Should diagnostic laparoscopy be conducted before hormonal treatment in early-stage endometrial cancer?

We read the article by Minig et al. [1] with great interest. The authors evaluated the efficacy of levonorgestrel-releasing intrauterine device (LNG-IUD) and gonadotropin-releasing hormone (GnRH) for treating patients with atypical endometrial hyperplasia (AEH) or early-stage endometrial cancer, grade I, who wanted to maintain their fertility. The research demonstrated that the combined therapy of LNG-IUD plus GnRH agonist had a substantial effect on tumor regression in some of those patients. In their results, five patients (14%) who were included in the study diagnosed with concomitant ovarian cancer when they underwent diagnostic laparoscopy. We have several questions for this.

Soliman et al. [2] reported 19% (36 of 188) of synchronous ovarian cancer in their retrospective cohort study for young premenopausal patients with endometrial cancer, although they included all stages of endometrial cancers in their study. A Gynecologic Oncology Group study that evaluated spread patterns of stage I endometrial cancer revealed that 144 (22%) of 621 patients had extrauterine disease including lymph node metastasis, adnexal lesion, and intraperitoneal spread [3]. However, other researchers suggested a negligible risk for extrauterine disease in early-stage endometrial cancer [4]. In a multicenter phase II study to assess the efficacy of medroxyprogesterone acetate (MPA) therapy for endometrial cancer, the researchers did not carry out diagnostic laparoscopy for staging of disease but used magnetic resonance imaging [5]. We would like to know the opinion of Minig et al. about whether diagnostic laparoscopy should be conducted to confirm the disease status of patients who are supposed to be in early-stage endometrial cancer before MPA treatment, and then, to exclude the patients with advanced endometrial cancer or concomitant ovarian cancer, what kind of procedures, such as pelvic lymph node dissection, para-aortic lymph node dissection, and ovarian biopsy, should be included in the operative laparoscopy? In addition, it is difficult to distinguish whether concomitant ovarian cancer is primary or metastatic. How do the authors differentiate primary disease on ovary from metastatic disease?

In treating patients with AEH or endometrial cancer, LNG-IUD and GnRH analogue were used for 1 year and for 6 months, respectively. As the authors indicated in their literature, all patients who had complete remission (CR) experienced CR at 6 months after the treatment initiation. It might be due to the additive effect of GnRH agonist on LNG-IUD. When extending treatment period of GnRH agonist for 1 year, we wonder the authors’ opinion about the risk–benefit consideration of GnRH analogue.

Korean Gynecologic Oncology Group (KGOG) had conducted a pilot study on treatment effect of LNG-IUD for endometrial hyperplasia [6] and Kim et al. also performed a pilot study of MPA plus LNG-IUD for early-stage endometrial cancer in young women (unpublished data). Our study found that MPA plus LNG-IUD treatment was effective and safe. Based on this result, KGOG just started a multicenter prospective study (KGOG 2009) to demonstrate the effect of MPA plus LNG-IUD in treating patients with early-stage endometrial cancer. Could we get any comments or opinion on this trial? We believe that the study by Minig et al. would be beneficial to keep conducting KGOG 2009 study and analyze the results in future.

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disclosure
The authors declare no conflicts of interest.

references
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doi:10.1093/annonc/mdq764
Published online 27 January 2011