

Determining the stage of endometrial cancer for its surgical treatment



TO THE EDITORS: Marchocki et al¹ addressed an important topic regarding sentinel lymph node (SLN) mapping for high-grade endometrial cancer (EC) cases to determine the value of pelvic lymphadenectomy with hysterectomy in its treatment. Although the article stated that SLN biopsy was considered as the “standard of care” for the participating centers included in the study, other methodologies for determining the staging of EC using different imaging techniques should be strongly considered as a best practice. This is especially true, given the well-recognized confusion and difficulties using such SLN mapping, with its use of different dyes (colorimetric and radioactive) and dye injection sites and the possible need for surgeon certification for its performance, as is stated in the article. The 100% accuracy of using preoperative 3-dimensional transvaginal sonography for this has been documented multiple times from different authors,^{2–4} and this should not be ignored. The use of SLN mapping to optimally select those cases of EC benefiting from pelvic lymphadenectomy in high-stage or low-stage EC cases is certainly worthwhile. However, comparing the practical ease, associated cost, and overall generalizability of these diagnostic techniques⁵ must be considered before any “standard of care” is recognized. Moreover, the reproducibility and consistency of performing SLN mapping, the availability and accuracy of the frozen section,⁶ and the preoperative prediction of the staging of EC are important to consider. Evidence obtained from meta-analyses along with practicality should dictate standard medical practice, in terms of the optimal method to use in preparation for the surgical treatment of EC, whether to expect to perform a pelvic lymphadenectomy. The benefit of lymphadenectomy performance for stage IB has been suggested, with its greater risk of lymph node metastasis, if it is known at the time of surgery.⁷ ■

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Sentinel lymph node biopsy in high-grade endometrial cancer



We thank Levine and Fernandez for their interest in our study,¹ and we agree that the implementation of sentinel lymph node (SLN) biopsy into clinical practice may be associated with an additional certification requirement and learning curve. However, we do not view this process as a barrier but rather as a form of quality assurance required for all new surgical techniques to ensure patient safety.

Endometrial cancer (EC) is staged surgically to determine the most appropriate adjuvant treatment, as lymph node status is one of the most important prognostic factors for survival.² Traditionally, full pelvic and para-aortic lymphadenectomies have been recommended as part of the staging for patients with high-grade EC. However, randomized controlled trials have demonstrated that lymphadenectomy

has no direct therapeutic benefit and is associated with significant morbidity.³

Our study aimed to determine whether SLN biopsy could replace full lymphadenectomy for surgical staging and assess the value of lymphadenectomy. We found that SLN biopsy accurately detects lymph node metastases in patients with high-grade EC (pooled detection rates of 91%, pooled sensitivity of 92%, and pooled negative predictive value of 97% per patient). These results were similar to those obtained in other cancer sites (vulva, breast, and skin), where SLN biopsy is a well-accepted standard of care, and suggested that SLN biopsy could replace full lymphadenectomy in patients with high-grade EC.

In their discussion, Levine and Fernandez referenced several studies assessing preoperative use of 3-dimensional ultrasound as a predictive tool for myometrial invasion and cervical involvement in patients with low-grade EC. This approach has been proposed as a means of identifying patients at low risk of nodal involvement, in whom lymphadenectomy could be omitted. Although we agree that such an approach might be beneficial in patients with low-grade EC, its use may be limited in patients with high-grade EC, who are at a much higher risk of nodal metastases. We believe that imaging techniques are unlikely to ever replace surgical staging, which provides histologic confirmation of lymph node status. ■

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Physiological approaches to reducing blood loss during cesarean delivery



TO THE EDITORS: Jaffer et al¹ highlight the pharmacologic agents that prevent postpartum hemorrhage during cesarean delivery. However, there may be preceding physiological mechanisms that can help to reduce blood loss during elective procedures. Taking a few extra seconds during delivery may be beneficial as follows:

1. After exposing the fetal membranes, a 3-5 mm incision permits controlled decompression of the uterus for 30 seconds.
2. Delivery of the fetal head along with more amniotic fluid further decompresses the uterus.
3. At 60 seconds after rupture of the membranes, delivery will be assisted by spontaneous uterine contraction.

4. A further 60 seconds allows for delayed cord clamping, and the separated placenta can be delivered by controlled cord traction.

“Slow” decompression of the uterus reduces the “stretch” of the amniotic membranes, including the recently described layer of purinergic P2X3 “stretch” receptors in the maternal chorion (Figure), whose activation may enable depolarization and contraction of the myometrium.² Slow decompression of the uterus may provide time for “purinergic mechanosensory transduction” to convert the mechanical stimulus (“loss of stretch”) into spontaneous uterine activity to assist with delivery and hemostasis.^{3,4} Rapid delivery of the neonate may not allow time for these physiological processes and may