**What is the uterus?**

The uterus (womb) is in the lower abdomen behind the bladder. The inside of the uterus is where a baby grows if you become pregnant. The inside lining of the uterus is called the endometrium. This builds up and is then shed each month as a ‘period’ in women who have not yet gone through the menopause. The thick body of the uterus is called the myometrium and is made of specialised muscle tissue.

The lowest part of the uterus is called the cervix which pushes just into the top part of the vagina. At the top of the uterus are the right and left fallopian tubes which carry the eggs released from the ovaries to the inside of the uterus.

**What is Uterine Cancer?**

There are two types of uterine cancer. Endometrial cancer, which originates in the inner lining (endometrium) of the uterus, is the most common form of uterine cancer, making up about 90% of total uterine cancer cases.

Uterine sarcoma, which originates in the outer muscle tissue lining (myometrium) of the uterus, is a much less common form of uterine cancer, comprising of less than 10% of all cases of uterine cancer.

**Causes**

It is not known what causes endometrial cancer, but there are a number of risk factors. Those most commonly affected are between the ages of 50 and 70 and have been through the menopause.

It is thought that having a high amount of the female hormone oestrogen in your body for a significant amount of time may increase the risk of getting cancer of the lining of the uterus (endometrial cancer). This means that women who have never been pregnant, had a late menopause (after the age of about 52), or started their periods early, are at a slightly higher risk.

If you are taking HRT (hormone replacement therapy) you need to make sure the type of HRT you are taking is suitable for you. Women who are taking HRT that does not contain the hormone progesterone may be at a higher risk of getting endometrial cancer, unless they have already had a hysterectomy. Women taking HRT with both oestrogen and progesterone are at slightly less risk of getting endometrial cancer. Your GP will take these factors into account when prescribing your HRT.

If you have been receiving treatment with the hormone tamoxifen for breast cancer, this may slightly increase your risk of endometrial cancer, because it may have a similar effect to oestrogen. The risk is small compared to the benefits of using tamoxifen to treat breast cancer.

Women who are overweight, have diabetes or high blood pressure, growths on the ovaries that produce oestrogen, endometrial hyperplasia (a non cancerous condition where the womb lining builds up more than usual) or polycystic ovary syndrome are also at a higher risk.

You may be at a higher risk of endometrial cancer if anyone in your family has had endometrial, breast, ovary, stomach or colon cancer, or if you have personally had breast or colon cancer.

If you are taking the combined contraceptive pill this may decrease your chances of developing endometrial cancer. This effect lasts for a few years after you stop taking the pill.

**Source:** www.patient.co.uk

**Source:** www.womens-health.co.uk

**People with concerns about their own health should contact their GP or cancer team**

**WELSH CANCER INTELLIGENCE AND SURVEILLANCE UNIT**

[www.wcisu.wales.nhs.uk](http://www.wcisu.wales.nhs.uk)
**Symptoms**

Women's periods stop after the menopause so there is no more bleeding from the vagina. The most common symptom of endometrial cancer is bleeding from the vagina after the menopause. This may start as light bleeding accompanied by a watery discharge but usually becomes heavier with time.

If you develop endometrial cancer before the menopause, you may notice bleeding between periods (also known as spotting) or very heavy bleeding from the vagina after the menopause. This may start as light bleeding accompanied by a watery discharge but usually becomes heavier.

Other, less common symptoms may include:

- pain in the abdomen, back, or legs,
- pain or bleeding during sex and/or when urinating,
- a change in bowel habits (such as constipation), and
- weight loss.

These symptoms might be caused by something else, such as fibroids or the menopause. It is important to see your GP as soon as possible so you can find out what the problem is and get early treatment.

**How is endometrial cancer diagnosed?**

To confirm the diagnosis

A doctor will usually do a vaginal examination if you have symptoms which may possibly be due to endometrial cancer. He or she may feel an enlarged uterus. However, even if the examination is normal, if endometrial cancer is suspected you will usually need to have a further test to confirm the diagnosis, usually one of the following:

- Endometrial sampling. This is where a thin tube is passed into the uterus. By using gentle suction, small samples of the endometrium can often be obtained. This can be done without an anaesthetic. The sample (biopsy) is looked at under the microscope to check for abnormal cancerous cells.
- Hysteroscopy. This is where a doctor uses a hysteroscope which is a thin telescope that is pushed through the cervix into the uterus. The doctor can see the lining of the uterus and take samples (biopsies) of abnormal looking areas. This can be done without an anaesthetic.
- D and C (dilation and curettage). This test is done less commonly these days. It involves the cervix being dilated (widened), and then an instrument called a curette is inserted into the uterus to scrape samples of tissue from the endometrium to be looked at under the microscope. You need a general anaesthetic for a D and C.

You may also have an ultrasound scan of the uterus. An ultrasound scan is a safe and painless test which uses sound waves to create images of organs and structures inside your body. The probe of the scanner may be placed on your abdomen to scan the uterus. A small probe is also commonly placed inside the vagina to scan the uterus from this angle. An MRI scan is now normally arranged to help to try and stage preoperatively. This helps to plan the operative procedure.

