

AVANÇOS NO TRATAMENTO DO CÂNCER DE ENDOMÉTRIO

JAN PAWEL ANDRADE PACHNICKI UFPR ✧ UP ✧ FEPAR

**31 MAIO
A 2 JUN
2018**

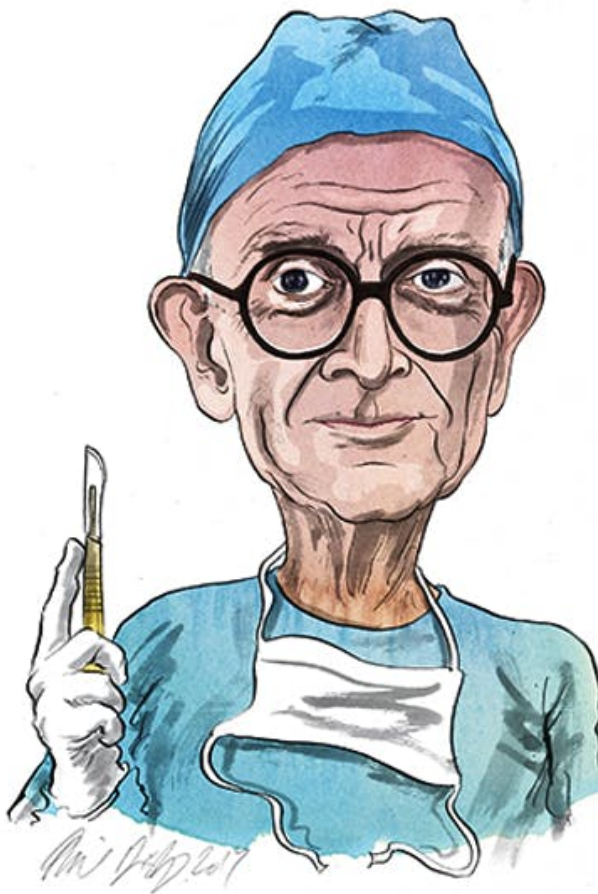
XIX CONGRESSO SUL-BRASILEIRO
DE GINECOLOGIA E OBSTETRÍCIA
IV JORNADA SUL-BRASILEIRA
DE MASTOLOGIA



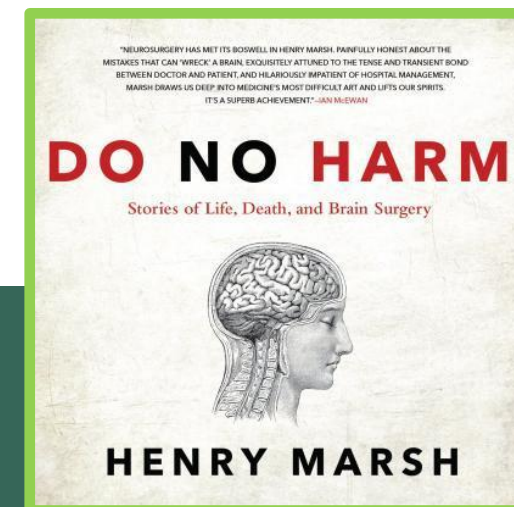


DECLARAÇÃO DE CONFLITO DE INTERESSE:

**NORMA 1595/2000 DO CONSELHO FEDERAL DE MEDICINA
RESOLUÇÃO RDC 102/2000 DA AGÊNCIA NACIONAL DE VIGILÂNCIA
SANITÁRIA**




3 MESES... 3 ANOS... 30 ANOS...



INTRODUÇÃO

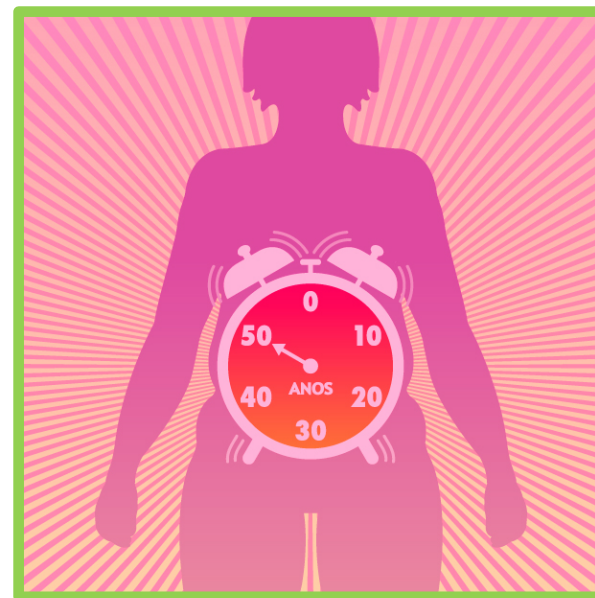
- Brasil 2018:
310.300 novos casos em mulheres !!!

	Localização primária	Casos	%
Mulheres 	Mama Feminina	59.700	29,5%
	Cólon e Reto	18.980	9,4%
	Colo do Útero	16.370	8,1%
	Traqueia, Brônquio e Pulmão	12.530	6,2%
	Glândula Tireoide	8.040	4,0%
	Estômago	7.750	3,8%
	Corpo do Útero	6.600	3,3%
	Ovário	6.150	3,0%
	Sistema Nervoso Central	5.510	2,7%
	Leucemias	4.860	2,4%

INTRODUÇÃO

CÂNCER DE ENDOMÉTRIO – 2018

- MUNDO
 - 90% em > 50 anos
 - ≡ 290.000 novos casos
- BRASIL
 - 6.600 novos casos
 - RE = 6,22 / 100.000 mulheres



