a sampling of enlarged/suspicious pelvic nodes. The rate of positive lymph nodes was 5% versus 18% in the group of patients who received the full pelvic node dissection versus the sampling of enlarged/suspicious nodes, respectively. Disease-free and overall survival were similar in both treatment arms. In summary, this trial shows while there is no role for a systematic pelvic lymph node dissection in every patient, the spaces of the pelvic side wall should be opened and enlarged or suspicious nodes should be removed.
A full pelvic node clearance is associated with a substantial risk of debilitating lymphedema of the legs. For this very reason, I think ASTEC is an important trial because it justifies to limit our surgical aggressiveness towards this disease which carries such a good overall outcome.

Please do not hesitate to contact me to discuss specific cases on the phone (☎ 3847 3033; Page 3830 5824).



Andreas Obermair