Cancer of the Corpus Uteri

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About 35,000 new cases of endometrial cancer are diagnosed each year in the United States, making it the most common gynecologic cancer and the fourth most common cancer among women. The majority of these tumors are discovered at an early stage, and more than 80% of patients pass the 5-year survival benchmark without a recurrence (see chart, left).

ERT for Survivors of Endometrial Cancer? A New Trial Will Resolve Debate

A nationwide trial to resolve the controversy over the safety of estrogen replacement therapy for survivors of endometrial cancer will start enrolling patients this summer, researchers announced last week at the annual meeting of the American College of Obstetricians and Gynecologists in Las Vegas.

Prescribing ERT for patients with a history of endometrial cancer is controversial because about 85% of endometrial cancers are estrogen dependent. However, two small studies have suggested that ERT does not increase the risk of recurrence, challenging conventional wisdom and creating the current debate. In women with no history of endometrial cancer, hormone replacement is often prescribed after menopause to reduce the risk of cardiovascular disease and osteoporosis and to relieve menopausal symptoms.

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Although the trial’s outcome could affect thousands of patients, the protocol itself could have another kind of impact. In an effort to facilitate clinical trial participation by oncologists, GOG has simplified data collection and reporting requirements for this study, said Edward Trimble, M.D., head of surgery in NCI’s Cancer Therapy Evaluation Program. The criteria for patient eligibility are minimal, and GOG is not requiring that physicians send in pathology slides for review.

“We hope that this trial can become a model for future large, uncomplicated, community-based cancer trials,” Trimble said. The evidence suggesting that ERT is safe comes from two studies in the 1980s involving several hundred women who had been diagnosed with stage I disease. In these nonrandomized studies, women taking estrogen had no increased risk of recurrence after median time periods, respectively, of 26 and 64 months.

The new trial — prospective, controlled, randomized, and double-blinded — will compare ERT to a placebo, after surgery, in more than 2,000 women with stage I or II disease. Women will be checked every 6 months for 3 years and then annually for 2 more years, according to principal investigator Richard Barakat, M.D., of Memorial Sloan-Kettering Cancer Center in New York City. Findings could be available in about 5 years.

— Caroline McNeil

National Cancer Policy Board Hears Pleas for Priority At First Public Forum

The first public meeting of the newly formed National Cancer Policy Board on March 31 resembled a cancer-related town meeting. The board members listened to a roster of medical specialty groups, cancer advocacy groups, and other organizations vie for priority standing in the board’s “To Do” list, expected to be released this month.

Three new board members were also introduced at this meeting: Bertha A. Ford, a staff nurse at the Columbus Cancer Clinic, Ohio; William L. Roper, M.D., senior vice president and chief medical officer of Prudential Health Care, Roseland, N.J.; and John R. Sefrin, Ph.D., chief executive officer of the American Cancer Society, Atlanta. Fran Visco, president of the National Breast Cancer Coalition, was named to the board as the News went to press. Seventeen other members were named in February (see News, March 5), bringing the total to 21.

Access and Money

The board has stated its expectation to focus on topics that “concern multiple forms of cancer or clinical services, not a specific type or site of cancer, line of research, or clinical service,” but the specialty medical and advocacy groups used their testimony time to promote their own concerns. Concerns voiced by more than one speaker were patient access to clinical trials and cancer-care specialists, especially for patients in managed care systems and underserved populations, and funding for cancer research for particular cancers and as a whole.

Jill Rathbun of the Society of Gynecologic Oncologists asked the board “to address the issue of how insurance coverage, or more importantly a lack of insurance coverage, affects whether an individual will enroll in a clinical trial.” She added that other barriers to participation in trials also exist and that the board should evaluate those and then propose solutions.

The SGO also asked the board to evaluate the direct and indirect costs of lack of access to cancer specialists, “like SGO members,” for women insured under managed care. Rathbun noted that a lack of referral can cause a woman to have unnecessary diagnostic tests and surgeries before a diagnosis of gynecologic cancer is made.

Similarly, the Oncology Nursing Society felt the board should “inform the nation, consumers, payers, provider networks, and legislators about what constitutes quality cancer care,” said ONS President Kathi H. Mooney, R.N., Ph.D.

Mooney cited several examples of how managed care plans foil health care workers, including one that restricted access to palliative therapies and one that removed credentials from name tags so that the patients would not know if a trained nurse or an aide was administering their care.

“Unfortunately, the consumer makes an erroneous assumption that the person in white providing their care looks like...