



SOCIÉTÉ TUNISIENNE DE
GYNECOLOGIE OBSTÉTRIQUE
الجمعية التونسية لطب
الأمراض النسائية والتوليد



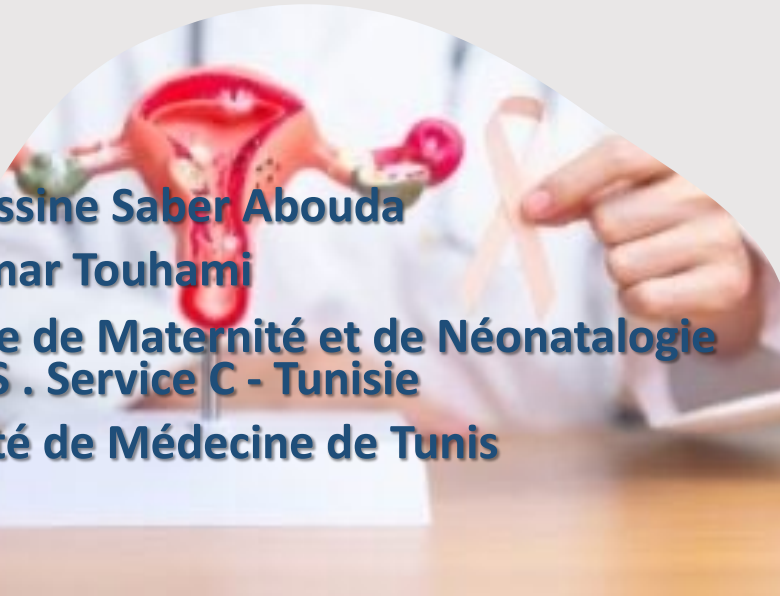
Cancer de l'endomètre et fertilité

Pr Hassine Saber Abouda

Dr Omar Touhami

Centre de Maternité et de Néonatalogie
TUNIS . Service C - Tunisie

Faculté de Médecine de Tunis




GynAzur

Du jeudi 11 au
vendredi 12 Juin
2026

PALAIS DES CONGRÈS
D'ANTIBES JUAN-LES-PINS
FRANCE

24^{ème}

CONGRÈS INTERNATIONAL
DE GYNECOLOGIE
OBSTÉTRIQUE
& REPRODUCTION
DE LA CÔTE D'AZUR

PROGRAMME

LOGISTIQUE
INSCRIPTIONS ET HOTELS
Sabrina PARRA
sparra@antipolis-events.com
Tél. : +33 04 22 10 60 19

PARTENAIRES
Loraine MAUMY
lmaumy@antipolis-events.com
Tél. : +33 04 22 10 60 17

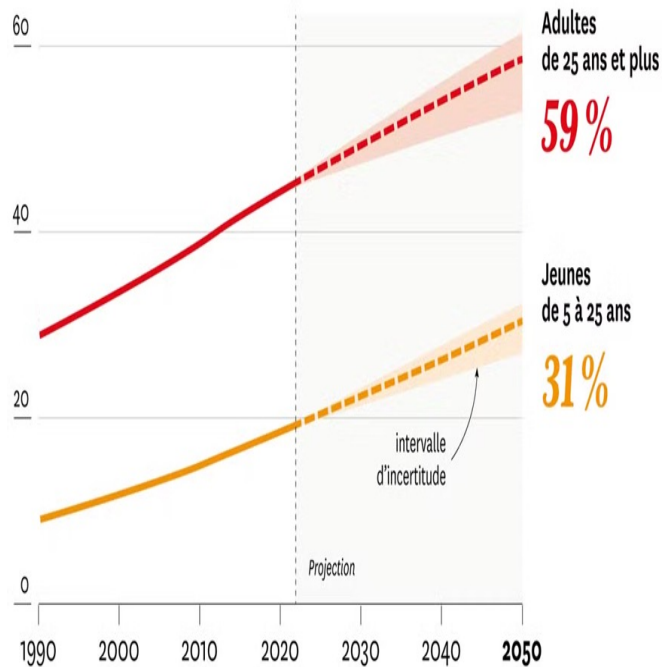
COORDINATION
SCIENTIFIQUE
Pr André BONGAIN
gynazur@gmail.com



Importance du sujet

L'explosion de l'obésité devrait se poursuivre

Évolution de la prévalence du surpoids et de l'obésité dans la population mondiale

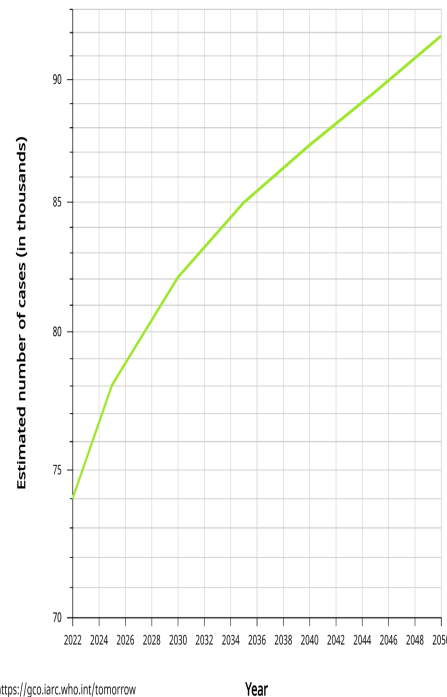


SOURCE : "THE GUARDIAN" (IHME, GLOBAL BURDEN OF DISEASE STUDY 2021)

Cancer Tomorrow | IARC - <https://gco.iarc.who.int/tomorrow>
Data version : Globocan 2022 (version 1.1)
© All Rights Reserved 2025

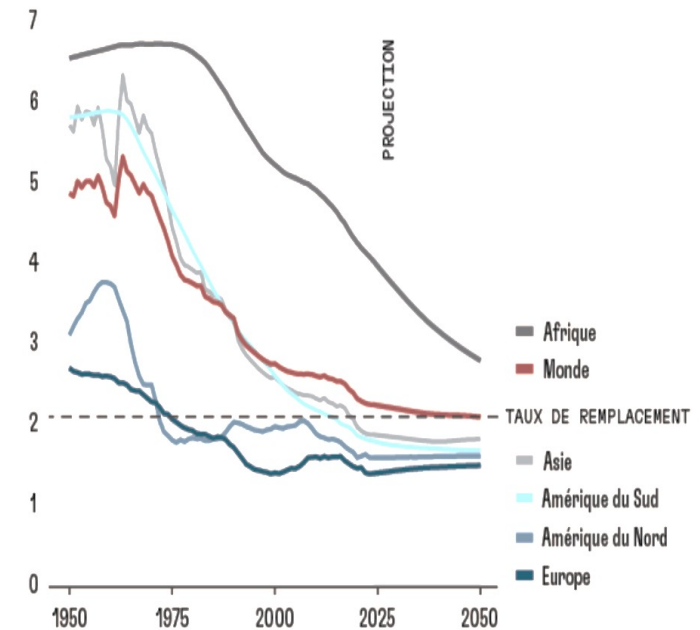


World Health Organization



Chute libre de la fécondité

Autrefois situés bien au-dessus du seuil de remplacement, les taux de natalité ont chuté partout dans le monde. (taux de fécondité total)



International Agency
for Research on Cancer
World Health
Organization

SOURCE : ONU, World Population Prospects (édition 2024), scénario de fécondité moyenne.

Cas Clinique

Âge 32 ans

IMC 35

SOPK

Suivie pour infertilité depuis 3 ans

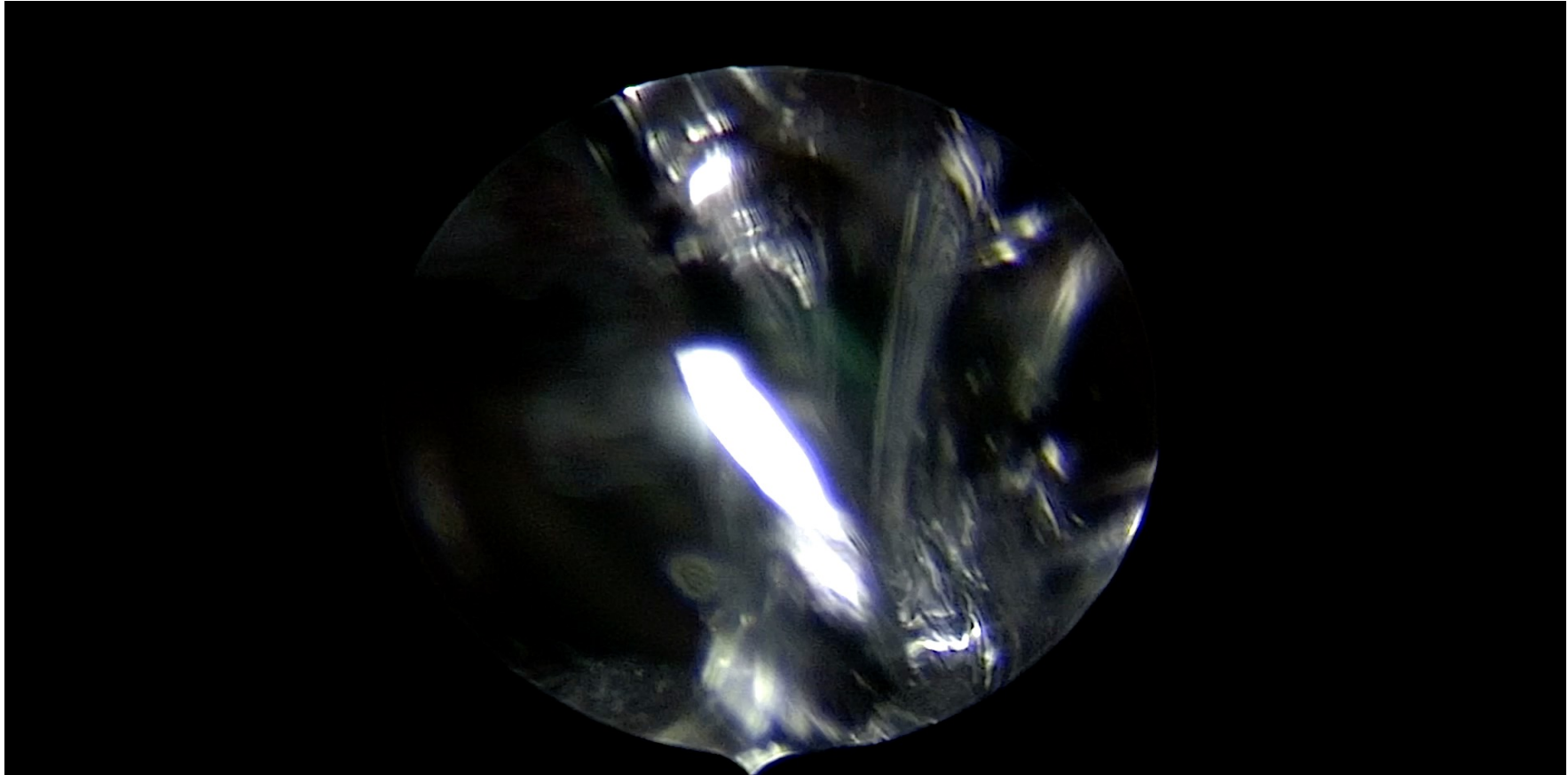
Et qui présente des épisodes de SUA

Échographie: endomètre à 14 mm siège d'un polype de 7 mm



Image generée à partir de ChatGPT5

VAGINO-HSC DG



Question 1: Quel diagnostic évoquez vous?

