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Endometrial cancer: department experience

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Abstract:
Background*: to evaluate the results of the surgical treatment and the prognostic elements in our patients.*
Material and method*: from January 2016 to December 2018, 86 patients were operated on in the oncological surgery department A of the CPMC.*
Results*: The mean age of the patients was 58.54 years [32-88], more than half had a history of metabolic disease, five patients had a history of lynch syndrome.*
Fifty-four patients were classified ASA II, 62.7%; the most frequent histological type in our population is type I (endometriotic adenocarcinoma) [84%], the majority of patients were classified stage I by FIGO (International Federation of Gynecologists and Obstetricians), i.e. (62.7%) in preoperative and (52%) postoperative after definitive anatomo-pathological results. Adjuvant treatments depended on these final results.
Conclusion*: Endometrial cancer is considered favorable because it is most often limited to the uterus. Nevertheless, this is a heterogeneous pathology and the overall 5-year survival can vary from 92% to 42% in stages I of FiGO depending on the histological characteristics of the tumor.*
Keywords: *endometrial cancer, lymphadenectomy, lymphovascular invasion, radiotherapy, chemotherapy.*

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I. Introduction

Endometrial cancer is the most common gynecological cancer in developed countries. In terms of incidence, it ranks 4 th among cancers in women. (1,3,4)
It occurs most often in postmenopausal women between 55 and 65 years old. In 14% of cases in the pre-menopausal period and in 05% of cases before age 40. (1, 13)

II. Material and method

From January 2016 to December 2018, 86 patients were treated for endometrial cancer. The patients had previously undergone a biopsy curettage, a pelvic MRI and a complete preoperative assessment, the final pathological examination was carried out at the level of the anatomopathological department of the Pierre and Marie Curie Center (CPMC).
The anatomo-clinical aspect, the histological type and the results after surgery were analyzed retrospectively.

III. Results

The mean age of our patients was 58.54 years [32-88], 25 patients were nulliparous, more than 50% had a history of metabolic disease and five patients (5.8%) had a history of lynch. The average body mass index (BMI) was 32.96 Kg / m2 [20-53], 54 patients were classified ASA II or 65%. Type I (endometrioid adenocarcinoma) was the most common histologic type (84%) while type II (serous, clear cell adenocarcinoma and carcinosarcomas) with a poorer prognosis accounted for 15%.

According to the FIGO classification; preoperatively: 62.7% was classified as stage I, 11.6% was classified as stage II, 19.7% was classified as stage III and 02% was classified as stage IV. Postoperatively, the FIGO classification did not change much compared to the preoperative: stage I (52%), stage II (10%), stage III (30%) and stage IV (03%).

Surgical management included total hysterectomy with bilateral adnexectomy, sometimes pelvic and / or lumbar-aortic lymphadenectomy was associated.

Pelvic dissection was performed in 52% of cases and lumboaortic in 11%, the sentinel node technique was not performed in our series. According to the final anatomopathological results on surgical specimens,

adjuvant treatment was associated: chemotherapy in 21%, brachytherapy in 21% and radiotherapy in 29% (summarized in Table 1).

Table (1) :characteristics of the sample

Caractéristics	**Patients(n=86)**
Age	58,54 (32-88)
History	05 Lynch disease, metabolic disease >50% ,25 nulliparous
BMI (Kg/m2)	32,96 (20-53)
Histological type	Type I=73 (84%) ; type II=13 (15%)
FIGO pre-op	I=54(62,7%), II =10 (11,6%), III=17(19,7%), IV=2(2%), NP=3(3%)
FIGO post-op	I=45(52%), II=9 (10%), III=26(30%), IV= 3(3%), NP=3(3%)
Tumor size (cm)	5,43 (1,5-12)
Lymphnodepelvic dissection :45(52%)	+16 (18%) -29 (33%)
Aorticlymphnodedissection:10 (11%)	+5(05%) -5(05%)
Number ofnodes Lympho vascular involvement	16,64 (2-38) Yes :19 (22%) no :67(77%)
Adjuvanttreatment	CT :18 (21%), curietherapy :18(21%), RTH : 25(29%)

CT: chemotherapy, RTH: radiotherapy

The risk of recurrence is estimated on the basis of prognostic criteria grouping together various groups (low risk of recurrence, intermediate risk and high risk); summarized in Table 2.

