Katarina Jeremić, J Cancer Sci Ther 2017, 9:6(Suppl)
DOI: 10.4172/1948-5956-C1-105

Challenges of therapeutic options in treatment of early stages of endometrial cancer

Katarina Jeremić
Clinical Center of Serbia, Serbia

Conservative approaches of early-stage endometrial carcinoma includes hormonal therapy, in selected group of young patients with endometrial carcinoma with age less than 45 years and wishes to preserve fertility, that shows low grade 1 endometrioid adenocarcinomas limited to the endometrium with MRI excluded myomaterial invasion, without evidence of limphovascular space involvement or extrauterine disease (cervical, ovarian, lymphnodal or any other extra-uterine disease). The diagnosis is proven by two experienced gynoncology pathologists review of analyzed endometrial samples. It could be collected by biopsy, hysteroscopy or dilatation & curatage and if it possible PgR analysis should be done. Invasive procedures for collecting endometrial samples are hysteroscopy that permits evaluation of endometrial cavity and biopsy of suspicious lesion. The accuracy of hysteroscopy is high with sensitivity rate of 86.4% and specific rate of 99.2%, even higher in the diagnosis, than in excluding it. The possible dissemination of malignant cells through fallopian tubes during hysteroscopy, has not been proven in meta-analysis in early stage of the disease. Obligate pretreatment assessments include biopsy, hysteroscopy or dilatation & curatage, radiologic imaging, contrast MRI (to exclude myometrial invasion, exclude extrauterine spread of disease, ovarian, lymphonodal, cervical involvement) even laparoscopy and assessment of ovaries, peritoneum and PW + SLN, as also CA 125, X ray for chests examination. The results according to many studies are that almost a two third of patients (50-75% of patients) that are treated with gestagen therapy have complete response, but 20-45% patients will have recurrence even after initial response and 25% would not answer on the therapy. Follow up is repeating of endometrial biopsies by hysteroscopy every 3 months which is recommended, until there is a complete response or achieving pregnancy. Surgery is recommended if there is no response after 6 months of medication treatment. Hormonal therapy that could be applied is progestins that inhibits the estrogenic effect and suppresses cell proliferation (medroxy progesterone acetate, megestrl acetate), GnRh analogues, but also local gestagens (IUD), oral natural progesterons, aromatase inhibitors - antiestrogens as also three step endoscopic (hysteroscopic) resection - remove tumour, surrounding endometrium, myometrium.

Biography

Katarina Jeremić attended Medical School, University of Belgrade in 1996, MD in 2000, PhD in 2006 and Academic Special Studies in Gynecology and Obstetrics. She has 19 years of Clinical Experience, working as Gynecologist at Clinic for Gynecology & Obstetrics Clinical Centre of Serbia, which is the biggest one in whole region. She is currently the Head of Gynecologic Oncology Department and also member of many scientific projects on Cancer and Pregnancy. She worked at the Medical Faculty, University Belgrade as Lecturer and Associate Professor of Gynecology and Obstetrics. She has 50 publications in CC/SCI expanded and JCR indexed, and participated in more than 50 international congresses, with a total number of 150 publications. She is a member of FIGO, ESGO, and other societies.

jeremic.udruzenje@gmail.com

Notes: