

Current Treatment Options in Patients with Synchronous Primary Endometrial and Ovarian Cancers

Editorial

Nowadays, synchronous primary cancers represent a very rare clinical entity [1-9]. Especially in patients with malignancies of the female genital tract, only 0.5-1.7% of them harbour synchronous primary cancers [10-15]. Among them, synchronous primary endometrial and ovarian cancers (SPEOC) is the most common combination of cancers of the female genital tract [1,6,10,11,13]. They usually develop in young, obese, premenopausal and nulliparous women and the average age at diagnosis is approximately 50 years [10,15-21]. Those patients are commonly 10 - 20 years younger than patients with single primary endometrial or ovarian cancer [11,18,19,21,22].

To begin with, most international scientific societies (ACOG, FIGO and ESMO) recommend the systematic surgical staging as the initial treatment approach in patients with malignancies of the female genital tract [3,4,7,8,10,11,13,17-20,23-30]. In particular, the systematic surgical staging in those patients with SPEOC includes: total abdominal hysterectomy with bilateral salpingo-oophorectomy, total omentectomy, appendectomy, pelvic and para-aortic lymphadenectomy, complete resection of all disease, biopsies of any suspicious lesions and pelvic washings [3-8,11,13,17-19,23,24,27,21].

The systematic surgical staging in patients with SPEOC can be accomplished either with laparotomy or laparoscopy. Laparotomy is the preferable treatment approach for systematic surgical staging especially in patients with advanced stage disease. Minimally invasive techniques (laparoscopy and robotic-assisted surgery) offer essential advantages mainly in overweight and elderly patients (smaller incisions, better visualization, shorter hospital stay, less postoperative pain, quick recovery and low risk for postoperative complications). However, they are significantly more difficult and time consuming and require advanced surgical skills. This is the reason why, minimally invasive techniques are less popular and are mainly implemented in patients with early stage disease [3-8,11,13,17-19,23,24,27,31].

It is interesting to note, that pelvic and para-aortic lymphadenectomy plays a crucial role in the systematic surgical staging of patients with SPEOC. Moreover pelvic and para-aortic lymphadenectomy represents the only way to diagnose patients with stage III disease [3-8,27,31]. The radical extent of pelvic and para-aortic lymph node dissection (more than 14 lymph nodes) in patients with SPEOC, increases significantly the risk for postoperative complications [3-8,23-25,32,34]. Consequently, in elderly patients and in patients with comorbidities (obesity, diabetes mellitus and coronary artery disease), the surgeon should carefully weigh the increased morbidity with any survival advantage [3-8,26,35,36].

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On the other hand, according to the recommendations of the international scientific societies (ACOG, FIGO and ESMO), postoperative adjuvant treatment (radiotherapy and/or chemotherapy) plays an equally important role in patients with malignancies of the female genital tract and either increased risk for recurrence or at advanced disease stage [3,4,7,8,10,11,13,17-20,23-29]. However, in patients with SPEOC, postoperative adjuvant treatment has a controversial role [17,20,37]. In this light, postoperative adjuvant treatment should be individualized based on the risk of recurrence of each individual primary cancer [3-8,37,38]. Additionally, the postoperative adjuvant treatment of each primary cancer should not affect the postoperative adjuvant treatment of the other neoplasm [3-8,10,13,18-20,22-24,37,39-42].

The postoperative adjuvant radiotherapy in patients with SPEOC includes vaginal brachytherapy and external radiotherapy [3-8,23-25]. Vaginal brachytherapy is the adjuvant treatment of choice for intermediate risk endometrial cancer (EC) patients (stage IA grade 3 endometrioid type EC, stage IB grade 1-2 endometrioid type EC) [3-8,28,43-48]. It is well tolerated and minimizes the risk of local recurrences but has no impact on overall survival [43,45,47,49]. Moreover, it is associated with well-tolerated side effects and improved quality of life [3-8,43,45,47,49]. Especially for intermediate risk EC patients, vaginal brachytherapy and external pelvic radiotherapy are equivalent in achieving local control of the disease [28,43-46].

Likewise, external pelvic radiotherapy represents the adjuvant treatment of choice in high risk EC patients (stage IB grade 3 endometrioid type EC, stage I non-endometrioid type EC) [3-8,28,44,46,49]. It is not well tolerated, being associated

with significant morbidity and impairment in the quality of life [3-8,43,50]. Despite the fact that external pelvic radiotherapy reduces the risk for local recurrences, it has no impact on overall survival [3-8,43,45,47,50,51].

In contrast, postoperative adjuvant chemotherapy is the adjuvant treatment of choice in patients with SPEOC and advanced stage disease [3-8,38]. The most common used chemotherapeutic agents in patients with SPEOC, are taxanes, anthracyclines and platinum compounds. The administration of postoperative adjuvant chemotherapy achieves high response rates in patients with SPEOC [3-8,18,20]. Nowadays, the postoperative combination of adjuvant radiotherapy with adjuvant chemotherapy shows promising results, especially in high risk or at advanced stage SPEOC patients. The combined application of adjuvant radiotherapy and adjuvant chemotherapy reduces the risk of relapse or death and increases overall survival in SPEOC patients [3-8,18,20,28,44,46,49].

In conclusion, the systematic surgical staging plays a crucial role in the treatment of SPEOC and offers many diagnostic, prognostic and therapeutic advantages [3-8,10,11,13,17-20,23,24,26]. Additionally, it allows more sound and objective decisions on the necessity of postoperative adjuvant treatment in patients with SPEOC, in order to maximize survival and minimize the morbidity of over-treatment (radiation injury, regimen-related toxicity) and the effects of under-treatment (recurrent disease, increased mortality) [3-8,23-26].

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