Cyclin-dependent kinase inhibitor p21 in endometrial carcinoma

To the Editors: Reading the article of Kohler et al. (Kohler MF, Carney P, Dodge R, Soper JT, Clarke-Pearson DL, Marks JR, et al. p53 Overexpression in advanced-stage endometrial adenocarcinoma. Am J Obstet Gynecol 1996;175:1246–52), it was interesting to see that the racial disparity of survival in endometrial cancer might be due to the higher frequency of p53 overexpression in black women. In accordance with their results, we found p53 overexpression in 202 endometrial adenocarcinomas to be associated with higher stage, higher grade, and poor survival. Moreover, we established high proliferative activity, determined immunohistochemically by the detection of topoisomerase IIα, as independent predictor of poor survival in endometrial carcinoma by multivariate analysis.[1]

Additionally we investigated the prognostic significance of the recently identified cyclin-dependent kinase inhibitor p21, which is induced by wild-type p53, in endometrial carcinoma.[2] Expression of p21 was not related to p53 expression, proliferative activity, or survival of patients. We conclude that overexpression of p53 in endometrial carcinoma is not associated with cell cycle inhibitor p21, suggesting the existence of alternative pathways for p21 induction.

The investigation of racial differences in the mechanism of transactivation of cyclin D kinase inhibitor p21 gene expression by wild-type p53 could be helpful in understanding the pathway of p21 induction.

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Response declined

Preeclampsia and diabetes

To the Editors: Ness and Roberts (Ness RB, Roberts JM. Heterogeneous causes constituting the single syndrome of preeclampsia: A hypothesis and its implications. Am J Obstet Gynecol 1996;175:1365–70) have suggested that the clinical syndrome of preeclampsia has several causes that can be divided into two main groups, the first subtype originating in the placenta and the second subtype originating in the mother from preexisting disease. Theirs is an attractive and plausible viewpoint with which I have much sympathy.

However, included in the group of maternal disorders alleged to predispose directly to preeclampsia is diabetes mellitus. I recently proposed an explanation for this weak association supported by HLA-DR data.[1] In brief, I suggested that preeclampsia and type 1 diabetes share a common immunogenetic susceptibility that correlates with tumor necrosis factor-α responses. My hypothesis is not inconsistent with that of Ness and Roberts and perhaps better accounts for the observation that nondiabetic women who have preeclampsia in pregnancy are at increased risk for insulin-dependent diabetes in later life.[2]

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Hypothesis of preeclampsia requires inclusion of the role of platelets

To the Editors: We read with interest the important article by Ness and Roberts (Ness RB, Roberts JM. Heterogeneous causes constituting the single syndrome of preeclampsia: A hypothesis and its implications. Am J Obstet Gynecol 1996;175:1365-70) in which they described their hypothesis of preeclampsia. They suggest that there are distinct origins of preeclampsia, each with its own pathologic characteristics and natural history. One genesis is the result of reduced placental perfusion and another results from maternal disorders that preexist pregnancy. "Oxidative stress" may be a key for the common explanation for all the clinical and pathologic signs associated with preeclampsia; however, we are afraid that the role of platelets in the pathogenesis of that disease needs to be taken into consideration.

Platelet-activating factor has an important role in the female genital tract during human reproduction, including ovulation, fertilization, implantation, embryo development, and initiation of parturition. An increased consumption of platelets, resulting in a mild, transient thrombocytopenia in the mother, was observed as a first maternal response to pregnancy. Wallenburg et al.[1] (1986) has suggested that activated platelets are involved