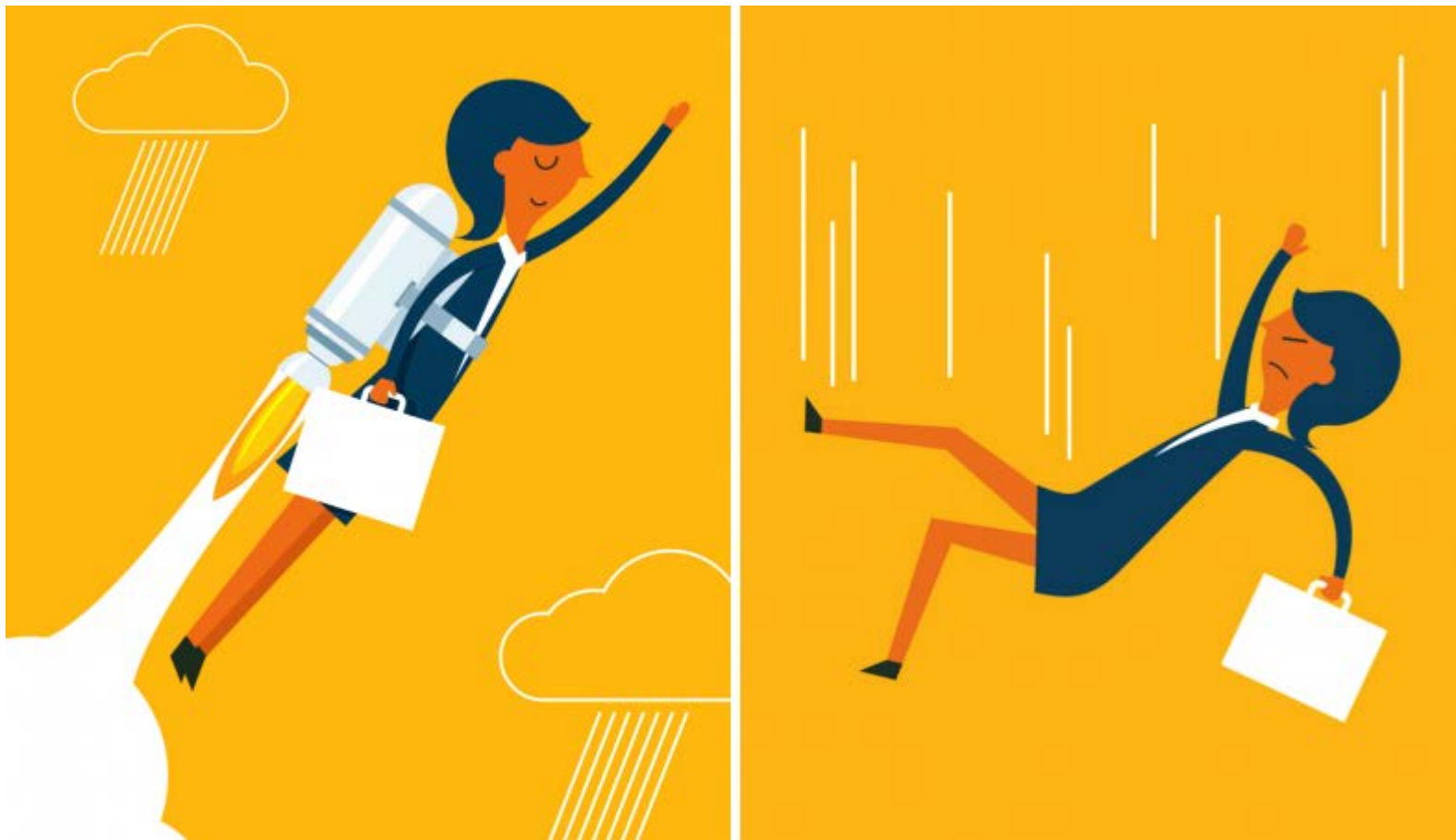
INTRODUÇÃO

CÂNCER DE ENDOMÉTRIO – 2018

- Por que falar dele ???



O QUE HÁ DE NOVO ?



TRATAMENTO CIRÚRGICO

ARTICLE

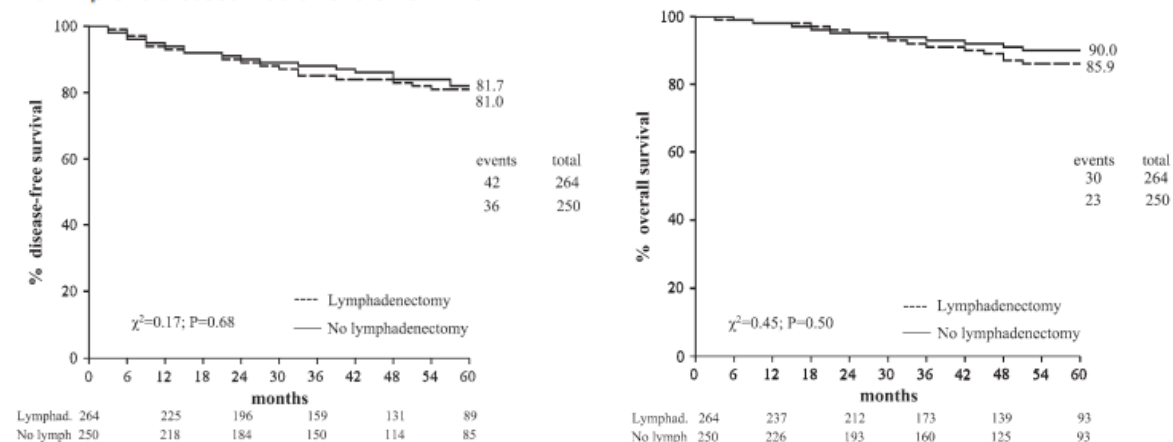
J Natl Cancer Inst 2008;100:1707-1716

Systematic Pelvic Lymphadenectomy vs No Lymphadenectomy in Early-Stage Endometrial Carcinoma: Randomized Clinical Trial

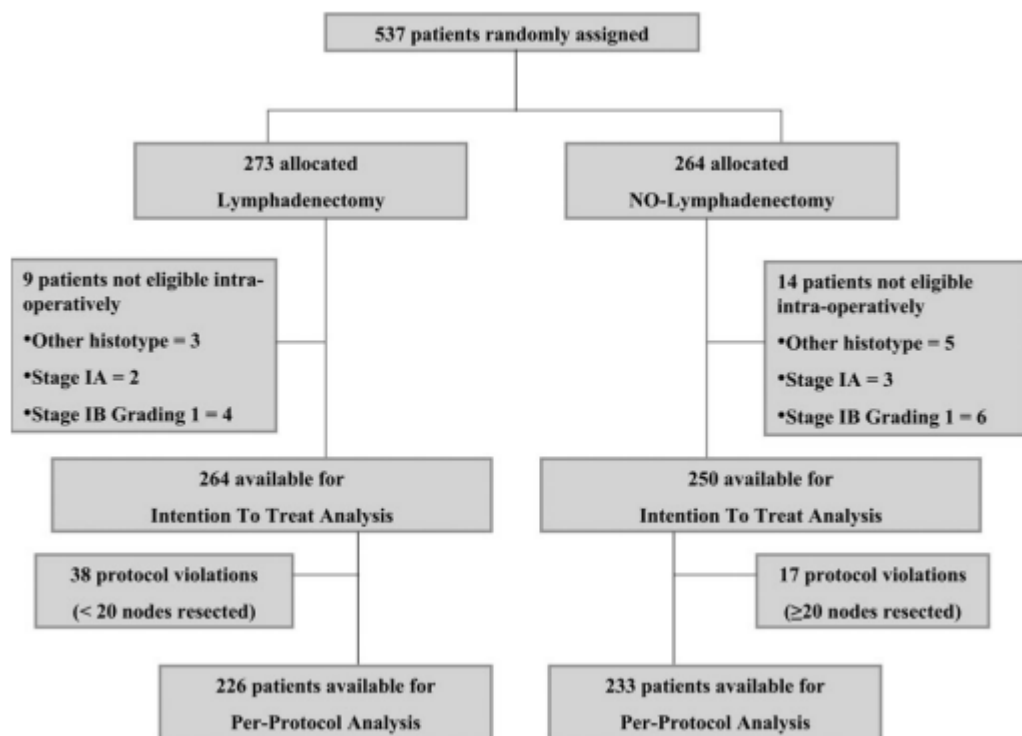
Pierluigi Benedetti Panici, Stefano Basile, Francesco Maneschi, Andrea Alberto Lissoni, Mauro Signorelli, Giovanni Scambia, Roberto Angioli, Saverio Tateo, Giorgia Mangili, Dionyssios Katsaros, Gaetano Garozzo, Elio Campagnutta, Nicoletta Donadello, Stefano Greggi, Mauro Melpignano, Francesco Raspagliesi, Nicola Ragni, Gennaro Cormio, Roberto Grassi, Massimo Franchi, Diana Giannarelli, Roldano Fossati, Valter Torri, Mariangela Amoroso, Clara Crocè, Costantino Mangioni

Conclusion

Although systematic pelvic lymphadenectomy statistically significantly improved surgical staging, it did not improve disease-free or overall survival.



