Reply to "The routine use of progestins might be a good choice for patients with recurrent low-grade endometrial stromal sarcoma after definite surgery"

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Dear Editor,

First, we thank Dr. Li for his interests,[1] positive comments, and constructive queries on our study entitled "Hormone therapy following surgery in low-grade endometrial stromal sarcoma: Is it related to a decrease in recurrence rate?",[2] and for opportunity to respond to the issues. Low-grade endometrial stromal sarcoma (LGESS) is an extremely rare kind of tumor. Because of its rarity, there are no large scale studies focused on only LGESS. Our study included retrospective data between 1985 and 2016. Twenty-three patients underwent adjuvant therapy in this long period. The information about background of those is shown in Table. Besides the changes in approaches to LGESS, the International Federation of Gynecology and Obstetrics (FIGO) stage structures of ESS also changed in the course of time. Therefore, treatment distribution was various and decisions about the use of adjuvant therapy and the adjuvant therapy regime following surgery were made by the senior surgeon and the gynecologic oncology counsel within 30 years in our clinic as mentioned in the Methods section. The remarkable result of our study is that none of the patients treated with hormone therapy following surgery had recurrence, whereas recurrence occurred in 38.5% of the patients who underwent surgery only (p = 0.039). Furthermore, although most of the patients had early stage disease by nature of the LGESS, there was not a significant difference in the distribution of disease stage between the patients who underwent surgery with and without hormone therapy (p = 0.432).

Table

Stage distribution of the patients who received adjuvant therapy

Adjuvant therapy type	The revised FIGO 2009 stage
CT + HT	3C (n:1)
HT	1A (n:5), 1B (n:3), 2B (n:1), 3A (n:1), 3B (n:1), 3C (n:1)
CT	1 [n:6 ⇒ NS (n:4), 1A (n:1), 1B (n:1)]; 3A (n:1)
RT	2A (n:1), 2B (n:1), 3C (n:1)

CT = chemotherapy; HT = hormone therapy; NS = not specified; RT = radiotherapy.

Prognosis of LGESS is shown generally good; however, the recurrence rate was reported as 24% to 50%.[3] As highlighted in editor letter, the surgery and hormonal therapy was the dominant treatment type in recurrence management and the response rate was high. In the literature, despite of the low 5-year disease-free survival (DFS) that was reported as 66% to 93%, disease-specific survival (DSS) was reported above 95%.[4] In our study, the overall 5-year DFS and 5-year DSS rates were 72% and 97%, respectively, as reported earlier. Although hormone therapy following surgery was seen as a viable option for women with recurrent LGESS, we could not reach a distinct conclusion about this issue due to the small sample size of the recurrent patients for making subgroup analysis. Large scale studies are needed to draw conclusion in this topic.

In the literature, the incidence of lymph node metastasis among all patients with LGESS who undergo lymphadenectomy is 7% to 30%, versus 5% (range: 0% to 16%) in those with clinically apparent early stage disease.[5] The rate of lymph node metastasis was 14.3% (n=3) among the patients who underwent lymphadenectomy in our study. As mentioned, the recurrence rate was lower in patients who underwent lymphadenectomy; however, we could not show statistical significance (14.3% vs. 46.7%, p = 0.058). Therefore, the outcomes of the lymphadenectomy are still unclear. In our study, the recurrence pattern was not different between patients treated with and without lymphadenectomy.

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