SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Ospedaliero - Universitaria di Ferrara

Società Medico Chirurgica di Ferrara

Università degli Studi di Ferrara

Carcinoma dell'endometrio:

Approccio Multidisciplinare

Nuovo Ospedale S.Anna – Cona, 09 Febbraio 2019

Linee guida del trattamento

Dott.ssa Ruby Martinello

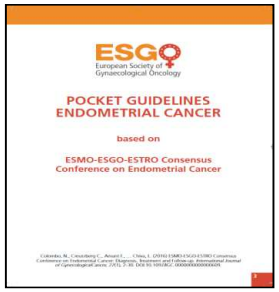
Clinica Ostetrica e Ginecologica, Azienda Ospedaliero-Universitaria S. Anna, Cona - Ferrara

ESMO

ESGO
European Society of Gynaecological Oncology

ESTRO
European Society for RADIOTHERAPY & ONCOLOGY

2016



2018

NCCN National Comprehensive Cancer Network®

2018

Aiom
Associazione Italiana di Oncologia Medica

2018

SGO
Society of Gynecolo

2015

Quando utilizziamo le raccomandazioni?


special articles

Annals of Oncology

Annals of Oncology 27: 16–41, 2016
doi:10.1093/annonc/mdv484

ESMO-ESGO-ESTRO Consensus Conference on Endometrial Cancer: diagnosis, treatment and follow-up†

N. Colombo[1*], C. Creutzberg[2], F. Amant[3,4], T. Bosse[5], A. González-Martín[6,7], J. Ledermann[8], C. Marth[9], R. Nout[10], D. Querleu[11,12], M.R. Mirza[13], C. Sessa[14] & the ESMO-ESGO-ESTRO Endometrial Consensus Conference Working Group[‡]

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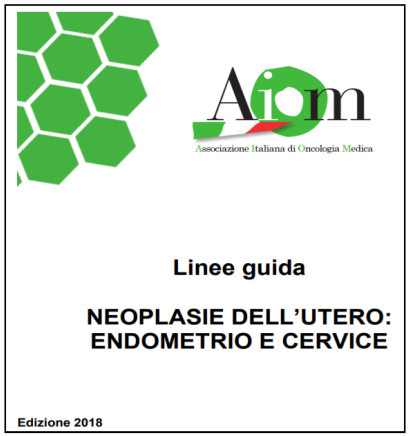
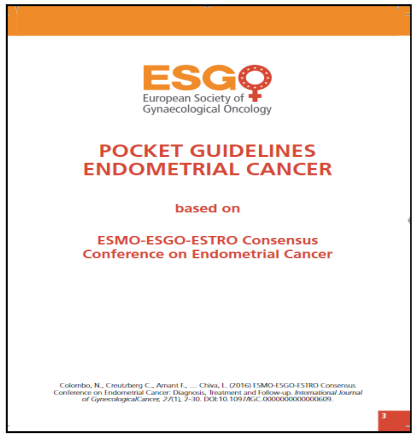