■ 2008



TRATAMENTO CIRÚRGICO

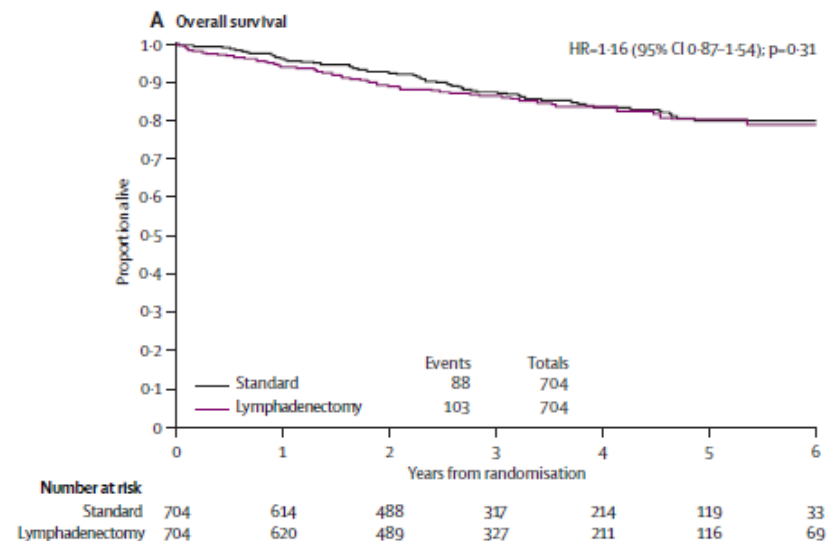
- 2009
- 85 centros – 4 países
- 1408 mulheres

Efficacy of systematic pelvic lymphadenectomy in endometrial cancer (MRC ASTEC trial): a randomised study

*The writing committee on behalf of the ASTEC study group**

Lancet 2009; 373: 125–36

Interpretation Our results show no evidence of benefit in terms of overall or recurrence-free survival for pelvic lymphadenectomy in women with early endometrial cancer. Pelvic lymphadenectomy cannot be recommended as routine procedure for therapeutic purposes outside of clinical trials.



TRATAMIENTO CIRÚRGICO

- 2016
- Mayo x Memorial SK
- Linfadenectomia x SLN
- 1135 casos...



HHS Public Access

Author manuscript

Gynecol Oncol. Author manuscript; available in PMC 2017 March 01.

Published in final edited form as:

Gynecol Oncol. 2016 March ; 140(3): 394–399. doi:10.1016/j.ygyno.2015.12.028.

Comparison of a Sentinel Lymph Node and a Selective Lymphadenectomy Algorithm in Patients with Endometrioid Endometrial Carcinoma and Limited Myometrial Invasion

Ane Gerda Zahl Eriksson, MD^a, Jen Ducie, MD^a, Narisha Ali, MS, PA-C^a, Michaela E. McGree, BS^b, Amy L. Weaver, MS^b, Giorgio Bogani, MD^c, William A. Cliby, MD^d, Sean C. Dowdy, MD^d, Jamie N. Bakkum-Gamez, MD^d, Nadeem R. Abu-Rustum, MD^{a,e}, Andrea Mariani, MD^d, and Mario M. Leitao Jr, MD^{a,e}

In conclusion, when comparing these two approaches to surgical staging of low-risk endometrial carcinoma, we found that pelvic lymph nodes were excised in a larger proportion of patients when applying an SLN algorithm versus a selective LND algorithm; however, fewer lymph nodes were removed per patient with the SLN algorithm, the algorithm yielded a higher detection rate in stage IIIC1 disease, and the median number of positive pelvic nodes per patient was the same. For stage IIIC2 disease, both algorithms achieved the same detection rate. The application of an SLN algorithm does not appear to compromise oncologic outcomes within this short follow-up. Our findings strongly support the use of an SLN mapping algorithm, instead of a comprehensive lymphadenectomy, in patients with endometrioid endometrial cancer and myometrial invasion <50%. Of note, patients with grade 1 or 2 cancer and tumor diameter of 2 cm or less may be able to avoid any type of nodal assessment if they can be reliably identified pre- and intraoperatively. The clinical significance of disease detected on ultrastaging and the role of adjuvant therapy in these cases is yet to be determined. Prospective assessment of the SLN algorithm is needed and currently underway .

TRATAMIENTO CIRÚRGICO

- 2018
- 3712 casos
- RAS x LS x XLAP

Accepted Manuscript

Title: Robotic, Laparoscopic, or Open Hysterectomy - Surgical Outcomes by Approach in Endometrial Cancer

Author: Tiffany L. Beck, Melissa A. Schiff, Barbara A. Goff, Renata R. Urban

PII: S1553-4650(18)30044-X

DOI: <https://doi.org/10.1016/j.jmig.2018.01.010>

Reference: JMIG 3397

To appear in: *The Journal of Minimally Invasive Gynecology*



CONCLUSIONS: RAS is as an alternative to LS in the treatment of endometrial cancer, and preferable to laparotomy. The use of RAS resulted in fewer early readmissions compared to LS and resulted in an increased proportion of cases via minimally invasive surgery.

TRATAMIENTO CIRÚRGICO

- 2018
- 16 casos
- Obesidade...

