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Original research

Management of endometrial cancer in Italy: A national survey endorsed by the Italian Society of Gynecologic Oncology

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HIGHLIGHTS

Q1
- Endometrial carcinoma is a frequent cancer in developed countries, but with evidence for discrepant clinical management.
- Under the auspices of the Italian Society of Gynecologic Oncology, a survey on endometrial cancer management in Italy was performed.
- This survey demonstrates a significant improvement in the clinical care achieved over the last decades in Italy.
- High-risk cases could be selected by an appropriate clinical screening, and only these referred to reference centers.

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ABSTRACT

Introduction: Endometrial carcinoma (EC) is a frequent cancer in developed countries, but with evidence for discrepant clinical management. Under the auspices of the Italian Society of Gynecologic Oncology (SIOG), we conducted a survey among Italian centers with ≥20 surgeries for gynecological cancer per year, trying to depict a reliable picture of EC management in our country. **Methods**: The questionnaire focused on preoperative/surgical staging and adjuvant treatment. Of the 283 questionnaires delivered, 35% were sent back. **Results**: Diagnostic hysteroscopy is performed in 78% of centers. In clinical stage I, 52% adopt a laparotomic access, 15% totally laparoscopic, 9% laparoscopic/vaginal, 2% vaginal, 22% tailored approach. Elective use of laparoscopy significantly differs between institutions ($p < 0.001$): 40% (≥20 EC/yr) vs. 12% (<20). Pelvic and aortic lymphadenectomy is selectively performed by 77% and 68% of centers, respectively, depending on pre/intraoperative factors. Non-endometrioid histology, poor-grade and deep myoinvasion are indicated as the highest-risk factors. Adjuvant therapy is given to pathologically node-negative patients by 60%, and to intermediate-risk patients by 47%. Elective adjuvant treatment is still radiotherapy, but chemotherapy is adopted, mostly combined with radiation, by 40%. There is a multidisciplinary team in 64% of centers, but in 59% adjuvant treatment is to be administered outside the institution. **Conclusions**: These data demonstrate a significant improvement in the clinical care achieved over the last decades in Italy. Centralization of EC treatment would not be

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feasible neither useful. High-risk cases could be selected by an appropriate clinical screening, and these only referred to reference centers.

1. Introduction

Endometrial carcinoma (EC) is the fourth most common cancer among women in Italy, accounting for 5% of all malignant neoplasms with 8200 estimated new cases for 2013 (incidence trend 1996–2010: +0.7%). About 70% of these patients are diagnosed at an early stage, resulting in a favorable prognosis, with 5-year overall survival rate of 77% (survival trend 1990–2007: +4%) [1].

Despite being the most common gynecological cancer in developed countries, there is evidence for many differences and discrepancies in the clinical management [2].

Both the preoperative and surgical staging are still object of controversies. There is no general agreement on basic questions, such as the routine use of diagnostic hysteroscopy, and on which imaging technique should be considered as indispensable. With respect to surgery, lymph node dissection (LND) represents the main point of discussion, based on the lack of evidence of its therapeutic impact [3,4]. When and how should it be performed? Various are the algorithms (if any) adopted by different centers, including or not intraoperative frozen sections of the uterine specimen.

Also, the indications to adjuvant treatment (and which?) are not uniform and seem to be more dependent on local habits and resources rather than on data of evidence. Such a clinical scenario reflects the scientific uncertainties still present but may be also related to missing update of information [5].

Under the auspices of the Italian Society of Gynecologic Oncology (SIOG), we have conducted a survey among the Italian centers involved in the gynecologic cancer care, trying to depict a reliable picture of the EC management in our country.

2. Methods

Data were collected by means of a questionnaire concerning specific diagnostic and therapeutic options. This questionnaire was mailed to the gynecologic centers listed in the Italian National Health Service (NHS) directory. Selected were only those centers with at least 20 surgical operations for gynecological cancer, per year.

