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Correspondence

Hysteroscopic resection for women with FIGO IA grade 1 endometrioid-type endometrial cancer

Dear Editor

We read with interest the article by Yang HC et al. [1] on the use of hysteroscopic resection and oral high-dose progestin treatment in young women with FIGO stage IA well-differential endometrioid-type endometrial cancer [1]. The authors retrospectively reviewed 6 women aged between 30 and 36 years diagnosed with grade 1 stage IA endometrioid-type endometrial cancer that underwent hysteroscopic tumor resection followed by oral progestin therapy with either 160 mg megestrol acetate or 500 mg medroxyprogesterone acetate for at least 6 months [1]. During the median follow-up of 32 months, one patient had a successful spontaneous pregnancy and full term delivery and the other 5 patients were totally free of disease [1]. Therefore, the authors recommended that hysteroscopic resection of tumor followed by high-dose progestin treatment was a safe conservative therapy strategy for early-stage and well-differentiated endometrioid-type endometrial cancer in young women who wished to preserve fertility [1]. Finally, one patient had a successful pregnancy and term delivery, contributing to 20% (1/5) delivered live newborns, which is comparable with a recent meta-analysis and systematic review (20% in women taking progestin; 14% in women treated with intrauterine device (IUD)); and 35% in women undergoing combination of progestin and IUD [2]. This review also found the worst pregnancy outcome in patients treated with IUD alone [2]. Dr. Greenwald and colleagues used the Surveillance, Epidemiology, and End Results database between 1993 and 2012 to evaluate the outcome of women with localized, low-grade endometrial cancer who were aged <45 years and found that these selected patients for hormone therapy to preserve fertility, which is managed carefully by experienced experts, does not appear to significantly worsen clinical outcomes [3]. We congratulated their success in the management of the patients (with 100% successful remission rate or survival rate and 20% delivery term baby rate) and final publication of the authors. However, we have some comments for this article and hope to receive the authors' response.

First, as shown by authors, when the patients have complete remission of disease, they are encouraged to prepare pregnancy or levonorgestrel releasing IUD (LNG-IUD) was used as maintenance therapy [1]. In case 2, this 36-year-old woman had a term delivery by cesarean section. We are wondering to know the clinical course of this patient, since this patient has a relatively long follow-up period (49 months). Does this follow-up period include the time after hysterectomy? When she got

pregnancy (after complete remission)? Before she got pregnancy, was there any treatment? Why the patient needed cesarean section? Was there any possibility of the patient undergoing cesarean hysterectomy?

Second, it is well known that high-dose progestin can be used in the management of women with FIGO IA grade 1 endometrioid-type endometrial cancer [4]; however, it is unknown how long the progestin treatment should be used and what is the better way to give progestin [4,5]. It is reported that regression rate might be higher after treatment by LNG-IUD compared to that by oral progestins (90% vs. 69%) [5]. It is also noted that hysteroscopic resection of tumor followed by LNG-IUD is another fertility sparing option, because of a high complete response rate (86%), a high pregnancy rate (92%) and a high live birth rate (83%) [5]. We have published one very interesting case report to show rapid tumor growth after removal of IUD [6], suggesting that intrauterine administration might be a better route, partly explained by high local concentration of progestin [7].

Third, the interval or frequency of invasive procedure, such as aspiration biopsy, dilated and curettage, hysteroscopy is also debated [4]. As shown by authors, the follow-up period ranged from 4 months to 49 months and the biopsy number ranged between 2 and 4, suggesting that biopsy was performed in every one year (12 and more months). Although the authors have already explained their policy, such as abnormal uterine bleeding, and a suspicious lesion detected by ultrasound, to perform a diagnostic hysteroscopic or uterine curettage biopsy, it is still unclear the clear definition which needs re-confirmation of complete remission. Uterine spotting (did it mean abnormal bleeding by authors?) is frequently found when the patients have been treated with LNG-IUD, based on our experiences [8–10].

Could the authors kindly respond to the above-mentioned questions? Thank you.

Competing interests

The authors declare that they have no competing interests.

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