Endometrioid endometrial cancer treated with open or laparoscopic approach: is there a dilemma?

To the Editor,

It was with a great deal of interest, we read the article entitled: "Surgical treatment of endometrioid endometrial carcinoma - laparotomy versus laparoscopy" by Baum et al. (1). The authors present the perioperative outcomes, pathologic findings and long-term oncological findings of their cohort of endometrioid endometrial cancer patients treated either by laparotomy or laparoscopy. The findings were, as expected, in favor of the laparoscopic group regarding the blood loss, hospital stay, intraoperative, and severe postoperative complications. No differences were identified in the nodal yield status, progression free and overall survival between the two groups (1). The study is in accordance with the findings of a recent metanalysis (2).

ESGO/ESTRO/ESP guidelines for the management of patients with endometrial cancer recommend that a minimally invasive approach is preferred, even in high-risk endometrial cancer patients (3). Awareness is raised regarding the avoidance of any intra-peritoneal tumor spillage, including tumor rupture or morcellation (including in a bag), while if vaginal extraction risks uterine rupture, mini-laparotomy or use of an endobag is proposed (3). Moreover, the ESGO accreditation in endometrial cancer surgery is an award attributed to institutions that can offer optimal levels of surgical care, based on specific quality indicators among which the following: a minimum target of 60% of patients with early stage endometrial carcinoma need to be treated with minimally invasive surgery; >60% proportion of patients with body mass index >35 kg/m^2 need to be treated with minimally invasive surgery; less than 10% conversions from minimally invasive surgery to open surgery; and less than 1% proportion of early stage endometrial carcinoma cases with ruptured uterus (4).

Based on the above, ESGO considers a minimally invasive approach the standard of care for endometrioid endometrial cancer patients. Although, the findings of the LACC trial raised concerns regarding the oncological safety of patients undergoing radical endoscopic surgery in cervical cancer patients (5), such concerns are not raised in endometrial cancer cohort studies. An older systematic review showed that the application of uterine manipulators had no clear correlation with endometrial cancer recurrence, although the included trials in the review were of low methodological quality (6). A recent meta-analysis showed that the use of a uterine manipulator for a minimally invasive approach in such patients does not increase the rate of recurrence and lymph-vascular space invasion (7). Furthermore, other studies propose user-friendly tips and tricks to optimize the application of minimal invasive approach (8). Last but not least, it should be highlighted that such patients should be treated by a gynecologic oncologist, or a trained surgeon specifically dedicated to gynaecological cancer in tertiary cancer centres, as supported by ESGO (4).

Once again, we would like to thank the authors for their excellent retrospective study.

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Received: 30 November, 2022 **Accepted:** 24 January, 2023

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DOI: 10.4274/jtgga.galenos.2023.2022-11-1

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Author's Response

Dear Colleagues,

We thank you for your general appreciation of our manuscript and kind comments. Our data highlight the superiority of the laparoscopic approach over open surgery for the treatment of endometrioid endometrial cancer in terms of overall morbidity, intraoperative complications, blood loss, post-surgical recovery, as well as the incidence and severity of postoperative complications in this population. Both approaches permitted a systematic pelvic and para-aortic lymphadenectomy with a sufficient amount of resected lymph nodes. The laparoscopic approach appears to be as safe as the conventional open technique, but provides a better surgical outcome and might therefore be more beneficial for the patient.

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