Of the 283 questionnaires delivered, 99 (35%) were filled in and sent back by the end of January 2013. Sixty-one percent and 39% were from Northern and Central-Southern Italian institutions, respectively. Most questionnaires (78%) were from General Hospitals, while the remaining 21% from Teaching Hospitals/Cancer Centers. Overall, only 42% of centers have treated more than 20 cases of EC in the last year.

The questionnaire focused on three principal areas: 1) preoperative staging (evaluation of: cervical infiltration, depth of myometrial invasion, lymph node status, endometrial tumor size, dosage of serum tumor markers, revision of external pathological diagnosis); 2) surgical staging and therapy (type of hysterectomy in FIGO Stage I, histotype, tumor size and infiltration of cervical canal under consideration for surgical management, peritoneal cytology, intraoperative frozen sections, criteria for LND, surgical conduct in the presence of obvious intraperitoneal metastasis); 3) adjuvant treatment (which categories are considered at high- and intermediate-risk, any change in the risk assessment in the absence of LND, indications for adjuvant therapy in node-negative patients, adjuvant treatment in high- and intermediate-risk, presence of an intra-institutional department of pathology, radiotherapy and medical oncology, capability of performing a brachytherapy, where and by whom the choice of any adjuvant treatment is made).

3. Results

3.1. Preoperative staging

The great majority of centers believe that the evaluation of myometrial invasion (94%), cervical canal (93%), lymph node status

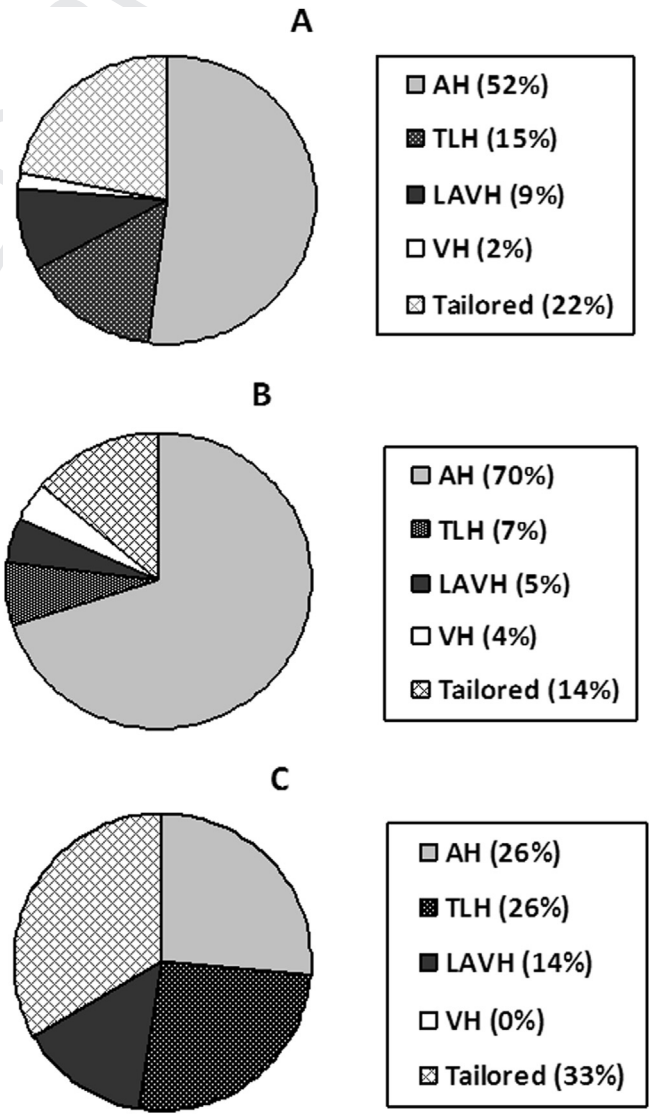

Fig. 1. Surgical staging and treatment: A) Overall; B) General Hospitals with <20 cases of cancer/year; C) Teaching Hospitals/Cancer Centers with >20 cases of cancer/year (Legend: AH, abdominal hysterectomy; TLH, total laparoscopic hysterectomy; LAVH, laparoscopy-assisted vaginal hysterectomy; VH, vaginal hysterectomy; Tailored, based on patient/disease characteristics).

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