Place de l'hystéroscopie diagnostique = Gold Standard

Les gynécologues devraient tenter d'exclure la présence d'un carcinome concomitant chez les patientes présentant un diagnostic présumptif d'EIN-HEA. L'examen hystéroscopique, accompagné d'un échantillonnage supplémentaire de l'endomètre, constitue la méthode la plus précise pour détecter un carcinome concomitant.

ACOG 2023

Pour Qui ?

La tumeur

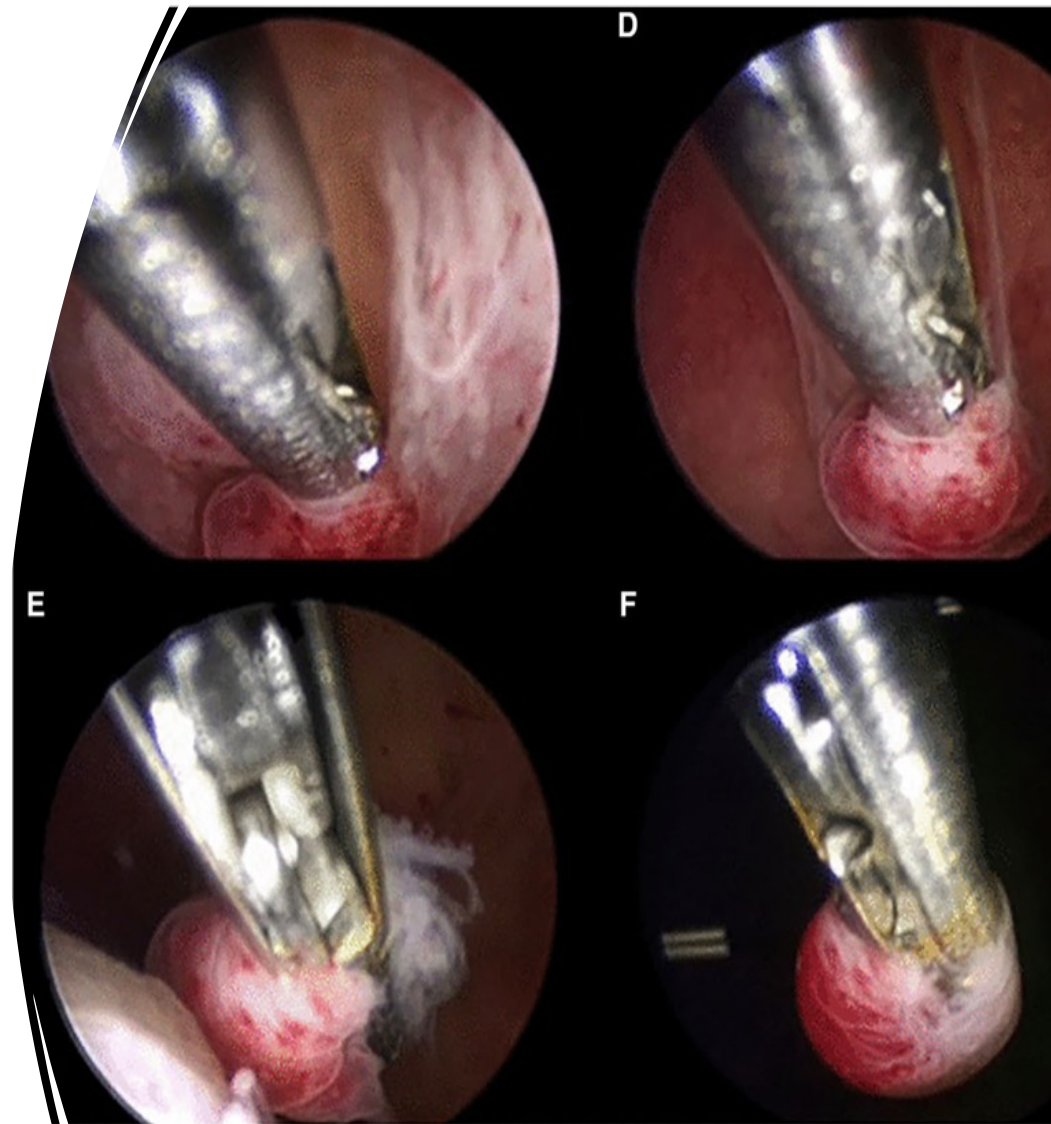
Comment faire la biopsie ?

- HSC OPERATOIRE :
technique de biopsie

GRASP TECHNIQUE

Establishing a reliable histopathology

- Hysteroscopic-guided endometrial biopsy is preferred over blind biopsy for confirming diagnosis of endometrial carcinoma (Level of evidence III, Grade A).



Hysteroscopic endometrial biopsy with 'grasp technique' (sequentially ordered from A to F)

Cas Clinique (suite)

- Le compte rendu anapath: carcinome endométroïde grade 1
- **Révision** des lames par anapatho : **ADK Endométroïde**
- IRM pelvienne : EE = 20 mm, pas d'évidence d'infiltration du myomètre, pas de masse annexielle, pas d'ADP
- CA-125 = 27

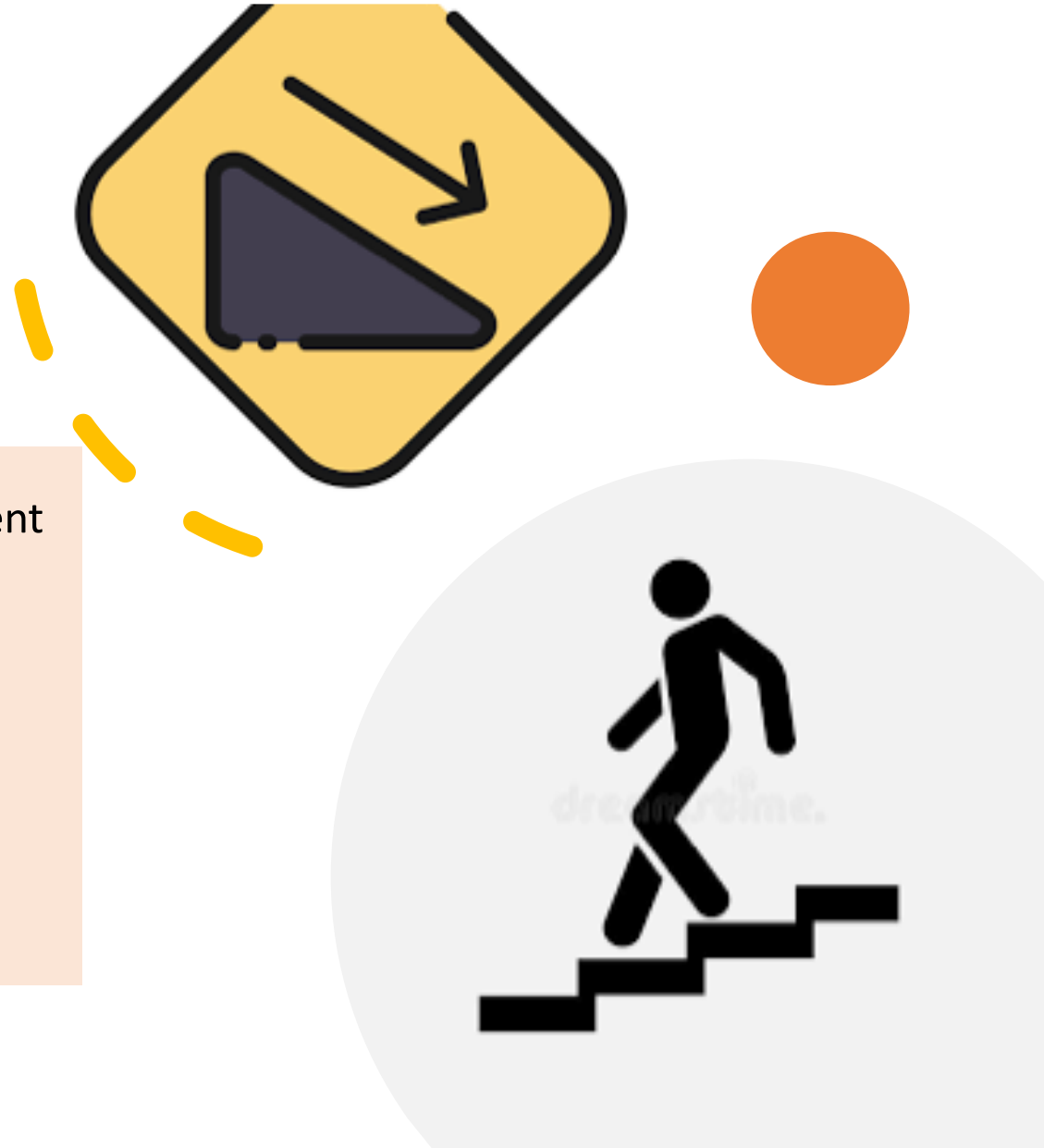
La patiente désire préserver sa fertilité

Question 2: Peut-on opter pour un traitement conservateur utérin ?

Désescalade thérapeutique et modalités

La désescalade consiste à limiter le recours à des traitements invasifs en sélectionnant judicieusement les patientes éligibles et en adaptant l'intensité thérapeutique selon:

- les facteurs pronostiques (grade, stade, classification moléculaire)
- le bilan pré-thérapeutique



Désescalade thérapeutique et modalités

- Meilleure compréhension 🧐
- Meilleure exploration 🕒
- Meilleure stadification 🧐



Désescalade thérapeutique et modalités

Objectifs:

- Préserver la fertilité
- Eviter la morbidité



Désescalade thérapeutique et modalités

- MAIS +++++
- Il faut être prudent entre **Pronostic Oncologique** et **Pronostic de fertilité**



NECESSITE DE BIEN CIBLER LES INDICATIONS EXACTES

- QUAND ?
- POUR QUI ?
- COMMENT ?



human
reproduction
open

ESHRE PAGES

ESGO/ESHRE/ESGE Guidelines for the fertility-sparing treatment of patients with endometrial carcinoma^{†,‡}

Alexandros Rodolakis ^{1*}, Giovanni Scambia ², François Planchamp ³, Maribel Acien ⁴, Attilio Di Spiezio Sardo⁵, Martin Farrugia⁶, Michael Grynberg^{7,8,9}, Maja Pakiz ¹⁰, Kitty Pavlakis^{11,12}, Nathalie Vermeulen ¹³, Gianfranco Zannoni ¹⁴, Ignacio Zapardiel ¹⁵, and Kirsten Louise Tryde Macklon¹⁶

QUAND ?



Cut off pour l'âge ?

