

Recent Advances in the Management of Synchronous Primary Endometrial and Ovarian Cancers

Georgios Androutsopoulos* and Georgios Decavalas

Department of Obstetrics and Gynecology,
University of Patras, Medical School, Greece

***Corresponding author:** Georgios Androutsopoulos, Department of Obstetrics and Gynecology, University of Patras, Medical School, Rion 26504, Greece, Tel: +306974088092; Email: androutsopoulos@upatras.gr; androutsopoulosgeorgios@hotmail.com

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Editorial

Synchronous primary cancers are very rare in the general population [1-15]. Especially in malignancies of the female genital tract, only a small proportion between 0.5 and 1.7 % are synchronous primary cancers [1,4,6,7,9-117]. Among them, synchronous primary endometrial and ovarian cancers (SPEOC) remains the most common combination [1-4,6,10-13,15].

Patients with SPEOC usually are young, obese, premenopausal and nulliparous [1,6,10,11,13,17-23]. They commonly develop SPEOC about 10 - 20 years earlier than patients with single primary endometrial or ovarian cancer [4,10,11,13,20,21,23,24]. Moreover, the average age at diagnosis of SPEOC is approximately 50 years [1,10,11,13,17-23].

Recent years, many international scientific societies (ACOG, FIGO and ESMO) have recommended systematic surgical staging as the initial treatment approach in patients with malignancies of the female genital tract [1,4-6,10-13,15,19-22,25-34]. This is mainly because systematic surgical staging offers a lot of diagnostic, prognostic and therapeutic benefits [1,4-6,10-13,15,19-22,25-34].

More specifically, the systematic surgical staging in patients with SPEOC includes: total abdominal hysterectomy with bilateral salpingo-oophorectomy, total omentectomy, appendectomy, pelvic and para-aortic lymphadenectomy, complete resection of all disease, biopsies of any suspicious lesion and pelvic washings [3-6,10-13,15,19-21,27,35].

The systematic surgical staging in patients with SPEOC can be performed either with the standard (laparotomy) or the minimally invasive approach (laparoscopy and robotic-assisted surgery) [3-6,10-13,15,19-21,27,35]. Laparotomy is the preferable surgical approach for systematic surgical staging especially in patients with SPEOC and advanced stage disease [3-6,10-13,15,19-21,27,35]. Minimally invasive approach is mainly applied in patients with SPEOC and early stage disease [3-6,10-13,15,19-21,27,35].

Both surgical approaches have similar recurrence, overall survival and disease-free survival rates, when applied in patients with SPEOC and early stage disease [6,10,11,13,15]. However, minimally invasive techniques offer significant advantages especially in overweight and elderly patients (smaller incisions, better visualization, shorter hospital stay, less postoperative pain, quick recovery and low risk for postoperative complications) [3-6,10-13,15,19-21,27,35]. Moreover, minimally invasive techniques are significantly more difficult and time consuming and require special surgical skills [3-6,10-13,15,19-21,27,35]. This is the reason why, they are less popular among surgeons and they are mainly applied in patients with early stage disease [3-6,10-13,15,19-21,27,35].

It is worth noting, that pelvic and para-aortic lymphadenectomy plays an essential role in the systematic surgical staging of patients with SPEOC [3,5,6,10,11,13,27,35]. Pelvic

and para-aortic lymphadenectomy represents the only way to diagnose correctly stage III disease, in patients with SPEOC [6,10,11,13,27,32,35]. Additionally, there is a significant increase in morbidity and postoperative complications in cases of extended pelvic and para-aortic lymph node dissection (more than 14 lymph nodes) [6,10,11,13,15,29-32,36-38]. This is the reason why, surgeons should carefully weigh the increased morbidity and postoperative complications with any survival advantage, especially in elderly patients and in patients with comorbidities (obesity, diabetes mellitus and coronary artery disease) [6,10,11,13,15,25,29-32,36-40].

