Lymphadenectomy in endometrial cancer
Lymphadenectomy for the management of endometrial cancer

Cochrane Gynaecological Cancer Group.

2009

No evidence that lymphadenectomy decreases the risk of death or disease recurrence.
Effi cacy of systematic pelvic lymphadenectomy in endometrial cancer (MRC ASTEC trial): a randomised study *Lancet* 2009

- 85 centres in four countries
- 1408 women with endometrial carcinoma confined to the uterus
- Group 1: hysterectomy and BSO, peritoneal washings, and palpation of para-aortic nodes
- Group 2: standard surgery plus
- Lymphadenectomy
- Primary outcome: overall survival
- No benefit of lymphadenectomy
Survival effect of para-aortic lymphadenectomy in endometrial cancer (SEPAL study): a retrospective cohort analysis

- 671 patients
- Group 1: systematic pelvic lymphadenectomy
- Group 2: systematic pelvic lymphadenectomy combined pelvic and para-aortic lymphadenectomy
- primary outcome: overall survival
## Risk of recurrence

<table>
<thead>
<tr>
<th>Tumour type</th>
<th>Lymph-vascular space invasion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low risk</strong></td>
<td></td>
</tr>
<tr>
<td>FIGO stage IA</td>
<td>Grade 1–2 endometrioid adenocarcinoma</td>
</tr>
<tr>
<td>FIGO stage IB</td>
<td>Grade 1–2 endometrioid adenocarcinoma</td>
</tr>
<tr>
<td><strong>Intermediate risk</strong></td>
<td></td>
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<tr>
<td>FIGO stage IA</td>
<td>Grade 3 endometrioid adenocarcinoma; any grade of nonendometrioid carcinoma (serous adenocarcinoma, clear cell adenocarcinoma, or other type of carcinoma)</td>
</tr>
<tr>
<td>FIGO stage IB</td>
<td>Grade 1–2 endometrioid adenocarcinoma</td>
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<td>FIGO stage IB</td>
<td>Grade 3 endometrioid adenocarcinoma; any grade of non-endometrioid carcinoma (serous adenocarcinoma, clear cell adenocarcinoma, or other type of carcinoma)</td>
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<tr>
<td><strong>High risk</strong></td>
<td></td>
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<tr>
<td>FIGO stage III</td>
<td>Any</td>
</tr>
<tr>
<td>FIGO stage IV</td>
<td>Any</td>
</tr>
</tbody>
</table>
Outcomes of SEPAL study

• the survival effect of lymphadenectomy is restricted in low-risk patients

• patients of intermediate or high risk, complete, systematic lymphadenectomy in both the pelvic and para-aortic regions has substantial therapeutic effects.
ASTEC pitfalls

• follow-up period was short (median of 37 months, with 35·7% of surviving patients followed up for less than 3 years
• lymphadenectomy was selective rather than systematic. Nine or fewer lymph nodes were removed in 35% of patients in the lymphadenectomy group
• No para-aortic lymphadenectomy, which would have negated the therapeutic effect of lymphadenectomy because more than half of patients with pelvic lymph node metastasis have para-aortic node metastasis
Lymphadenectomy in Ovarian cancer


• systematic lymphadenectomy increased overall survival in patients with all-stage disease who underwent optimal debulking surgery

• lack of RCTs
Lymphadenectomy in Ovarian cancer

• The role of lymph node resection in ovarian cancer: analysis of the surveillance, epidemiology, and end results (SEER) database BJOG. 2010 Jun 18. [Epub ahead of print]

• retrospective review of 49 783 patients

• beneficial effect of lymphadenectomy in epithelial ovarian tumours, regardless of the stage of disease and extent of surgery
Cervical cancer

• Primary surgery versus primary radiation therapy with or without chemotherapy for early adenocarcinoma of the uterine cervix [Cochrane Gynaecological Cancer Group](#).

• one RCT recommend surgery for early stage Adenocarcinoma of the uterine cervix

• majority of operated patients required adjuvant radiotherapy

• Primary chemoradiation remains a second best alternative for patients unfit for surgery

• chemoradiation is probably first choice in patients with (MRI or PET-CT-suspected) positive lymph nodes.