



PREVENTION OF ENDOMETRIAL CANCER

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ABSTRACT

Endometrial carcinoma is a malignancy originating from the epithelial cells lining the uterine cavity. ^{1,3} Currently, endometrial carcinoma is often found in gynecological malignancies. Endometrial carcinoma is the sixth leading cause of death from malignancy in women. In Indonesia, endometrial cancer ranks third for genital cancer after cervical (cervical) and ovarian cancer. An endometrial biopsy is done to diagnose and evaluate abnormal intrauterine bleeding, t. However, in patients who cannot undergo an endometrial biopsy because of cervical stenosis or symptoms persist despite normal biopsy results, dilatation and curettage may be performed under anesthesia. Dilatation and curettage procedures are currently the gold standard for the diagnosis of endometrial cancer.² Microscopic examination of endometrial biopsy and endocervical curettage can usually confirm the diagnosis of endometrioid or mucinous adenocarcinoma but rarely can be associated with the initial lesion of cervical adenocarcinoma in situ or atypical hyperplasia of the endometrium. The prognosis of patients with this type is poor and has a lower survival rate than patients with type 1. In addition, in some types of type 2 endometrial adenocarcinoma found an increase in molecules that are generally found in type 1, this indicates that type 2 endometrial adenocarcinoma can occur as a worsening. from the pre-existing type 1. ⁴ The risk of endometrial cancer is strongly associated with family history, Therefore, screening is needed as early as possible.⁶

Keywords: carcinoma, endometrial. cancer.



INTRODUCTION

Endometrial carcinoma is a malignancy originating from the epithelial cells lining the uterine cavity.^{1,3} Currently, endometrial carcinoma is often found in gynecological malignancies. Endometrial carcinoma is the sixth leading cause of death from malignancy in women. In Indonesia, endometrial cancer ranks third for genital cancer after cervical (cervical) and ovarian cancer. Overall, approximately 2-3% of women will develop endometrial carcinoma during their lifetime.¹ Endometrial carcinoma often presents with symptoms at an early stage, so this disease should be diagnosed early. The average 5-year life expectancy (comparing the average life expectancy for cancer patients and non-cancer patients at the same age) is relatively high in developed countries, such as in America, it can reach 69%, although in developing countries it is lower than in developed countries. Cancer incidence rates and average life expectancy are currently recorded in cancer registers that have been established in many countries, but not all cases have been recorded. For example, in developing countries, which still lack public awareness to contact the medical team and early cancer detection services that have not been fully implemented in developing countries.^{1,3} The majority of malignancies that arise in the uterine body are endometrial cancer, especially adenocarcinoma, which accounts for 70-75% of endometrial carcinoma cases.

The increase in the incidence of endometrial carcinoma is associated with increased health status. The life expectancy of women is getting higher, resulting in the number of older women being increasingly accompanied by hormone replacement therapy to overcome the symptoms of menopause.^{1,2} Since it was announced for the first time in Indonesia, the number of COVID-19 cases has increased from time to time, so it needs attention. In practice, during a pandemic, the management of COVID-19 requires the cooperation of all professions to handle it. A management guide that is simple and easy to understand and implement by all parties throughout Indonesia is needed.³ Most cases of endometrial carcinoma (80%) are associated with the endometrium being exposed to chronic (hormonal) estrogen stimulation from other endogenous and exogenous sources. These estrogen-associated (estrogen-dependent) cancers tend to be hyperplastic and better differentiated and generally have a good prognosis.

Meanwhile, the type of endometrial cancer that is not estrogen-dependent (non estrogen-dependent) develops with non-hyperplasia and is poorly differentiated and more aggressive. Many cases of endometrial carcinoma are reported in women without known risk factors, such as those with hormonal disorders. Several studies have shown that polycystic ovary syndrome and insulin resistance, which are components of the metabolic syndrome, may play a role in the pathogenesis of endometrial carcinoma.^{1,2,3} Most of the main complaints suffered by endometrial cancer patients are abnormal postmenopausal bleeding for postmenopausal patients and intermenstrual bleeding for non menopausal patients. A clinician should carefully evaluate for excessive menstrual bleeding or spotting.

To evaluate for abnormal intrauterine bleeding, the diagnosis is made by endometrial biopsy. However, in patients who cannot undergo an endometrial biopsy because of



cervical stenosis or symptoms persist despite normal biopsy results, dilatation and curettage may be performed under anesthesia. Dilatation and curettage procedures are currently the gold standard for the diagnosis of endometrial cancer.² Microscopic examination of endometrial biopsy and endocervical curettage can usually confirm the diagnosis of endometrioid or mucinous adenocarcinoma but rarely can be associated with the initial lesion of cervical adenocarcinoma in situ or atypical hyperplasia of the endometrium.

