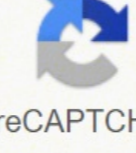


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	2012–2015	1988–2011	P
2012–2015	17,105 (40.40)	8,567 (41.47)	
Marital status			0.105
Married	22,726 (53.68)	11,454 (54.10)	
Single	8,168 (19.29)	4,046 (19.11)	
Others	11,446 (27.03)	5,670 (26.78)	
Tumor size (cm)			0.243
≤2	10,437 (24.65)	5,171 (24.43)	
2.1–5	20,917 (49.40)	10,463 (49.42)	
5.1–10	8,571 (20.24)	4,321 (20.41)	
>10	2,415 (5.70)	1,215 (5.74)	
Histological type			0.418
EEA	37,041 (87.48)	18,468 (87.24)	
SEA	3,185 (7.52)	1,621 (7.66)	
Other types	2,114 (4.99)	1,081 (5.11)	
Myometrial invasion			0.682
<50%	27,721 (65.47)	13,792 (65.14)	
≥50%	14,619 (34.53)	7,378 (34.86)	
Cervical stromal invasion			0.959
Negative	33,797 (79.82)	16,884 (79.75)	
Positive	8,543 (20.18)	4,286 (20.25)	

New Revised FIGO 2008 Staging System for Endometrial Cancer Produces Better Discrimination in Survival Compared With the 1988 Staging System

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Background and Objectives: The aim of this study was to analyze the stage migration and survival of endometrial cancer by the revised FIGO 2008 staging system compared with the 1988 staging system.

Methods: A total of 355 patients with endometrial cancer, who underwent complete surgical staging, were enrolled. We compared the surgical stages and survival by FIGO 1988 staging system with those by FIGO 2008 staging system.

Results: 2008 FIGO staging system resulted in an increase of stage I patients and decrease of stage II and IIIa patients. The 5-year overall survival (OS) rates for patients with 2008 FIGO stage IA and IB disease were 98.2% and 91.9%, respectively ($P = 0.004$). Five-year OS rate of new stage II (82.6%) was significantly worse than that of new stage IA (98.2%, $P = 0.003$). Patients with positive washing cytology alone revealed a 5-year OS rate similar to that of patients with new stage IIIA disease (96.2% vs. 90.9%, respectively; $P = 0.55$). The 5-year OS rate for patients with stage IIIC1 disease was improved compared with that for patients with stage IIIC2 disease (85.7% vs. 63.0%, respectively; $P = 0.08$).

Conclusion: New revised FIGO 2008 staging system for endometrial cancer produced better discrimination in OS outcomes compared with the 1988 system.

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Key Words: endometrial cancer; surgical staging; revised FIGO 2008 staging system; survival

INTRODUCTION

The 1988 International Federation of Gynecology and Obstetrics (FIGO) surgical staging has been utilized in the management of endometrial cancer patients. The revised 2008 FIGO staging system for endometrial cancer is a further attempt to refine the surgical staging system [1]. The new system incorporates several changes, as follows: Within stage I, 1988 stages IA and IB are combined to form a single group 2008 IA. Therefore, 1988 stage IC, which included patients with >50% myometrial invasion (MI), is staged as 2008 stage IB. Patients with 1988 stage IIA disease (cervical glandular involvement) are classified with stage IA or stage IB disease according to the depth of MI. Stage II includes only patients with cervical stromal involvement. Within stage III, positive pelvic washings will no longer dictate a stage of IIIA and will be noted separately from stage. Stage IIIC was separated into stage IIIC1, which includes patients with positive pelvic nodes, and stage IIIC2, which includes patients with positive para-aortic nodes.

The objective of our study was to validate these changes in our patient cohort who underwent complete surgical staging including pelvic and para-aortic lymphadenectomy by comparing survival outcomes of patients staged according to the 1988 FIGO staging system with outcomes obtained when patients were staged according to the new 2008 FIGO staging system.

