Endometrial carcinoma in young women: A study from a tertiary care institute in India


Summary & Conclusion:

1. When endometrial carcinoma is diagnosed in younger women (≤ 40 yrs), there are two concerns
   a. Is it a genetic cancer? (likely in 25% in present group: family history in 4 & IHC in one)
   b. To offer fertility sparing treatment after stringent selection criteria (stage 1a G1)

2. Fertility sparing treatment is with oral progestogens plus LNG IUCD
3. There were 20% (2/10) live births & 20% (2/10) failures in the present group till date
3. Hysterectomy recommended after childbirth; close surveillance if women postpone it

Background
Endometrial carcinoma affects older women and the average age of diagnosis is 60 years; only 4-10% are less than 40 years. In younger women, loss of fertility is a concern and a few carefully selected women may be offered conservative treatment in order to preserve their reproductive potential.

We present data of 20 women (age ≤ 40 years) with endometrial carcinoma treated in Post Graduate Institute of Medical Education & Research, Chandigarh, a tertiary care Institute in North India.

Methods
• 2010 to 2017 (7 years)
• Retrospective analysis of women of age 40 years or less with endometrial carcinoma or endometrial hyperplasia with atypia

Results
• Age range: 27 to 40 years
• Presenting symptom: heavy / irregular bleeding (anovulation)
• Family History: Uterine, breast or gall bladder CA in 4/20
• Parity: zero to 2
• Histology: 7/20: Atypia / G1 endometrioid adenoCA
  10/20: G1 endometrioid adenoCA
  3/20: G2 endometrioid adenoCA
• Genetic likely: 25% (5/20)
• Stage: (based on imaging & hysterectomy, if done)
  1a in 19/20
  2 in 1/20 (revised from G2 to undifferentiated & loss of MLH-1, suggesting genetic CA)
• Treatment:
  a. Conservative treatment for future fertility: 10/20
  b. Hysterectomy with BSO & LN: 8/20
  c. Died before hysterectomy (pulmonary embolism): 1/20 (G2)
  d. Did not attend hospital (due to her husband’s illness): 1/20

Conservative treatment (fertility sparing): 10/20 (50%)
• Criteria: HPE = G1 or atypia (after hysteroscopic evaluation)
  MRI showed no myometrial invasion
  Compliance to treatment & follow-up
  No suspicion of genetic CA on HPE & IHC /family history
• Outcome:
  Failed treatment: hysterectomy = 2/10 (20%)
  (1. LNG IUD+MPA 120mg/d x 3 mths)
  (2. megestrol 160mg/d x6mths)
  ART & live birth = 2/10 (20%)
  (1. LNG IUD+ MPA 80mg/dx10mths, OI + IUI, 2009, on FU)
  (2. LNG IUD + megestrol 120mg/d x6mths, IVF 2014, on FU)
  These two want to postpone hysterectomy, aged 46 & 44 yrs now
  On treatment or ART = 6/10 (60%)
  (One had synchronous endometrioid adenoca left ovary, stage 1a, G1, had staging laparotomy & salpingo-oophorectomy, received 4 cycles chemotherapy with GnRH for ovarian protection, now ART)

Future Plan: To see effect of LNG IUCD plus oral progestogens in CA endometrium
Other research: Recurrent Gestational Trophoblastic Disease & genetic basis, Cervical cancer screening

Summary of fertility sparing treatment in CA endometrium (RCOG, 2013)