Accepted Manuscript

Title: Left Lateral Endosurgical Extraperitoneal Total Hysterectomy with Para-Aortic and Pelvic Lymphadenectomy. A Novel Approach for the Obese Patient with Endometrial Cancer

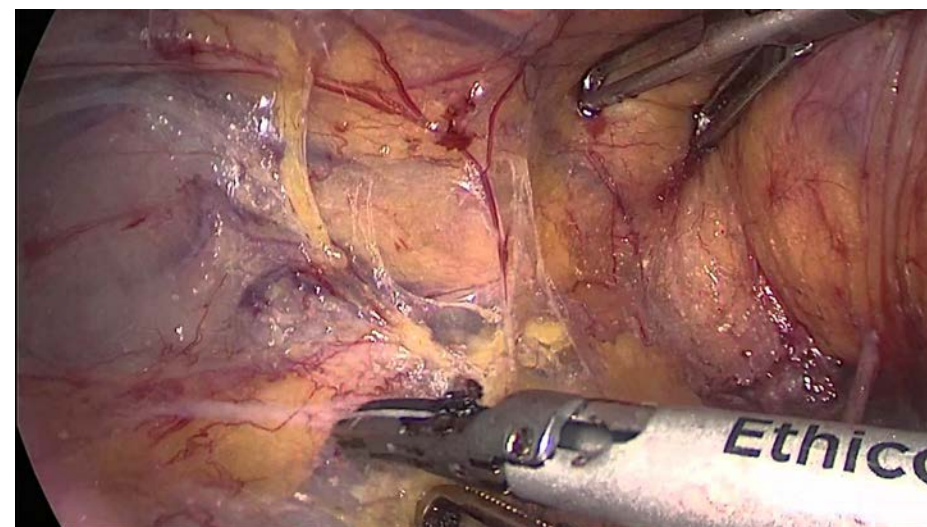
Author: Gwenael Ferron, Javier De Santiago, Denis Querleu, Alejandra Martinez, Martina Aida Angeles, Berenice Boulet, Frederic Guyon, Ignacio Zapardiel

PII: S1553-4650(17)31326-2

DOI: <https://doi.org/10.1016/j.jmig.2017.11.019>

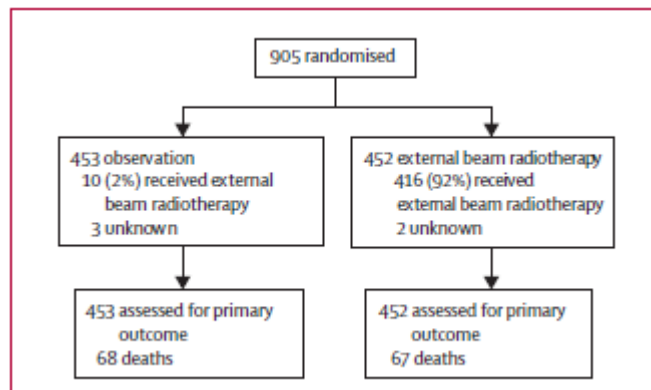
Reference: JMIG 3357

To appear in: *The Journal of Minimally Invasive Gynecology*



RADIOTERAPIA

- 2009
- 112 centros – 7 países

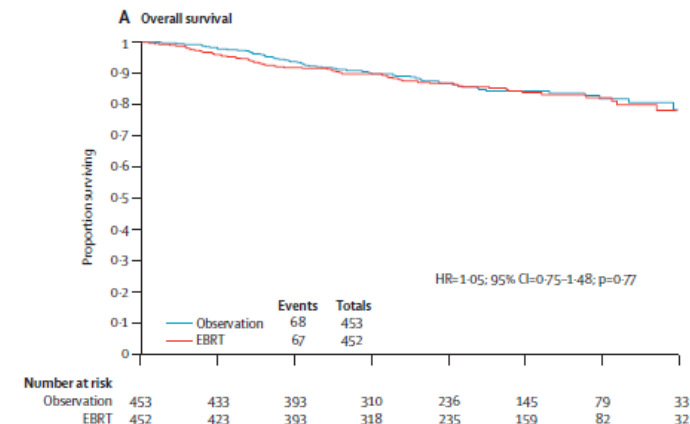


Adjuvant external beam radiotherapy in the treatment of endometrial cancer (MRC ASTEC and NCIC CTG EN.5 randomised trials): pooled trial results, systematic review, and meta-analysis

*The ASTEC/EN.5 writing committee on behalf of the ASTEC/EN.5 Study Group**

Lancet 2009; 373: 137–46

Interpretation Adjuvant external beam radiotherapy cannot be recommended as part of routine treatment for women with intermediate-risk or high-risk early-stage endometrial cancer with the aim of improving survival. The absolute benefit of external beam radiotherapy in preventing isolated local recurrence is small and is not without toxicity.



RADIOTERAPIA

- 2015

- ASTRO

American Society for Radiation
Oncology

- ASCO

American Society of Clinical
Oncology

JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

J Clin Oncol 33:2908-2913.

Postoperative Radiation Therapy for Endometrial Cancer: American Society of Clinical Oncology Clinical Practice Guideline Endorsement of the American Society for Radiation Oncology Evidence-Based Guideline

*Larissa A. Meyer, Kari Bohlke, Matthew A. Powell, Amanda N. Fader, Gregg E. Franklin, Larissa J. Lee,
Daniela Matei, Lourie Coallier, and Alexi A. Wright*

Recommendations

Surveillance without adjuvant radiation therapy is a reasonable option for women without residual disease in the hysterectomy specimen and for women with grade 1 or 2 cancer and < 50% myometrial invasion, especially when no other high-risk features are present. For women with grade 1 or 2 cancer and \geq 50% myometrial invasion or grade 3 cancer and < 50% myometrial invasion, vaginal brachytherapy is as effective as pelvic radiation therapy at preventing vaginal recurrence and is preferred. Patients with grade 3 cancer and \geq 50% myometrial invasion or cervical stroma invasion may benefit from pelvic radiation to prevent pelvic recurrence. For women with high-risk early-stage disease and advanced disease, the ASCO Endorsement Panel added qualifying statements to the ASTRO recommendations to provide stronger statements in favor of chemotherapy (with or without radiation therapy).

QUIMIOTERAPIA + RADIOTERAPIA

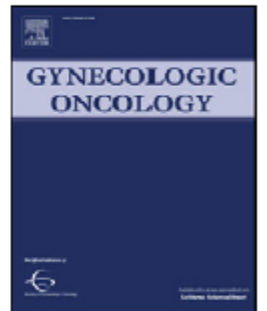
Gynecologic Oncology 134 (2014) 438–440

- 2014
- 601 mulheres

A randomized phase III trial of pelvic radiation therapy (PXRT) versus vaginal cuff brachytherapy followed by paclitaxel/carboplatin chemotherapy (VCB/C) in patients with high risk (HR), early stage endometrial cancer (EC): A Gynecologic Oncology Group trial

D.S. McMeekin^a, V.L. Filiaci^b, C. Aghajanian^c, J. Cho^d, J.W. Kim^e, P.A. DiSilvestro^f, D. O'Malley^g, T.J. Rutherford^h, L. Van Leⁱ, M.E. Randall^j

Conclusions: This study did not demonstrate a superiority of VCB/C to PXRT in women with HR endometrial cancer. Both arms appeared to be well tolerated with high completion rates. Health outcomes and translational research are ongoing from participants in this study.