ESGO/ESHRE/ESGE Guidelines for the fertility-sparing treatment of patients with endometrial carcinoma^{†,‡}

Alexandros Rodolakis^{1*}, Giovanni Scambia², François Planchamp³, Maribel Acien⁴, Attilio Di Spiezio Sardo⁵, Martin Farrugia⁶, Michael Grynberg^{7,8,9}, Maja Pakiz¹⁰, Kitty Pavlakis^{11,12}, Nathalie Vermeulen¹³, Gianfranco Zannoni¹⁴, Ignacio Zapardiel¹⁵, and Kirsten Louise Tryde Macklon¹⁶

Age-specific age limits

- Women should be counselled about their reduced chances of achieving a live birth with their own gametes with increased age (Level of evidence II, Grade A).

ESGO/ESHRE/ESGE Guidelines for the fertility-sparing treatment of patients with endometrial carcinoma^{†,‡}

Alexandros Rodolakis ^{1*}, Giovanni Scambia ², François Planchamp ³, Maribel Acien ⁴, Attilio Di Spiezio Sardo⁵, Martin Farrugia⁶, Michael Grynberg^{7,8,9}, Maja Pakiz ¹⁰, Kitty Pavlakis^{11,12}, Nathalie Vermeulen ¹³, Gianfranco Zannoni ¹⁴, Ignacio Zapardiel ¹⁵, and Kirsten Louise Tryde Macklon¹⁶

Chances of pregnancy and live birth among women undergoing conservative management of early-stage endometrial cancer: a systematic review and meta-analysis

Erica Herrera Cappelletti ^{1 2}, Jonas Humann ², Rafael Torrejón ², Pietro Gambadauro ^{1 2 3 4}

Affiliations + expand

PMID: 34935045 PMID: PMC8888991 DOI: 10.1093/humupd/dmab041

As with any woman seeking to become pregnant, age is a prognostic factor for success also in women with endometrial carcinoma. In a recent meta-analysis, it was found that the highest chance of achieving a live birth for women with endometrial carcinoma was in those younger than 35 years (live birth rate 30.7%). In studies including women up to age 40 years, a live birth rate of 23.0% was reported (Herrera Cappelletti *et al.*, 2022).

POUR QUI ?

SELECTION des Patientes +++
Fort désir de Grossesse :
Possibilité de Fertilité

Possibilité de Fertilité



Evaluer les paramètres de la fertilité

AMH

FSH

CFA

POUR QUI ?



human
reproduction
open

ESHRE PAGES

ESGO/ESHRE/ESGE Guidelines for the fertility-sparing treatment of patients with endometrial carcinoma^{†,‡}

Alexandros Rodolakis ^{1*}, Giovanni Scambia ², François Planchamp ³, Maribel Acien ⁴, Attilio Di Spiezio Sardo ⁵, Martin Farrugia ⁶, Michael Grynberg ^{7,8,9}, Maja Pakiz ¹⁰, Kitty Pavlakis ^{11,12}, Nathalie Vermeulen ¹³, Gianfranco Zannoni ¹⁴, Ignacio Zapardiel ¹⁵, and Kirsten Louise Tryde Macklon ¹⁶

General recommendations

- Patients with a pregnancy wish should be referred to specialized care, especially those with genetic syndrome (Level of evidence V, Grade A).
- Joint care and counselling with a multidisciplinary team of at least gynaecologic oncologists, fertility specialists, pathologists and radiologists should be proposed to all patients with a pregnancy wish (Level of evidence V, Grade A).

SELECTION des Patientes +++

Fort désir de Grossesse :

- Possibilité de Fertilité
- Expliquer à la patiente

• **RCP ++++**

Reproductive potential

- No recommendations can be given based on the literature. However, evaluation of the reproductive potential and consultation with fertility specialists should be performed prior to fertility-sparing treatment (Level of evidence V, Grade B).

POUR QUI ?



La Tumeur

Quel type histologique

Quel grade ?

• Quel stade?

ESGO/ESHRE/ESGE Guidelines for the fertility-sparing treatment of patients with endometrial carcinoma^{†,‡}

Alexandros Rodolakis^{1*}, Giovanni Scambia²,
François Planchamp³, Maribel Acien⁴, Attilio Di Spiezio Sardo⁵,
Martin Farrugia⁶, Michael Grynberg^{7,8,9}, Maja Pakiz¹⁰,
Kitty Paviakis^{11,12}, Nathalie Vermeulen¹³, Gianfranco Zannoni¹⁴,
Ignacio Zapardiel¹⁵, and Kirsten Louise Tryde Macklon¹⁶

POUR QUI ?



Quel type histologique

Carcinome endométriode

Jeune Age

Hormonosensible

Bon Pronostic

human
reproduction
open

ESHRE PAGES

ESGO/ESHRE/ESGE Guidelines for the fertility-sparing treatment of patients with endometrial carcinoma^{†,‡}

Alexandros Rodolakis ^{1*}, Giovanni Scambia ²,
François Planchamp ³, Maribel Acien ⁴, Attilio Di Spiezio Sardo⁵,
Martin Farrugia⁶, Michael Grynberg^{7,8,9}, Maja Pakiz ¹⁰,
Kitty Pavlakis^{1,12}, Nathalie Vermeulen ¹³, Gianfranco Zannoni ¹⁴,
Ignacio Zapardiel ¹⁵, and Kirsten Louise Tryde Macklon¹⁶

POUR QUI ?

Quel grade ?

Système de grading FIGO

Grade 1

Although the International Society of Gynaecological Pathologists recommends the use of a binary grading system by combining Grades 1 and 2 into a single low-grade category which reduces the degree of disagreement, for patients desiring a fertility-sparing treatment approach, it will continue to be necessary to distinguish Grades 1 and 2 (Soslow et al., 2019).

Recommendations

Review of initial pathology by an experienced histopathologist

- A request for a second opinion by an experienced histopathologist is recommended if fertility-sparing treatment is considered (Level of evidence III, Grade A).
- The G1, G2, G3 grading system is recommended. The binary grading system for endometrial carcinoma should not be used for these patients (Level of evidence III, Grade A).

Quel stade?

- Evaluation de l'invasion myométriale :
IRM pelvienne
- Evaluation locorégionale:
IRM ou Echographie Pelvienne
- Métastases :
TDM ou IRM lombo-aortique

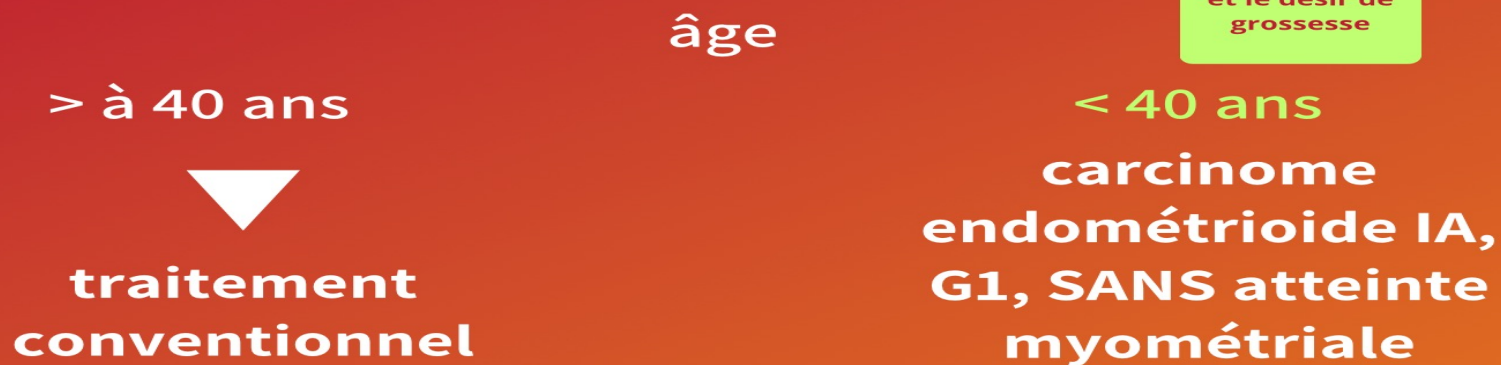
Myometrial invasion

- Pre-operative assessment of myometrial invasion in patients with endometrial carcinoma should be performed using MRI or transvaginal US by a specialized radiologist/sonographer. Standardized high-quality protocols for MRI should be used to reach the highest possible accuracy (Level of evidence III, Grade A).
- CT should not be used for pre-operative assessment of myometrial invasion in patients with endometrial carcinoma (Level of evidence III, Grade A).

Exclude extra-uterine disease/synchronous or metastatic

- MRI or CT scan is recommended for detecting pelvic or para-aortic lymph nodes and distant metastases (Level of evidence II, Grade B).
- Adnexal involvement should be ruled out by pelvic MRI or transvaginal US (Level of evidence II, B).

Algorithme



- Fertility-sparing treatment is considered for endometrioid patients with endometrial carcinoma with Grade I, Stage IA without myometrial invasion and without risk factors (Level of evidence V, Grade A).

CAS PARTICULIERS:

- GRADE 2 et ou invasion Myométriale ?

- Evidence for Grade 2 endometrioid endometrial carcinoma is limited. Therefore, fertility-sparing treatment should be discussed on a case-by-case basis (Level of evidence IV, Grade C).

The role of hysteroscopic resection

- If an early and focal myometrial invasion (1–2 mm) is suspected from the resection material, a fertility-sparing approach may be discussed on a case-by-case basis. In this circumstance, complete hysteroscopic lesion resection, followed by oral progestins and/or levonorgestrel-intra-uterine device, can be proposed as fertility-sparing treatment (Level of evidence IV, Grade C).

À discuter au cas par cas : RCP +++++

Question 3 : Quel est le meilleur traitement ?

- 1- Acétate de megestrol 160 à 320 mg/j**
- 2- Acétate de medroxyprogesterone 400 à 600 mg/j**
- 3- Acétate de chlormadinone 5 à 15 mg/j**
- 4- Dispositif intra-utérin au levonorgestrel 52 mg**

Traitement Médical (Hormonal): Quels Progestatifs?

- Medroxyprogesterone Acetate 400 mg à 600 mg par Jour
- Megestrol Acetate 160 à 320 mg par jour
- DIU Levonorgestrel 52mg - 20µg/24h +++



ESGO/ESHRE/ESGE Guidelines for the fertility-sparing treatment of patients with endometrial carcinoma^{†,‡}

Alexandros Rodolakis^{1*}, Giovanni Scambia²,
François Planchamp³, Maribel Acien⁴, Attilio Di Spiezio Sardo⁵,
Martin Farrugia⁶, Michael Grynberg^{7,8,9}, Maja Pakiz¹⁰,
Kitty Pavlakis^{11,12}, Nathalie Vermeulen¹³, Gianfranco Zannoni¹⁴,
Ignacio Zapardiel¹⁵, and Kirsten Louise Tryde Macklon¹⁶

Dose of progestins

- Orally administered megestrol acetate at a dose of 160–320 mg/day or medroxyprogesterone acetate at a dose of 400–600 mg/day is recommended (Level of evidence III, Grade B).
- A levonorgestrel-intra-uterine device at a dose of 52 mg, alone or in combination with oral progestins, is a safe and effective approach (Level of evidence III, Grade B).

