433 Teams

OBSTETRICS & GYNECOLOGY

Uterine Malignancy

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OBJECTIVES:

1- Mention the differential diagnosis of post-menopausal bleeding.
2- List the risk factors for endometrial hyperplasia and endometrial cancer
3- Mention types of endometrial hyperplasia
4- Discuss the diagnosis and management of endometrial hyperplasia
5- Describe the signs and symptoms of endometrial cancer
6- Discuss the diagnostic work up for a patient with post menopausal bleeding.
7- Describe the staging of endometrial carcinoma
8- Discuss management of endometrial cancer according to the stage
9- Discuss the prognosis of endometrial carcinoma versus sarcoma

Dxx of postmenopausal bleeding:

- exogenous estrogens (Most commonly)

- atrophic endometritis, vaginitis

- Endometrial cancer

- endometrial or cervical polyps

- endometrial hyperplasia

- Miscellaneous (e.g., cervical cancer, uterine sarcoma, urethral caruncle, trauma)

Endometrial hyperplasia:

Over abundant growth of the endometrium generally caused by persistent levels of estrogen unopposed by progesterone.

Hyperplasia is most frequently seen at the extremes of a woman's reproductive years when ovulation is infrequent.

Risk factors :

1. **Polycystic ovary syndrome.**
2. Estrogen-producing tumors such as **granulosa– theca cell tumors.**
3. **Obesity** " caused by peripheral conversion of androgens to estrogen in adipose cells".
4. Prolonged use of **exogenous estrogens** without progestins.
5. Use of **tamoxifen.**

Types of endometrial hyperplasia:

- simple hyperplasia.
- complex hyperplasia:

two subcategories (with and without atypia).

(complex atypical hyperplasia has about 20% to 30% of cases progress to endometrial carcinoma if untreated)

Diagnosis:

Hx of intermenstrual bleeding or unexplained heavy or prolonged bleeding. **Endometrial sampling** is necessary to obtain a histologic diagnosis. Fractional D&C or hysteroscopically directed biopsy, may be needed to rule out carcinoma or other pathology. **In postmenopausal women, a thin (<4 mm) endometrial stripe on transvaginal ultrasound is reassuring.**

Management:

In reproductive-aged women without Atypia: sloughing of the hyperplastic endometrium and prevention recurrence.

If simple hyperplasia without atypia: initially with a progestin, such as 10 days each month for 3 months. (biopsy should be repeated to confirm normalization of the endometrium).

Complex hyperplasia: must be evaluated with a fractional D&C and should be initially treated with daily progestin therapy for 3 to 6 months.

Complex hyperplasia with atypia: is treated by hysterectomy after carcinoma has been excluded.

***Endometrial ablation is absolutely contraindicated in any of these situations until the endometrium normalizes.**

Endometrial cancer

Symptoms:

Vaginal bleeding is the most common symptom, postmenopausal bleeding is **always abnormal and must be investigated.**

Signs: **physical examination may show** obesity, hypertension, and the stigmata of DM. chest should be examined for any effusion and the abdomen carefully palpated and percussed to exclude ascites, hepatomegaly or any evidence of metastasis. pelvic examination, the external genitalia, cervix and vagina are usually normal. **A patulous (opened or distended) cervical os or a firm, expanded cervix may indicate extension of the disease.** The uterus may be of normal size or enlarged, depending on the extent of the disease and the presence or absence of other uterine conditions, such as adenomyosis and fibroid. The adnexa should be palpated for evidence of extrauterine metastases or an ovarian neoplasm. **A granulosa cell tumor or an endometrioid ovarian carcinoma may occasionally coexist with endometrial cancer.**

Diagnosis:

Any woman who presents with postmenopausal bleeding should have a transvaginal ultrasound. If the endometrial thickness is greater than 5 mm, further evaluation is necessary (Biopsy).

Staging: (surgical staging, based on pathologic confirmation of the extent of spread). **About 75% of endometrial cancers are endometrioid adenocarcinomas.**

TABLE 41-2

INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS (FIGO) STAGING OF ENDOMETRIAL CARCINOMA (1988)

Stage Ia	Tumor limited to endometrium
Stage Ib	Invasion through less than half of the myometrium
Stage Ic	Invasion equal to or more than half of the myometrium
Stage IIa	Endocervical glandular involvement only
Stage IIb	Cervical stroma invasion
Stage IIIa	Tumor invades serosa or adnexa or both, or positive peritoneal cytologic findings, or both
Stage IIIb	Vaginal metastases
Stage IIIc	Metastases to pelvic or para-aortic lymph nodes, or both
Stage IVa	Tumor invasion of bladder or bowel mucosa, or both
Stage IVb	Distant metastases including intraabdominal or inguinal lymph nodes, or both
Histologic grade does not change the stage	
Grade 1	Well differentiated
Grade 2	Moderately differentiated
Grade 3	Poorly differentiated

Management according to the stage :

Stage I :

1- Surgery : **An exploratory laparotomy with total abdominal hysterectomy and bilateral salpingo-oophorectomy is performed on all patients, unless there are absolute medical contraindications.**

2- Radiotherapy

3- Hormonal therapy: these tumors are usually early stage and low-grade, with a desire to preserve fertility. **High-dose medroxyprogesterone acetate for 3 to 6 months.**

Stage II : **primary radical hysterectomy, bilateral salpingo-oo-phorectomy, together with pelvic and para-aortic lymphadenectomy, may be performed.** if positive lymphadenopathy, postoperative external-beam pelvic or extended-field radiation is required.