METHODS

Patients

A total of 397 patients with endometrial cancer underwent extensive surgery including systematic pelvic and para-aortic

lymphadenectomy from 1982 to 2005 at Hokkaido University Hospital, Sapporo, Japan. The patients with concomitant other malignancies and those who underwent hysterectomy and bilateral salpingo-oophorectomy (BSO) alone were excluded from this study. All subjects underwent modified radical hysterectomy, BSO, and systematic retroperitoneal lymphadenectomy as previously described [2]. Stage IV disease with distant metastases (bore or lung metastasis) was excluded from this analysis. We, therefore, defined patients with stage IV endometrial cancer showing peritoneal metastasis. The patients with an intermediate or high risk for recurrence [3] were treated with adjuvant chemotherapy of 350 mg/m² cyclophosphamide, 40 mg/m² adriamycin, and 50–70 mg/m² cisplatin (CAP) or paclitaxel 175 mg/m², carboplatin AUC5, every 3 weeks for four to six cycles. The following histopathologic prognostic factors were included in this analysis: histologic subtype, depth of MI, architectural grade (AG), nuclear grade (NG), lymphovascular space invasion (LVI), ovarian metastasis, and lymph node metastasis (LNM). All risk factors were determined as previously described [2].

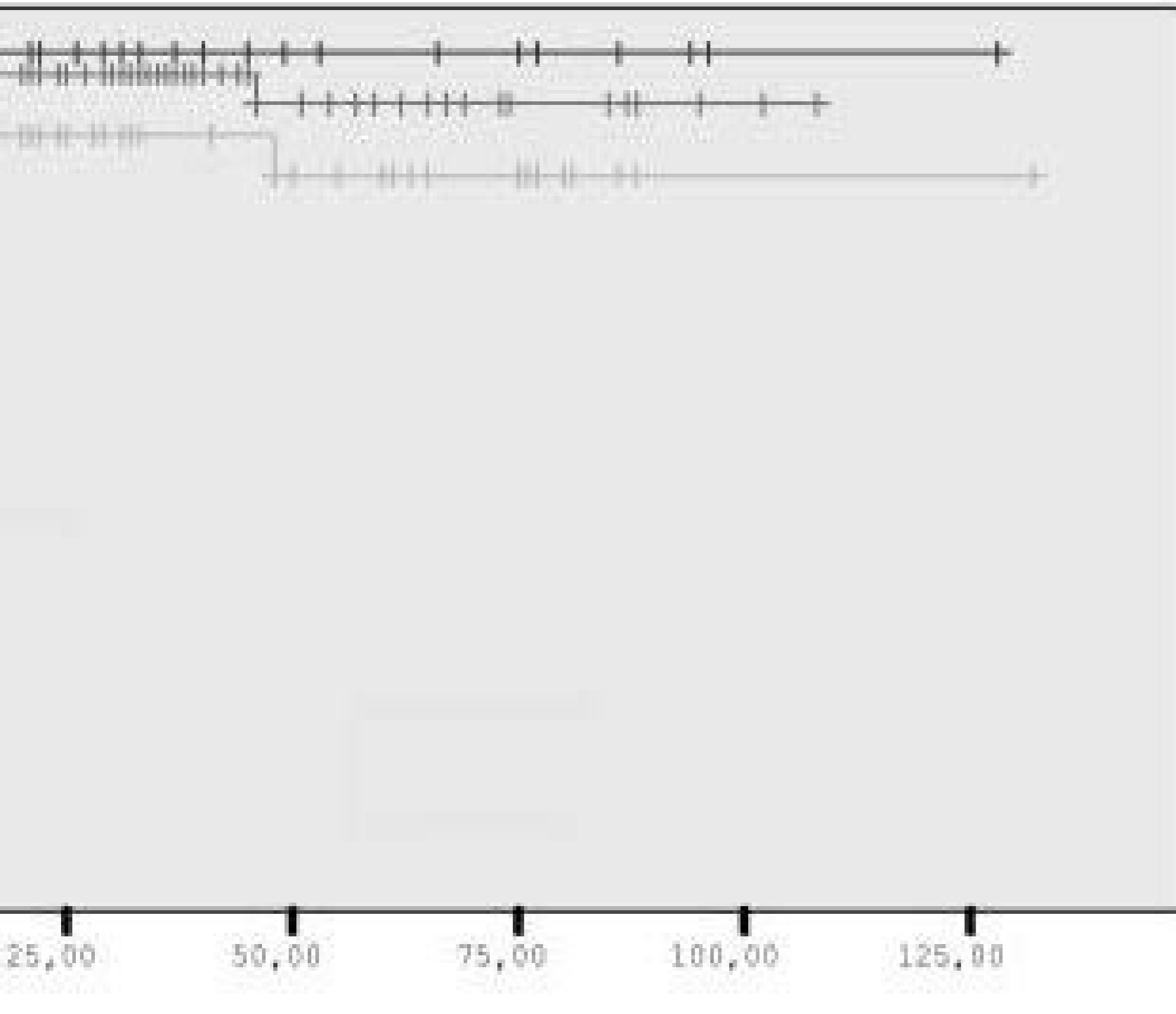
Conflicts of interest: none.

