

Uterine papillary serous cancer



There is much about the management of endometrial cancer that remains controversial. The literature contains very little good evidence to guide our practice on uterine papillary serous cancer (UPSC). UPSC is an aggressive histological subtype of endometrial cancer, accounting for less than 5% of its incidence, but 40% of its mortality. UPSC has a higher propensity for lymphovascular space invasion (LVSI), and intraperitoneal as well as extra-abdominal spread, than the more common endometrioid cancers. Approximately two thirds of women with UPSC have disease outside of the uterus at the time of diagnosis. Recurrence and mortality rates are high for all stages of this disease. Given the poor prognosis, most clinicians argue for adjuvant treatment for early-stage UPSC, but there is no standardised postoperative treatment available. The question which is difficult to answer is: "Does a combination of pelvic radiotherapy and adjuvant chemotherapy improve overall survival in this patient group?"

Most studies in the literature on UPSC are retrospective, and although advice on management is often given, very little good evidence for that advice is contained in the article. We are advised that comprehensive surgical staging with cytoreductive surgery is mandatory and beneficial for UPSC patients, and that systemic chemotherapy combined with radiation should be prescribed for all, or at least considered as an adjuvant therapy in those patients with more advanced stage-disease.

There are a number of confounding factors. Randomised controlled trials are difficult to complete because of the small numbers. Serous and clear cell cancers are grouped together in some studies, again because of the small numbers.

Narayan et al suggest in a 2011 study on endometrial carcinoma that irrespective of the histological type, node and LVSI negative patients should be regarded as having a very low risk of failure. This was based on limited numbers, but suggests that UPSC patients would also be at low risk of recurrence.¹

It is stated in the Hogberg reviews^{2,3} that chemotherapy is often recommended for patients with serous or clear cell carcinomas, but that neither the Nordic Society of Gynecologic Oncology (NSOG)-Endometrial Cancer (EC)-9501/European Organization for the Research and Treatment of Cancer (EORTC)-55991 and MaNGO ILLIAD-III trials, nor the Gynecologic Oncology Group 122 (GOG-122) study, support the recommendation. In the NSOG-EC-9501/EORTC-55991 study, radiation alone versus adjuvant chemotherapy, before or after radiation in the serous or clear cell subset (n = 78), did not show evidence of benefit from adjuvant chemotherapy on progression-free survival.

Obermair et al⁴ performed a prospective phase II trial in 2011, which also showed no improvement in overall survival when pelvic radiotherapy and chemotherapy followed surgery in UPSC patients.

The Pelvic Radiation Alone in High Risk and Advanced Stage Endometrial Carcinoma (Portec-3) study included patients with stage IA-III serous and clear cell histology. It remains to be seen if the serous subset of this study can offer management advice.

GOG-249, a randomised phase III trial of pelvic radiation therapy versus vaginal cuff brachytherapy followed by paclitaxel/carboplatin chemotherapy in patients with high-risk, early-stage endometrial cancer findings, was presented at a Society of Gynecologic Oncology meeting

in 2014, and contained a serous (n = 90) and clear cell (n = 30) subset. The addition of chemotherapy did not significantly improve survival.

This edition of the journal includes a retrospective study of UPSC from a large gynaecological oncology department in Melbourne, Australia. The variation in the adjuvant management of the cases shows the difficulty in making informed management decisions for these women with serous endometrial carcinomas. Increasingly, there appears to be a tendency to treat all women with USPC with adjuvant radiotherapy and chemotherapy because of the often-seen poor prognosis. There is no good evidence for or against this approach. However, prescribing pelvic radiotherapy for all UPSC, and adding chemotherapy only if disease is confirmed outside the pelvis at initial surgery or for recurrence, may be a more rational and acceptable approach until more evidence is forthcoming.

David Allen, MBChB, MMed(O&G), PhD, FCOG(SA), AFRACMA, FRANZCOG, CGO

Gynaecological Oncologist, Mercy Hospital for Women, Melbourne, Australia

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