Le meilleur traitement



Cochrane Database of Systematic Reviews



JNCI: Journal of the National Cancer Institute, 2024, 116(5), 653-664
<https://doi.org/10.1093/jnci/djao023>
 Advance Access Publication Date: February 1, 2024
 Review

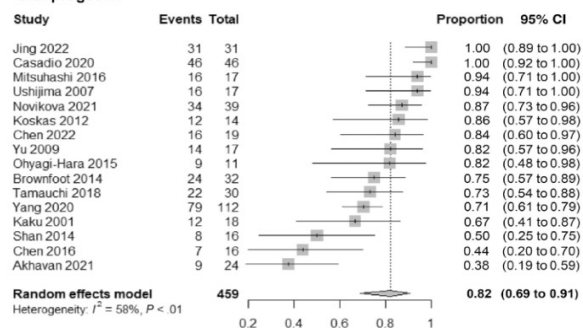
Levonorgestrel-releasing intrauterine device therapy vs oral progestin treatment for reproductive-aged patients with endometrial intraepithelial neoplasia: a systematic review and meta-analysis

Yukio Suzuki, MD, PhD,^{1,4} Jennifer S. Ferris, PhD,^{1,2,4} Ling Chen, MD, MPH,¹ Shayan Dloum, MD,^{1,4,5} John Usseglio, MPH,² Koji Matsuo, MD, PhD,⁶ Xiao Xu, PhD,^{1,2} Dawn L. Hershman, MD,^{1,2,4,5} Jason D. Wright, MD,^{1,4,5,6}

Fertility-sparing treatment for atypical endometrial hyperplasia and endometrial cancer (Review)

Fernandez-Montoli ME, Sabadell J, Contreras Perez NA, Verdaguer Menéndez-Arango P, Julia Torres C, Lleberia J

Oral progestin



LNG-IUD

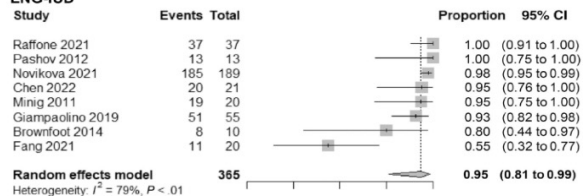


Figure 2. Forest plots showing the best complete response proportion within 12 months. CI = confidence interval; LNG-IUD = levonorgestrel intrauterine device.

When comparing Levonorgestrel IUS to oral progestin, data from two RCTs showed no evidence of a difference in CR in women with AEH (data not pooled): RR 1.78 (95% CI 0.98 to 3.25; 89 women), and RR 1.24 (95% CI 0.86 to 1.78; 19 women), both low-certainty evidence. One RCT found that levonorgestrel IUS may decrease severe adverse events (weight gain) slightly (RR 0.19; 95% CI 0.04 to 0.84; 1 RCT, 118 women; low-certainty evidence)

Question 3 : Quel marqueur en pathologie permet de mieux prédire la réponse aux progestatifs ?

1- Récepteurs hormonaux

2- p53

3- MMR

4- POLE

Les récepteurs hormonaux

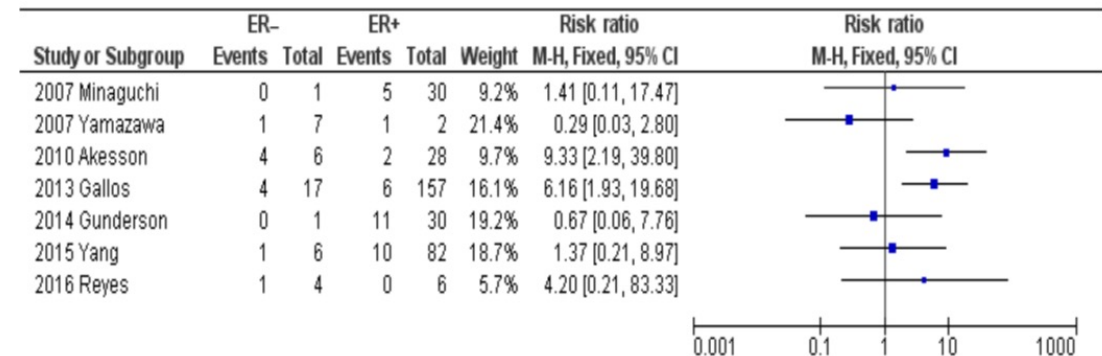
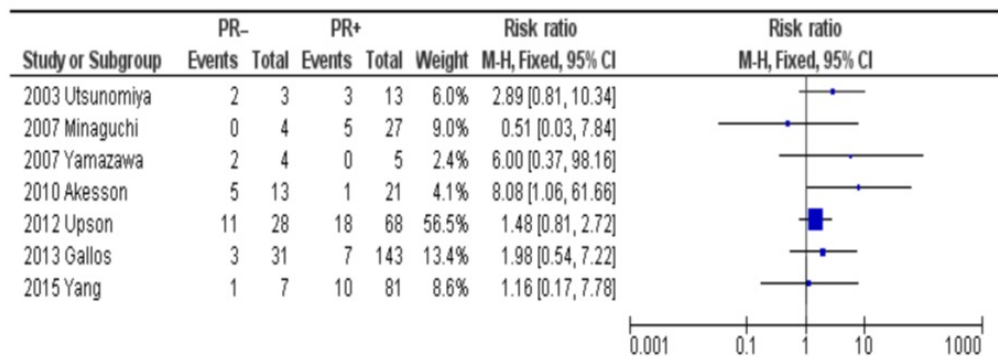
Received: 19 September 2018 | Accepted: 16 February 2019
DOI: 10.1111/aogs.13587

SYSTEMATIC REVIEW



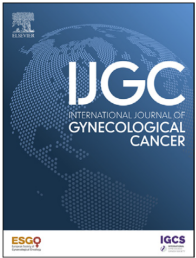
Immunohistochemical predictive markers of response to conservative treatment of endometrial hyperplasia and early endometrial cancer: A systematic review

Antonio Travaglino¹ | Antonio Raffone² | Gabriele Saccone² | Luigi Insabato¹ | Antonio Mollo² | Giuseppe De Placido² | Fulvio Zullo²



ORIGINAL RESEARCH

Performance of molecular classification in predicting oncologic outcomes of fertility-sparing treatment for atypical endometrial hyperplasia and endometrial cancer



Filippo Alberto Ferrari^{a,b,*}, Stefano Uccella^a, Massimo Franchi^a, Giovanni Scambia^c, Francesco Fanfani^c, Anna Fagotti^c, Matteo Pavone^{c,d,e}, Francesco Raspagliesi^b, Giorgio Bogani^b



Figure 2 Outcome of patients with different molecular sub-types. CR, complete response; MMRd, mismatch repair deficiency/microsatellite-instable; NSMP, no specific mutational profile; PD/SD, progression disease or stable disease; POLEmut, POLE mutated; PR, partial response; p53abn, TP53-mutant or p53 abnormal.

Figure 3 CR and recurrences of patients with different molecular sub-types. CR, complete response; MMRd, mismatch repair deficiency/microsatellite-instable; NSMP, no specific mutational profile; PD/SD, progression disease or stable disease; POLEmut, POLE mutated; PR, partial response; p53abn, TP53-mutant or p53 abnormal.

MMR / p53 (biologie moléculaire)

Meta-Analysis > Eur J Obstet Gynecol Reprod Biol. 2024 Nov;302:177-183.

doi: 10.1016/j.ejogrb.2024.09.006. Epub 2024 Sep 12.

Fertility-sparing treatment in MSI-H/MMRd endometrial carcinoma or atypical endometrial hyperplasia: A systematic review and meta-analysis

Tianyu Zhang ¹, Xinyue Zhang ¹, Peng Peng ¹, Jiaxin Yang ²

Affiliations + expand

PMID: 39288504 DOI: 10.1016/j.ejogrb.2024.09.006

intégration systématique du statut MMR/MSI et p53
les tumeurs dMMR/MSI-H ou p53-abn présentent un
risque élevé d'échec.

RC 61.8% seulement avec un délai plus long

Taux de récurrence élevé 41.2%

syndrome de Lynch: taux de récurrence 77.8%

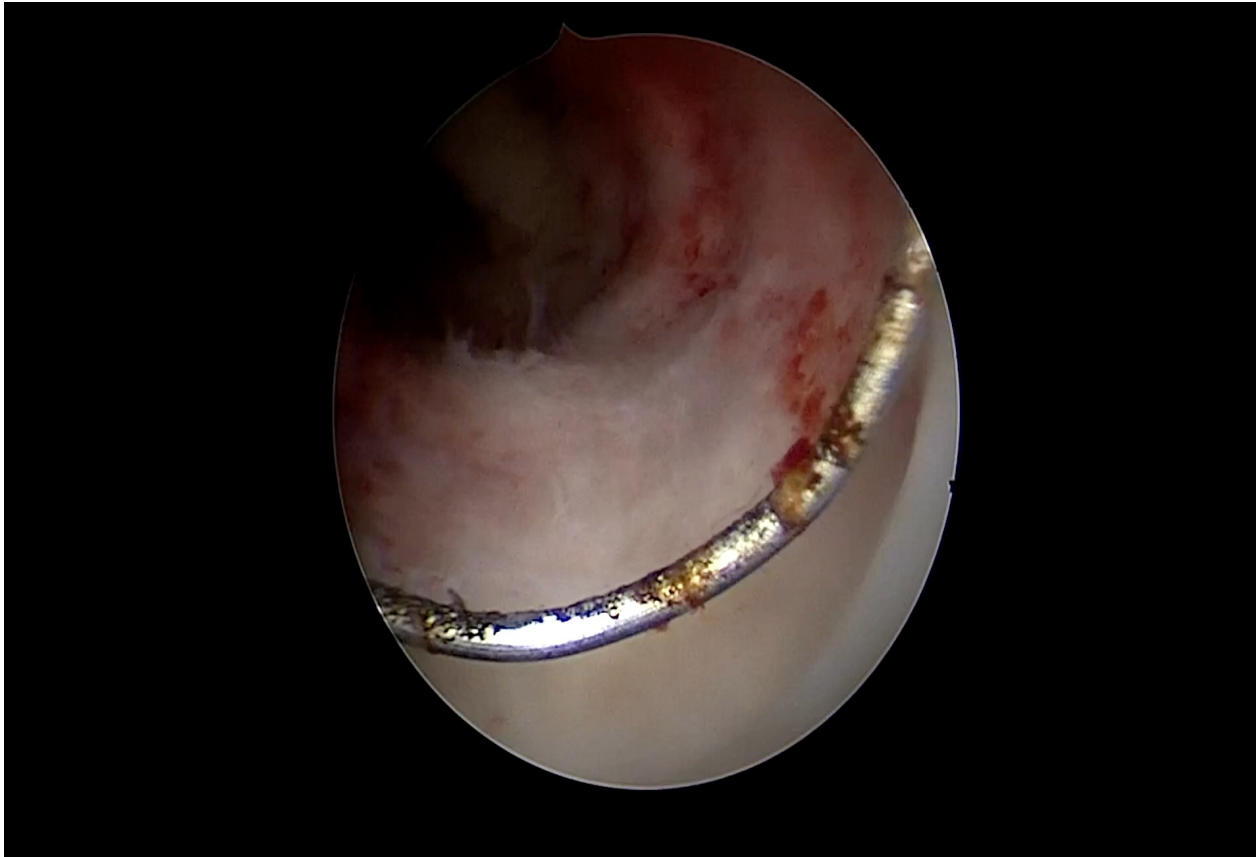
Faible taux de conception naturelle / Recours à la PMA

→ **Décision thérapeutique plus personnalisée.**

Question 5 : Quelles mesures devraient être associées au traitement progestatif ?