The histologic features of endometrial cancer often overlap or are contaminated with endocervical cells. Hysteroscopy for early detection (a diagnostic procedure by looking directly into the uterus with a hysteroscope which is usually performed in conjunction with dilatation and curettage) has high sensitivity and specificity in diagnosing and evaluating the uterus if an early lesion of endometrial carcinoma is suspected. Based on histopathology, there are 2 types of endometrial cancer: type 1 endometrial adenocarcinoma with well-differentiated characteristics and superficial invasion. This type is sensitive to progesterone, and patients tend to have a good prognosis. Type 2 endometrial adenocarcinoma is poorly differentiated or aggressive histologic (clear cell, papillary serous) and invades the myometrium. The prognosis of patients with this type is poor and has a lower survival rate than patients with type 1. In addition, in some types of type 2 endometrial adenocarcinoma found an increase in molecules that are generally found in type 1, this indicates that type 2 endometrial adenocarcinoma can occur as a worsening from the pre-existing type 1.⁴ The risk of endometrial cancer is strongly associated with family history, Therefore, screening is needed as early as possible.⁶

For this reason, preventive management is the primary choice for the community to overcome the development of endometrial cancer, especially in Indonesia.⁹

METHODS

This community service activity is conducted in an online educational seminar through the Zoom conference application on Saturday, 14 August 2021, commemorating the 58th DIES Natalis of the Faculty of Medicine, Sriwijaya University. This activity was also held in collaboration with the Research and Community Service Unit of the Faculty of Medicine, Sriwijaya University, PNPB Faculty of Medicine, Sriwijaya University, Indonesian gynecological oncology association. This online educational seminar participants were all obstetric and gynecology residents, general practitioners, nurses, and midwives.



DISCUSSION

Patients with endometrial carcinoma mostly have to undergo a hysterectomy. Surgical staging includes median incision, peritoneal washings, exploration of metastases, total hysterectomy, bilateral salpingo-oophorectomy, pelvic and para-aortic lymphadenectomy. Some specialists only perform biopsy samples of lymph nodes, especially those that are enlarged.^{2,6}

In stage II, where there is evidence of endocervical involvement, the uterus is removed radically (radical hysterectomy). However, some experts continue to perform a total hysterectomy if it is believed that the malignancy is of endometrial origin, arguing that the most common site of recurrence is vaginal, and the recurrence rate is less than 10%.^{2,6} In stages III and IV, radiation and chemotherapy can be performed. Treatment of stage III and IV patients is highly individualized with radiation and chemotherapy. Some literature for stage III and IV with metastases still recommends palliative hysterectomy with removal of both tubes and ovaries and excision of metastases if possible, depending on the patient's condition, expected benefits, and the expert's decision team. Surgery can be followed by radiation therapy and chemotherapy.^(2,4) Radiotherapy Stages I and II who are medically inoperable are only given radiation therapy. The 5-year survival rate decreases by 20-30% compared to patients with surgery and radiation therapy. Low-risk patients (stage IA grade 1 or 2) do not require postoperative adjuvant radiation. Adjuvant radiation is given to Patients with stage 1, if aged over 60 years, grade III and or invasion of more than half myometrium. Furthermore, Patients with stage II A/II B, grade I, II, III Patients with stage IIIA or more are treated separately.^{2,3} Medical therapy Chemotherapy Cisplatin and doxorubicin are the most sensitive agents. Other chemotherapeutic agents are paclitaxel, doxorubicin, and ifosfamide. Hormone Tumors that have estrogen and progesterone receptors will respond better to hormone therapy. Oral progestin administration is as effective as intramuscular administration. One-third of patients who experience relapse respond to progestins ^{2,3} Pap smears are done every year. No routine chest X-ray is needed. CA-125 levels should be monitored if they are elevated at diagnosis.²

Low risk: endometrial carcinoma confined to the endometrium (stage IA: absent or <50% myometrial invasion) intermediate risk: endometrial carcinoma in the endometrial area and invades the myometrium >50%, including patients with stage IA, IB and some patients with stage II who have not invaded the cervix. High risk: includes patients with endometrial.



CONCLUSION

In connection with the absence of definite management of the COVID-19 area. Preventive measures are currently the main choice. In addition, in some types of type 2 endometrial adenocarcinoma found an increase in molecules that are generally found in type 1, this indicates that type 2 endometrial adenocarcinoma can occur as a worsening. from the pre-existing type 1. ⁴ The risk of endometrial cancer is strongly associated with family history, Therefore, screening is needed as early as possible.

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