Two young patients with endometrial cancer who newly developed double cancer in their ovaries after endometrial tumor disappearance through high-dose progesterone therapy and endometrial curettage.

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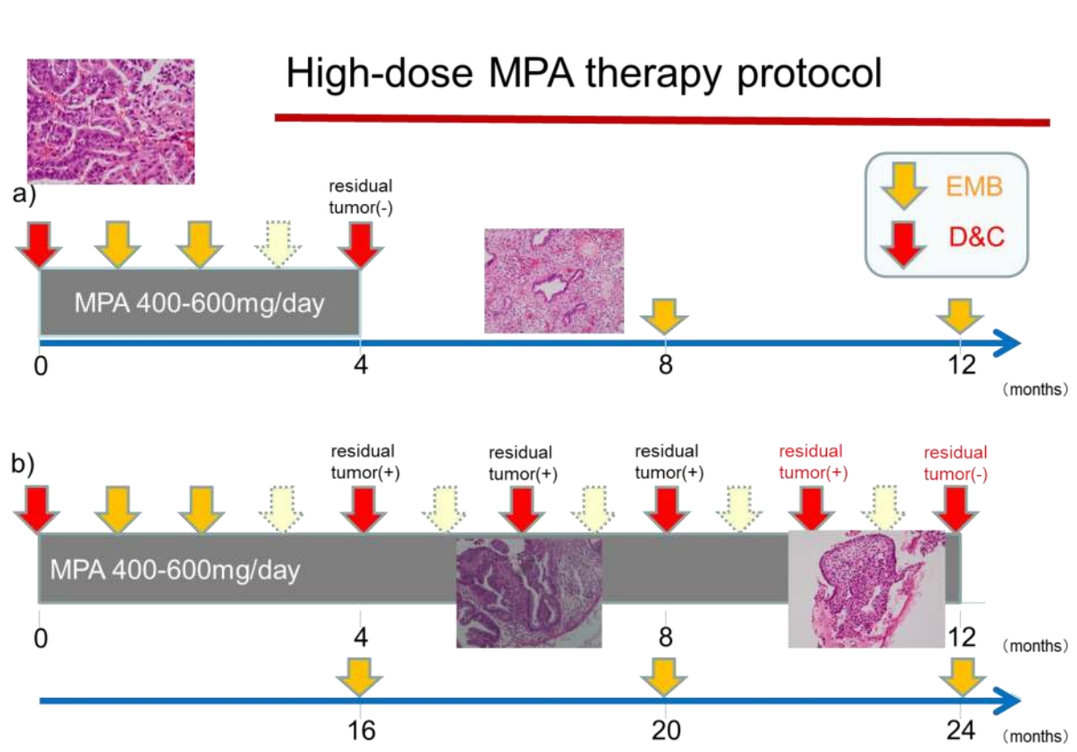
Introduction / Background: Standard treatment for endometrial cancer (EC) and atypical endometrial hyperplasia (AEH) is total hysterectomy and bilateral salpingo-oophorectomy (BSO), however, young patients with early-stage EC and AEH in reproductive age often hope to preserve their fertility. The oncologic outcomes in long follow-up remain unclear especially regarding the incidences of recurrence or double cancer. We experienced two patients with EC who newly developed double cancer in their ovaries after medication of high-dose medroxyprogesterone acetate (MPA) for fertility-preservation.

Methodology: In principle, we survey the patients after MPA therapy every four months using vaginal ultrasound check, endometrial histological/cytological examinations, measurement of serum CA125, and pelvic MRI once a year.

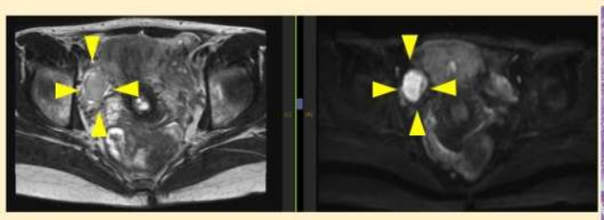
Results: The 44 y/0 patient had received MPA therapy and cyclic surveillance every 4 to 6 months in the previous hospital, and she was introduced to our hospital with 3 year-recurrence-free interval. However, trans-vaginal (TV) echo showed solid tumor measuring 18 mm in diameter in the right ovary, and the serum CA125 was 32 U/ml. MRI revealed solid tumor with positive Gd-enhancement. Hysterectomy with RSO and LS was performed. Pathological examination revealed endometrioid carcinoma (EMC) G1 in uterus (pT1A), and mucin-producing EMC G1 in the right ovary (pT1A, primary ovarian cancer). Another 38 y/o patient had finished MPA therapy 4 months before. TV echo showed solid tumors measuring 30mm in both ovaries, and the serum CA125 was 112 U/ml. MRI revealed solid tumors in both ovaries with positive Gd-enhancement. Hysterectomy with BSO, retroperitoneal lymphadenectomy was performed. Pathological examination revealed EMC G1 in uterus (pT1A), and mucin-producing EMC G2 in both ovaries (pT1B, bilateral primary ovarian cancers). Both patients have no recurrence after operation without adjuvant chemotherapy for 12 months.