**Staging and Grading**

The stages of endometrial cancer are:

- **Stage 1** The tumour is contained within the endometrium (womb lining) or the muscle layers of the womb.
- **Stage 2** The tumour has spread into the cervix.
- **Stage 3** The tumour has spread into nearby tissues, such as the supporting membranes in the pelvic area, the vagina, or nearby lymph nodes.
- **Stage 4** The tumour has spread beyond the womb into surrounding organs, such as the bladder or bowel, or to other parts of the body. If the cancer has spread to other parts of the body this is secondary (or metastatic) womb cancer.

**Recurrent endometrial cancer** is when the cancer comes back some time after initial treatment.

**Grading**

Grading refers to the appearance of the cancer cells under the microscope. The grade gives an idea of how quickly the cancer may develop. There are three grades:

- grade 1 (well differentiated)
- grade 2 (moderately differentiated)
- grade 3 (poorly differentiated).

Well differentiated cancer cells look very like normal endometrial cells. They are usually slow-growing and less likely to spread. In poorly differentiated tumours, the cells look very abnormal. They are likely to grow more quickly and are more likely to spread.

Source: www.nhsdirect.nhs.uk, WCISU

Source: www.patient.co.uk, WCISU

Source: www.canercure.org.uk, WCISU
What are the treatment options for endometrial cancer?

Surgery and/or radiotherapy are the main treatments used for endometrial cancer. Hormone treatment or chemotherapy are also used in some circumstances. The treatment advised for each case depends on various factors such as the stage of the cancer (how large the cancer is and whether it has spread), and your general health.

You should have a full discussion with a specialist who knows your case. They will be able to give the pros and cons, likely success rate, possible side-effects, and other details about the various possible treatment options for your type of cancer. You should also discuss with your specialist the aims of treatment. For example:

- In some cases, treatment aims to cure the cancer. In most cases of endometrial cancer the condition is diagnosed at an early stage. There is a good chance of a cure if it is treated in the early stages. (Doctors tend to use the word ‘remission’ rather than the word ‘cured’. Remission means there is no evidence of cancer following treatment. If you are ‘in remission’, you may be cured. However, in some cases a cancer returns months or years later. This is why doctors are sometimes reluctant to use the word cured.)
- In some cases, treatment aims to control the cancer. If a cure is not realistic, with treatment it is often possible to limit the growth or spread of the cancer so that it progresses less rapidly. This may keep you free of symptoms for some time.
- In some cases, treatment aims to ease symptoms. For example, if a cancer is advanced then you may require treatments such as painkillers or other treatments to help keep you free of pain or other symptoms. Some treatments may be used to reduce the size of a cancer which may ease symptoms such as pain.

Surgery

An operation to remove the uterus (hysterectomy) and ovaries is a common treatment. If the cancer is at an early stage and has not spread, then surgery alone can be curative. If the cancer has spread to other parts of the body, surgery may still be advised, often in addition to other treatments. Even if the cancer is advanced and a cure is not possible, some surgical techniques may still have a place to ease symptoms. For example, to relieve a blockage of the bowel or urinary tract which has been caused by the spread of the cancer.

Radiotherapy

Radiotherapy is a treatment which uses high energy beams of radiation which are focussed on cancerous tissue. This kills cancer cells, or stops cancer cells from multiplying. Radiotherapy alone can be curative for early stage endometrial cancer and may be an alternative to surgery. In some cases radiotherapy may be advised in addition to surgery.

Even if the cancer is advanced and a cure is not possible, radiotherapy may still have a place to ease symptoms. For example, radiotherapy may be used to shrink secondary tumours which have developed in other parts of the body and are causing pain.

Hormone treatments

Normal cells in the endometrium are responsive to the female hormones oestrogen and progesterone. In some cases of endometrial cancer, taking progesterone slows down the growth of the cancer cells. This treatment is considered more often in cases where the cancer has spread from the uterus to other parts of the body.

Chemotherapy

Chemotherapy is a treatment of cancer by using anti-cancer drugs which kill cancer cells, or stop them from multiplying. Chemotherapy is not a standard treatment for endometrial cancer but may be given in certain situations (usually in addition to radiotherapy or surgery).

Source: www.patient.co.uk

Benefits and disadvantages of treatment

Many people are frightened at the idea of having cancer treatments, because of the side effects that can occur. Some people ask what would happen if they did not have any treatment.

Although treatments such as radiotherapy can cause side effects, these can usually be well controlled with medicines.

Treatment can be given for different reasons and the potential benefits will vary depending upon the individual situation.

Early-stage womb cancer

In women with early-stage endometrial cancer, surgery is usually done with the aim of curing the cancer and, in most cases, is successful. Sometimes additional treatments such as radiotherapy are given after the surgery to reduce the risks of the cancer coming back.

Advanced womb cancer

If the cancer is at a more advanced stage or has come back (recurred), treatment may only be able to control it, leading to an improvement in symptoms and a better quality of life. However, for some people in this situation, treatment will have no effect upon the cancer and they will get the side effects without any of the benefit.

Source: www.cancerbacup.org.uk
SUMMARY

Uterine cancer is the 5th most common cancer in women in Wales, accounting for 4.1% of all female cancers for the period 1992-2006. The percentage annual change in the European Age Standardised Rate for incidence at 3.1% was statistically significant at the 1% level. There has generally been an increase in incidence of this cancer over the fifteen year period 1992-2006.

Females

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17.8%

Prevalence Statistics (at 31 December 2006) in Wales

Females

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* Please note the following information is for Wales only *