

Coffee May Reduce Endometrial Cancer Risk

BY HEIDI SPLETE

SAN FRANCISCO — Women who drank more than 2.5 cups of coffee daily had a significantly lower risk of endometrial cancer, compared with women who didn't drink coffee, according to a study of more than 20,000 postmenopausal women.

Previous studies have shown that coffee has an inverse association with endometrial cancer risk, Dr. Stefano Uccella of the Mayo Clinic in Rochester, Minn., said in a poster presented at the annual meeting of the Society of Gynecologic Oncologists.

He and his colleagues reviewed the impact of coffee and other sources of caffeine on endometrial cancer risk in the

Iowa Women's Health Study, a prospective cohort investigation of postmenopausal women that has been ongoing since 1986. The study population included 23,356 women, 5,218 of whom met criteria for obesity. The women completed a 126-item food frequency questionnaire at enrollment.

The researchers identified 471 cases of endometrial cancer through 2005, using information from the Iowa SEER (Surveillance Epidemiology and End Results) cancer registry.

Overall, women who consumed more than 2.5 cups of coffee daily were significantly less likely to develop endometrial cancer, compared with women who drank no coffee

(odds ratio 0.65), after investigators controlled for variables including smoking, diabetes, hypertension, estrogen use, reproductive history, body mass index, body fat distribution, alcohol use, and caloric intake.

Overall caffeine intake greater than 385 mg/day also was significantly associated with a reduced risk of endometrial cancer, compared with a daily caffeine intake of less than 30 mg (OR 0.80). But no significant associations were found between endometrial cancer risk and the consumption of tea, regular or diet cola, chocolate candy, or chocolate baked goods, the researchers noted.

When the results were separated by BMI, the association



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Postmenopausal women who drank 2.5 cups nearly halved their endometrial cancer risk.

between coffee and a reduced risk of endometrial cancer remained significant in the subset

of obese women (BMI 30 kg/m² or higher) who consumed more than 2.5 cups of coffee daily, compared with obese women who did not drink coffee (OR 0.57).

The significance of the association between coffee consumption and the risk of endometrial cancer was somewhat attenuated in women with a BMI less than 30 (OR 0.77).

The results support findings from previous studies, and suggest that more research is needed to assess coffee's potential protective effect against endometrial cancer, the researchers wrote. ■

Disclosures: Dr. Uccella reported having no conflicts.

Guided Ultrasound Ablation Improves Fibroid Symptoms

BY KERRI WACHTER

TAMPA — Ninety percent of women who underwent magnetic resonance-guided focused ultrasound ablation for uterine fibroids reported symptom improvement as excellent or considerable at 12 months' follow-up, in a small study of the noninvasive treatment.

"This is an effective noninvasive treatment option for patients, with an alternative treatment rate and reported symptom improvement in patients that is very comparable to the litera-



ture for myomectomy and uterine artery embolization," Dr. Gina K. Hesley said at the annual meeting of the Society of Interventional Radiology.

In MR-guided focused ultrasound ablation (MRgFUS), high-intensity focused ultrasound is used during an MR scan to thermally destroy pathogenic tissue—in this case fibroids. The main advantage of MRgFUS is that the procedure is noninvasive. The concomitant use of MRI allows precise targeting of the fibroid and monitoring of the temperature increase in the fibroid tissue.

A total of 125 patients were scheduled for MRgFUS at the Mayo Clinic between March 2005 and September 2008. The researchers followed 119 patients who completed MRgFUS treatment for 12 months using phone interviews to assess symptomatic relief and any additional procedures for fibroid-related symptoms.

The women in the study were premenopausal and had no desire to have children in the future, noted Dr. Hesley of the department of radiology at the Mayo Clinic in Rochester, Minn. They had to have at

least one uterine fibroid of at least 3 cm in diameter. Women with many uterine fibroids were counseled to have uterine embolization instead of MRgFUS.

