Correspondence

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Hereditary portion as an initial genetic approach in gynecologic cancer: synchronous tumor of ovary and endometrium

To the editor: Hereditary portion and genetic status are very important to work out strategies for cancer prevention and early detection in gynecologic cancers. Familial history of related cancers within the second degree relatives are approximately 10% and 20% in endometrial cancer and ovarian cancer, respectively [1,2]. The proportion of genetic background and germline mutation in Korean women with gynecologic cancer is comparable to those of western ethnics [1,2].

Two interesting articles dealing synchronous cancers of endometrium and ovary appeared in the December issue [3,4]. The 5-year overall survival of women with synchronous cancers of endometrium and ovary was 78% from Singapore [3]. The majority of them were at early stage (83% and 83% for endometrial and ovarian cancer, respectively). The rate of recurrence was 13.6% (6/46). The site of recurrence could be depicted in detail to understand the course of synchronous cancers of endometrium and ovary.

Kim et al. [4] reported 32 synchronous tumors of endometrium and ovary treated between 1995 and 2001 of Samsung Medical Center. Of 32 patients, 9 patients (28%) have a family history of cancer. In table 4, lung cancer, pancreatic cancer, or stomach cancer was included. Related to hereditary non-polyposis colorectal cancer (HNPCC), Amsterdam criteria II or revised criteria of suspected HNPCC was used. The criteria for familial history used in the study should be clearly specified. Therefore, definitive incidence of HNPCC using clinical criteria could be clearly depicted.

The proportion of both endometrioid adenocarcinoma in endometrium and ovary were 50% (18/36) and 74% (34/46) from Korea and Singapore, respectively [3,4]. The authors from two studies could reveal the proportion of synchronous tumor from metachronous tumor among both endometriod histology in endometrium and ovary from cancer registry of endometrial cancer and ovarian cancer, respectively. Clarifying the proportion of synchronous tumor of endometrium and ovary is the beginning of the basic research and clinical application of hereditary gynecologic cancer.

CONFLICT OF INTEREST

No potential conflict of interest about this article was reported.

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Heon Jong Yoo, Sang-Yoon Park, Myong Cheol Lim

Center of Uterine Cancer, Research Institute and Hospital, National Cancer Center, Goyang, Korea

Correspondence to Myong Cheol Lim
Center for Uterine Cancer, Research Institute and Hospital, National Cancer Center, 323 Ilsan-ro, Ilsandong-gu, Goyang 410-769, Korea. Tel: 82-31-920-1763, Fax: 82-31-920-1238, E-mail: gynlim@ncc.re.kr

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In reply: We thank Dr. Yoo, Park, and Lim for their sincere interest in our study and comments. We know diagnostic approach for Lynch syndrome should be based on Amsterdam criteria. At the same time, selecting suitable patients using Amsterdam criteria has been reported to be associated with high false negative rate [1]. In our algorithm based on immunohistochemical analysis and family history, we defined 'high-risk family history' as patients who have at least one first-degree relative cancer patient according to medical record and telephone interview. This family history was used as adjunctive criteria to immunohistochemical analysis (MLH1, MSH2, and MSH6) in our study.

Our selection process started with finding simultaneous or double primary (multiple) gynecologic malignancy through medical chart searching not using total ovary and endometrial cancer registry patients. Therefore we cannot show exact data right now about "proportion of synchronous tumor from metachronous tumor among both endometrioid histology in endometrium and ovary". However, it is certain that metachronous tumor of endometrioid carcinoma in the ovary and endometrium may be very rare because most of primary surgery of both endometrial cancer and ovarian cancer include hysterectomy and bilateral salphingo-oophorectomy. In addition, synchronous tumors in the ovary and endometrium are also not common. In one study, among 5,366 ovarian carcinoma patients, there were 460 with endometrioid subtype patients. In addition, among 460 patients, 11.5% (40/460) has been investigated to have a same endometrioid type endometrioid carcinoma [2].

CONFLICT OF INTEREST

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Byoung-Gie Kim

Department of Obstetrics and Gynecology, Samsung Medical Center, Sungkyunkwan University School of Medicine, Seoul, Korea

Correspondence to Byoung-Gie Kim
Department of Obstetrics and Gynecology, Samsung Medical Center, Sungkyunkwan University School of Medicine, 50 Irwon-dong, Gangnam-gu, Seoul 135-710, Korea. Tel: 82-2-3410-3518, Fax: 82-2-3410-0630, E-mail: bgkim@skku.edu

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