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Editorial

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Is endometrial cancer changing?

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Endometrial cancer can be dividen into two types I and II. Type I is the endometroide cancer (G1 and G2) with a hormonal drive etiology and the more aggressive Type II is the G3 endometroide, clear cell, serous cancer and carcinosarcoma type. Type II endometrial cancer are often older, normal weight; type II are estrogen idependent and associated with endometrial atrophy. With extended life expectancy and growing part of population with obesity the incidence of endometrial cancer is growing.

Endometrial cancer is an important cause of death but not the primary cause of mortality. We do not have question about preventive strategies on cervical cancer have successful in decreasing cervical cancer. Cervical cancer remains a hallmark of low access to health care.

Implementation of screening could help to significantly decrease the incidence of and mortality from cervical cancer. Endometrial cancer has not a screening strategy has proven efficacy for women with risk to develop hereditary non-polyposis colon cancer or Lynch syndrome or any type of endometrial cancer. Endometrial biopsy could improve screening performance but the acceptability to women of this screening strategy and potential compliance with such a strategy are unknown. Furthermore, the relevance of outpatient hysteroscopy in detection of endometrial cancer is still under investigation.

A significant increase of endometrial cancer type II, including G3, serous cancer, cell clear, and carcinosarcomas, were observed in 12 years, in our hospital. This tumor subtype require a more treatments than G1/G2 tumors. This represent an overload in medical oncology services because often needs chemotherapy or radiotherapy or both. Whereas Type I, G1/G2 tumor are treated with hysterectomy with bilateral adenexectomy with or without lymphadenectomy.

We have a large number of patients examined over 12 years, and we observe a change in endometrial cancer; this observation has been reported in different countries; with forms more aggresive, in the current clinical practice.

The budget is always limited in health, now developed countries and developing countries have to take actions on prevention or early detection because need spend more money in this emerging cancer. But in endometrial cancer is not easy.

Educating women so that they are aware of ways to improve their general health, to minimize their own risk factors and to identify signs of change in their own health which may be markers of impending cancer will help to reduce the burden of disease and improve the prognosis for endometrial cancer at an earlier stage.

In the general population, evidence to support screening for endometrial cancer is insufficient. However, women-particularly those who are overweight-should be informed by their family doctor about the risks of endometrial cancer, and encouraged to consult their physician immediately in cases of uterine bleeding or spotting during the perimenopausal period. We do not have new evidence in early detection of endometrial cancer o aggressive shape endometrial cancer.

Primary prevention should be strengthened and stronger polices enforced against the mayor cancer risk factors, tobacco, alcohol, obesity, and enviromental agents. We need to shift focus from curative to preventive medicine, but this needs to be reflected in health budgets. We have to continue investigate and propose improvements and savings to the health system.

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