- 1- HSC opératoire**
- 2- Metformine**
- 3- Activité physique**
- 4- Changements alimentaires**
- 5- Perte de poids**

- HSC OPERATOIRE :



Progestatifs seuls : RC = 76.3 – 77.6 %

Progestatifs + HSC : RC = 90 – 95.3 %

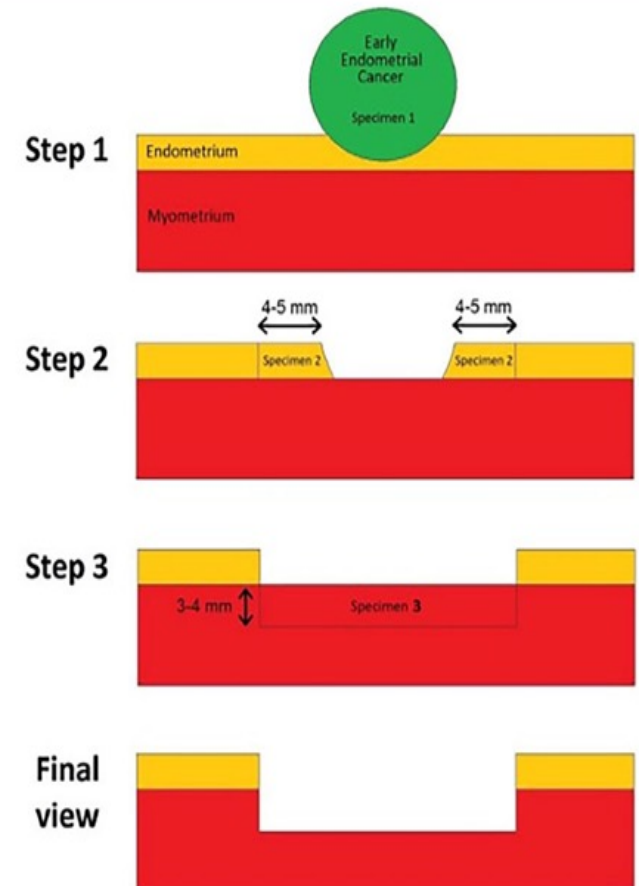


Figure 4. Schematic representation of hysteroscopic resection of focal endometrial endometrioid carcinoma following the 'three steps' technique.

Métformine

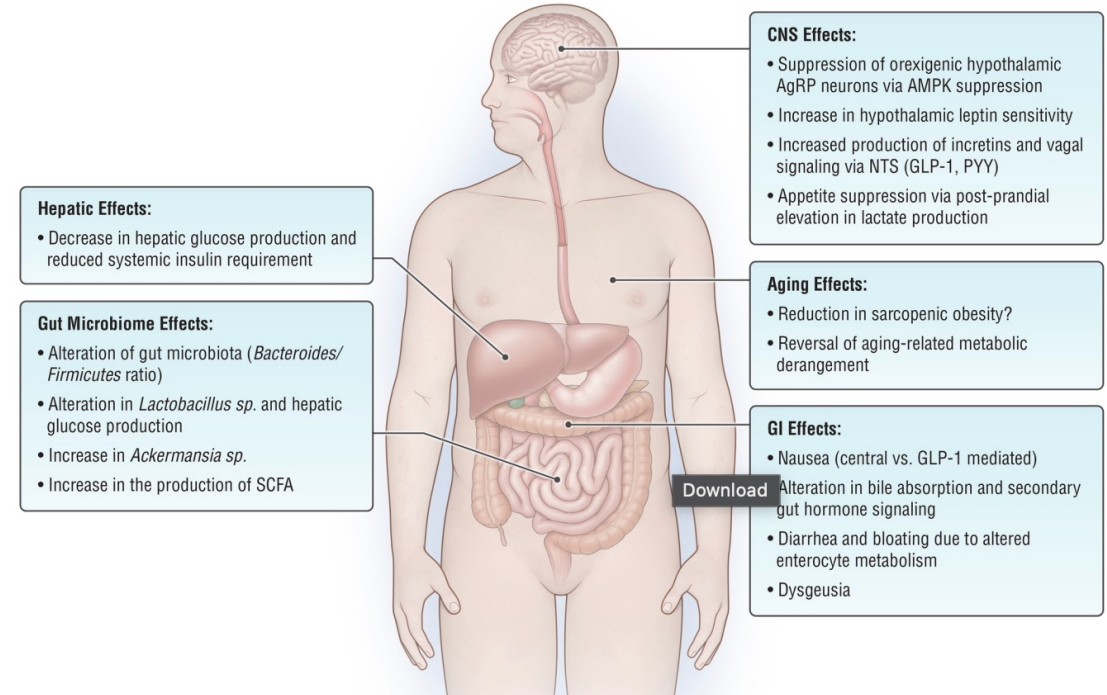
Current Obesity Reports (2019) 8:156–164
<https://doi.org/10.1007/s13679-019-00335-3>

OBSESITY TREATMENT (CM APOVIAN, SECTION EDITOR)

Metformin: Mechanisms in Human Obesity and Weight Loss

Armen Yerevanian^{1,2,3} • Alexander A. Soukas^{1,2,3}

Regulation of Obesity, Appetite, and Weight Loss by Metformin



Progestatif seul

vs

metformine + progestatif



61% moins de prise de poids



Metformin and progestins in women with atypical hyperplasia or endometrial cancer: systematic review and meta-analysis

Leila Adamyan^{1,2} · Laura Pivazyan² · Sapiyat Isaeva³ · Roman Shapovalenko³ · Araksya Zakaryan³

Received: 19 October 2023 / Accepted: 4 February 2024

© The Author(s), under exclusive licence to Springer-Verlag GmbH Germany, part of Springer Nature 2024

- **bénéfice adjuvant remis en question**
- **signal positif chez patientes obèses/insulino-résistantes.**
- **Pas encore standard.**

Réf : Adamyan L. et al., 2024.



Cochrane Database of Systematic Reviews

Fertility-sparing treatment for atypical endometrial hyperplasia and endometrial cancer (Review)

Fernandez-Montoli ME, Sabadell J, Contreras Perez NA, Verdaguer Menéndez-Arango P, Julia Torres C, Lleberia J

Progestatif + metformine :
légère amélioration de la réponse complète,
pas d'impact sur survie/fertilité,
pas d'effets indésirables graves.

Perte de poids

Gynecologic Oncology 161 (2021) 143–151



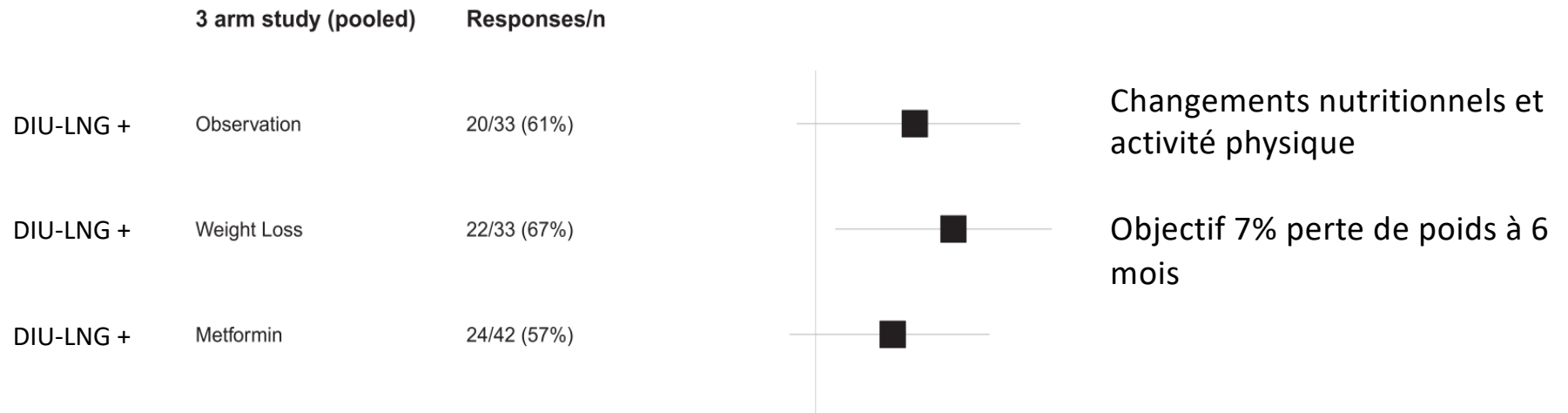
Contents lists available at ScienceDirect

Gynecologic Oncology

journal homepage: www.elsevier.com/locate/ygyno



Complete pathological response following levonorgestrel intrauterine device in clinically stage 1 endometrial adenocarcinoma: Results of a randomized clinical trial



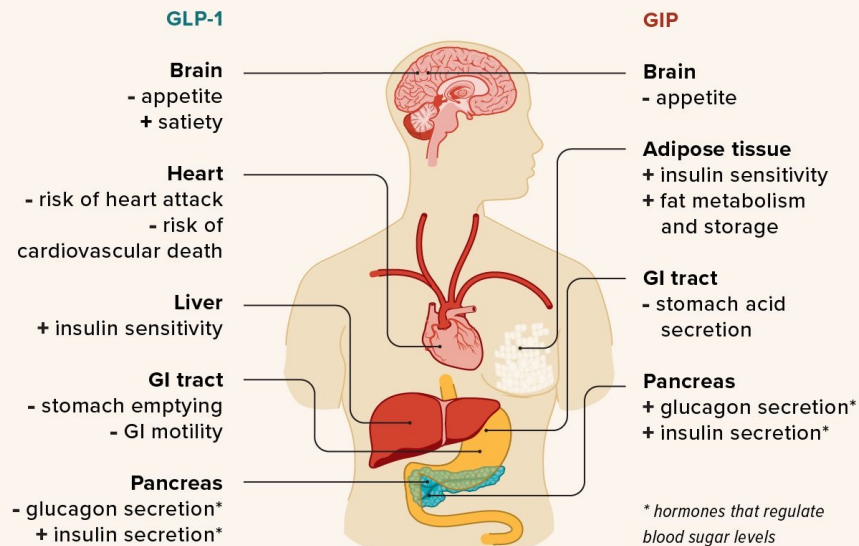
Activité **physique**

- De manière générale, l'activité physique permet de diminuer le risque de cancer de l'endomètre
- Très peu de données pour l'activité physique seule
- Souvent étudiée dans le contexte d'interventions au niveau du style de vie pour promouvoir la perte de poids

Agonistes GLP-1

How do GLP-1 Medications Work?

GLP-1 medications work by mimicking one or two naturally produced hormones: glucagon-like peptide-1 (**GLP-1**) and gastric inhibitory polypeptide (**GIP**).



Many GLP-1 drugs (like Ozempic and Wegovy) act by binding to GLP-1 receptors, resulting in the same effects of GLP-1 seen above.

