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Original Article

Outcome of ovarian preservation during surgical treatment for endometrial cancer: A Taiwanese Gynecologic Oncology Group study



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ABSTRACT

Objective: The goal of this study was to investigate the impact of ovarian preservation on the survival of women with early-stage endometrial cancer, particularly young women.

Materials and methods: A study cohort of 64 patients with histologically confirmed early-stage endometrial cancer was retrospectively collected from 10 member hospitals of the Taiwanese Gynecologic Oncology Group between 1998 and 2009. Survivorship and overall survival were compared between these two groups using a log-rank test.

Results: All patients who underwent surgery were adult women with a mean age of 40.4 ± 9.2 years (range 24–63 years). Ovary-preserving surgery was performed in 38 (59.4%) patients who desired to preserve their ovaries, incidentally in 19 (29.7%) patients with a preoperative diagnosis other than endometrial carcinoma, and in seven patients (10.9%) with unknown reasons. The 5-year recurrence-free survival rate was 98.3% with a median follow up of 44.6 months (range 1.0–126.9 months). Eight patients required adjuvant treatment (12.5%); one patient had documented local recurrence (1.6%); and no metachronous ovarian malignancy occurred during follow up.

Conclusion: Preservation of bilateral ovaries does not increase cancer-related mortality. A more conservative approach to surgical staging may be considered in premenopausal women with early-stage endometrial cancer without risk factors.

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Introduction

Uterine cancer remains one of the leading causes of cancer mortality in women worldwide. Approximately 287,100 women developed uterine cancer with a mortality rate of 1.7 to 2.4 per 100,000 women in 2008 worldwide [1]. In Taiwan, the incidence

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rate increased from 6.17 to 10.86 per 100,000 from 2001 to 2011 [2]. The primary treatment for early-stage endometrial cancer involves hysterectomy and bilateral salpingo-oophorectomy (BSO) [3]. The BSO procedure aims to exclude occult ovarian metastases and decrease estrogen production; given that endometrial cancer is an estrogen-responsive disease. However, ever since the 1988 International Federation of Gynecology and Obstetrics (FIGO) guidelines for endometrial cancer staging [4], there has been controversy regarding the necessity of aggressive surgical staging, including BSO and lymphadenectomy, particularly in young women with early-stage disease. Traditionally, endometrial cancer has been considered a disease of postmenopausal women with a median age of 52–54 years [2]. However, a recent study has shown that up to 14% of women with endometrial cancer are premenopausal [5]. In Taiwan, > 30% of cases occur in premenopausal patients and 10% in women under the age of 40 years [2]. The immediate consequence of the BSO procedure leads to surgical menopause in young women, leading to undesired climacteric symptoms, particularly hot flashes, sleep disorders, and long-term effects, as well as long-term risks to cardiovascular and bone health [3]. Nevertheless, the BSO procedure may not be necessary in women with early-stage endometrial carcinoma due to the relatively low incidence of ovarian metastases. Only ~5% of these women have ovarian metastases [6,7]. The prognosis for endometrial carcinoma in premenopausal women tends to be favorable, with a 5-year survival rate > 90% in early-stage disease [8]. Ali-Fehmi et al [9] suggested that early-stage, well-differentiated endometrial cancer is most commonly encountered in young patients. Moreover, Lee et al [10] reported that the risk of a coexisting malignancy is negligible in patients with minimal preoperative risk factors and no intraoperative evidence of advanced disease. Since no prospective clinical trial is currently available on the survival outcomes of BSO versus ovarian conservation at hysterectomy, the present study aimed to investigate the impact of ovarian preservation on the survival of women with early-stage endometrial cancer, particularly in young women.

Materials and methods

Individual patient data of histologically confirmed, early-stage endometrial cancer (Types I and II) were retrospectively collected from the data registry of the 10 member hospitals of the Taiwanese Gynecologic Oncology Group (TGOG) between 1998 and 2009. A total of 6098 patients were initially identified from the registries during the study period, among whom, 72 patients had either unilateral or bilateral ovarian preservation. After excluding patients with unilateral ovarian preservation, 64 patients were included in the final analysis. Detailed information on the patients was carefully reviewed and extracted from individual medical charts. Parameters abstracted from the medical documents included age at diagnosis, gravity and parity, preoperative diagnosis, date of diagnosis, reasons for preserving ovaries, date of recurrence, date of last follow up, follow-up results for recurrence or secondary malignancies, histological type, stage, grade, tumor size, lymphovascular space involvement, lymph node metastases, depth of myometrial invasion, and disease-free and overall survival. Evidence of recurrence was confirmed by pathological or radiological examination. The follow-up time was defined as the time from initial diagnosis to the time of death or last follow up. Disease-free survival was calculated as the number of months from cancer diagnosis to date of recurrence or last follow up. Tumor staging was assigned in accordance with the FIGO 1988 staging system. Stage of tumor was assigned based on available pathological findings, and unevaluated areas such as both adnexa and lymph node status were considered negative for metastatic disease based on intraoperative

examination. The research was approved by the respective Institutional Review Boards and Ethics Committees of the 10 member hospitals of the TGOG.

Frequency was presented for categorical variables. Survival analysis was evaluated using Kaplan–Meier test, and statistical differences in survival were compared using a log-rank test. All reported *p* values corresponded to two-sided tests, and a *p* value < 0.05 was considered significant. All analyses were carried out using SPSS version 17 software (SPSS, Chicago, IL, USA).

Results

The clinicopathological profiles and treatment modalities of the study cohort are listed in Table 1. More than three-fifths of the patients (67.2%) were young women < 45 years of age (mean 40.4 ± 9.2 years, range 24–63 years) at initial diagnosis. FIGO stages IA and IB were the most common postoperative surgical stages, which represented approximately four-fifths of all patients (53/64, 83%). The most frequent preoperative diagnosis associated with hysterectomy was endometrial carcinoma (46.9%), followed by

Table 1
Patient characteristics.

Characteristics	Patients with retained ovaries (n = 64)	
	n	%
Age, y		
≤30	10	15.6
31–35	11	17.2
36–40	13	20.3
41–45	9	14.1
>45	21	32.8
Type of hysterectomy		
TAH	35	54.7
LAVH	24	37.5
TVH	3	4.7
RH/MRH	2	3.1
Preoperative diagnosis		
Endometrial carcinoma	30	46.9
Endometrial hyperplasia	22	34.4
Leiomyoma/adenomyosis	9	14.1
Uterine prolapse	3	4.6
Reasons for ovarian preservation		
Young age (≤45 y) and/or patient's desire	38	59.4
Other preoperative diagnosis ^a		
Unknown	7	10.9
Myometrial invasion		
<1/2	58	90.6
≥1/2	6	9.4
Final histology		
Endometrioid	55	85.9
Nonendometrioid	9	14.1
Histological grade		
1	51	79.7
2	12	18.8
3	1	1.5
Postoperative FIGO stage (incomplete ^b)		
Ia	38	59.4
Ib	15	23.4
Ic	4	6.3
IIa	6	9.4
IIb	1	1.5

^a Diagnosis that does not require oophorectomy and incidental ovarian preservation.

^b Unevaluated areas, such as both adnexae, or lymph node status were considered negative. FIGO = International Federation of Gynecology and Obstetrics; LAVH = laparoscopy assisted vaginal hysterectomy; MRH = modified radical hysterectomy; RH = radical hysterectomy; TAH = total abdominal hysterectomy; TVH = total vaginal hysterectomy.

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