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Carcinoma of Uterus

Carcinoma of the body of the uterus seems to be commoner than it used to be. A striking alteration has taken place in the frequency of cervical in relation to corporeal carcinoma. Whereas in former years it was said that carcinoma of the cervix was five or even ten times commoner than carcinoma of the corpus, recent series show that nowadays the ratio is about two to one.

A recent study by J. E. Anderson and colleagues[1] draws attention again to some of the special features of endometrial carcinoma. It commonly affects women between 50 and 60 years of age. Often it is associated with a late menopause,[2] though about a quarter of the cases occur before the menopause.[3] In contrast to carcinoma of the cervix a considerable proportion of patients with carcinoma of the corpus are nulliparous; often they are obese[2] and about one-third of them have fibroids.[2] Some, but not all, authors have reported frequently finding decreased carbohydrate tolerance and diabetes mellitus (especially the type found in obese women) in these patients.[2 4] There is considerable evidence, too, that dysfunctional uterine bleeding, endometrial polypi, and various forms of endometrial hyperplasia — indicating oestrogenic overactivity — may predispose to the development of endometrial carcinoma.[2 5 6] As S. Way suggested, some or all of these conditions may be the result of abnormal activity of the anterior pituitary gland.

By far the commonest presenting symptom is irregular uterine bleeding. In 70% of cases this is post-menopausal. In the absence of frank bleeding there is nearly always a blood-stained discharge. Pain, tending to be colicky, is fairly common. It is not sufficiently realized that the uterus often feels small (in conformity with the normal senile state), but it may be enlarged by growth, pyometra, or accompanying fibroids, and it may be fixed by extension of malignant growth.

The only certain method of diagnosis is by curettage. It is imperative that curettage should be performed in all cases of irregular bleeding in patients approaching or after the menopause. The presence of another cause of bleeding, such as senile vaginitis or polypi or a history that the patient has been taking oestrogens (a frequent occurrence nowadays), does not absolve the surgeon from the need to perform a curettage.

For many years total hysterectomy and bilateral salpingo-oophorectomy (with suture or packing of the cervix) has remained the standard treatment of endometrial carcinoma. Primary treatment by radiotherapy is reserved for unfit patients. The results are not so good as once supposed, many series showing a five-year cure rate of only about 60%. This knowledge, and particularly the frequency with which vaginal metastases occur to mar the results, has led gynaecologists to extend their attack on the disease by performing a more radical operation or by employing radium or x rays pre- or post-operatively. Nowadays most surgeons perform an extended hysterectomy, including removal of the upper third of the vagina, while a minority do a pelvic lymphadenectomy or even a full Wertheim's

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hysterectomy. Most gynaecologists now believe that the combination of hysterectomy and irradiation gives better results than operation alone and that by this means a five-year cure rate of 70% or more can be expected. Groups of patients receiving different treatment are not always strictly comparable, but several series lend support to this contention,[3 7 8] and the trend of treatment at present is towards radium, preferably pre-operatively, followed in one to four weeks by an extended hysterectomy and bilateral salpingo-oophorectomy. The place of Wertheim's hysterectomy is more difficult to decide.[9] It turns on the frequency with which pelvic lymph nodes are affected, and this is uncertain. Earlier estimates were as high as 20% or even 30%, but in most of these series there was some selection of cases. W. R. Winterton's[10] figure of 10% is probably more realistic because he performs Wertheim's hysterectomy in all cases. The incidence certainly seems likely to be less than 15%. At present only a few surgeons perform Wertheim's hysterectomy as a routine, most reserving it for cases in which the growth has invaded the cervix or there is other evidence of spread beyond the uterus.

One of the most important factors in prognosis for any patient with cancer is the clinical stage of the disease, and endometrial carcinoma is no exception. Once disease has spread beyond the confines of the uterus the chances of survival are greatly reduced regardless of the treatment given. Anderson and colleagues[1] found this in their study. The patients with early disease limited to the corpus (stage 1) had a five-year survival rate of 80% (stage 1 cases receiving pre-operative irradiation followed by hysterectomy achieving the best figure of 91%). For patients with disease in stage 2 and stage 3 the five-year survival figures were 55% and 33% respectively.

