



## Endometrial Cancer

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### Editorial

Endometrial Cancer (EC) is fourth most common cancer. It contributes to 6% of cancers in women and one of the most frequently diagnosed gynecologic cancers. EC have been divided into two types, because of differences in risk factors, presentation, histopathology and behavior. Type I Adenocarcinoma, most common variety associated with Endometrial Hyperplasia (EH), unopposed estrogenic stimulation without adequate opposition by progestin and Type II, serous carcinoma, clear cell carcinoma, anaplastic carcinoma in atrophic endometrium in older women, high risk histologic types. Over the years researchers have recognized many risk factors for EC. They include elderly age, nulliparity, infertility, early menarche, late menopause: obesity, diabetes, hypertension, Insulin resistance, dyslipidaemia, Polycystic Ovary Syndrome (PCOS), unopposed estrogen therapy, animal origin nutrients, families with hereditary non polyposis of colon cancer and so on. Long-term Tamoxifen therapy in breast cancer is another risk factor. However observations linking blood pressure, glucose metabolism, and insulin resistance to EC have come mostly from retrospective studies and planned research is needed. Earlier obesity and insulin resistance were not fully recognized as potential risk factors for EC. Now DM has been found to be a risk factor for Type I EC, however the association was not found in Type II EC. Further about endometrial hyperplasia neither all EH are precancerous, nor associated with EC, so division has been made for appropriate diagnosis and management.

A typical EH is precursor for most endometrioid type adenocarcinomas. It should be considered and ruled out in all the cases of heavy, prolonged, frequent, or irregular uterine bleeding in women of any age, especially older than 30 years. The high cancer risk conferred by an endometrial intraepithelial neoplasia (EIN), must be carefully considered in deciding upon appropriate therapy. Oral use of progestins, such as megestrol acetate and medroxyprogesterone acetate are the most commonly used methods. The most notable studies are about the treatment of EH using levonorgestrel-releasing intrauterine system. Total hysterectomy is curative for AEH / EIN and provides a definitive standard for assessment of a concurrent carcinoma. Birth control pills, plant origin nutrients, dietary fiber, retinol,  $\beta$ -carotene, vitamin C, E, may decrease the risk. In PCOS cases there seems to be impact of metformin on EC outcomes, recurrence or overall survival. Weight loss and exercise, the most effective steps, women could take to prevent developing metabolic syndrome, which has linkage could reduce EC also. Although certain factors increase risk for development of EC, they do not always cause the disease. Many women with one or more risk factors never develop EC others with EC do not have any known risk factors. Even if there is one or more risk factor, there is no way to know which, if any, of factors was responsible.

At present, various methods used for diagnosing and staging the EC include- cervical/vaginal cytology, endometrial cytology, endometrial biopsy, transvaginal ultrasonography histopathology, immune histochemistry magnetic resonance imaging, hysteroscopy, and dilatation and curettage. Total hysterectomy with adnexectomy and bilateral pelvic lymphadenectomy, and total lymphadenocolpohysterectomy with bilateral adnexectomy. Despite potential for either synchronous or metachronous ovarian cancer, several researchers report safety of ovarian preservation during hysterectomy in young women with EC. In advanced cases adjuvant radio chemotherapy have definite place. Hormone therapy depends upon immune histochemistry for hormone receptors. While medical as well as surgical extra uterine spread is poor prognostic factor in EC. Conservative management in young women is possible when EC is limited to endometrium. Despite a long history of disease and great efforts in research, there is no practical and accurate system to know true precancerous lesions. So there is a limitation to prevention of EC. Screening is controversial. Diagnosis is possible only after curettage and histopathology. Therapy is varied. Researchers have

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recommended gynaecological examination, transvaginal ultrasound, aspiration biopsy from 30 to 35 years in mutation carriers. As per the consensus among experts, periodic health examination, screening for EC by any tool are not recommended because there is no scientific evidence to support benefit of such examinations in menopausal

and postmenopausal women who have no identified risk factors. EC, common genital tract cancer is surrounded by controversies in screening and therapy. Prognosis is good even beyond early disease. A lot of more research is needed about prevention, various associations and best therapy.