Brief Advice from Gynae-Oncology:-
Treatment for these women must be individualised.
Endometrial adenocarcinoma should almost always be treated by hysterectomy and BSO. We await results of the FEMME trial which may support a more conservative approach in some cases. At present, if the pathology confirms a grade 1 adenocarcinoma and MRI suggests there is no or minimal invasion then it is reasonable to consider a non-operative strategy. This will usually be insertion of a Mirena IUS (IntraUterine System) at hysteroscopy followed by further hysteroscopy 6 months later to replace the Mirena and check histology. If adenocarcinoma remains then we should either consider surgery or radiation (intracavity and pelvic). The effectiveness of radiotherapy used as an alternative in this situation is unknown. 2

Thus a conservative approach is warranted if further childbearing is sought or if either the patient or the surgeon is unlikely to survive the operation! Some of the patients have multiple comorbidities and their life expectancy without cancer is likely less than five years in which case we should have a slightly less aggressive approach in mandating a hysterectomy.
Outcome for this Patient:- Surgery was postponed. Patient was strongly advised to optimise astma management and lose weight, reinforced in the letter to her GP, including considering use of Optifast for rapid preoperative weight loss. After optimising inhalers and weaning of oral steroids, there were no further exacerbations of asthma. She lost 11kgs in four months, and then had laparoscopic surgery in January (TLH/BSO/adhesiolysis). Tumour was superficial and therefore PLND was not undertaken. Tolerated Trendelenburg position. Discharged well on Day 2 post operatively.