1) Dopo la stadiazione clinico-strumentale per approccio terapeutico

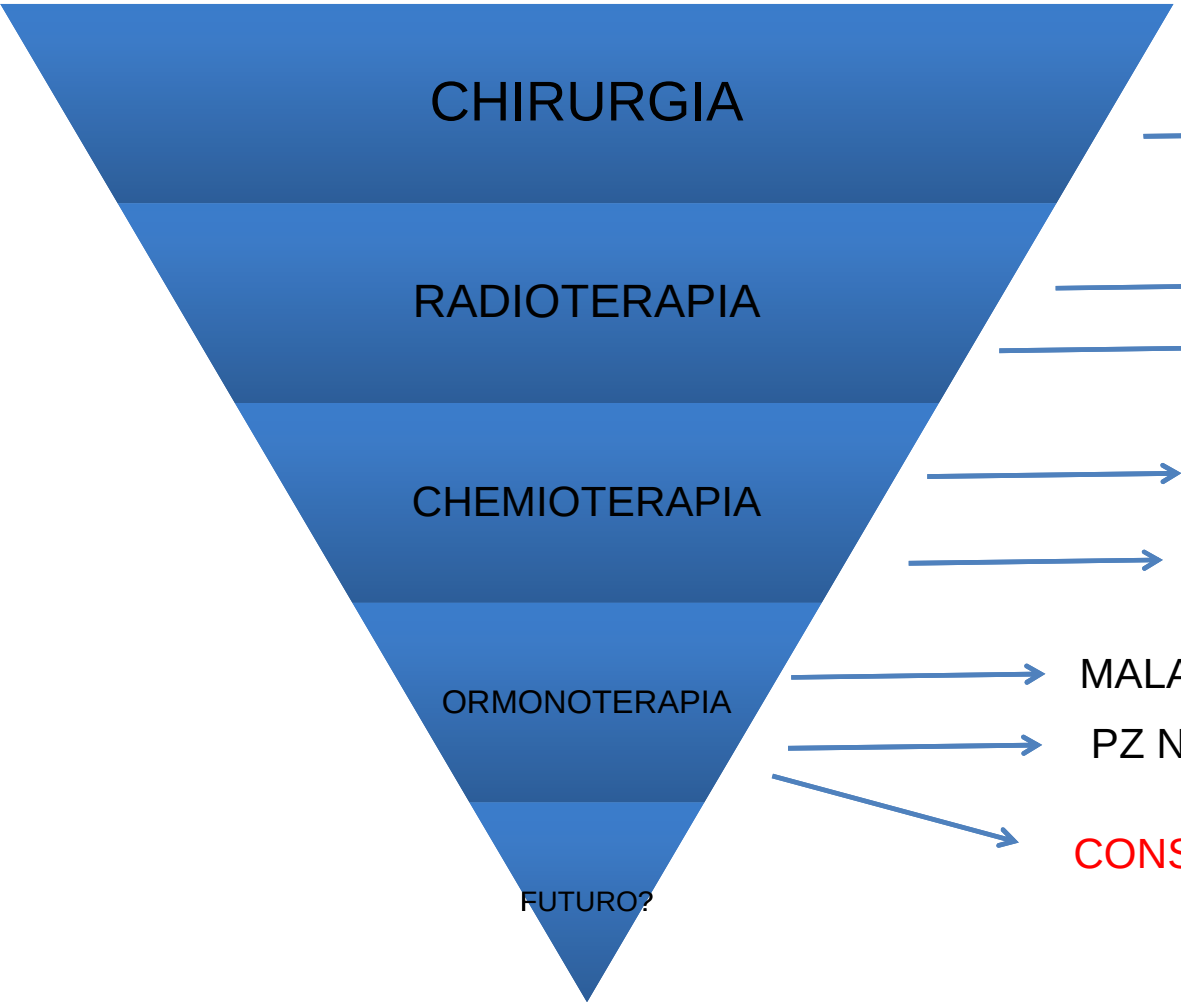
2) Dopo la stadiazione chirurgica per ev approccio adiuvante

PRIMA DIAGNOSI:

grading
istotipo
imaging

- apparente I stadio
- > I stadio

TERAPIE POSSIBILI



PZ OPERABILE, TUTTI GLI STADI

PZ NON OPERABILE

ADIUVANTE

MALATTIA METASTATICA

ADIUVANTE

MALATTIA METASTATICA

PZ NON OPERABILE

CONSERVAZIONE FERTILITA’

CHIRURGIA

I STADIO Istotipo Endometrioide

La chirurgia standard è l'isterectomia totale extrafasciale con salpingo-ovariectomia bilaterale senza asportazione dell'orletto vaginale

L.E.: IV
Racc: A

Peritoneal cytology is no longer considered mandatory for staging
(Ma peggior prognosi)

Ovariectomia per
- Prevenzione ca ovarico
- Escludere metastasi

Donne giovani: no BRCA mutations
no Sindrome di Lynch:
conservazione ovaie, si salpingectomia

II STADIO EC

NO CHIRURGIA RADICALE
(TIPO A o B)
SEMPRE LINFOADENECTOMIA

III-IV STADIO
CITORIDUZIONE
Se non possibile: radioterapia!