QUIMIOTERAPIA + RADIOTERAPIA

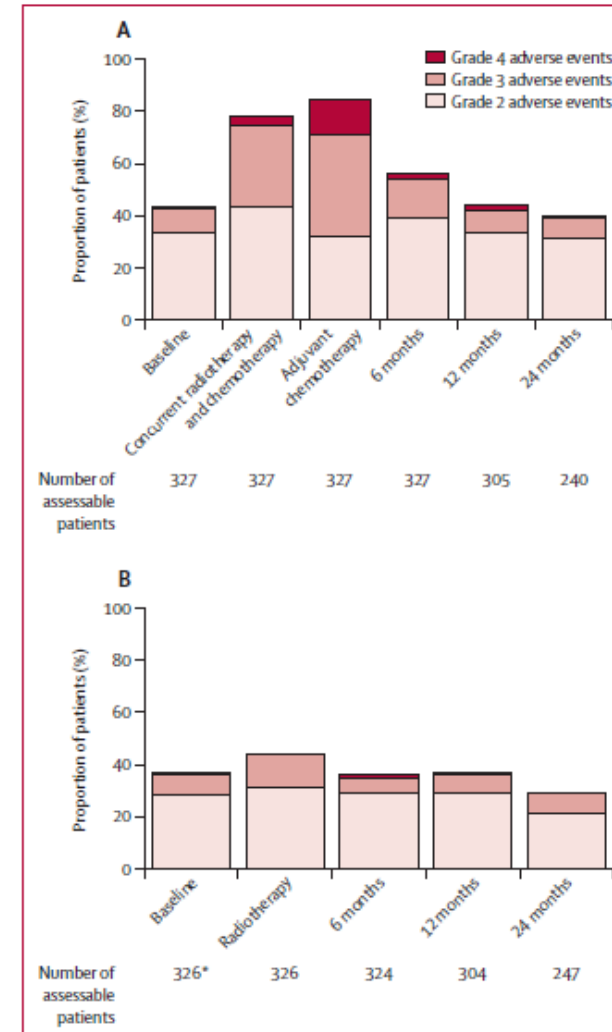
- 2016
- 103 centros...
- 660 mulheres

Toxicity and quality of life after adjuvant chemoradiotherapy versus radiotherapy alone for women with high-risk endometrial cancer (PORTEC-3): an open-label, multicentre, randomised, phase 3 trial

*Stephanie M de Boer, Melanie E Powell, Linda Mileskin, Dionyssios Katsaros, Paul Bessette, Christine Haie-Meder, Petronella B Ottevanger, Jonathan A Ledermann, Pearly Khaw, Alessandro Colombo, Anthony Fyles, Marie-Helene Baron, Henry C Kitchener, Hans W Nijman, Roy F Kruitwagen, Remi A Nout, Karen W Verhoeven-Adema, Vincent T Smit, Hein Putter, Carien L Creutzberg, for the PORTEC study group**

Interpretation Despite the increased physician and patient-reported toxicities, this schedule of adjuvant chemotherapy given during and after radiotherapy in patients with high-risk endometrial cancer is feasible, with rapid recovery after treatment, but with persistence of patient-reported sensory neurological symptoms in 25% of patients. We await the analysis of primary endpoints before final conclusions are made.

Lancet Oncol 2016; 17: 1114-26



QUIMIOTERAPIA + RADIOTERAPIA

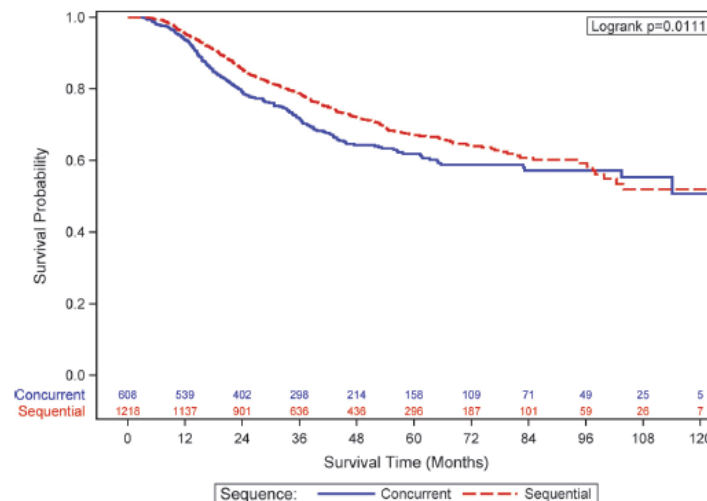
International Journal of Gynecological Cancer •

ORIGINAL STUDY

- 2017
- Coorte – 1826 mulheres

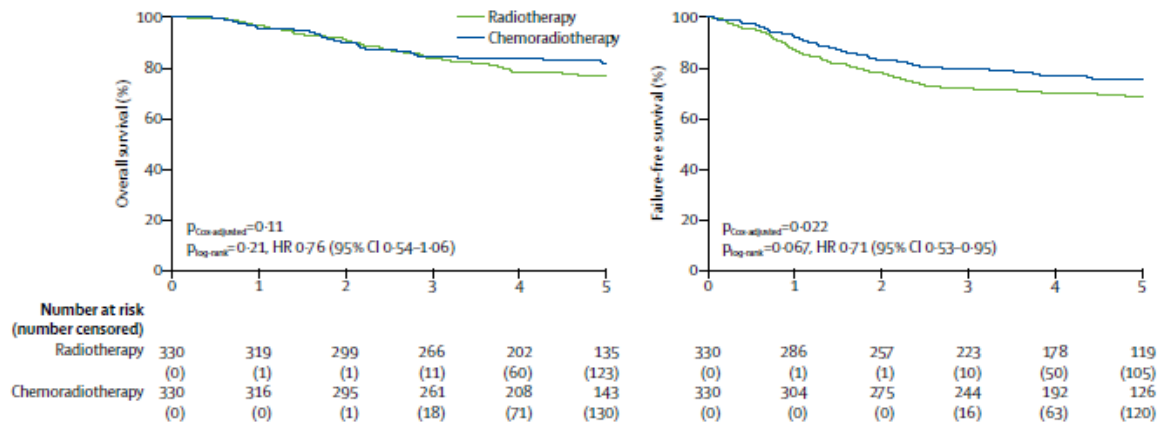
What Is the Optimal Adjuvant Treatment Sequence for Node-Positive Endometrial Cancer? Results of a National Cancer Database Analysis

Ankit Modh, MD, Ahmed I. Ghanem, MD,* Charlotte Burmeister, MS,† Rabbie K. Hanna, MD,‡ and Mohamed A. Elshaikh, MD**



Conclusions: This study suggests that upfront CT followed by RT may be a better treatment sequence for adjuvant therapy in women with advanced EC.

