however, overestimate endometrial risk in 5 patients (4 false-positive diagnoses of atypical cells, 1 false-positive diagnosis of cancer).

Endometrial cytology appears to be a promising method for endometrial monitoring although further studies are needed to evaluate the ideal timing of endometrial cytological sampling, the duration of monitoring, the approach to be adopted with elderly patients and the usefulness of other cytological sampling methods (lavage, aspiration). The approach to adopt in cases of cervical stenosis is not yet defined.

European Journal of Cancer, Vol. 34, Suppl. 4, p. S39, 1998

Printed in Great Britain
0959-8049/98$—see front matter

PII: S0959-8049(98)00106-3

III.8 Tamoxifen and Endometrial Cancer: How Should We Screen?

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THE NON-STEROIDAL anti-oestrogen tamoxifen has certain F.D.A. approved indications in the US. These are as follows:

(1) The treatment of postmenopausal women with advanced breast cancer.
(2) Adjuvant therapy in postmenopausal breast cancer with resected node positive disease.
(3) Postmenopausal women with metastatic breast cancer.
(4) Adjuvant therapy in women (pre- and postmenopausal) with resected node negative breast cancer.

It is known that tamoxifen with its mixed agonist and antagonist actions can promote the development of a second primary neoplasm in the uterine endometrium of women with breast cancer. The increased endometrial cancer risk is dose- and time-dependent and the risk appears to exceed the age-dependent increase in endometrial cancer that is known to affect women with breast cancer. This risk is 2–3 times higher than age-matched controls and it appears that treatment at a higher dose of tamoxifen (40 mg per day) gives rise to a higher grade and stage risk of endometrial cancer. In February 1996 the American College of Obstetricians and Gynaecologists (ACOG) issued recommendations regarding the use of tamoxifen. There can be little doubt that the benefits of tamoxifen far outweigh the risks of taking it, but the question does arise as to whether chemoprevention as prophylaxis of high-risk women should be encouraged. Although hyperplastic lesions are relatively frequent it does appear that these seldom develop into invasive cancers of the endometrium.

The ACOG recommendations are as follows:

(1) Women should have an annual gynaecological examination with cervical smear and a vaginal and recto-vaginal examination.
(2) Any abnormal bleeding or discharge should be fully evaluated.
(3) That medical practitioners should be alerted to the increased risk of endometrial cancer.
(4) All women that are entered into chemoprevention studies should be carefully monitored.
(5) If atypical endometrial hyperplasia develops then the tamoxifen should be stopped.
(6) If this is the case but tamoxifen is deemed to be essential in the management of the breast cancer then hysterectomy should be carried out.
(7) Subsequently tamoxifen may be restarted following hysterectomy for endometrial carcinoma.

The use of tamoxifen has clearly become a major factor in the increasing number of gynaecological referrals. There was a need to standardise the monitoring of such patients and of their further investigation. At the same time a decision needs to be taken on the place of oestrogen and other hormone replacement therapy in patients already being treated with tamoxifen for their breast cancer.

1. ACOG Committee on Gynecologic Practice. Tamoxifen and Endometrial Cancer. Feb 1996, **53**, 197–199.

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