

Editorial



Hysteroscopy in fertility-sparing management for early endometrial cancer: a double-edged sword

Jeong-Yeol Park

Department of Obstetrics and Gynecology, University of Ulsan College of Medicine, Asan Medical Center, Seoul, Korea

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Correspondence to

Jeong-Yeol Park

Department of Obstetrics and Gynecology,
University of Ulsan College of Medicine,
Asan Medical Center, 88 Olympic-ro 43-gil,
Songpa-gu, Seoul 05505, Korea.
E-mail: catgut1-0@hanmail.net

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ORCID

Jeong-Yeol Park
<http://orcid.org/0000-0003-2475-7123>

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► See the article “Fertility preserving treatment with hysteroscopic resection followed by progestin therapy in young women with early endometrial cancer” in volume 28, e2.

The fertility-sparing management using progestin is now widely accepted as the alternative treatment for young women who eagerly want to preserve their fertility [1]. The selection of patients who will achieve complete response is the most important step for successful fertility-sparing management [1]. Patients with endometrium-confined, well-differentiated, endometrioid adenocarcinoma are the proper candidates for this treatment [1]. The pooled complete response rate is 76.2% (95% confidence interval [CI], 68.0%–85.3%) and recurrence rate among complete responder is 40.6% (95% CI, 33.1%–49.8%) in a recent meta-analysis [2]. The complete response rate is high, although the recurrence rate is high as well after achieving complete response. Therefore, the goal of this treatment is to delay definitive treatment until the completion of family planning. The most popular type of fertility-sparing management is to receive high-dose, continuous, daily oral progestin after removing endometrial cancer tissues by dilatation, curettage and biopsy (DCBx) as much as possible [1]. The use of hysteroscopic resection of endometrial cancer tissues may have merits and demerits compared to DCBx. Hysteroscopic examination of the endometrial cavity may increase the diagnostic accuracy by providing the direct estimation of the tumor extent and by providing information on the myometrial invasion [3]. Hysteroscopic resection of endometrial cancer tissues may increase the therapeutic efficacy by excising the tumor completely under direct vision. However, it may be harmful because the possibility of the spread of exfoliated endometrial cancer cells into peritoneal cavity by liquid expansion medium [4]. It may also impact adversely on the pregnancy outcome because it can cause injury to the basal layer of endometrium or underlying myometrium by thermal injury or mechanical destruction [5]. These possible positive and negative effects of hysteroscopy in the fertility-sparing management of endometrial cancer have never been evaluated in prospective trial. The questions are not solved yet and still debated.

Falcon et al. [6] performed a prospective study to evaluate the role of hysteroscopy in the fertility-sparing management of endometrial cancer and reported the promising results in this issue. In this study, the authors performed hysteroscopic excision of the tumor with DCBx before using progestin. The complete response rate was 96.3% and recurrence rate in complete responders was 7.6%. Therefore, 85.7% of patients showed durable complete response with a median duration of 95 months. This result suggests the possible positive role of hysteroscopic excision of endometrial cancer tissues over DCBx in fertility-sparing

management of endometrial cancer. There was no peritoneal spread after hysteroscopic surgery in this series. Therefore, the risk of peritoneal spread of endometrial cancer cells by distension media may be minimal. The pregnancy rate and live birth rate among the patients who tried to conceive were 93.3% and 86.6%, respectively. Therefore, the impact of hysteroscopic excision of endometrial cancer tissues may be also minimal. The interpretation of the results of this study is limited because this is a small study and spans a long study period, and only half of study patients tried to conceive. However, the results of this study provide important clues to answer to long-awaited unsolved questions.

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