LSH: Ca Risk With Abnormal Bleeding After 40

BY MIRIAM E. TUCKER

FROM THE ANNUAL MEETING OF THE AAGL

LAS VEGAS – The overall incidence of malignancy was low among 808 women who underwent laparoscopic supracervical hysterectomy, but those aged 40 years and older with abnormal bleeding were at increased risk.

The findings, which were from a retrospective chart review, suggest that older women who have abnormal bleeding should be considered for total hysterectomy rather than laparoscopic supracervical hysterectomy (LSH) with morcellation. This is especially true for women aged 50 years and older with postmenopausal bleeding, said Dr. Kristal Taylor of the University of Texas, Houston.

LSH with morcellation has been increasing in popularity over the last few decades, given its advantages of less invasiveness, decreased morbidity and mortality, and reduced risk of pelvic floor and sexual dysfunction. However, there is a concern that the morcellation can lead to gross spillage of tumor (if present), resulting in up-staging and possible adverse consequences.

Indeed, in a recent study of 17 patients who were diagnosed with endometrial cancer after supracervical hysterectomy between January 2000 and March 2006, 2 of the 13 who underwent completion surgery were up-staged, both of whom had leiomyosarcoma originally resected with morcellation. No patient who initially underwent supracervical hysterectomy without morcellation was up-staged at the second surgery (Int. J. Gynecol. Cancer 2008;18:1065-70).

There have been no previous reports quantifying the risk of malignancy in LSH in the setting of general practice. Dr. Taylor and her associates reviewed the charts of all consecutive women who underwent planned LSH at the Women's Hospital of Texas, Houston, between Jan. 1, 2002, and Dec. 31, 2008.

The 808 women had a median age of 44 years (range, 23-79 years), body mass index of 27 kg/m^2 (range, 16-55), gravidity of 2, and parity of 2. Two-thirds (62%) were white, nearly a quarter (21.5%) were black, and 12% were Hispanic. One-fifth had hypertension, and more than a third had used oral contraceptives.

Of the total 808, 96% (777) underwent LSH with or without bilateral salpingo-oophorectomy, whereas the other 31 patients were converted to other types of operations. Adhesions were the most common indication for conversion (17 of the 31).

Endometrial neoplasia was found in 2.5% of the 808 (20 patients), including 13 with endometrial hyperplasia, 3 with hyperplasia confined to a polyp, and 4 with uterine cancer (two endometrial cancers, one leiomyosarcoma, and one stromal carcinoma).

In all, the risk for cancer among the total 808 study population was 0.5%, Dr. Taylor reported.

By age, the incidence of neoplasia (including both hyperplasia and cancer) was 1.9% of the 212 women aged younger than 40 years, and 1.7% of 454 patients aged 40-49 years, compared with 5.6% of the 142 aged 50 years and older. The difference between women aged at least 50 vs. younger than 50 years was statistically significant, with an odds ratio of 3.25 and confidence interval that does not include one, suggesting that the two groups most likely do have different odds of neoplasia.

However, Dr. Taylor noted, "It's a pretty wide confidence interval. … Bottom line, if we had more cases, we might be more confident that the odds are truly greater in the older women."

Neoplasia was found in 3.1% of the 548 women with abnormal bleeding (either menorrhagia or postmenopausal bleeding), compared with just 1.2% of the 260 without abnormal bleeding. That overall difference was not statistically significant.

But there was a relationship with age. Among the women aged younger than 40 years (none of whom had overt cancer), the risk for neoplasia with abnormal bleeding was 2.2%, compared with 1.4% without abnormal bleeding, an insignificant difference. Similarly, the neoplasia risk among those aged 40-49 (including three with overt cancer) was 2.1% with abnormal bleeding vs. 0.8% without, also not statistically different.

There were 58 patients identified as "menopausal" in a total of 142 who were aged 50 years and older, and there were 77 women aged 50 years and older with abnormal bleeding. In all, 26 women were coded as having postmenopausal bleeding, including 6 who were aged 40-49 years and 20 who were aged 50 and older. No neoplasias were found in the younger group, compared with five (19.2%) in the older group.

Thus, the incidence of neoplasia among women with postmenopausal bleeding was 25% (5 of 20) for those aged 50 and older vs. 0% (0 of 6) for those younger than 50. Among those aged 50 and older, the risk for neoplasia among those with abnormal bleeding was 9.1% (7 of 77), compared with just 1.5% for those without abnormal bleeding (1 of 65). Here, the difference between those aged at least 50 vs. younger than 50 was not statistically significant, but did represent a strong trend, Dr. Taylor said.