QUIMIOTERAPIA + RADIOTERAPIA



www.thelancet.com/oncology Published online February 12, 2018 [http://dx.doi.org/10.1016/S1470-2045\(18\)30079-2](http://dx.doi.org/10.1016/S1470-2045(18)30079-2)

Adjuvant chemoradiotherapy versus radiotherapy alone for women with high-risk endometrial cancer (PORTEC-3): final results of an international, open-label, multicentre, randomised, phase 3 trial

Stephanie M de Boer, Melanie E Powell, Linda Mileskin, Dionyssios Katsaros, Paul Bessette, Christine Haie-Meder, Petronella B Ottevanger, Jonathan A Ledermann, Pearly Khaw, Alessandro Colombo, Anthony Fyles, Marie-Helene Baron, Ina M Jürgenliemk-Schulz, Henry C Kitchener, Hans W Nijman, Godfrey Wilson, Susan Brooks, Silvestro Carinelli, Diane Provencher, Chantal Hanzen, Ludy CH W Lutgens, Vincent TH B M Smit, Naveena Singh, Viet Do, Romerai D'Amico, Remi A Nout, Amanda Feeney, Karen W Verhoeven-Adema, Hein Putter, Carien L Creutzberg, on behalf of the PORTEC study group*

- 2018
- 103 centros...
- 660 mulheres

Interpretation Adjuvant chemotherapy given during and after radiotherapy for high-risk endometrial cancer did not improve 5-year overall survival, although it did increase failure-free survival. Women with high-risk endometrial cancer should be individually counselled about this combined treatment. Continued follow-up is needed to evaluate long-term survival.

TERAPIAS ALVO

■ 2018

F1000Research

REVIEW

Recent Advances in Endometrial Cancer

Arthur-Quan Tran, Paola Gehrig

Gynecologic Oncology, University of North Carolina at Chapel Hill, NC, USA

Treatment	Molecular Target	Phase of Study	Population	Results
Bevacizumab	VEGF-A	II ⁵⁷	Recurrent or persistent endometrial cancer	RR: 7/52 (13.5%) CR: 1/52 (2%) PR: 6/52 (11.5%)
		II ⁵⁸	Advanced or recurrent endometrial cancer	RR: 11/15 (73%) CR: 5/15 (33%) PR: 6/15 (40%)
with temsirolimus		II ⁵⁹	Recurrent or persistent endometrial cancer	RR: 12/49 (24.5%) CR: 1/49 (2%) PR: 11/49 (22%)
with radiation therapy		II ⁶⁰	Recurrent endometrial or ovarian cancer	RR: N/A
with radiation therapy		II ⁶¹	Endometrial cancer with high-risk factors	RR: N/A
with chemotherapy		II ⁶²	Advanced or recurrent endometrial cancer	RR: N/A
Thalidomide		II ⁶³	Recurrent endometrial cancer	RR: 3/24 (12.5%) CR: 0/24 (0%) PR: 3/24 (12.5%) SD: 2/24 (8%)
Aflibercept	VEGF-A and VEGF-A isoforms	II ⁶⁴	Recurrent or persistent endometrial cancer	RR: 3/42 (7%) CR: 0/42 (0%) PR: 3/42 (7%)
Sorafenib	TKI, VEGF receptors	II ⁶⁵	Advance uterine carcinoma or carcinosarcoma	RR: 2/40 (5%) CR: 0/40 (0%) PR: 2/40 (5%) SD: 17/40 (42.5%)
Dovitinib	TKI, VEGF receptors	II ⁶⁶	Progressive or advanced endometrial cancer	RR: 6/53 (11%) CR: 0/53 (0%) PR: 6/53 (11%)
Nintedanib	TKI, VEGF receptors	II ⁶⁷	Recurrent or persistent endometrial cancer	RR: 3/32 (9%) CR: 0/32 (0%) PR: 3/32 (9%)
Brivanib	TKI, VEGF receptors	II ⁶⁸	Recurrent or persistent endometrial cancer	RR: 8/43 (19%) CR: 1/43 (2%) PR: 7/43 (17%)
Sunitinib	TKI, VEGF receptors	II ⁶⁹	Recurrent or metastatic endometrial cancer or carcinosarcoma	RR: 6/33 (18%) CR: 0/33 (0%) PR: 6/33 (18%) SD: 10/33 (30%)
Gefitinib	EGF receptors	II ⁷⁴	Recurrent or persistent endometrial cancer	RR: 1/26 (4%) CR: 1/26 (4%) PR: 0/26 (0%) SD: 7/26 (27%)
Erlotinib	EGF receptors	II ⁷²	Advanced or recurrent endometrial cancer	RR: 4/32 (12.5%) CR: 0/32 (0%) PR: 4/32 (12.5%) SD: 15/32 (47%)
Lapatinib	EGF receptors	II ⁷⁵	Recurrent or persistent endometrial cancer	RR: 1/30 (3%) CR: 0/30 (0%) PR: 1/30 (3%) SD: 7/30 (23%)

TERAPIAS ALVO

■ 2018

F1000Research

REVIEW

Recent Advances in Endometrial Cancer

Arthur-Quan Tran, Paola Gehrig

Gynecologic Oncology, University of North Carolina at Chapel Hill, NC, USA

Treatment	Molecular Target	Phase of Study	Population	Results
Trastuzumab	HER2/neu	II ¹⁹	Advanced or recurrent endometrial cancer	RR: 0/33 (0%) CR: 0/33 (0%) PR: 0/33 (0%) SD: 12/33 (36%)
Ridaforsolimus	mTOR	II ²²	Advanced endometrial cancer	RR: 0/64 (0%) CR: 0/64 (0%) PR: 0/64 (0%) SD: 22/64 (35%)
		II ²³	Advanced or recurrent endometrial cancer	RR: 3/31 (9%) CR: 0/64 (0%) PR: 3/31 (9%) SD: 18/34 (53%)
		II ²⁴	Advanced endometrial cancer	RR: 5/45 (11%) CR: 0/45 (0%) PR: 5/45 (11%) SD: 8/45 (18%)
Everolimus	mTOR	II ²⁵	Recurrent endometrial cancer	RR: 0/28 (0%) CR: 0/28 (0%) PR: 0/28 (0%) SD: 12/28 (43%)
<i>with letrozole</i>	mTOR	II ²⁷	Recurrent or progressive endometrial cancer	RR: 11/35 (32%) CR: 9/35 (26%) PR: 2/35 (6%) SD: 4/35 (11%)
Temsirolimus	mTOR	II ²⁸	Advanced or recurrent endometrial cancer	RR: 9/54 (17%) CR: 0/54 (0%) PR: 9/54 (17%) SD: 32/54 (59%)
<i>with bevacizumab</i>		II ²⁹	Recurrent or persistent endometrial cancer	RR: 12/49 (24.5%) CR: 1/49 (2%) PR: 11/49 (22.5%)
Pilralisib	PI3K	II ³⁰	Advanced or recurrent endometrial cancer	RR: 4/67 (6%) CR: 2/67 (3%) PR: 2/67 (3%) SD: 25/67 (37%)
GDC-0980	PI3K/mTOR	II ³¹	Recurrent or persistent endometrial cancer	RR: 4/55 (7%) CR: 2/55 (3.5%) PR: 2/55 (3.5%)

CR, complete response; EGF, epidermal growth factor; HER, human epidermal growth receptor; mTOR, mammalian target of rapamycin; PI3K, phosphoinositide 3-kinase; PR, partial response; RR, response rate; SD, stable disease; TKI, tyrosine kinase inhibitor; VEGF, vascular endothelial growth factor.