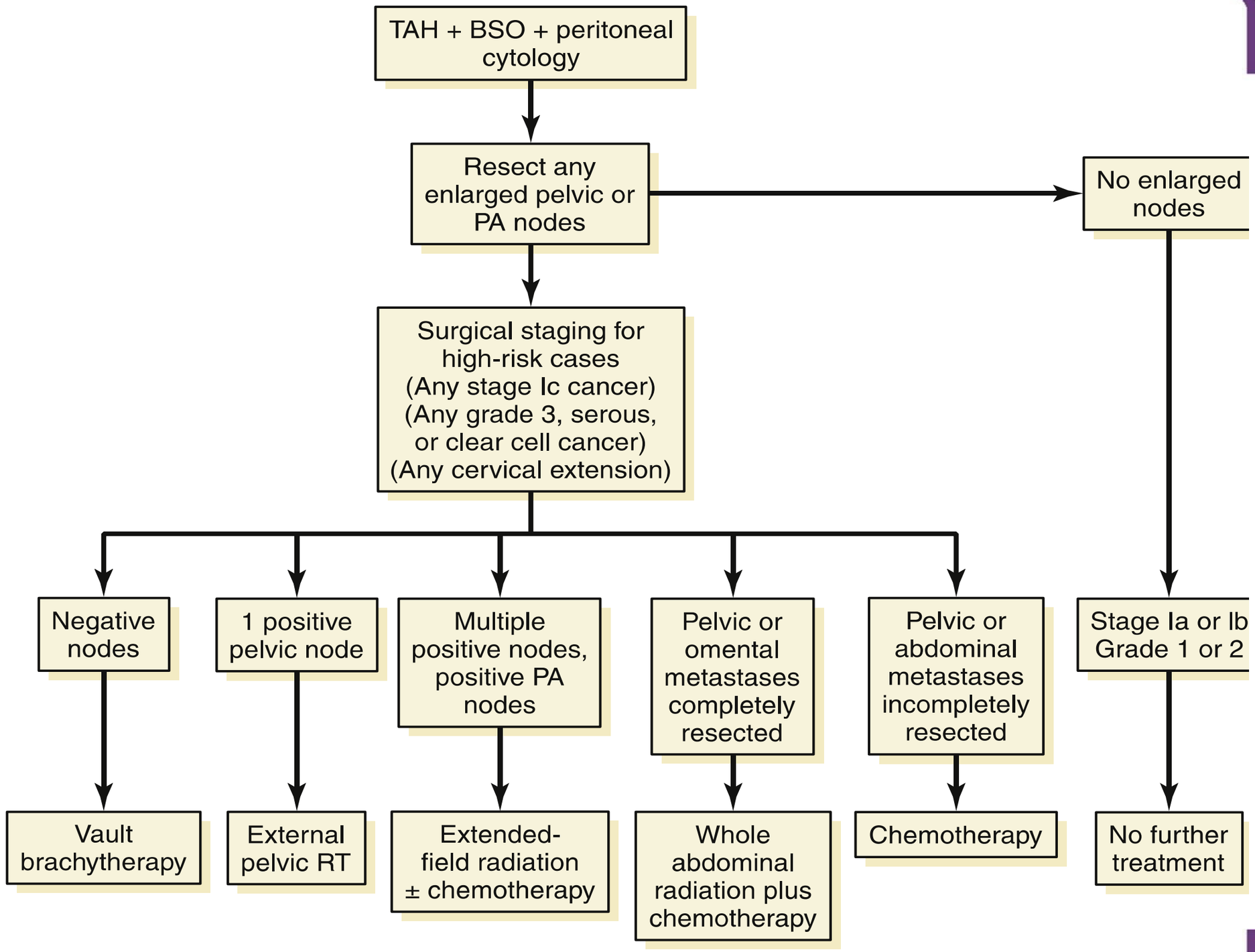

FIGURE 41-4 Algorithm for the treatment of stage I and occult stage II endometrial cancer. BSO, bilateral salpingo-oophorectomy; PA, para-aortic; RT, radiation therapy; TAH, total abdominal hysterectomy.

Advanced stage: For advanced disease, treatment is individualized. The uterus, tubes, and ovaries should be removed, if pos- sible, for palliation of bleeding and other pelvic symptoms.

Chemotherapy: in patients with advanced endometrial cancer (combination of cisplatin and doxorubicin).
Recurrent disease: **Metastases in other sites, such as the upper abdomen, lungs, or liver, are treated initially with high-dose progestins or antiestrogens. (**About one third of recurrent endometrial carcinomas contain estrogen and progesterone receptors) **If disease progresses while the patient is receiving progestins, chemotherapy may be offered.**
Utrine sarcomas : sarcomas tend to be more advanced at the time of diagnosis, are more likely to disseminate hematogenously, and have much lower 2- and 5-year survival rates.

Prognosis of endometrial cancer Vs Prognosis of endometrial sarcoma:

Prognosis of endometrial cancer: The majority of women will be diagnosed with early-stage disease and are cured with surgery. The overall 20-year **survival** rate for all forms of **endometrial cancer** is about 80%. This in comparison to 62% for clear cell and 53% for papillary**carcinomas**. **Prognosis** depends on the type and stage of tumour.

Prognosis of endometrial sarcoma: The disease has a 5-year survival rate.

***American cancer society.**

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