However, some medications (like Mounjaro and Zepbound) are unique in that they bind to GLP-1 and GIP receptors, resulting in a combined effect.

healthline

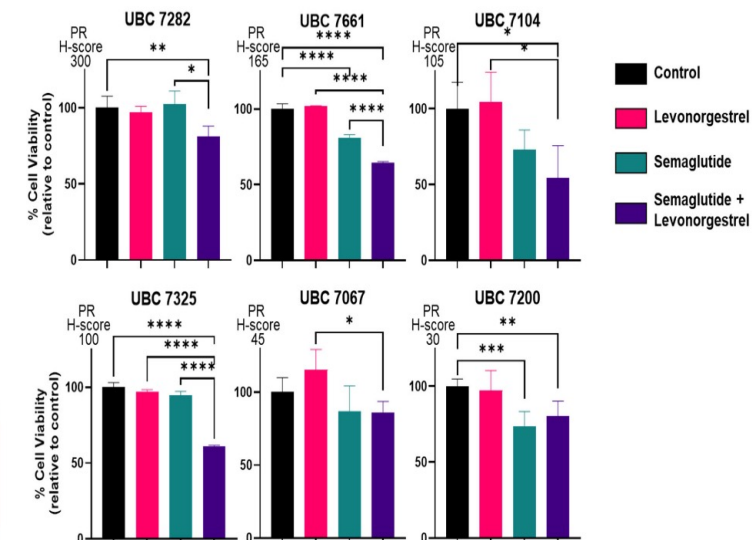
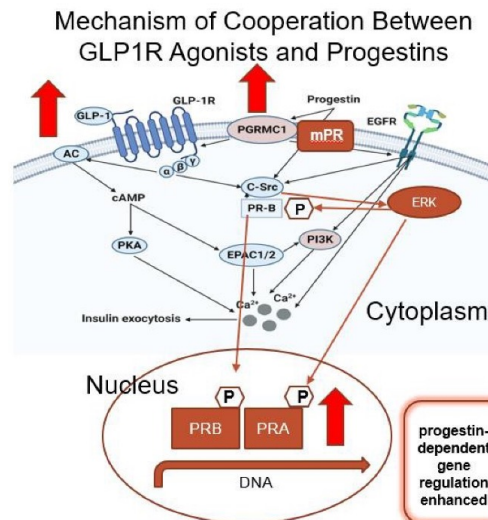


Article

Enhancing Progestin Therapy with a Glucagon-Like Peptide 1 Agonist for the Conservative Management of Endometrial Cancer

Andrea R. Hagemann ¹, Ian S. Hagemann ^{1,2}, David G. Mutch ¹, Eric J. Devor ³, Paige K. Malmrose ⁴, Yuping Zhang ³, Abigail M. Morrison ³, Kristina W. Thiel ^{3,*} and Kimberly K. Leslie ^{5,*}

Hagemann AR et al, 2025



Agonistes GLP-1 (semaglutide, liraglutide)

- approche métabolique innovante
- phase II en cours pour AEH/EC précoces.

Cureus
Part of **SPRINGER NATURE**

Open Access Review Article

The Potential Role of Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists as a Type of Conservative Treatment of Endometrial Cancer in Women of Reproductive Age: A Review of the Literature and a Call for Study

Maria Zoi Bourou¹, Alkis Matsas¹, Georgios Valsamakis¹, Nikolaos Vlahos¹, Theodoros Panoskaltsis¹

¹. Second Department of Obstetrics and Gynecology, National and Kapodistrian University of Athens Medical School, Aretaieio University Hospital, Athens, GRC

Corresponding author: Theodoros Panoskaltsis, panoskaltsistheo@gmail.com

Review began 09/09/2024
Review ended 09/15/2024
Published 09/18/2024

© Copyright 2024
Bourou et al. This is an open access article distributed under the terms of the Creative Commons Attribution License CC-BY 4.0., which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

DOI: 10.7759/cureus.69678

without adding GLP-1 analogs [28]. Endometrial cancer is closely linked to obesity. Several studies have shown that losing 5% of body weight over a three-year period can lead to a 39% reduction in the risk of

Réf : NCI 2024.

Agonistes GLP-1

Weight-loss Drug for Fertility-Sparing Treatment of Atypical Hyperplasia and Low-grade Cancer of the Endometrium (WE-FiERCE)

 **UHN** University Health Network, Toronto

Status and phase

Not yet enrolling ⓘ

Phase 2

Conditions

Endometrial Cancer

Atypical Hyperplasia

Treatments

 Drug: Mirena

 Drug: Mounjaro

Study type

Interventional ⓘ

Funder types

Other ⓘ

Identifiers

[NCT06073184](#)

25-5042

Question 5 : Quelle devrait être la durée du traitement ?

- 1- 3 mois**
- 2- 6 mois**
- 3- 9 mois**
- 4- 12 mois**
- 5- 18 mois**

Durée du traitement



National
Comprehensive
Cancer
Network®

PLEASE NOTE that use of this NCCN Content is governed by the End-User License Agreement, and you MAY NOT distribute this Content or use it with any artificial intelligence model or tool.
Printed by omar touhami on 10/18/2025 3:52:21 PM. Copyright © 2025 National Comprehensive Cancer Network, Inc. All Rights Reserved.

NCCN Guidelines Version 3.2025 Endometrial Carcinoma

[NCCN Guidelines Index](#)
[Table of Contents](#)
[Discussion](#)

CRITERIA FOR CONSIDERING FERTILITY-SPARING OPTIONS FOR MANAGEMENT OF ENDOMETRIAL CARCINOMA (All criteria must be met)

- Well-differentiated (grade 1) endometrioid adenocarcinoma on dilation and curettage (D&C) confirmed by expert pathology review
- Disease limited to the endometrium on MRI (preferred) or transvaginal ultrasoundⁱ
- Absence of suspicious or metastatic disease on imaging
- No contraindications to medical therapy or pregnancy
- Patients should undergo counseling that fertility-sparing option is NOT standard of care for the treatment of endometrial carcinoma

- Consultation with a fertility expert prior to therapy
- Recommend molecular evaluation of tumor and evaluation for inherited cancer risk ([UN-1](#))
- Ensure negative pregnancy test

PRIMARY TREATMENT

- Continuous progestin-based therapy:
 - ▶ Megestrol
 - ▶ Medroxyprogesterone
 - ▶ Levonorgestrel IUD (preferred for fertility preservation)
- Consider dual-progestin therapy [(megestrol or medroxyprogesterone) + levonorgestrel IUD]
- Weight management/lifestyle modification counseling^u

SURVEILLANCE

Endometrial evaluation every 3–6 mo (either D&C or endometrial biopsy)

Complete response by 6 mo

Encourage conception (with continued surveillance/ endometrial sampling every 6–12 mo and consider maintenance progestin-based therapy if patient is not actively trying to conceive)

Endometrial cancer present at 6–12 moⁱ

TH/BSO with staging^{d,e} after childbearing complete or progression of disease on endometrial sampling ([ENDO-1](#))

- Ovarian preservation may be considered in select patients who are premenopausal

TH/BSO with staging^{d,e} (preferred by 12 months) ([ENDO-1](#))

- Ovarian preservation may be considered in select patients

Comment ?

- **Critères de succès**



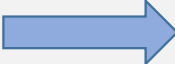
2 biopsies à 3 mois d'intervalle négatives par HSC

- **Suivi par**

1/Examen clinique

2/Echographie pelvienne

3/HSC biopsie

 **chaque 3 mois**

Follow-up with maintenance treatment for patients willing or not willing to conceive immediately

- Two consecutive endometrial biopsies showing complete response with a minimal interval of 3 months are necessary to consider the success of the fertility-sparing treatment (Level of evidence IV, Grade C).
- The complete response is mandatory to consider follow-up with maintenance treatment until pregnancy is planned (Level of evidence II, Grade A).
- Clinical pelvic examination and US scan are recommended at every 3-month follow-up visit (Level of evidence IV, Grade B).

Durée du traitement

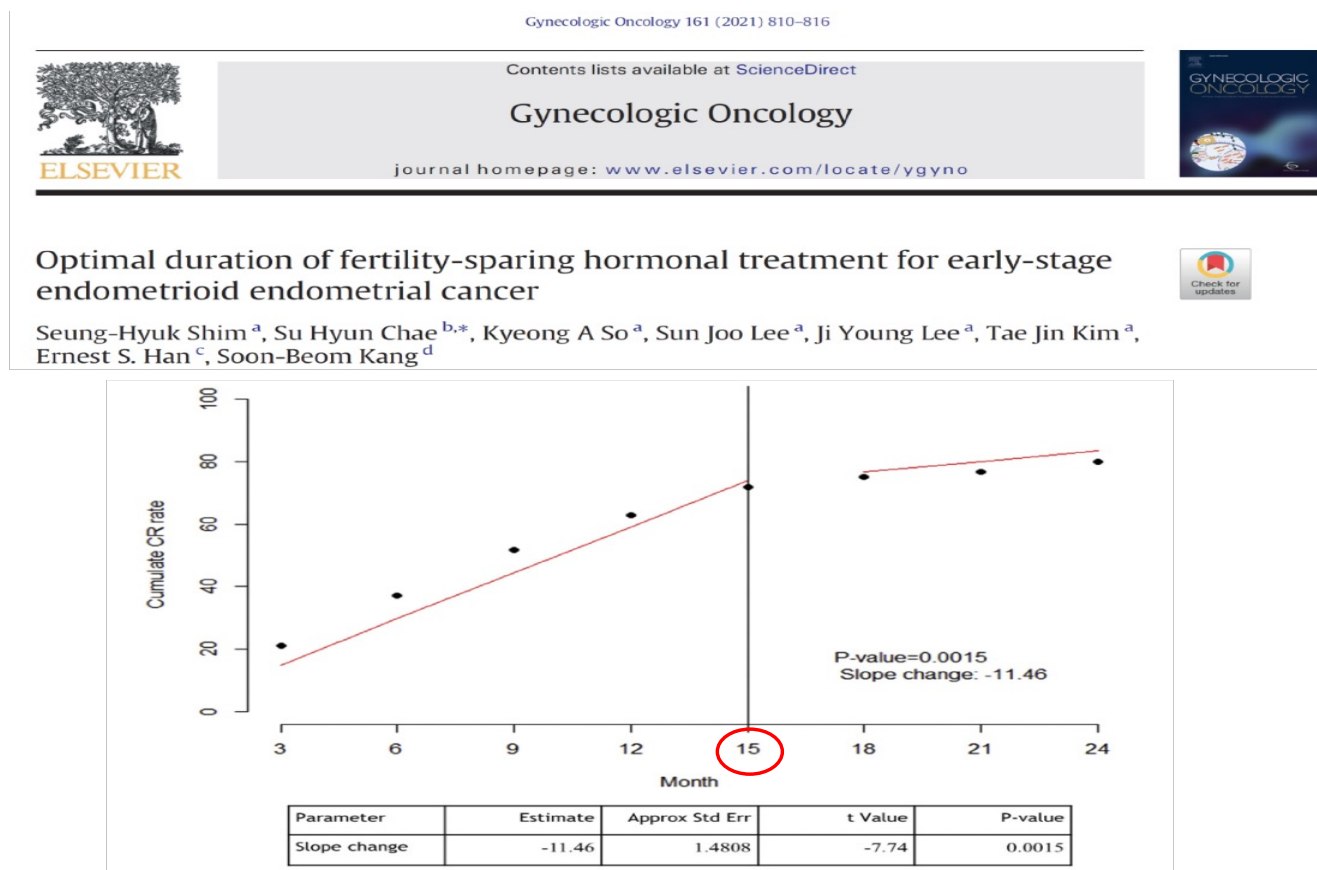


Fig. 3. Cumulative CR rates according to the timeline from the date of FST initiation. During the first 15 months of FST (first segment), the cumulative CR rate was increasing from 13.1% to 73.8%. From 18 to 24 months of FST (second segment), the cumulative CR rate was increasing from 77.0% to 83.6%. In segmented regression analysis, the slope was significantly different between the two segments (slope change = -11.46 , $P = 0.0015$). FST, fertility-sparing treatment; CR, complete response.