The value of early diagnosis is apparent. Occasionally an unsuspected case is discovered by vaginal or cervical smears,[11] but unfortunately the number is much smaller than for cases of cervical neoplasm, and attempts to improve the reliability of the method by intrauterine aspiration or brushing have no advantage over curettage. An out-patient procedure providing a reliable method of early diagnosis—before the onset of bleeding—would be a notable advance. At present emphasis must be placed on the need for curettage whenever the possibility of endometrial carcinoma is suspected.

[1] Anderson, J. E., Meltzer, H. D., Scarborough, J. E., Smith, R. R., and Turner, M., *Cancer (Philad.)*, 1965, **18**, 955.
[2] Way, S., *J. Obstet. Gynaec. Brit. Emp.*, 1954, **61**, 46.
[3] Roberts, D. W. T., ibid., 1961, **68**, 132.
[4] Palmer, J. P., Reinhard, M. C., Sadugor, M. G., and Goltz, H. L., *Amer. J. Obstet. Gynec.*, 1949, **58**, 457.
[5] Way, S., *Malignant Disease of Female Genital Tract*. London. 1951.
[6] Dockerty, M. B., Lovelady, S. B., and Foust, G. T., *Amer. J. Obstet. Gynec.*, 1951, **61**, 966.
[7] McLennan, C. E., ibid., 1960, **80**, 982.
[8] Nolan, J. F., and Harrison, L. A., *Obstet. and Gynec.*, 1961, **17**, 601.
[9] Hawksworth, W., *Proc. roy. Soc. Med.*, 1964, **57**, 467.
[10] Winterton, W. R., ibid., 1964, **57**, 471.
[11] Boddington, M. M., and Spriggs, A. I., *Brit. med. J.*, 1965, **1**, 1523.

Therapeutic Abortion

Lord Silkin's promised amendments to his Abortion Bill[1] are to be debated in committee in the House of Lords on 1 and 3 February. The amendments are in part the result of representations made to Lord Silkin by the Council of the B.M.A.,[2] which was advised by its special committee on therapeutic abortion under the chairmanship of Dr. E. A. Gerrard. But some of the B.M.A.'s points have not been met. In addition Lord Dilhorne, Opposition spokesman in the Lords, and the Bishop of Exeter have both tabled amendments which, if carried, would materially modify the Bill. Support for some change in the law on abortion is undoubtedly widespread, but it is clear that agreement on the nature of the changes will not be easy to reach. Since it is upon the medical profession that the responsibility of giving effect to any new measures will fall, doctors will follow the House of Lords debate closely.

Maternal indications for therapeutic abortion are stated in clause 1 of the revised Bill as follows:

> "(a) The continuance of the pregnancy would involve serious risk to the life or grave injury to the health whether physical or mental of the pregnant woman whether before at or after the birth of the child."
>
> "(c) The pregnant woman is or will be physically or mentally inadequate to be the mother of a child or of another child as the case may be."
>
> "(d) The pregnant woman is a defective or became pregnant when under the age of sixteen or as the result of rape or of intercourse which was an offence under section 128 of the Mental Health Act 1959 or section 97 of the Mental Health (Scotland) Act 1960 (relating to sexual intercourse with patients)."

Both Lord Dilhorne and the Bishop of Exeter (who is probably voicing the official Church of England view) want section (c) taken out of the Bill. The B.M.A. Council prefers the wording suggested in the recent report from the Church Assembly Board for Social Responsibility[3]:

> "(1) It shall be lawful for a registered medical practitioner to terminate pregnancy in good faith in the reasonable belief that if the pregnancy were allowed to continue there would be grave risk of the patient's death or of serious injury to her health or physical or mental well-being.
>
> "(2) In determining whether or not there is a grave risk of serious injury to health or physical or mental well-being account may be taken of the patient's total environment, actual or reasonably foreseeable."

Lord Silkin meets the Church's point on the relevance of "total environment" by including the words ". . . the registered medical practitioners may take into consideration the total environment actual or foreseeable of the pregnant woman" in the new section (1) to clause 2. Lord Dilhorne, however, wants this section removed.

The section in the Bill on foetal indications for therapeutic abortion has been revised and now reads (clause 1(b)):

[1] *Brit. med. J.*, 1965, **2**, 1441.
[2] *Brit. med. J. Suppl.*, 1966, **1**, 19.
[3] *Abortion: An Ethical Discussion*, 1965. Church Information Office, London.
[4] *The Times*, 21 January 1966.
[5] *Brit. med. J. Suppl.*, 1965, **2**, 54.

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