Conclusions: Strictly careful follow-up every 4 months using TV echo and CA125 is needed after fertility-preserving MPA therapy for detecting heterochronous overlapping cancers in ovaries.

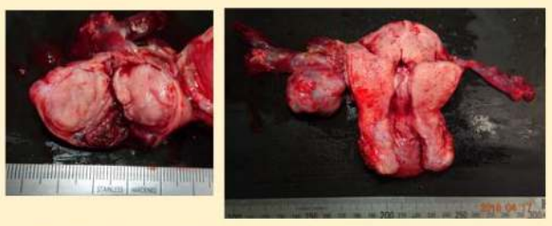
Disclosure: Nothing to disclose



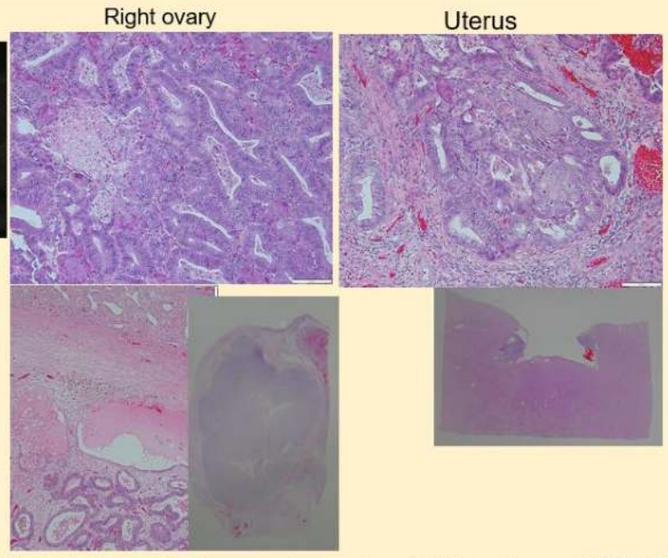
Case 1 44 y/o, G0P0, 3 years after previous MPA therapy for G1 endometrioid carcinoma (estimated as stage IA without myometrial invasion)



MRI revealed solid tumor with high signal in DWI setting.

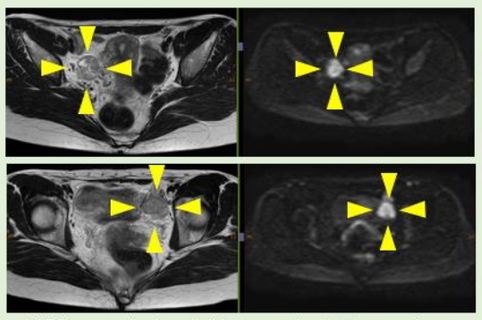


Hysterectomy with RSO and LS was performed.

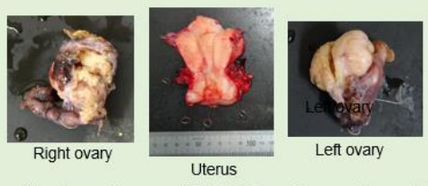


Pathological examination revealed endometrioid carcinoma (EMC) G1 in uterus (pT1A), and mucin-producing EMC G1 associated with endometriosis in the right ovary (pT1A, primary ovarian cancer).

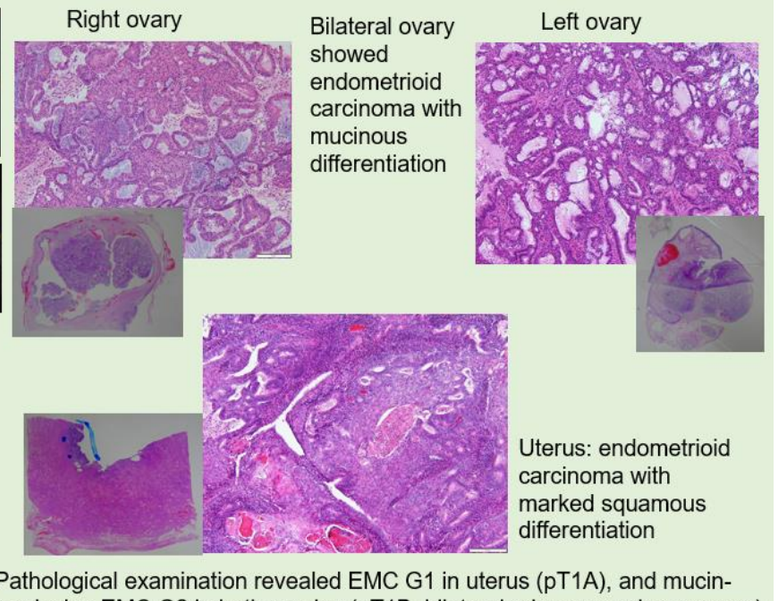
Case 2 38 y/o, G0P0, 4 months after previous MPA therapy for G1 endometrioid carcinoma (estimated as stage IA without myometrial invasion)



MRI revealed solid tumors in both ovaries with high signal in DWI setting.



Hysterectomy with BSO, retroperitoneal lymphadenectomy was performed.



Pathological examination revealed EMC G1 in uterus (pT1A), and mucin-producing EMC G2 in both ovaries (pT1B, bilateral primary ovarian cancers).