

The debate concerning the proper indications for additional surgical procedures like lymphadenectomy, as well as postoperative treatments, is longstanding.

Both prospective randomized trials evaluating hysterectomy, with or without lymph node dissection, showed pelvic lymphadenectomy does not influence survival, with findings subsequently confirmed by a metaanalysis.²

Likewise, in spite of variegated retrospective analyses of selected groups of patients, aortic lymphadenectomy failed to demonstrate survival benefit in any prospective trials.³

As to adjuvant therapies, we agree with the authors that an optimal treatment is still unknown. Many trials demonstrated that radiation may improve local control without any impact on overall survival for patients affected by uterine-confined disease.⁴

In our opinion, the question should not be whether lymphadenectomy alters adjuvant radiation rate but rather whether nodal resection could have an impact on the natural history of endometrial carcinoma.

Data seem to suggest nodal status may represent a collateral marker of biological disease aggressiveness, without providing definitive indications on cancer spread.³

To date, there is no reliable marker to identify high-risk patients, needing strict follow-up, with or without adjuvant treatments.

In a randomized trial of women with apparent stages I-IIA endometrial cancer (Post-Operative Radiation Therapy for Endometrial Carcinoma-2), vaginal brachytherapy resulted not inferior to pelvic radiation in preventing locoregional relapse.⁴

So, are we going down the wrong road?

It appears illogical to avoid a treatment jeopardized by considerable morbidity and costs without survival benefit (ie, radiotherapy) by choosing another procedure (ie, lymphadenectomy), this too blighted by costs and morbidity, with no proven survival benefit.

Until we have reliable biomolecular markers, brachytherapy seems a reasonable choice when aiming for locoregional control, especially for nonsexually active women, or else chemotherapy treatment could be used to control a suspected systemic spread of disease.

In these cases, without pelvic radiotherapy, salvage lymphadenectomy could be safely performed in the case of nodal relapse. ■

Stefano Basile, MD, PhD
 Maria Giovanna Salerno, MD, Chief Dept.
 II Department of Gynecology and Obstetrics
 Azienda Ospedaliero Universitaria Pisana
 Via Roma 67
 56126 Pisa, Italy
 s.basile@ao-pisa.toscana.it

Pierluigi Benedetti Panici, MD, Professor
 Department of Gynecology and Obstetrics
 La Sapienza University
 Viale del policlinico 155
 00161 Rome, Italy

The authors report no conflict of interest.

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REPLY

We appreciate the interest of Dr Basile and his colleagues in our work. Utilizing a large population-based database of patients with endometrial cancer treated from 1988 to 2006, we noted that those women who underwent lymphadenectomy were less likely to receive adjuvant external beam radiotherapy than those who did not undergo nodal evaluation. The association between lymphadenectomy and avoidance of radiation was strongest for women with intermediate risk tumors (Fédération Internationale de Gynécologie et d'Obstétrique 1988 stage IB grades 2 and 3 and stage IC grades 1 and 2).

Basile et al suggest that the proper question to ask is not whether lymphadenectomy influences the use of radiation but rather whether lymphadenectomy influences the natural history and survival of patients with endometrial cancer? In theory, we certainly agree with this point. Despite methodologic issues that have been well discussed, 2 large randomized trials failed to show a survival benefit for lymphadenectomy.^{1,2} Likewise, the Post-Operative Radiation Therapy for Endometrial Carcinoma (PORTEC)-2 investigators noted that vaginal brachytherapy was not inferior to pelvic radiation for women with apparent early-stage endometrial cancer.³

However, in clinical practice the issue is not as straightforward and clear-cut as to whether lymphadenectomy influences survival. Decisions regarding adjuvant therapy must be made and a fair question is whether lymphadenectomy helps to guide clinicians in these decisions. Much of the difficulty with these decisions arises from the lack of clear data defining optimal adjuvant therapy for endometrial cancer. The appropriate treatment for high-risk disease confined to the uterus as well as for patients with isolated nodal disease remains a subject of active debate. In the United States, patients with stage IIIC endometrial cancer are frequently treated with multimodality therapy including both chemotherapy and radiation.⁴ The purpose of the radiation is to sterilize nodal disease. Is chemoradiation superior to chemotherapy alone? If so, should we omit pelvic radiation in a patient with a grade 2 tumor invading 90% of the endometrium who did not undergo lymphadenectomy but has a nearly 20% risk of nodal disease?⁵ Although it is

unclear what the correct answers are to these questions, these are decisions faced every day by oncologists.

A strength of population-based registry studies lies in the ability of these investigations to capture the way patients are actually treated in real world settings. We believe our findings clearly demonstrate that lymphadenectomy influenced treatment planning for endometrial cancer. We recognize that the publication of PORTEC-2 will likely decrease the magnitude of our findings in the coming years. However, in areas of clinical uncertainty, the data provided by lymphadenectomy have an important influence on management. ■

Charu Sharma, MD
Department of Radiation Oncology
Columbia University College of Physicians and Surgeons
161 Fort Washington Ave., 8th Floor
New York, NY 10032

Israel Deutsch, MD
Department of Radiation Oncology and
Herbert Irving Comprehensive Cancer Center
Columbia University College of Physicians and Surgeons

Thomas J. Herzog, MD
Division of Gynecologic Oncology and
Herbert Irving Comprehensive Cancer Center
Columbia University College of Physicians and Surgeons

Jason D. Wright, MD
Division of Gynecologic Oncology and
Herbert Irving Comprehensive Cancer Center
Columbia University College of Physicians and Surgeons
jw2459@columbia.edu

The authors report no conflict of interest.

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Safety and efficiency of multiple square sutures to avoid peripartum hysterectomy

TO THE EDITORS: Bateman et al¹ reported an increased rate of hysterectomy for severe postpartum hemorrhage in the United States from 1994-2007. This study is pessimistic and does not reflect the high efficiency of new surgical procedures to stop severe postpartum hemorrhage. Indeed, the first publication on the very high success rate of multiple square sutures to control severe postpartum hemorrhage was in 2000;² therefore, it is normal that the application of this technique in routine practice and its positive consequences appear many years later. This explains the reason that there is no drop in peripartum hysterectomy rates. Indeed, multiple square sutures are very efficient to control severe postpartum hemorrhage when they are applied correctly.^{2,3} The rate of success is >90% on uterine atony.^{2,3} Moreover, fertility is preserved after multiple square sutures, and subsequent pregnancies are possible.^{2,3}

Since 2004, after the introduction of multiple square sutures in our department to control severe hemorrhage, we have observed a drop in hysterectomy rates after uterine atony during cesarean section delivery. Severe postpartum hemorrhage remains difficult to control in cases of placenta accreta or percreta, but rarely in the case of uterine atony, which is the most frequent situation.

Because severe postpartum hemorrhage that is not controlled by medical treatment is rare, even in big maternity centers, obstetricians should be trained to perform multiple

square sutures in emergency situations and on inanimate surgical models to avoid hysterectomy. ■

Souhail Alouini, MD, PhD
Louis Mesnard, MD
Department of Obstetrics and Gynecology
Regional Hospital Center of Orleans
1 Porte Madeleine, 45000, Orleans, France
alouini.s@orange.fr

The authors report no conflict of interest.

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REPLY

We appreciate the interest of Drs Alouini and Mesnard in our study. We share the authors' enthusiasm for uterine compres-