TERAPIAS ALVO

- 2018
- 75 pacientes com doença localmente avançada ou metastática

Obstetrical and Gynecological Survey

Safety and Antitumor Activity of Pembrolizumab in Advanced Programmed Death Ligand 1–Positive Endometrial Cancer: Results From the KEYNOTE-028 Study

Patrick A. Ott, Yung-Jue Bang, Dominique Berton-Rigaud, Elena Elez, Michael J. Pishvaian, Hope S. Rugo, Igor Puzanov, Janice M. Mehnert, Kyaw L. Aung, Juanita Lopez, Marion Carrigan, Sanatan Saraf, Mei Chen, and Jean-Charles Soria

Dana-Farber Cancer Institute, Boston, MA (P.A.O.); Seoul National University College of Medicine, Seoul, Republic of Korea (Y.-J.B.); Institut de Cancérologie de l'Ouest Centre René Gauducheau, Saint-Herblain, France (D.B.-R.); Vall d'Hebron Institute of Oncology, Barcelona, Spain (E.E.); Lombardi Comprehensive Cancer Center, Georgetown University, Washington, DC (M.J.P.); University of California San Francisco, San Francisco, CA (H.S.R.); Roswell Park Cancer Institute, Buffalo, NY (I.P.); Rutgers Cancer Institute of New Jersey, New Brunswick, NJ (J.M.M.); Princess Margaret Cancer Centre, Toronto, Ontario, Canada (K.L.A.); The Institute of Cancer Research and The Royal Marsden NHS Foundation Trust, London, United Kingdom (J.L.); Merck, Kenilworth, NJ (M. Carrigan, S.S., M. Chen); and Gustave Roussy and University Paris-Sud, Villejuif, France (J.-C.S.)

J Clin Oncol 2017;35:2535–2541

These data show that pembrolizumab has a favorable safety profile and durable antitumor activity in patients with heavily pretreated advanced PD-L1–positive EC. The safety and efficacy of pembrolizumab and the utility of biomarkers including PD-L1 in a cohort of patients with EC are being investigated in the phase 2 multicohort KEYNOTE-158 trial.

HORMONIOTERAPIA

Adjuvant progestagens for endometrial cancer (Review)

Martin-Hirsch PPL, Bryant A, Keep SL, Kitchener HC, Lilford R

- 2015
- 7 trials → 4556 mulheres



AUTHORS' CONCLUSIONS

Implications for practice

Progestagens have an established place in the palliative treatment of women with advanced endometrial cancer. However, a review of the currently available trials failed to demonstrate that adjuvant progestagen therapy has a significant beneficial effect on survival. The trials included in this review are predominantly based on low risk patients where adequate statistical precision is hard to attain as the survival of early disease is extremely good. However, the available evidence points towards the conclusion that progestagens may have no role in the primary treatment of endometrial cancer.

HORMONIOTERAPIA

International Journal of Gynecological Cancer •

- 2017
- 28 estudos
- 619 mulheres

REVIEW ARTICLE

Fertility-Preserving Treatment in Young Women With Grade 1 Presumed Stage IA Endometrial Adenocarcinoma *A Meta-Analysis*

Zunpan Fan, MD, Hui Li, MD,† Rui Hu, MD,* Yuling Liu, MD,* Xinyu Liu, MD,* and Liping Gu, MD**

Conclusions: The existing results show that patients who received hysteroscopic resection followed by progestin therapy achieved the highest CRR. Patients who received oral progestin only might be more likely to recur and have more systemic adverse effects. Recent intrauterine progestin therapy such as levonorgestrel-releasing intrauterine system combined with gonadotropin-release hormone receptor agonist/progestin have a satisfactory PregR and low ReR rate. Considering the inherent limitations of the studies we included, further well-designed, randomized controlled trials are necessary to confirm and update this analysis.

Study	Country	Year	Age Median (Range) (y)	No. Total	Treatment Methods (mg/d)
Hahn et al ⁷ 2009	Korea	1996–2006	31 (21–43)	35	MPA (250–1500) and/or MA (160)
Minaguchi et al ⁸ 2007	Japan	1989–2003	19–37	19	MPA (400–600)
Park et al ⁹ 2013	Korea	1996–2010	31.3 (21–40)	148	MPA (30–1500) or MA (40–240)
Hara et al ¹⁰ 2015	Japan	2000–2012	34.2 (20–45)	16	MPA (400–600)
Wang et al ¹¹ 2014	Taiwan	1991–2010	32 (18–40)	37	MA (160)
Park et al ¹² 2013	Korea	1996–2012	30 (23–40)	23	MA (40–240) or MPA (80–1000)
Shirali et al ¹³ 2012	Iran	2000–2011	32 (24–42)	16	MA (160)
Park et al ¹⁴ 2012	Korea	2000–2008	30 (21–38)	14	MPA (250–500) or MA (160–240)
Perri et al ¹⁵ 2011	Canada	1971–2006	<40	27	NA (5) MPA (100–200) MA (160–320)
Cade et al ¹⁶ 2013	Australia	–2013	32 (23–42)	10	MA (60–200)
Eftekhari et al ¹⁷ 2009	Iran	1999–2005	29 (21–45)	21	MA (160–320)
Ushijima et al ¹⁸ 2007	Japan	—	31.7 (20–39)	22	MPA (600)
Shobeiri et al ¹⁹ 2013	Iran	2002–2011	30 (24–45)	8	MA (320)
Yamazawa et al ²⁰ 2007	Japan	1999–2005	36 (28–40)	9	MA (400)
Dursun et al ²¹ 2012	Turkey	1970–2000	31 (23–40)	43	MA, MPA
Yahata et al ²² 2006	Japan	1995–2004	31.9 (26–37)	8	MPA (600)
Falcone et al ²³ 2017	Italy	2001–2016	37.5 (18–40)	28	HSC, LNU-IUS
Wang et al ²⁴ 2015	China	2006–2012	29.5 (25–34)	6	HSC, MA
Shan et al ²⁵ 2013	China	2006–2012	30 (20–36)	14	HSC, MA
Mazzon et al ²⁶ 2010	Italy	2001–2009	33 (27–39)	6	HSC, MA (160)
Laurelli et al ²⁷ 2010	Italy	2002–2008	38 (26–40)	14	HSC, LNG-IUS/MA (160)
Parlakgumus et al ²⁸ 2013	Japan	2004–2011	36.2 (28–38)	5	HSC, D (10)/MA (80)/MPA (160)
Minig et al ²⁹ 2010	Italy	1996–2009	34 (22–40)	14	LNG-IUS, GnRH-a
Pronin et al ³⁰ 2015	Russia	2009–2012	33 (28–42)	32	LNG-IUS, GnRH-a
Kim et al ³¹ 2013	Korea	2008–2012	—, (29–40)	16	LNG-IUS, MPA (500)
Kim et al ³² 2011	Korea	2008–2011	38 (38–41)	5	LNG-IUS, MPA (250–500)
Cade et al ³³ 2010	Australia	–2010	35 (23–53)	12	LNG-IUS, MPA (200)
Pashov et al ³⁴ 2012	Russia	2006–2012	30.2 (26–36)	11	LNG-IUS, GnRH-a

