FOCUS: CANCER OF THE ENDOMETRIUM

In 2010, the American Cancer Society estimated that 43,470 cases of cancer of the uterine corpus (body of the uterus) will be diagnosed in the United States, with 810 in Maryland. Although incidence rates have been decreasing since 1997, an estimated 7,950 deaths are expected in 2010.

The most common symptom of endometrial cancer is any abnormal vaginal bleeding or spotting, especially in postmenopausal women. In addition, pelvic pain and pain during urination or intercourse should be evaluated by a gynecologist. There are no routine screening tests for endometrial cancer, but because of postmenopausal bleeding, most women will visit their doctor and be diagnosed at an early stage.

Risk factors include use of estrogen without progestin during menopause, obesity, late menopause, never having had children, a history of polycystic ovary syndrome or hereditary non-polyposis colon cancer (HNPCC). Use of tamoxifen increases risk slightly.

Endometrial cancers are usually treated initially with surgery by a gynecologic oncologist and depending on stage at diagnosis, later stage patients may also receive radiation, hormones, and/or chemotherapy.

Table 4 shows the results of a 5 year survival study of 344 stageable patients diagnosed and/or treated at GBMC between 2000 and 2005 by stage at diagnosis compared to 16,867 patients in the National Cancer Data Base(NCDB) from 2003, their most recently analyzed year. Survival is comparable for all stages, with a 7.5% 5 year survival advantage for Stage 3 GBMC patients. Although the small sample size may account for the difference in survival for the stage 3 patients, another possiblility is a difference in treatment.

Tables 3a-3d compare treatment for all patients, including stage 3 patients. Fewer stage 3 GBMC patients received surgery alone. The majority (54.5%) of GBMC patients with stage 3 cancer were treated with surgery and radiation compared to 24.2% of the NCDB sample, although more of the NCDB patients received surgery, radiation and chemotherapy. Patients receiving hormones with any other modality were grouped into other treatments. The National Comprehensive Cancer Network (NCCN) clinical practice guidelines recommend multimodal treatment using surgery, chemotherapy and/or radiation for Stage 3 disease.

In 2010, 68 analytic cases of endometrial cancer were diagnosed and/or treated at GBMC. Table 2 shows a comparison of stage at diagnosis between the study years. In 2010, a slightly higher percentage of patients were diagnosed with stage 1 disease. At the same time, a slightly higher percentage of patients were diagnosed with stage 3 disease. When evaluating treatment among the 7 stage 3 patients, 42.9% received surgery, radiation and chemotherapy compared to 15.2% of the patients from 2000-2005 receiving the three modalities. Some of the2010 patients are on clinical trials which are investigating different chemotherapy regimens in combination with surgery and/or radiation.

The Greater Baltimore Medical Center has 7 clinical trials open for patients with endometrial cancer, including a Phase 3 trial of pelvic radiation therapy versus vaginal cuff brachytherapy followed by chemotherapy in patients with high risk, early stage endometrial carcinoma. All clinical trials information can be obtained on the GBMC website [www.gbmc.org](http://www.gbmc.org).

The Greater Baltimore Medical Center has a comprehensive multidisciplinary approach to all patients with gynecological malignancies. GBMC has an integrated teaching program with the Johns Hopkins Gynecologic Oncology Fellowship Program. Every patient with a gynecologic malignancy is evaluated in a biweekly conference that includes gynecological oncologists, medical oncologists, radiation oncologists, pathologists, nurse practitioners and members of the clinical trials team. All patients are assessed for eligibility for national clinical trials through the Gynecological Oncology Group (GOG).

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