

therapy is contra-indicated for problems with metabolism. Another more recent indication for endometrial ablation is endometrial hyperplasia in the perimenopausal age, without cellular atypias. Presurgical assessment must include diagnostic hysteroscopy and an endometrial biopsy, in order to check for malignancies. Many techniques can be used to perform endometrial ablation. We prefer the resectoscope, because of its low cost, the speed of the procedure, and the fact that it permits the histological examination of samples in every patient.

Effective endometrial ablation requires the complete destruction of the endometrium with the preservation of the isthmic area, where there is non-functional endometrium which can recolonize the entire cavity in 1 or 2 months without a real functional response; this type of endometrium prevents the formation of adhesions. Possible complications of the procedure are intra or post-operative bleeding, uterine perforation and intracavitary adhesions; in practice, the incidence of such complications has been extremely low. To sum up, endometrial ablation is a valid alternative to hysterectomy in many cases of AUF in perimenopausal women.

In conclusion, hysteroscopic surgery offers many advantages: short hospitalisation, rapid recovery, low costs, less discomfort for the patients and very often better results than traditional abdominal surgery^(1, 2, 3).

The authors would like to stress that a good training in diagnostic hysteroscopy and general surgery are essential for anyone wishing to perform operative hysteroscopy.

REFERENCES

- 1) Hamou J.E., Mencaglia L., Perino A., Gilardi G.: "L'elettroresezione en hysteroscopie et microcolpohysteroscopie operative". In: 'Isteroscopia operativa e laser chirurgia in ginecologia'. Cittadini E., Scarselli G., Mencaglia L., Perino A., Roma, CIC Edizioni Internazionali Publisher, 1988, p. 31.
- 2) Baggish M.S., Barbot J., Valle R.F.: "Diagnostic and operative hysteroscopy". A Text and Atlas, Year Book Medical Publishers, Inc., 1989.
- 3) Siegler A.M., Valle R.F., Lindemann H.J., Mencaglia L.: "Therapeutic Hysteroscopy Indications and Techniques Mosby Company. St. Louis, 1990.

MICROCARCINOMA OF THE CERVIX: DIAGNOSIS AND TREATMENT

S. COSTA (*) - G. MARTINELLI (**) - L. MARTELLINI (*) - P. TERZANO (*)
G. COMERCI (*) - C. ORLANDI (*)

University of Bologna

(*) II Dept. of Obstetrics and Gynecology - (**) Institute of Pathology

Over the years microinvasive carcinoma of the cervix has been regarded by pathologists and clinicians under many headings and no unanimously accepted definition exists to date. This lack of uniformity in the classification accounts for the still debated problem of therapeutic approach in the microinvasive lesions.

Since 1960 the FIGO Committee has changed more than once its criteria to define Stage IA carcinoma achieving in 1985 the ultimate definition that adopts the subdivision into Stage IA1 and Stage IA2. However, the validity of such a staging classification does not meet a unanimous consensus since it appears not precise enough to guide the clinician in the treatment of earliest forms of invasive cancer. Conversely, some investigators accept as more or less workable the definition proposed by the Society of Gynecologic Oncologists (SGO). These confounding problems leave some concerning questions unsolved: what constitutes the onset of invasion and determines the metastatic potential; which is the significance of histomorphologic variables and how they can influence the outcome of therapy.

In this report 51 patients affected by microinvasive carcinomas with a follow-up of at least 5 years, were retrospectively analyzed. Treatment modalities included conization in 9 patients, removal of the cervical stump in 1, hysterectomy in 23 patients (3 had also lymphadenectomy) and radical hysterectomy plus lymphadenectomy in 18 cases.

Emphasis was given to the preoperative assessment of microcarcinoma, underlining how a presumptive diagnosis can be achieved by the combination of cytology, colposcopy evaluation and histologic examination of colposcopically directed biopsies. However, it is advisable to proceed with conization of the cervix to assess the presence of a microinvasive carcinoma. In our series conization was performed in 9 cases and histological diagnosis was consistent with 1 high grade SIL, Stage IA2 microcarcinoma with negative cone margins and 7 Stage IA1 lesions of which 4 had positive margins. Of these 9 patients, 4 had no further treatment. Of the other 5 patients, in one case conization was repeated and diagnosis of Stage IA1 with negative cone margins was made. 3 patients with Stage IA1 carcinoma showing "non in sano" margins and 1 with Stage IA2 microcarcinomas underwent hysterectomy and microscopic examination did not show any residual disease. Status of cone margins seems to be a relevant parameter in selecting patients for conservative therapy.

Tumor histotype appears of no importance in the prognosis of the lesion. Conversely, tumor grade correlated with depth of stromal invasion. Microscopic lymph-vascular invasion was related to depth of stromal invasion being absent in Stage IA1 cases and evident in 7 of 30 Stage IA2 microcarcinoma.

There were lymphnode metastases in 2 of the 21 patients with dissected nodes (9.5%) and they were present in patients with Stage IA2 lesion.

Recurrences occurred in 3 patients with Stage IA2 microcarcinoma and lymph-vascular involvement. Two of these had also lymphnode metastases and died of disease. Available data from the literature, as well as our experience, identify depth of invasion as a variable strongly related to lymphnode metastases and recurrences.

The treatment of microcarcinoma of course, is intended to satisfy the need of reducing the morbidity due to a radical therapeutic approach while attaining complete cure. Although other and our reports do not provide unquestionable proof that a specific therapeutic measure is the most appropriate one, some recommended guidelines for behaviour may be suggested.

In Stage IA1 microcarcinoma, non radical therapy may be safely performed. Caution should be exercised in Stage IA2 microcarcinoma and lymph-vascular involvement should be meticulously evaluated. Lesions of < 3 mm depth of invasion without lymph-vascular involvement might be treated by simple hysterectomy. In any of the other lesions that fall into the Stage IA2 category, radical or modified radical surgery with pelvic node dissection appears mandatory.

PERSONAL EXPERIENCES WITH EXENTERATIONS IN PATIENTS WITH GYNECOLOGIC MALIGNANCIES

H. G. BENDER
Frankfurt, Germany

While exenterations have been widely performed in centers for gynecologic oncology in the United States the acceptance of this procedure has been considerably less in European Countries.

Frequently arguments have been used against exenterations claiming that these procedures are dangerous and connected with a high mortality and morbidity, ineffective and mutilating.