HORMONIOTERAPIA

J Gynecol Oncol. 2018 Mar;29(2):e21
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Original Article

- 2018
- 244 mulheres
- Preservação da fertilidade (hiperplasia e câncer inicial)

In conclusion, repeated treatment is sufficiently effective for intrauterine recurrence after hormonal therapy, as previously reported in smaller studies. However, some previous reports have suggested that in 2%–4% of patients, there is a risk of duplicated ovarian cancer or an increase in cancer stage (\geq stage II). Therefore, when intrauterine recurrence is identified after hormone therapy, it is necessary to confirm whether the tumor is limited to the endometrium and to clarify whether the histological type is AEH or G1. Pelvic MRI, chest-pelvic CT (or positron emission tomography-CT), and total endometrial curettage are needed to ensure that the patient meets the eligibility criteria for the initial and repeated hormonal treatments.

Is repeated high-dose medroxyprogesterone acetate (MPA) therapy permissible for patients with early stage endometrial cancer or atypical endometrial hyperplasia who desire preserving fertility?

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HORMONIOTERAPIA

- 2018
- 46 mulheres
- Preservação da fertilidade
(hiperplasia e câncer inicial)

Original Research

Obstet Gynecol. 2018 Jan;131(1):109-116.

Treatment of Low-Risk Endometrial Cancer and Complex Atypical Hyperplasia With the Levonorgestrel-Releasing Intrauterine Device

Navdeep Pal, MBBS, MPH, Russell R. Broaddus, MD, PhD, Diana L. Urbauer, MS, Nyla Balakrishnan, BDS, MPH, Andrea Milbourne, MD, Kathleen M. Schmeler, MD, MPH, Larissa A. Meyer, MD, MPH, Pamela T. Soliman, MD, MPH, Karen H. Lu, MD, Pedro T. Ramirez, MD, Lois Ramondetta, MD, Diane C. Bodurka, MD, MPH, and Shannon N. Westin, MD, MPH

CONCLUSION: Levonorgestrel-releasing IUD therapy for the conservative treatment of complex atypical hyperplasia or early-grade endometrial cancer resulted in return to normal histology in a majority of patients.

OUTROS AGENTES...

Gynecologic Oncology 132 (2014) 438–442



Contents lists available at [ScienceDirect](#)

Gynecologic Oncology

journal homepage: www.elsevier.com/locate/ygyno



- 2014
- 363 mulheres
- Ca de endométrio e DM...

Metformin is associated with improved survival in endometrial cancer

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Conclusion. Metformin use was associated with improved RFS and OS but not TTR, most likely due to improving all-cause mortality. Its role in modifying cancer recurrence remains unclear. Prospective studies that capture metformin exposure prior to, during and post endometrial cancer treatment may help define the role of metformin upon cancer specific and overall health outcomes.

IMUNOTERAPIA

- 2015
- PD-1 e PD-L1...
- Pesquisas em fase I...

Longoria and Eskander *Gynecologic Oncology Research and Practice* (2015) 2:11
DOI 10.1186/s40661-015-0020-3

Gynecologic Oncology
Research and Practice

REVIEW

Open Access

Immunotherapy in endometrial cancer - an evolving therapeutic paradigm

Teresa C. Longoria and Ramez N. Eskander*

Immune Checkpoint Inhibitors

Table 3 PD-1 and PD-L1 expression levels in uterine cancer (450 specimens) [67]

Histology	PD-1	PD-L1
	% Expression based on IHC staining*	
Endometrioid	77.9	39.7
Serous Carcinoma	68.2	10.2
Carcinosarcoma	80.0	22.2
Leiomyosarcoma	46.9	36.0
Stromal Sarcoma	64.3	64.3
Clear Cell Carcinoma	69.2	23.1

Conclusion

Despite existing evidence that endometrial cancer, particularly the most aggressive forms of the disease, is sufficiently immunogenic to be a reasonable candidate for immunomodulation, attempts to expand the role of active and/or passive immunotherapy in the treatment of this condition have been limited. At a time when the U.S. FDA-approved indications for immune checkpoint inhibitors is steadily amassing, progress in the endometrial cancer arena has been slow. Uniquely, endometrial cancer is the only gynecologic cancer with a rising incidence and mortality, and identifying effective therapies for patient with metastatic or recurrent disease is critical.

TAKE HOME MESSAGE

- Cirurgia: avaliar o real valor da linfadenectomia...
- Quimioterapia: doença avançada / metastática...
- Radioterapia: padrão para controle de recidiva loco regional...
- Terapias Alvo: esperança de tratamento personalizado...

TAKE HOME MESSAGE

clinical practice guidelines

Annals of Oncology 24 (Supplement 6): vi33–vi38, 2013
doi:10.1093/annonc/mdt353

Endometrial cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up[†]

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on behalf of the ESMO Guidelines Working Group*

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These Clinical Practice Guidelines are endorsed by the Japanese Society of Medical Oncology (JSMO)

Stage I	I A G1–G2	Hysterectomy with bilateral salpingo-oophorectomy
	I A G3	Hysterectomy with bilateral salpingo-oophorectomy ± bilateral pelvic-para-aortic lymphadenectomy
	I B G1 G2 G3	Hysterectomy with bilateral salpingo-oophorectomy ± bilateral pelvic-para-aortic lymphadenectomy
Stage II		Radical hysterectomy with bilateral salpingo-oophorectomy and bilateral pelvic-para-aortic lymphadenectomy
Stage III		Maximal surgical cytoreduction with a good performance status
Stage IV	IV A	Anterior and posterior pelvic exenteration
	IV B	Systemic therapeutical approach with palliative surgery

Stage I	I A G1–G2	Observation
	I A G3	Observation or vaginal BT - If negative prognostic factor pelvic RT and/or adjunctive chemotherapy could be considered
	I B G1 G2	Observation or vaginal BT - If negative prognostic factor pelvic RT and/or adjunctive chemotherapy could be considered
	IB G3	Pelvic RT - If negative prognostic factor: combination of radiation and chemotherapy could be considered
Stage II		Pelvic RT and vaginal BT - If grade 1–2 tumour, myometrial invasion <50%, negative LVSI and complete surgical staging: brachytherapy alone - If negative prognostic factor: chemotherapy ± radiation
Stage III–IV		Chemotherapy
		If positive nodes: sequential radiotherapy If metastatic disease: chemotherapy – RT for palliative treatment



OBRIGADO!

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