

## Editorial



# Comments on: Fertility-sparing treatment for intramucous, moderately differentiated, endometrioid endometrial cancer: a Gynecologic Cancer Inter-Group (GCIG) study

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### Conflict of Interest

No potential conflict of interest relevant to this  
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Recently, Falcone et al. [1] reported the oncologic and reproductive outcomes of fertility-sparing treatment in women with endometrium-confined, grade 2, endometrioid endometrial cancer using Gynecologic Cancer Inter-Group (GCIG)-endorsed registry. This is the largest series ever reported on the grade 2, endometrial cancer [1]. The complete response rate (73.9%) and recurrence rate (41.1%) in this report was similar with those obtained in grade 1 endometrial cancer [1]. Therefore, it seems that fertility-sparing treatment can be a reasonable treatment option for women with endometrium-confined, grade 2, endometrioid endometrial cancer. In order to expand the indication of fertility-sparing treatment in endometrial cancer, studies are being conducted to apply fertility-sparing treatment not only to grade 2 but also to endometrial cancer with superficial myometrial invasion [2]. There are several additional considerations to apply fertility-sparing treatment in endometrial cancer which is more advanced than endometrium-confined, grade 1, endometrioid endometrial cancer.

The first point to consider is the inadequate accuracy of imaging studies in diagnosing extra uterine metastases. Enhanced magnetic resonance imaging (MRI) and positron emission tomogram-computed tomogram (PET-CT) are regarded the best imaging modalities for pre-treatment evaluation of endometrial cancer. However, even if the cancer is confined to the uterus and there is no extra uterine metastasis on both of MRI and PET-CT, there are about 7% of cases where lymph node metastasis is found in postoperative pathology [3]. In Falcone et al.'s study [1], there was a case in whom lymph node metastasis occurred during fertility-sparing treatment. Of course, in this case, it is not known whether there was lymph node metastasis even at the time of initial diagnosis. In addition, only one of 23 grade 2 diseases remains unresolved, so it cannot be said to be worse than the course after standard treatment. In the case of grade 2 or superficial myometrial invasion, there may be more of these cases, so diagnostic laparoscopy should be considered more actively, and sentinel lymph node mapping can be considered [4]. In addition, during fertility-sparing treatment, imaging studies to evaluate extra uterine metastasis should be included in response evaluation.

The second point to consider is that more effective hormone therapy should be used. The use of progestin-releasing intrauterine device (IUD) alone is satisfactory in endometrial hyperplasia [5], but appears to be limited compared to high-dose oral progestin in the treatment of endometrial cancer [6]. High-dose oral progestin or a combination of high-dose oral progestin and progestin releasing-IUD may be better [7]. Research is also being conducted to evaluate whether adding gonadotropin-releasing hormone agonist or metformin to high-dose oral progestin or progestin-releasing IUD is more efficient [8,9].

The third point to be considered is efforts to reduce the recurrence rate after complete remission. Endometrial cancer in young women occurs in patients with risk factors such as obesity, polycystic ovary syndrome or anovulation, etc. Therefore, endometrial cancer occurring after complete remission in these patients may be a recurrence, but it may be a new occurrence due to risk factors. To prevent this recurrence, it is recommended to use oral contraceptives, low dose progestin therapy or progestin-releasing IUD. In addition, pregnancy itself plays a role in reducing the recurrence of endometrial cancer, so it is important to try pregnancy immediately after complete remission.

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