

Lymph node status (Core)

The anatomic location and number of lymph nodes dissected, the number containing tumour and the size of the largest tumour deposit should be accurately documented in the pathology report. According to TNM8,¹ nodal involvement should be recorded as the presence of isolated tumour cells (ITC, <0.2 mm), micrometastases (MIC, 0.2-2 mm) or macrometastases (MAC, >2 mm). MAC are regarded as pN1, MIC as pN1 (mi) and ITCs are pN0 (i+); ITCs do not upstage a neoplasm. Involvement of pelvic and/or para-aortic lymph nodes by uterine sarcoma will upstage the sarcoma. The number of lymph nodes examined and number of lymph nodes involved by tumour should be reported for regional lymphadenectomies, if performed.

Because of the low risk of metastatic disease in lymph nodes, routine lymph node dissection is typically not undertaken in low stage uterine leiomyosarcomas.²⁻⁴ Moreover, lymphadenectomy is not routinely undertaken for uterine leiomyosarcoma as it does not appear to impact overall survival.⁴⁻⁶ Nevertheless, lymph node resection should be performed if the lymph nodes appears enlarged or suspicious.⁷ The reported frequency of lymph node involvement in low grade endometrial stromal sarcomas ranges from 3.6% to 10%,⁸⁻¹⁰ and from 10.2% to 44% for high grade endometrial stromal sarcoma.^{8,11} The prognostic importance of lymphadenectomy for endometrial stromal sarcomas has been a subject of debate,^{9,12-15} although a recent meta-analysis concluded that for localised endometrial stromal sarcoma and leiomyosarcoma, lymphadenectomy is not recommended.⁶

Lymph node metastasis is a significant prognostic factor in uterine adenocarcinoma.¹⁶ However, lymphadenectomy is not typically performed unless lymph nodes appear enlarged and/or suspicious as the rate of nodal metastasis is low (6.5%).¹⁷

References

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