Endometrial cancer

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1 Endometrial cancer is the most common gynecologic malignant disease in Canada

In 2017, the incidence and mortality rate of endometrial cancer were 35.7 and 5.3 per 100 000, respectively; both rates are rising.[1] Type I cancer is low grade and carries a good prognosis. Type II is high grade, is often detected when already in an advanced stage and accounts for 70% of all deaths from endometrial cancer.[2]

2 Advancing age and obesity are the key risk factors (Box 1)

With every 10 unit increase in body mass index, the relative risk for developing endometrial cancer is 2.89 (95% confidence interval 2.62–3.18).[3] Obesity and polycystic ovary syndrome are modifiable risk factors. Use of combined hormonal contraceptives or progestin-only products (including the levonorgestrel intrauterine system) may prevent endometrial cancer.[4]

3 Postmenopausal vaginal bleeding or premenopausal abnormal bleeding is the usual presenting sign

Clinicians should ask patients about postmenopausal and abnormal bleeding as part of routine health surveillance. Premenopausal patients with new abnormal (i.e., heavy or irregular) uterine bleeding aged 40 years or older, or those younger than 40 years with risk factors, should be investigated for endometrial cancer.[4]

4 Patients should be referred to a gynecologist if endometrial biopsy is abnormal, unobtainable or unavailable in primary care, or if postmenopausal or abnormal uterine bleeding persists after a normal biopsy

Biopsy carries a high sensitivity (90%–100%) and specificity (98%–100%) for detecting endometrial cancer and, where possible, should be performed in primary care.[5] Although transvaginal ultrasound should also be ordered to investigate other causes of abnormal bleeding, a biopsy is always required, as some patients with type II endometrial cancer present with endometrial thickness less than 5 mm.[6]

5 With early detection and treatment, prognosis is good

The 5-year survival rate for all stage 1 endometrial cancers is greater than 80%.[1] Primary treatment is total hysterectomy with bilateral salpingo-oophorectomy and, often, lymph node assessment using a minimally invasive approach. Progestins may be considered for fertility preservation or in candidates unsuitable for surgery.[2]

Box 1: Common risk factors for endometrial cancer[4]

- Advancing age
- Obesity: 10-fold increased risk if body mass index > 30
- Oligomenorrhea or polycystic ovary syndrome
- Use of unopposed estrogen therapy or tamoxifen
- Lynch syndrome: 40% lifetime risk

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