

Are we ready for conservative treatment in ovarian cancer?

To the editor: Ovarian cancer is a rare malignancy, which is the 4th in frequency of all gynecologic malignancies; however, it represents the most lethal gynecological cancer. Ovarian cancer in young patients is also rare; it is considered that 3% to 17% of all epithelial ovarian cancers occur in women less than 40 years. The presentation of majority epithelial ovarian cancers is in advanced stages (The International Federation of Gynecology and Obstetrics [FIGO] III to IV) when 5-year overall survival is less than 30%. When presented in early stages the 5-year overall survival reaches 90% for FIGO stage I. Pregnancy rate in women after fertility-sparing surgery in cases of early ovarian cancer is 63% to 100%, with a 20% abortion rate [1].

The proportion of patients with early ovarian cancer demanding fertility-preserving techniques is increasing. This represents a challenge to the gynecologic oncologist when setting the limits in order to not affect the prognosis and survival of these patients.

Management of FIGO stages I to II includes bilateral salpingoophorectomy and hysterectomy, so it is mandatory to identify women desiring preserve fertility. Most studies published to date conclude that preserving the uterus and contralateral ovary in very early stages (FIGO IA and IB), with a histological grade differentiated or moderately differentiated (G1 to G2), could be a reasonable option [2].

After reading the last paper from Ditto et al. [3] we are quite concerned about their conclusions, since in their series the authors included 5 FIGO stage IC cases, and 5 grade 3 tumors with a recurrence rate of 22% in the fertility-preserving group. Authors concluded that considering their results, fertility sparing surgery in early epithelial ovarian cancer seems to be safe, which on the basis of the current evidence it is very controversial and it seems to be unsafe for tumors FIGO IC/G3 and higher [1]. Moreover, although we partially agree with Kajiyama [4] on the low impact of preserving surgery in sur-

vival, we do not have enough evidence to assume FIGO stage IC and grade 3 tumors, and we completely agree on the idea that further investigation in this line is needed, mandatorily by multicentric cooperation.

Very limited authors have tried conservative treatment in FIGO stage IC and/or poorly differentiated tumors (G3), but with a moderate high rate of recurrence [5]. Some others consider removal of uterus and ovaries after birth, but in our opinion, preservation of endocrine function in selected young women is as important as fertility sparing approach, so we suggest the maintenance of the uterus and contralateral ovary delaying its removal until 45 years old with a close follow-up.

It is also important to consider the probability of the patient to get pregnant and to reach term, since after 40 years old the fertility rate drops dramatically, and maybe the low risk of recurrence could not be justify. This can also make the patient require assisted reproductive technology (ART), which is also unclear how it can affect the cancer process. The influence of ART nowadays is unclear and the results are controversial. ART could increase the rate of recurrent ovarian cancer or even the incidence of further estrogen-dependent cancers such as breast or endometrial. In the literature just borderline ovarian tumors are clearly related to ART. Moreover, the risk of recurrence in low-risk patients (ovarian cancer FIGO IA/IB–G1/G2) is very low, with just one case reported in literature after fertility sparing surgery and ART. There is a need of close collaboration between cancer centers and reproductive clinics in these cases, which may be advantageous to safeguard reproductive health among women [6].

In conclusion, we think we are ready for fertility-sparing surgery in early epithelial ovarian cancer as an effective alternative to conventional radical surgery in younger women but just for selected cases where recurrence rate is very low such as FIGO stage IA/IB–G1/G2, and we need to be very careful with stages IC and G3 individualizing every case.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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