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Perspective

Endometrial Cancer: Stages and Protocols

Tomohito Hagi*

Department of Orthopaedic Surgery, Mie University Graduate School of Medicine, Tsu City, Mie, Japan

DESCRIPTION

Endometrial cancer

Adenocarcinoma of the endometrium is the most prevalent type of endometrial cancer, which is also known as corpus uterine cancer or corpus cancer in the developed world. A lifetime diagnosis of this cancer is predicted to occur in 2.8% of women in the United States.

Endometrial Cancer TNM Classification:

- TNM FIGO phases for primary tumours: Surgical-pathological findings
- Primary tumour cannot be evaluated in TX
- T0: Absence of main tumour indication
- In situ carcinoma (preinvasive carcinoma)
- T1: Corpus uteri-confined tumour
- T1a: Endometrial-only tumour or one that has only partially invaded the myometrium
- T1b: Myometrium is at least partially invaded by the tumour.
- T2: Tumor invades the cervix's stromal connective tissue but does not spread outside of the uterus**
- T3a: Serosa and/or adnexa are involved in the tumour (direct extension or metastasis)
- T3b: Parametric involvement or vaginal involvement (direct extension or metastases)
- IIIC: Metastases to the para-aortic lymph nodes or pelvic nodes
- IV: Distant metastases or invasion of the colon or bladder mucosa by the tumour
- T4: Invasion of the intestine or bladder mucosa by the tumour (bullous edoema is not sufficient to classify a tumour as T4)
- localised lymph nodes (N)
- FIGO TNM stages: surgical-pathological results
- NX: No assessment of local lymph nodes
- N0: No localized metastases of lymph nodes
- N1: Metastasis of local lymph nodes to pelvic lymph nodes
- N1mi: Regional lymph node metastases to pelvic lymph nodes > 0.2 mm but 2.0 mm in diameter
- N1a: Regional lymph node metastases to pelvic lymph nodes > 2.0 mm in diameter
- N2: Positive or negative pelvic lymph nodes and regional lymph node metastases to para-aortic lymph nodes
- N2mi: Regional lymph node metastases to para-aortic lymph nodes > 0.2 mm but 2.0 mm in diameter, with or without positive pelvic lymph nodes.
- N2a: Positive or negative pelvic lymph nodes with regional lymph node metastases>2.0 mm in diameter to para-aortic lymph nodes.
- TNM FIGO stages for distant Metastases (M): surgical-pathological results
- No distant metastases, or M0
- M1: Far-reaching metastasis (includes metastasis to inguinal lymph nodes, intraperitoneal disease, or lung, liver, or bone metastases; it excludes metastasis to para-aortic lymph nodes, vagina, pelvic serosa, or adnexa)

Treatment protocols

The following list of endometrial cancer treatment guidelines includes the following:

- General advice on therapies
- Recommendations for high-risk, recurring, and metastatic disease
- Categories of risk
- General suggestions for endometrial cancer therapy

Check out the list below:

Surgery is the main form of treatment for endometrial cancer and includes hysterectomy, bilateral salpingo-oophorectomy, washings of the abdomen and pelvis, and examination of the lymph nodes; advanced disease may be treated with maximal surgical cytoreduction.

Since there haven't been many phase III studies evaluating various chemotherapy regimens, there isn't a consensus on what the best chemotherapy is.

In patients who experience disease recurrence while receiving first-line chemotherapy, salvage medicines like paclitaxel may be an alternative for second-line therapy.

Correspondence to: Tomohito Hagi, Department of Orthopaedic Surgery, Mie University Graduate School of Medicine, Tsu City, Mie, Japan, E-mail: Tomohito@hagi.jp

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Second-line therapy may include biomarker-directed systemic therapy.

Guidelines for treating a certain disease

The following are typical therapies for endometrial cancer that has spread locally:

Bilateral salpingo-oophorectomy and hysterectomy

When the myometrium has been invaded by more than 50% or when a grade 3 tumour with myometrial invasion is evident, hysterectomy with bilateral salpingo-oophorectomy and adjuvant radiation therapy is performed.

External Beam Radiation Therapy (EBR), brachytherapy, or a combination of the two may be used as Radiation Therapy (RT) to target areas where the presence of a tumour is known or suspected.

For individuals who are not candidates for surgery and whose disease is restricted to the uterus, radiation therapy has proven to be effective and well-tolerated.

Radiation therapy should be used to treat individuals who are inoperable with suspected or obvious cervical involvement. Candidates for surgery should be advised to have radical hysterectomy with bilateral salpingo-oophorectomy, cytology, and dissection of pelvic and para-aortic lymph nodes (75-80 Gy).

Imaging Tests (MRI or CT) or lab testing (CA 125 levels) should be used to evaluate patients with suspected extrauterine disease; if the results are negative, the patients should be treated as though they only have uterine disease.

Radiation therapy and brachytherapy, along with or without surgery and chemotherapy, should be used to treat patients with extrauterine pelvic illness.

If all of the following conditions are satisfied, patients who want to preserve their fertility may be candidates for continuous progestin-based therapy with megestrol, medroxyprogesterone, or a levonorgestrel intrauterine device and monitoring with endometrial sampling every three to six months:

Expert pathology analysis confirms well-differentiated (grade 1) endometrioid cancer discovered During Dilatation And Curettage (D&C)

Disease that can only be seen on an MRI (recommended) or transvaginal ultrasound of the endometrium

No suspicious or metastatic illness was detected on imaging

Pregnancy or medical treatment not prohibited

The patient has received counselling explaining that the standard of care for the treatment of endometrial cancer DOES NOT includes a fertility-preserving alternative. Risk categories for endometrial cancer patients.