NON EEC:
- STESSA CHIR DELL'ALTO RISCHIO
- SEMPRE OVARIECTOMIA
- OMENTECTOMIA NEL SIEROSO
non nel C.C.

CHIRURGIA

Ruolo della laparoscopia

Ruolo della linfoadenectomia

Ruolo del linfonodo sentinella

LAPAROSCOPIA vs LAPAROTOMIA

stessi risultati per DFS e OS
ma per laparoscopia:

>tempi operatori
<morbidità
<ospedalizzazione

I-II stadio (LAP2-GOG, 2012) LE 1 Racc A
Alto grado retrospettivo (2012) LE IV Racc C

vantaggi in
- Obese
- Anziane
- Co-morbidità

Tozzi et a, 2005

ESMO-ESGO-ESTRO CONSENSUS CONFERENCE

LAPAROSCOPIA vs LAPAROTOMIA

La chirurgia mini-invasiva è raccomandata nella gestione chirurgica del carcinoma endometriale a rischio basso e intermedio

LE:	*I*
R:	*A*

LAPAROSCOPY vs. LAPAROTOMY

National Comprehensive Cancer Network®

"Minimally invasive surgery (MIS) is the preferred approach **when technically feasible"**

Associazione Italiana di Oncologia Medica

"La chirurgia laparoscopica rispetto alla chirurgia laparotomica **dovrebbe essere presa in considerazione** perché offre risultati equivalenti in termini di ripresa di malattia con ridotte complicanze intra- e post-operatorie"
[B: positiva forte]

Society of Gynecolo

"Laparoscopy should be embraced as the standard surgical approach **for comprehensive surgical staging**"
[level of evidence: A]

LINFOADENECTOMIA

Fa parte della stadiazione ma controversa nel I stadio per:

- Indicazioni
- Estensione
- Ruolo

Indicazioni:

Nessuna G1-G2 <50%,

LE:II R:A

SCOPO STADIATIVO: G3 <50%

(no diff OS) G1-G2 >=50%

LE:II R:C

SI G3 >=50%

LE:IV R:B

Estensione: - pelvici e paraortici fino alle vene renali
- almeno 10/12 LFN

LE:III R:B

Ruolo: 1) migliore definizione prognostica
2) modulazione terapia adiuvante

LE:IV R:B

Sempre nel II-IV stadio

SENTINEL LYMPH NODE (SLN) MAPPING

L’asportazione del linfonodo sentinella (SLND) è ancora un approccio sperimentale, ma la letteratura suggerisce che sia fattibile.
La SLND aumenta le diagnosi di micro-metastasi e di cellule tumorali isolate; tuttavia, l‘impatto clinico di questi risultati non è chiaro

LE:IV
R:D

SENTINEL LYMPH NODE (SLN) MAPPING

National Comprehensive Cancer Network®

"SLN is under evalutaion: SLN mapping with ultrastaging may increase the detection of lymphnode metastasis with low false-negative rates in apparent uterine-confined disease"

AIOM

ızione Italiana di Oncologia M

"SLN ha mostrato una buona performance diagnostica e potrebbe rappresentare un buon compromesso (anche in pazienti a basso rischio)" [Livello 2]

SGO

Society of Gynecolo

"SLN dissection may reduce the morbidity associated with standard lymphadenectomy and may enhance the therapeutic benefit of surgical staging in early E.C."

Dubbio: sito di iniezione

Stadiazione FIGO 2018

FIGO CANCER REPORT 2018

WILEY GYNECOLOGY OBSTETRICS FIGO

Cancer of the corpus uteri

Frédéric Amant[1,2,3,*] | Mansoor Raza Mirza[4] | Martin Koskas[5] | Carien L. Creutzberg[6]

TABLE 1 Cancer of the corpus uteri.