Table 2: classification of relapse
Preoperatively

Low risk	**Intermédiate risk**	**High risk**
IA G1-G2 =25 (29%)	IA G3=3 (3%) IB G1-G2=23 (27%) Total: 30%	IB G3 =3 (3%) Stade II =29 (33%) Type II =13 (15%) Total :52%

After definitive anatomopathological examination:

Low risk IA G1-2, EV – 18 (21%)	**Intermédiaite risk EV-** IA G3 4 (4,6%) IB G1-2 :17 (19,7%)	**High intermédite risk EV +** IA G3 IB G1-2	**High risk** IB G3 :1 (1%) >stade II :37 (43%) Type II : 6(6%)
21%	24%	4,6%	50%

EV: vascular emboli

IV. Discussion

Endometrial cancer is the fourth leading cause of cancer in women, and is a pathology in industrialized countries [1,8]. In 2018 worldwide, nearly 382,100 new cases of endometrial cancer were identified, which represents approximately 4.4% of new cases of cancer in women.(13)

The prognosis of this cancer is deemed favorable, Overall survival at 5 years is estimated at 80% for stages I of FIGO: (tumor limited to the body of the uterus), 60% for stages FIGO II, 30% for FIGO III stages and 5% for FIGO IV stages. (2). However, it is a heterogeneous pathology and overall 5-year survival can vary from 92% to 42% in stages I depending on the histological type and grade of the tumor.(2)

ESMO (European Society of Medical Oncology) associated with work PORTEC (1,2,3) [Postoperative radiotherapy in endometrial carcinoma] has established a prognostic classification based on the risk of relapse in the early stages (stage I of FIGO) on which adjuvant therapy depends on it. In our series, we had 21% low risk; 24% intermediate risk; 4.6% high intermediate risk and 50% high risk. (12)

This cancer is associated with multiple comorbidities such as overweight, arterial hypertension and diabetes, the cardiovascular, renal or neurological complications of which must be taken into account in the therapeutic strategy.(2,3)

The risk factors for this pathology are relatively well known: the genetic predisposition of the HNPCC type (hereditary colorectal cancer without polyposis), the incidence of hereditary endometrial cancer is from 1.8% to 2.3%.(3), and factors linked to hyperestogenesis.(2,12)

In the vast majority of cases, endometrial adenocarcinomas are discovered at a localized stage (80% stage I) with a favorable prognosis and will be cured immediately after surgery and brachytherapy

or radiotherapy according to the risk of relapse.(1,3,4,12). However, survival in patients with metastatic or recurrent disease is generally poor.(14,16)

If radiotherapy and chemotherapy play an increasingly important role in the treatment of endometrial cancer, the initial management of this pathology remains surgical.(1,2,6). Hysterectomy with bilateral adnexectomy, initial lymphadenectomy or restaging according to the final pathological results is the sanction in the majority of cases when the patient is operable. In addition to its curative character and its impact on overall survival, surgery allows the tumor staging necessary for the choice of complementary treatments.(1,6,7,10,15)

Several authors suggest that lymphadenctomy is performed in the group with high intermediate risk and high risk of recurrence.(5,10,15). Two prospective randomized studies have shown the benefit of lymphadenctomy in endometrial cancer (Benedetti Panici et al. 2008; Kitchener et al. 2009) in the high risk group.(11)

Randomized trials have failed to demonstrate relapse-free survival benefit in stage I endometrial cancer.(15)

Studies have found several clinicopathologic factors with predictive value for tumor recurrence and worse survival, such as advanced age, deep myometrial invasion, grade 3 disease and lymphovascular invasion (LLI).(14,17,19)

In fact, lymphovascular invasion has long been considered a potential adverse prognostic factor in endometrial cancer. Studies found that ILV-positive patients had a higher rate of lymph node metastases (19) and were more likely to have local or distant relapse and generally had shorter overall survival (OS). (14,18, 19.20)

In our population, the risk factors for relapse are the most lymphovascular invasion and stage III.

The various gynecological oncology scientific societies consider all ILVsas a risk factor and recommend that patients with positiveILVs receive adjuvant treatment after surgery. (14)

V. Conclusion

Endometrial cancer is increasingly recognized as being very heterogeneous, like several types of biologically different tumors. For early stage diseases, the current practice is surgery followed by brachytherapy. Radiotherapy and / or chemotherapy, guided mainly by histopathological parameters, are mainly therapeutic weapons for the high risks of relapse.

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