Of the total eight women aged 50 and older with neoplasia, six had hyperplasia, one had a polyp with hyperplasia, and one had overt cancer, she reported.

Taken together, she said, the findings suggest that there's a low risk for neoplasia with LSH among women who are younger than 40 even if they have abnormal bleeding, as well as among women aged 49 and younger who do not have abnormal bleeding.

In contrast, there's a high risk among women aged 40 and older with abnormal bleeding, and among those aged 50 and older whether they have bleeding or not. At greatest risk of all are those aged 50 and older with abnormal bleeding.

Dr. Taylor said she had no relevant financial disclosures. ■

Repeat Biopsies When Breast Cancer Recurs, Data Suggest

BY BRUCE JANCIN

FROM THE SAN ANTONIO BREAST CANCER SYMPOSIUM

SAN ANTONIO – Estrogen receptor status flip-flops in 1 in 3 breast cancer patients when the primary tumor progresses to recurrence or distant metastasis, and HER2 status changes in 1 in 10, according to a Swedish study.

"Our data, together with other retrospective and prospective studies, really challenge the present management, which is to use primary tumor data for the management of metastatic disease," Dr. Jonas Bergh said.

VITALS

Major Finding: Estrogen receptor status changed from positive in the primary to negative in the relapse in 26% of patients and from negative to positive in 7%.

Data Source: A Swedish study of 459 breast cancer patients who were rebiopsied after relapse.

Disclosures: Dr. Bergh disclosed that he receives honoraria for lectures from Amgen, AstraZeneca, Novartis, Pfizer, Roche, and Sanofi-Aventis.

His argument that breast cancer relapses should be biopsied routinely for repeat hormone receptor and HER2 testing won widespread acceptance at the meeting.

"In the corridors around here the last couple of days this issue of primary tumor/metastasis heterogeneity has been the most discussed topic," Dr. Mitchell Dowsett noted in a conference-closing review highlighting the past year's major developments in translational breast cancer research. He called the proportion of patients with marker changes in Dr. Bergh's study "pretty startling."

"In 2010, I think the evidence supports rebiopsy if the result could affect management of the patient. And I do absolutely support this sort of analysis being mandatory in clinical trials of targeted therapy," said Dr. Dowsett, professor of translational research at Breakthrough Breast Cancer and of biochemical endocrinology at The Royal Marsden hospital, both in London.

Dr. Bergh presented a retrospective analysis that showed estrogen receptor status changed from positive in the primary to negative in the relapse specimen in 26% of 459 patients and from negative to positive in 7%.

"Hormone receptors are not stable during progression," concluded Dr. Bergh, professor of oncology at the Karolinska Institute, Stockholm.

The clinical relevance of this observation is underscored by the fact that patients who lost estrogen receptor positivity during tumor progression had a statistically significant 40% increase in the risk of dying compared with patients with stable estrogen receptor–positive disease, he added.

Moreover, among 118 patients whose HER2 status was known both in the primary tumor and the rebiopsied relapse, 7% lost their HER2 amplification and another 3% went from HER2-negative in the primary tumor to HER2-positive in the relapse.

Audience member Dr. Alastair M. Thompson rose to suggest that the time has come for biopsy of breast cancer recurrences or metastases to be considered the standard of care throughout the world.

Dr. Thompson of Ninewells Hospital and Medical School, Dundee, Scotland, was lead author of the Breast Recurrence in Tissues Study (BRITS), a recent prospective 137-patient study showing that one in six women with relapse of breast cancer would have their treatment changed as a result of rebiopsy of their recurrent or metastatic disease (Breast Cancer Res. 2010;12:R92 [doi:10.1186/bcr2771]).

Dr. Lisa A. Carey, in a conference-closing summary of the past year's progress in advanced breast cancer, noted that the 2010 ASCO meeting included three studies comprising roughly 520 patients, all showing "small but real changes" in hormone receptor and HER2 status between the primary tumor and metastatic disease.

"I think that rebiopsying at the time of relapse is a reasonable thing. The main reason to rebiopsy is to make sure you're treating what you think you're treating. I used to keep a list for my fellows of the psittacosis, nocardia, sarcoid, and other things that were masquerading as metastatic breast cancer," said Dr. Carey, medical director of the breast center at the University of North Carolina at Chapel Hill.

As for reanalyzing the hormone receptor and HER2 status, that is valuable, too, but with a caveat: "You have to be very cautious in using that information to guide therapy," she said. "For example, a hormone receptor–positive breast cancer that's negative on rebiopsy may or may not reflect endocrine-insensitive disease. I think that's a question that's left outstanding." ■