FIGO Stage	
I[a]	Tumor confined to the corpus uteri
IA[a]	No or less than half myometrial invasion
IB[a]	Invasion equal to or more than half of the myometrium
II[a]	Tumor invades cervical stroma, but does not extend beyond the uterus[b]
III[a]	Local and/or regional spread of the tumor
IIIA[a]	Tumor invades the serosa of the corpus uteri and/or adnexae[c]
IIIB[a]	Vaginal involvement and/or parametrial involvement[c]
IIIC[a]	Metastases to pelvic and/or para-aortic lymph nodes[c]
IIIC1[a]	Positive pelvic nodes
IIIC2[a]	Positive para-aortic nodes with or without positive pelvic lymph nodes
IV[a]	Tumor invades bladder and/or bowel mucosa, and/or distant metastases
IVA[a]	Tumor invasion of bladder and/or bowel mucosa
IVB[a]	Distant metastasis, including intra-abdominal metastases and/or inguinal nodes)

[a]Either G1, G2, or G3.
[b]Endocervical glandular involvement only should be considered as Stage I and no longer as Stage II.
[c]Positive cytology has to be reported separately without changing the stage.

Tabella 2. Nuovi gruppi di rischio per guidare l'uso di terapia adiuvante

Risk group	Description	LoE
Basso	Stadio I endometrioide, grado 1-2, invasione miometriale <50%, LVSI negativi	I
Intermedio	Stadio I endometrioide, grado 1-2, invasione miometriale ≥50%, LVSI negativi	I
Intermedio-alto	Stadio I endometrioide, grado 3, invasione miometriale <50%, indipendentemente dallo stato di LVSI	I
	Stadio I endometrioide, grado 1-2, LVSI inequivocabilmente positivi, indipendentemente dalla profondità di invasione	II
Alto	Stadio I endometrioide, grado 3, invasione miometriale ≥50%, indipendentemente dallo stato di LVSI	
	Stadio II	I
	Stadio III endometrioide, in assenza di malattia residua	I
	Non-endometrioide (carcinoma sieroso o a cellule chiare o indifferenziato, o carcinosarcoma)	I
Avanzato	Stadio III con malattia residua e stadio IVA	I
Metastatico	Stadio IVB	I

E' stata utilizzata la classificazione FIGO 2009; i fattori molecolari sono stati considerati ma non inclusi; la dimensione del tumore era considerata ma non inclusa; lo stato linfonodale può essere preso in considerazione per le raccomandazioni terapeutiche

STAGE I: ADJUVANT TREATMENT

ESMO-ESGO-ESTRO CONSENSUS CONFERENCE

STAGE I : NEW RISK GROUPS TO GUIDE ADJUVANT THERAPY USE		
Risk Group	**Description**	**LOE**
LOW	Endometrioid, grade 1-2, <50% myometrial invasion, LVSI negative	**I**
INTERMEDIATE	Endometrioid, grade 1-2, ≥50% myometrial invasion, LVSI negative	**I**
HIGH-INTERMEDIATE	Endometrioid, grade 3, <50% myometrial invasion, regardless of LVSI status Endometrioid, grade 1-2, LVSI unequivocally positive, regardless of depth of invasion	**I** **II**
HIGH	Endometrioid, grade 3, ≥50% myometrial invasion, regardless of LVSI status	**I**

STAGE I : NEW RISK GROUPS TO GUIDE ADJUVANT THERAPY USE		
Risk Group	**Description**	**LOE**
LOW	Endometrioid, grade 1-2, <50% myometrial invasion, LVSI negative	**I**
INTERMEDIATE	Endometrioid, grade 1-2, ≥50% myometrial invasion, LVSI negative	**I**
HIGH-INTERMEDIATE	Endometrioid, grade 3, <50% myometrial invasion, regardless of LVSI status Endometrioid, grade 1-2, LVSI unequivocally positive, regardless of depth of invasion	**I** **II**
	Endometrioid, grade 3, ≥50% myometrial invasion, regardless of LVSI status	**I**

no adjuvant treatment is recommended

LE:I
R:A

STAGE I : NEW RISK GROUPS TO GUIDE ADJUVANT THERAPY USE		
Risk Group	**Description**	**LOE**
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HIGH	Endometrioid, grade 3, ≥50% myometrial invasion, regardless of LVSI status	**I**