Comment ?



Duration of treatment

- The recommended duration of therapy is 6–12 months, within which a complete response should be achieved (Level of evidence III, Grade B).
- The maximum time to achieve complete response should not exceed 15 months (Level of evidence IV, Grade C).
- In the absence of any kind of response at 6 months, multidisciplinary counselling is recommended for adapting the management on a case-by-case basis (Level of evidence IV, Grade B).

Durée Maximum de Traitement:



15 mois pour avoir une rémission complète

Si Absence de Réponse au bout de 6 mois
Une RCP est recommandée

Cas Clinique : suite

Patho : perte **MSH 6**

Consultation en génétique : syndrome de **Lynch**

Écho de contrôle après 12 mois : EE = 7 mm,
Mirena en place

HSC de contrôle après 12 mois : endomètre
aspect normal

Biopsie : ADK End persistant



Image créée à partir de ChatGPT5

Question 6 : Quelles sont les options devant cet échec de traitement médical ?

- 1- Ajouter un autre progestatif**
- 2- Ajouter un inhibiteur de l'aromatase**
- 3- Traitement de l'obésité**
- 4- Hystéroscopie**

Original Article

LNG-IUS combined with progesterone ameliorates endometrial thickness and pregnancy outcomes of patients with early-stage endometrial cancer or atypical hyperplasia

Fang Fang^{1*}, Hao Xu^{2*}, Ling Wu¹, Linyi Hu¹, Ying Liu¹, Yinnan Li¹, Chunhua Zhang¹

Progestatif per os + DIU-LNG

Table 2. Comparison of efficacy in patients after treatment

Efficacy	Early-stage endometrial carcinoma				
	Complete remission (CR)	Partial remission (PR)	Stable disease (SD)	Progressive disease (PD)	Total effective rate
The control group (n=25)	15 (60.0)	3 (12.0)	5 (20.0)	2 (8.0)	18 (72.0)
The combination group (n=31)	27 (87.1)	2 (6.4)	2 (6.4)	0	29 (93.5)
χ^2/t					4.7641
P-value					0.0291
Efficacy	Atypical endometrial hyperplasia				
	Complete remission (CR)	Partial remission (PR)	Stable disease (SD)	Progressive disease (PD)	Total effective rate
The control group (n=20)	11 (55.0)	3 (15.0)	6 (20.0)	1 (5.0)	14 (70.0)
The combination group (n=27)	23 (85.2)	2 (7.4)	2 (7.4)	0	25 (92.6)
χ^2/t					4.1521
P-value					0.0416

Efficacité des traitements



**Cochrane
Library**

Cochrane Database of Systematic Reviews

Fertility-sparing treatment for atypical endometrial hyperplasia and endometrial cancer (Review)

Fernandez-Montoli ME, Sabadell J, Contreras Perez NA, Verdaguer Menéndez-Arango P, Julia Torres C, Lleberia J

Oral + DIU :
**pas de bénéfice supplémentaire
démontré**

Traitement de l'obésité

Les 3 piliers du traitement de l'obésité

Intervention psychologique et comportementale

- Approche cognitive-comportementale
- Gestion du sommeil, du temps et du stress
- Psychothérapie

Médication

- $IMC \geq 30$ (ou 27 si asiatique)
- Perte de poids
- Maintien de la perte de poids

Chirurgie bariatrique

- $IMC \geq 40$ OU ≥ 35 et ≥ 1 complication liée à l'obésité
- Consultation avec un chirurgien bariatrique quant au type de chirurgie optimal

Wharton et al, 2020

L'OBÉSITÉ CHEZ L'ADULTE

Guide de pratique clinique



L'IMC **N'EST PAS** UN OUTIL PRÉCIS POUR DÉPISTER LES COMPLICATIONS LIÉES À L'OBÉSITÉ

L'obésité est une maladie chronique complexe caractérisée par une accumulation anormale ou excessive de graisses corporelles qui est nuisible à la santé

Effets :

▼ santé ▼ qualité de vie ▼ espérance de vie

Les personnes vivant avec l'obésité font l'objet de préjugés et de stigmatisation en lien avec leur poids

→ Complications et mortalité accrues indépendamment du poids ou de l'IMC

Préjugés liés au poids Croire que les personnes vivant avec l'obésité manquent de volonté ou ne coopèrent pas
Stigmatisation Agir en fonction de croyances liées au poids

PARCOURS DU PATIENT ET GESTION DE L'OBÉSITÉ



-10%... On atteint ça comment ?

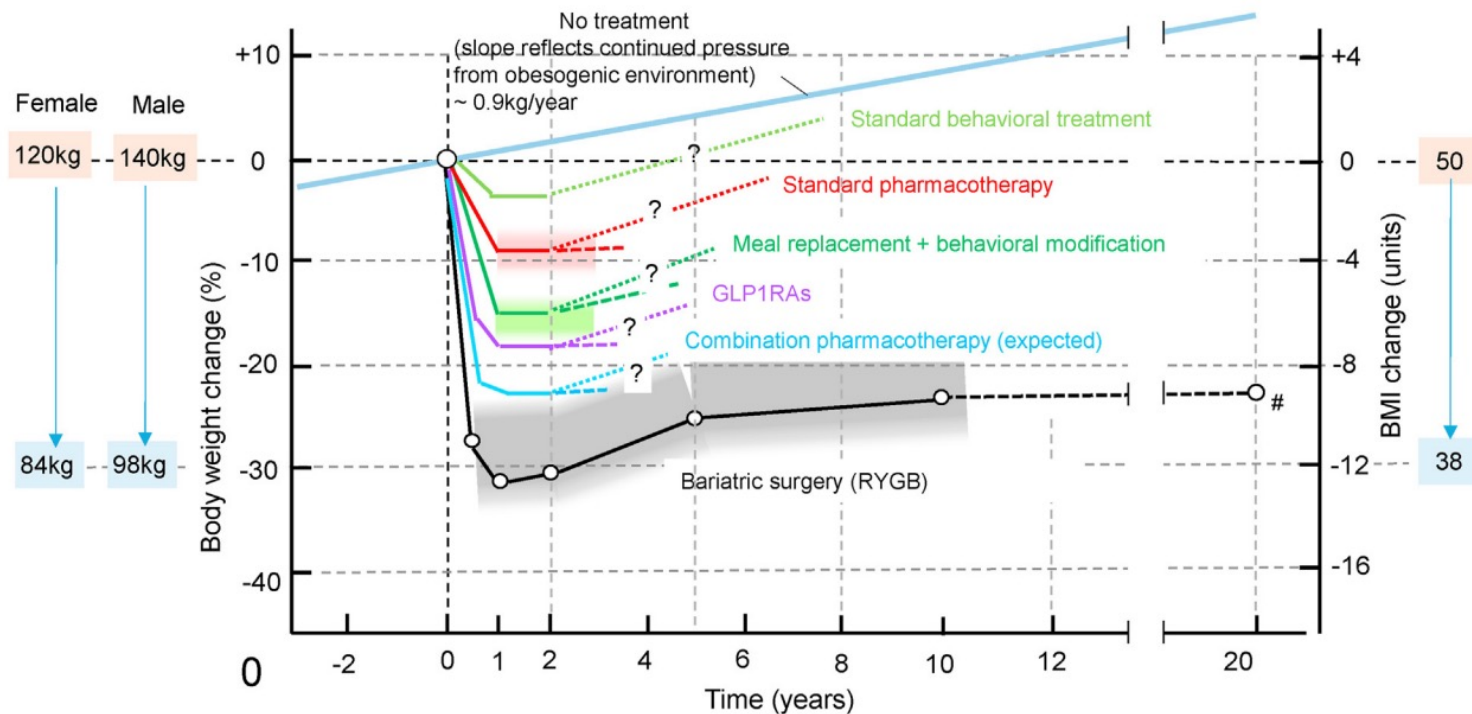


Figure 1: Comparative effectiveness of obesity treatments over time. Expected average changes in body weight and BMI of hypothetical male and female obese patients at age 40 over 20 years either untreated or treated with standard behavioral techniques and lifestyle changes (light green) in combination with standard anti-obesity drugs (red), hypocaloric diets (green), glucagon-like peptide receptor agonists (GLP1RAs, purple), combination pharmacotherapy (blue), or bariatric surgery (black). Based on non-systematically selected, mostly RCT studies. Note that except for bariatric surgery, most studies were limited to less than 3 years follow-up and typically show weight regain after cessation of interventions.

GnRH / Inhibiteurs de l'aromatase

ORIGINAL STUDY

Gonadotropin-Releasing Hormone Agonist Combined With a Levonorgestrel-Releasing Intrauterine System or Letrozole for Fertility-Preserving Treatment of Endometrial Carcinoma and Complex Atypical Hyperplasia in Young Women

Huimei Zhou, MD, Dongyan Cao, MD, Jiaxin Yang, MD, Keng Shen, MD, and Jinghe Lang, MD

International Journal of Gynecological Cancer • Volume 27, Number 6, July 2017

TABLE 2. Response to GnRHa combination treatment

	No.	CR	PR	SD	PD	Recurrence	CR %
Total	29	27	1	1	0	2	93.1
CAH	12	12	0	0	0	1	100
EC	17	15	1	1	0	1	88.2

SD, stable disease; PD, progressive disease.

TABLE 3. Treatment and outcome

Variable	CAH (n = 12)	EC (n = 15)	P
Time to remission, mo	3.3 ± 0.9	4.1 ± 1.4	0.017
Time to CR, mo	4.5 ± 1.9	5.0 ± 2.9	0.242
3 mo, n %	50.0%	26.7%	1.000
6 mo, n %	25.0%	33.3%	1.000
9 mo, n %	25.0%	33.3%	1.000

Analogues GnRH $\pm$ Letrozole

- schémas émergents (GnRH-a + letrozole ou LNG-IUD) ;
- essai randomisé multicentrique en cours (Liu Q. Trials 2024).