Symptomatic improvement was self-reported based on percent improvement. The researchers considered 0%-10% improvement as insignificant, 11%-40% improvement as moderate, 41%-70% improvement as considerable, and 71%-100% as excellent.

Following treatment, 15 patients were lost to follow-up and 4 patients had their fibroids removed during sur-

geries performed for reasons unrelated to fibroid symptoms. Of the remaining 100 patients, 8 underwent alternative treatments: 6 patients had hysterectomies, and 2 had myomectomies.

A total of 11 patients did not provide any information about symptomatic improvement, leaving 89 patients available for a phone interview at 12-months' follow-up. Of these, 97% reported overall symptom improvement (by responding "yes" to a question about improvement).

A total of 69 patients rated their percent improvement. In all, 74% rated their symptom improvement as excellent, 16% as considerable, 9% as moderate, and 1% as insignificant.

The researchers have received initial approval for National Institutes of Health funding of a randomized controlled trial comparing MRgFUS and uterine embolization. ■

Disclosures: Dr. Hesley has received grant support for other studies from InSightec, which makes the ExAblate system, but this study was not funded by outside sources.

Data Don't Support Routine Bilateral Oophorectomy

BY MICHELE G. SULLIVAN

Bilateral oophorectomy at the time of hysterectomy may do more harm than good, increasing the risk of death, cardiovascular disease, osteoporosis, and even lung cancer for a minimal trade-off in preventing ovarian cancer, according to an examination of available data.

An analysis of observational studies suggests that physicians and patients should fully discuss the issue before making a decision about which way to go at the time of hysterectomy. "Prudence suggests that a detailed informed consent process covering the risks and benefits of oophorectomy and ovarian conservation should be conducted with women faced with this important decision," Dr. William H. Parker wrote (J. Min. Invas. Gyn. 2010;17:161-6).

Dr. Parker of the John Wayne Cancer Institute at Saint John's Health Center, Santa Monica, Calif., plumbed numerous studies to examine the long-term health implications of premenopausal bilateral oophorectomy. The surgery is usually recommended at the time of hysterectomy because it eliminates any later risk of ovarian cancer, which kills about 15,000 women every year in the United States.

However, Dr. Parker said, less than 1% of women who have a hysterectomy with ovarian conservation go on to develop ovarian cancer. On the other hand, the Nurses' Health Study (NHS) and a recent Canadian study found that bilateral oophorectomy is associated with a 26% increased risk of lung cancer; the risk is even higher when patients don't take postsurgical estrogen, he wrote.

The NHS also provided informa-

tion about all-cause mortality in women who had both ovaries removed. Over a 24-year follow-up period, oophorectomy was associated with a 12% increase in all-cause mortality and significant increases in the risk of death from coronary artery disease (28%), lung cancer (31%), and all cancers (17%).

A randomized trial is underway to examine the short-term associations of bilateral oophorectomy with cardiovascular, bone, and sexual health, as well as health-related quality of life. "Until these and other data are available, removing the ovaries at the time of hysterectomy should be approached with caution," he said.

In an accompanying editorial, Dr. G. David Adamson of Palo Alto, Calif., agreed with Dr. Parker's assessment. "Oophorectomy is not necessarily the wrong decision for many women, but assessment of these data leads to the conclusion that more women are undergoing oophorectomy than should be the case."

The reason for this remains unclear, Dr. Adamson wrote (J. Min. Invas. Gyn. 2010;17:141-2). "Given that the data do not support widespread oophorectomy at the time of hysterectomy, it is problematic that so many patients have oophorectomy. This implies that the data don't support ovarian conservation in most situations, which is not true, or that physicians are not giving patients a balanced rendition of the literature evidence, for whatever reason, or that women are choosing on their own to have oophorectomy, which does not seem likely." ■

Disclosures: Neither Dr. Parker nor Dr. Adamson reported any conflicts.