1. Adjuvant brachitherapy is recommended to decrease vaginal recurrence

LE:I
R:B

2. No adjuvant treatment is an option, especially for patients aged <60 years

LE:II
R:C

STAGE I : NEW RISK GROUPS TO GUIDE ADJUVANT THERAPY USE		
Risk Group	**Description**	**LOE**
LOW	Endometrioid, grade 1-2, <50% myometrial invasion, LVSI negative	**I**
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HIGH	Endometrioid, grade 3, ≥50% myometrial invasion, regardless of LVSI status	**I**

La linfoadenectomia modula la terapia

1 – **Surgical nodal staging** performed, node negative:

A. Adjuvant brachiterapy is recommended to decrease vaginal recurrence
B. No adjuvant therapy is an option

2- **No surgical nodal staging**:

A. Adjuvant EBRT recommended for LVSI unequivocally positive to decrease pelvic recurrence
B. Adjuvant brachytherapy alone is recommended for grade 3 and LVSI negative to decrease vaginal recurrence

STAGE I : NEW RISK GROUPS TO GUIDE ADJUVANT THERAPY USE		
Risk Group	**Description**	**LOE**
LOW	Endometrioid, grade 1-2, <50% myometrial invasion, LVSI negative	I
INTERMEDIATE	Endometrioid, grade 1-2, ≥50% myometrial invasion, LVSI negative	I
HIGH-INTERMEDIATE	Endometrioid, grade 3, <50% myometrial invasion, regardless of LVSI status Endometrioid, grade 1-2, LVSI unequivocally positive, regardless of depth of invasion	I II
HIGH	Endometrioid, grade 3, ≥50% myometrial invasion, regardless of LVSI status	**I**

1 – **Surgical nodal staging** performed, **node negative**:

A. Adjuvant EBRT with limited fields should be considered to decrease locoregional recurrence
B. Adjuvant brachytherapy may be considered as an alternative to decrease vaginal recurrence
C. Adjuvant systemic therapy is under investigation

La linfoadenectomia modula la terapia

2- **No surgical nodal staging**:

A. Adjuvant EBRT is generally recommended for pelvic control and relapse
B. Sequential adjuvant chemotherapy may be considered to improve PFS and cancer-specific survival (CSS)
C. There is more evidence to support giving chemotherapy and EBRT in combination rather than either treatment modality alone

CONCLUSIONI - 1

I STADIO

CHIRURGIA-LINFOADENECTOMIA

1. **Standard surgery** is total extrafascial hysterectomy with BSO

2. **Minimally invasive** surgery is recommended in the surgical management of low- and intermediate-risk

3. **Lymphadenectomy**:
   Low risk: not recommended
   Intermediate risk: considered for staging purpose
   High risk: recommended

4. If lymphadenectomy is performed**, systematic removal of pelvic and para-aortic nodes** should be considered

5. **SLND** is still experimental

CONCLUSIONI - 2

TERAPIA ADIUVANTE I STADIO

LOW RISK

Grade 1-2
and
<50% myom. invas.
and
LVSI -

Observation

INTERMEDIATE RISK

Grade 1-2
and
≥ 50% myom. invas.
and
LVSI -

Observation (< 60 yrs)
Vs
Brachytherapy

HIGH INTERM. RISK

Grade 3
And
< 50% myom. invas.
Or
Grade 1-2
and
LVSI +

Brachy Vs Observation

EBRT se LVSI +
or
Brachytherapy se G3 e LVSI –
(no surgical nodal staging)

HIGH RISK

Grade 3
or
≥ 50% myom. invas.
and
LVSI +

EBRT
+/- Chemotherapy
(no surgical nodal staging)

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GRAZIE!

CONSERVAZIONE FERTILITA’ possibile pensarci perché:

MENO DEL 4% < 40 AA

ETA’ GIOVANILE : STADIO PRECOCE
BEN DIFFERENZIATO,
MIGLIORE PROGNOSI

Iperplasia atipica/ca endometrioide G1
RF non Biopsia
Più patologi/DEDICATI
NO LINEE GUIDA

MPA o MA o LNG-IUG (resetto?) Dopo 6 mesi : DC

Resp rate : 75%
Rec 30-40%

La gravidanza non aumenta rischio di recidiva

Live Birth Rate 28% spontaneo
38% fecond assistita

Isterectomia se:
-Fallimento
- Dopo le gravidanze