Liu et al. *Trials* (2024) 25:578
<https://doi.org/10.1186/s13063-024-08414-0>

Trials

STUDY PROTOCOL

Open Access

GnRH-a-based fertility-sparing treatment of atypical endometrial hyperplasia (AEH) and early endometrial carcinoma (EC) patients: a multicenter, open-label, randomized designed clinical trial protocol



Qian Liu¹, Huimei Zhou^{1*}, Mei Yu¹, Dongyan Cao^{1*} and Jiaxin Yang¹

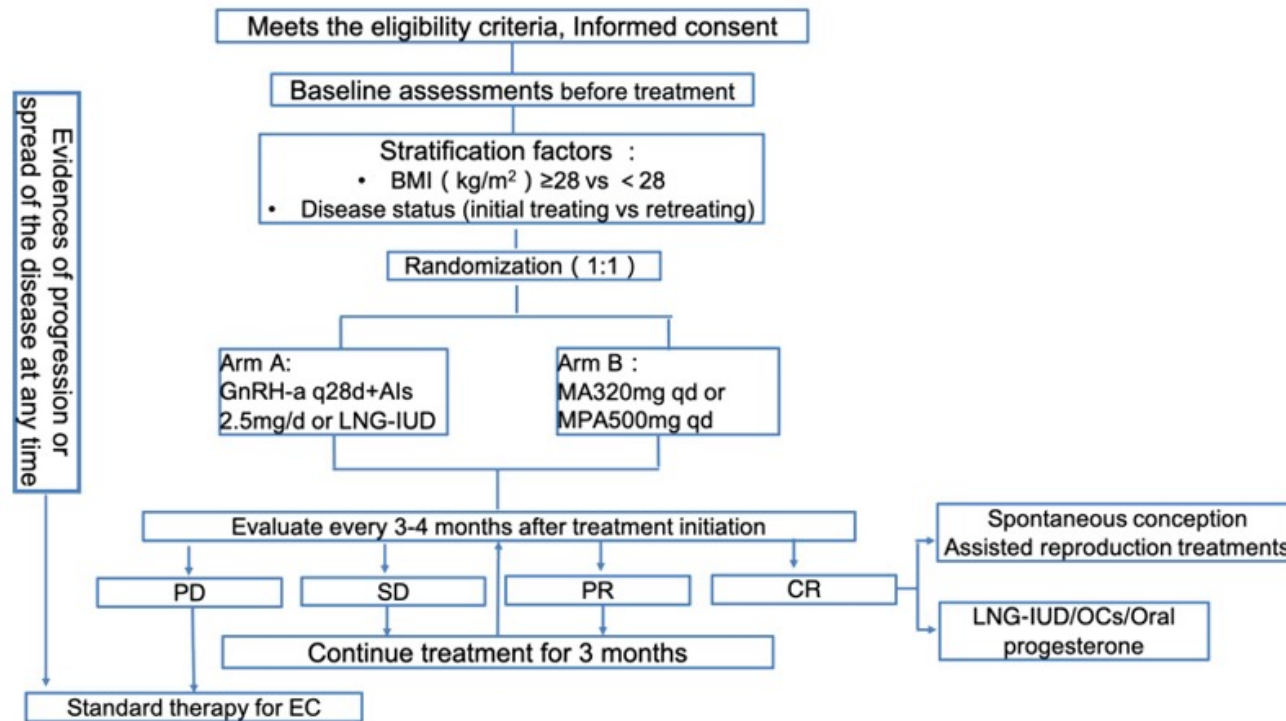


Fig. 1 Trial design

STUDY PROTOCOL

Open Access



GnRH-a-based fertility-sparing treatment of atypical endometrial hyperplasia (AEH) and early endometrial carcinoma (EC) patients: a multicenter, open-label, randomized designed clinical trial protocol

Qian Liu¹, Huimei Zhou^{1*}, Mei Yu¹, Dongyan Cao^{1*} and Jiaxin Yang¹

- **Evaluation à 12 semaines:**

Le groupe traité par protocole GnRH associé à letrozole ou à un stérilet SIU LNG a atteint un taux de RC de 71.4% VS 37% pour le groupe sous progestatifs

- **Evaluation à 24 semaines**

L'écart s'accroît avec un taux de RC de 97% à 98.5% contre 68.7% à 77.8%

Une prise de poids plus faible

Un taux de grossesse de 53.1 % chez les patientes ayant exprimé le désir de concevoir

Immunothérapie (anti-PD-1/PD-L1)

- intégration en néoadjuvant/conservateur pour patientes dMMR
- réponses pathologiques marquées
- Eerkens AL et al., Nature Commun. 2024

Article

<https://doi.org/10.1038/s41467-024-52098-8>

Neoadjuvant immune checkpoint blockade in women with mismatch repair deficient endometrial cancer: a phase I study

Received: 23 February 2024

A list of authors and their affiliations appears at the end of the paper

Accepted: 26 August 2024

Immunothérapie (anti-PD-1)



- Taux de RC clinique de 80 %
- les patientes atteintes d'un cancer de l'endomètre résécable dMMR/MSI-H
- Aucune récurrence n'a été observée lors du suivi
- l'essai est actuellement en phase II
- Cet essai explore le blocage de PD-1 comme alternative potentielle à la chirurgie et à la chimiothérapie, notamment chez les patientes présentant des comorbidités ou souhaitant préserver leur fertilité.

[Home](#) > [Conference](#) > [SGO Annual Meeting](#)

[News](#) | [Articles](#) | March 15, 2025

Nivolumab Yields High Clinical CR Rates Allowing for Surgery Omission in dMMR/MSI-H Endometrial Cancer

Author(s) [Megan Hollasch](#)

La Grossesse



Quand ?:

le plutôt possible risque de récurrence
++++

Délai de 6 à 9 mois afin de concevoir
sans recours à AMP

AMP si pas de grossesse ou d'emblée

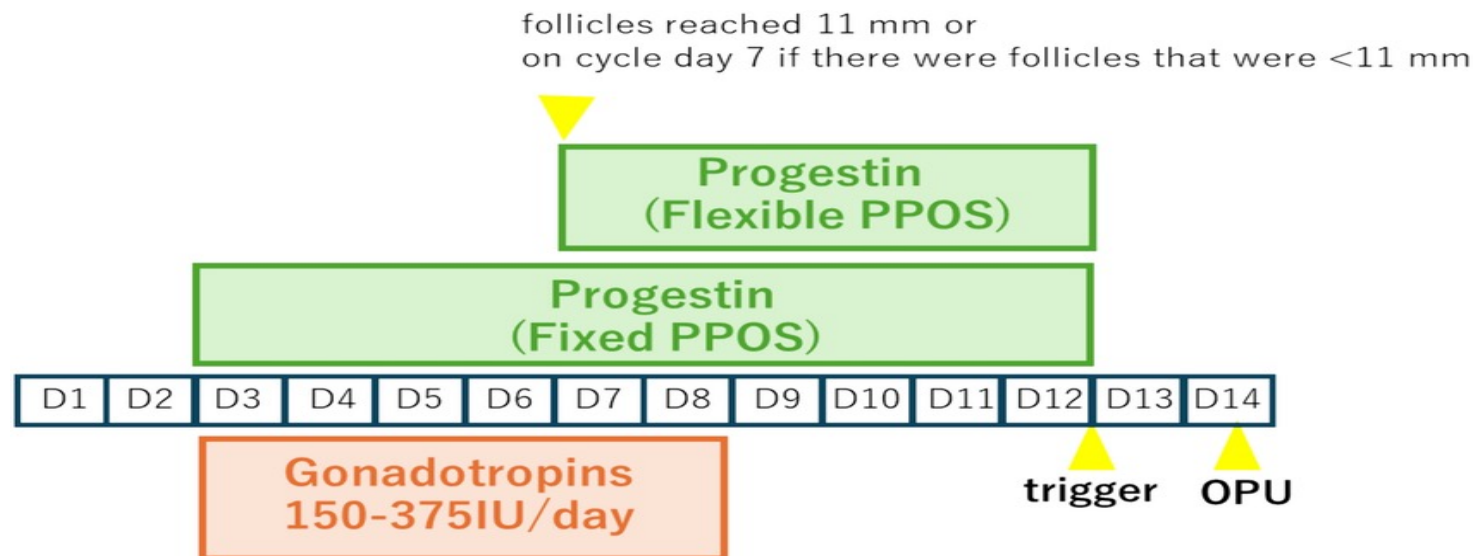
Pregnancy

- Women undergoing fertility-sparing treatment for endometrial hyperplasia or endometrial carcinoma should be encouraged to actively aim to conceive as soon as the complete response is achieved (Level of evidence V, Grade B).
- ART should be considered in order to improve success rate and reduce the interval to conception without a higher risk of recurrence (Level of evidence III, Grade B). However, natural conception may be considered in women with good reproductive potential within a defined time (6–9 months) (Level of evidence V, Grade C).
- Close surveillance by a multidisciplinary team should be continued and maintenance therapy with a levonorgestrel-intra-uterine device should be recommended to women who decline surgery after delivery and who do not plan their second pregnancy immediately after the first one (Level of evidence III, Grade B).

Grossesse... Comment ?

PPOS (Progestin-Primed Ovarian Stimulation) IVF

- Progestérone orale pour supprimer l'activité hypophysaire
- Réduit le nombre d'injections quotidiennes
- Minimise l'exposition à des taux hormonaux supra-physiologiques
- Tous les embryons doivent être congelés en raison des effets potentiels de la progestérone sur l'endomètre



Diagnostic pré-implantatoire

Pour les porteurs de mutations, un test génétique préimplantatoire pour les maladies monogéniques (**PGT-M**) peut être considéré afin de prévenir la transmission des variants pathogènes associés au **syndrome de Lynch**

Pronostic oncologique

- **La survie sans maladie** semble améliorée chez les femmes ayant conçu par rapport à celles n'ayant pas conçu
 - ✓ Ceci suggère qu'une grossesse pourrait être associée à une meilleure survie sans maladie
- **La mortalité** liée au traitement conservateur du cancer de l'endomètre est faible et reste comparable à celle de l'hystérectomie primaire

Traitement Radical

- Si Absence de Réponse
- Si échec de grossesse
- Récidive
- Après accouchement

2ème approche du traitement conservateur est envisageable au cas par cas pour les femmes désireuses de préserver la fertilité

Definitive and completion surgeries

- Definitive surgery is recommended in cases of non-responders, inability to conceive, recurrence or disease progression (Level of evidence II, Grade A).
- For patients with a strong desire to preserve fertility, a second conservative approach can be considered on a case-by-case basis (Level of evidence IV, Grade B).
- Completion surgery is recommended after completing childbearing (Level of evidence II, Grade A).
- Removal of ovaries should be considered on a case-by-case basis (Level of evidence III, Grade B).



Messages clés



« La prise en charge conservatrice du cancer de l'endomètre devient de plus en plus **personnalisée** : non seulement sur la fertilité, mais aussi sur le **profil moléculaire**, le **métabolisme**, et l'**immuno-profil** de la tumeur. »



Les essais 2024-25 ouvrent la voie à des combinaisons hormonothérapie + immunothérapie et à une adaptation fine du choix thérapeutique. »



MERCI!



36^{ème} Congrès National de la STGO

5,6 et 7
Novembre
2026

Thèmes :

- | | |
|--------------------------------------|---------------------------|
| 1- Foetopathies infectieuses | 6- Groupe de travail STGO |
| 2- Insuffisance ovarienne prématurée | 7- Greffe utérine |
| 3- STGO-FEFOG | 8- Thérapies fœtales |
| 4- Pathologie Cervicale | 9- AMP |
| 5- Endométriose | |