According to the recent recommendations of the international scientific societies (ACOG, FIGO and ESMO), postoperative adjuvant treatment (radiotherapy and/or chemotherapy) plays an equally important role in patients with malignancies of the female genital tract and increased risk of recurrence or at advanced disease stage [1,4-6,10-13,15,19-22,25-34]. Nevertheless, the efficacy of postoperative adjuvant treatment in patients with SPEOC, remains controversial [3,5,6,10,11,13,15,19,22,41]. In this light, postoperative adjuvant treatment in patients with SPEOC should be individualized based on the risk of recurrence of each individual primary cancer [3,5,6,10,11,13,15,19,22,41,42]. Furthermore, the application of postoperative adjuvant treatment of each primary cancer should not affect the postoperative adjuvant treatment of the other [1,3,5,6,10-13,15,19-22,24,41-46].

To begin with, in patients with SPEOC the postoperative adjuvant radiotherapy remains the treatment of choice for the endometrial component and includes vaginal brachytherapy and external radiotherapy [6,10,11,13,29-33].

Vaginal brachytherapy represents the adjuvant treatment of choice in intermediate risk endometrial cancer (EC) patients (stage IA grade 3 endometrioid type EC, stage IB grade 1-2 endometrioid type EC) [6,10,11,13,15,26,29-33,47-52]. The application of vaginal brachytherapy is well tolerated and associated with less side effects and better quality of life [6,10,11,13,15,26,29-33,47-53]. Furthermore, vaginal brachytherapy minimizes the risk for local recurrences, but it has no impact on overall survival [6,10,11,13,15,26,29-33,47-53]. Especially in intermediate risk EC patients, vaginal brachytherapy and external pelvic radiotherapy are equivalent in achieving local control of the disease [26,47-50].

Similarly, external pelvic radiotherapy remains the adjuvant treatment of choice in high risk EC patients (stage IB grade 3 endometrioid type EC, stage I non-endometrioid type EC) [6,10,11,13,15,26,29-33,47-53]. The application of external pelvic radiotherapy is not well tolerated and associated with more side effects, significant morbidity and impairment in quality of life [6,10,11,13,15,26,29-33,47-54]. Additionally, external pelvic radiotherapy minimizes the risk for local recurrences, but it does not affect overall survival [6,10,11,13,15,26,29-33,47-55].

On the other hand, in patients with SPEOC the postoper-

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ative adjuvant chemotherapy remains the treatment of choice for the ovarian component or for the advanced stage disease [6,10,11,13,15,29-33,42]. The most common chemotherapeutic regimens in patients with SPEOC, are: taxanes, anthracyclines and platinum compounds [6,10,11,13,15,20,42]. The administration of postoperative adjuvant chemotherapy in patients with SPEOC, achieves high response rates [6,10,11,13,15,20,22].

Likewise, in patients with SPEOC the postoperative combination of adjuvant radiotherapy with adjuvant chemotherapy shows promising results, especially in high risk EC or at advanced stage disease [6,10,11,13,15,20,22,26,48,50,53]. Moreover, the combined postoperative application of adjuvant radiotherapy and adjuvant chemotherapy significantly reduces the risk of relapse or death and increases overall survival in patients with SPEOC [3,5,6,10,13,20,22,26,32,48,50,53].

In conclusion, the systematic surgical staging plays an essential role in patients with SPEOC and offers many diagnostic, prognostic and therapeutic benefits [1,4-6,10-13,15,19-22]. Apart from that, systematic surgical staging allows more objective decisions regarding the necessity of postoperative adjuvant treatment in patients with SPEOC, in order to maximize survival and minimize the morbidity of over-treatment (radiation injury, regimen-related toxicity) and the effects of under-treatment (recurrent disease, increased mortality) [1,3-6,10-13,15,19-22].

Conflict of Interest

Authors declare that they have no conflict of interest.

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