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Medicine

Systematic Review and Meta-Analysis

Survival benefits of pelvic lymphadenectomy versus pelvic and para-aortic lymphadenectomy in patients with endometrial cancer

A meta-analysis

Yoon GS, Kim, Du, Ko, MD, PhD, Lee LL, MG, Hwang WJ, MD, PhD, Jo YH, MD, PhD*

Abstract

Background: Despite the pelvic and para-aortic lymphadenectomy (PLAD) is recommended as part of routine surgical staging for intermediate-risk endometrial cancer, the Ovarian Cancer and Gynecologic Cancer Research Group (OCGRG) Phase III trial (NCT01104789) demonstrated that PLAD does not improve overall survival in patients with endometrial cancer. However, the OCGRG trial did not include patients with advanced-stage endometrial cancer. Therefore, we performed a meta-analysis to evaluate the survival benefits of PLAD versus PLAD plus para-aortic lymphadenectomy (PPLAD) in patients with endometrial cancer. **Methods:** Literature search was conducted using Medline, Embase, and Cochrane Clinical Database for relevant articles. Studies were included if they reported the survival benefit of PLAD versus PPLAD in patients with endometrial cancer. Data were extracted from each study, and meta-analysis was performed using RevMan 5.3 software. **Results:** Five studies with a total of 3713 patients were included. Our meta-analysis revealed that PLAD plus para-aortic lymphadenectomy (PPLAD) group in patients with endometrial cancer (P=0.05, 95% confidence interval [CI], 0.02, 0.10; P=0.02, P<0.05, confidence interval [CI], 0.01, 0.10; P=0.02, P<0.05, confidence interval [CI], 0.01, 0.10; P=0.02, P<0.05, confidence interval [CI], 0.01, 0.10; P=0.02, P<0.05, confidence interval [CI], 0.01, 0.10). **Conclusions:** PLAD is associated with favorable survival outcomes in endometrial cancer patients who are intermediate- to high-risk. However, PLAD plus para-aortic lymphadenectomy (PPLAD) further stage-wise improvement does not appear to be superior to PLAD alone in patients with endometrial cancer. **Registration:** CRD420202867, <https://www.crd.org/CRD420202867>. **Keywords:** Endometrial cancer, Lymphadenectomy, Meta-analysis, Para-aortic lymphadenectomy

1. Introduction

Endometrial cancer is the most common gynecological malignancy in developed countries.¹ According to the recent statistics, the number of new endometrial cancer cases in the United States is expected to increase from 14,620 in 2017 to 18,000 in 2027.² The World Health Organization reported in 2017 that endometrial cancer is the most common gynecological cancer in women worldwide.³ The incidence of endometrial cancer has significantly increased over the past few decades.⁴ The overall 5-year survival rate of endometrial cancer is approximately 60% to 70%, but it varies according to the stage of the disease.⁵ The most common histologic type of endometrial cancer is endometrioid adenocarcinoma, which accounts for about 80% of all cases.⁶ The most common site of relapse is the local region, followed by distant relapse.⁷ Lymph node metastasis is the most common site of relapse in patients with endometrial cancer.⁸ Approximately 30% to 40% of patients with endometrial cancer have lymph node metastasis.⁹

1. RADIOLOGICAL STAGE

2. HISTOLOGICAL GRADE

3. HISTOLOGICAL TYPE

4. MYOMETRIAL INVASION DEPTH

5. LYMPHOVASCULAR INVASION

6. NODAL INVOLVEMENT

7. AGE

8. SEROUS INVOLVEMENT

9. CERVICAL INVOLVEMENT

10. TUMORAL SIZE

11. INVOLVEMENT OF THE LOWER UTERINE THIRD

12. STROMAL INVOLVEMENT OF THE UTERUS

13. EXTRAUTERINE EXTENSION

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Doctors use the TNM method to determine the stage of the cancer: T for tumor — size of the main area of prostate cancer; N for nodes — has the cancer spread to any lymph nodes and if so, to what extent; M for metastasis — has the cancer spread to other organs. Re-laparotomy after cesarean section: operative complications in surgical delivery. Percutaneous nephrostomy with extensions of the technique: step by step. Interventional radiologists play a critical role in treating complications such as ectopic implantation, postpartum hemorrhage, symptomatic ovarian cyst, post-cesarean section fluid collection, obstructive uropathy, and vesicouterine fistula.

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