The Women's HEALTH GROUP, P.C.

9195 Grant Street, Suite 410
Thornton, CO 80229
Phone: 303-280-2229(BABY)
Fax: 303-280-0765

300 Exempla Circle, Suite 470
Lafayette, CO 80026
303-665-6016
303-665-0121

6363 West 120th Avenue, Suite 300
Broomfield, CO 80020
303-460-7116
303-460-8204

www.whg-pc.com

HYPERPLASIA AND UTERINE CANCER

TYPES OF UTERINE CANCERS

The glandular lining gives rise to adenocarcinomas. Ninety-five percent, of uterine cancers are adenocarcinomas arising from the lining. The term uterine cancer usually refers to these adenocarcinomas. Adenocarcinomas are graded. Grade I cancers are expected to behave the best, Grade III cancers the worst.

Premalignant changes can occur in the lining of the uterus. These changes are almost always due to excessive stimulation of the endometrial glands by an excess of estrogen or a prolonged estrogen influence. They can occur in younger women who do not ovulate regularly as well as in older women who are obese. These changes are called endometrial hyperplasias. They are diagnosed usually by endometrial biopsy. They are not cancers but are often best treated by hysterectomy. If they occur in a young woman she may also be infertile due to irregular or infrequent ovulation. In these cases, the treatment is by drugs that cause ovulation. Your doctor may prescribe high dose progesterone or recommend a hysterectomy. If you ovulate you will no longer have unopposed estrogen stimulation because you now have the progesterone phase to the menstrual cycle. If you get pregnant then that will reverse the hyperplasia also. For most women the best treatment will probably be hysterectomy.

Papillary serous adenocarcinomas and clear cell adenocarcinomas are a subtype of uterine adenocarcinomas. They are different because of their increased potential to spread throughout the abdomen. The best treatment has yet to be demonstrated.

RISK FACTORS FOR UTERINE ADENOCARCINOMA

Age is the most important risk factor. This is a cancer of postmenopausal and perimenopausal women. There is also a well-recognized association with estrogen. Estrogen is a hormone produced by the ovary. One of the effects of the estrogen is to stimulate the endometrial glands to grow and proliferate.

If the woman has a problem that prevents ovulation then the ovary will continue to make estrogen. This will result in prolonged unopposed estrogen stimulation to the endometrial glands and this will increase the risk for cancer of these glands. Postmenopausal women who are taking estrogen also will have unopposed estrogen stimulation to the uterine glands and be at increased risk for developing an adenocarcinoma of the uterus. This is why a progestin such as Provera® is also prescribed. Postmenopausal women who are obese have an increased level of estrogen because the adipose (fat) tissue converts other normal body chemicals into estrogen. Women who take Tamoxifen® for breast cancer are also thought to be at increased risk because Tamoxifen® acts like an estrogen.
Conditions that increase the progesterone influence on the uterus decrease the risk for adenocarcinoma of the endometrium. Pregnancy is a time of increased progesterone levels, so women who have been pregnant most of their lives are at decreased risk. Women who have taken birth control pills for a long time are at decreased risk. Prolonged progestin influence on the endometrium produces a thinning and atrophy of the glands which is just the opposite of the effects of estrogen.

SYMPTOMS OF UTERINE CANCER

The most frequent symptom of cancer of the uterus is abnormal bleeding. In postmenopausal women any bleeding is considered cancer of the uterus until proven otherwise. The only way to prove that there is or is not a cancer inside the uterus is by removing some of the uterine lining as a biopsy. This can often be done easily in the office without any anesthesia, or it can be done in the operating room with an anesthetic. The procedure is called a D&C, dilatation of the cervix and curettage of the uterine lining. Sometimes a scope can be inserted through the cervix into the uterus and the lining visualized and biopsied directly. This is called hysteroscopy. The Pap test cannot assess the inside of the uterus and is of no value. Any postmenopausal bleeding must be taken seriously and evaluated. Occasionally a sonogram or ultrasound test that assesses the thickness of the endometrial lining can be helpful. It is fortunate that uterine cancers bleed early so symptoms are early and if the bleeding is not ignored, diagnosis is early. Three-fourths of all uterine cancers are diagnosed at an early stage. Of these about three-fourths are of favorable grade. This is why the number of deaths from uterine cancer is low even though it is the most frequently diagnosed gynecologic cancer.

TREATMENT

Treatment of uterine cancers is usually by a combination of surgery and radiation. Those that are at an early stage will be operated first with removal of the uterus, tubes and ovaries, to confirm the stage. If there is only limited invasion into the wall of the uterus and the grade is good, i.e. grade I or II, then the surgery will be sufficient and no radiation will be recommended. If of higher stage and grade then radiation to the pelvis will often be advised.

PROGNOSIS

Since most patients are diagnosed at an early stage and with an optimal grade, most patients are cured. Nevertheless, stage for stage it is just as bad a cancer as any other. Most recurrences will occur in the first two years. If none have occurred by five years the patient is considered cured.

NEVER, NEVER IGNORE POSTMENOPAUSAL BLEEDING, AND DO NOT LET YOUR DOCTOR IGNORE IT EITHER. YOU MUST PROVE THAT IT IS NOT DUE TO A UTERINE CANCER.