Abstract

Endometriosis is a common condition in women of reproductive age. According to several epidemiological studies endometriosis may be associated with increased risk of various malignancies. However, endometriosis-associated malignancy (EAM) is defined by certain histological criteria. About 80% of EAM have been found in the ovary, whereas 20% are localized in extragonadal sites like intestine, rectovaginal septum, abdominal wall, pleura and others. Some authors suggest that EAM arise from atypical endometriosis as an intermediate lesion between endometriosis and cancer. Moreover, a number of genetic alterations, like loss of heterozygosity (LOH), PTEN, ARID1A and p53 mutations have been found in both endometriosis and EAM. Endometriosis-associated ovarian cancer (EAOC) is mostly a well or intermediate differentiated tumor of endometroid or clear cell histological sub-type. Women affected by EAOC are on average five to ten years younger than non-EAOC patients; in most of the cases EAOC is a low stage disease with favorable clinical outcome. Since EAM is a rare condition systematic data on EAM are still missing. A systematic retrospective study on endometriosis-associated malignancies (EAM study) is currently being conducted by the Endometriosis Research Foundation together with the study groups on ovarian and uterine tumors of the working group for gynecological oncology (AGO) (gyn@mlk-berlin.de).

Zusammenfassung

Endometriosis and Cancer Risk – Epidemiological Data

According to several epidemiological studies endometriosis is associated with increased risk of various malignancies with the best evidence for ovarian cancer [6–18]. Furthermore, a number of cohort and case control studies demonstrated an epidemiological association of endometriosis with endometrial cancer, breast cancer, colorectal cancer, non-Hodgkin lymphoma and others [8, 19, 20]. The clinical significance of the association between endometriosis and non-gynecologic malignancies is poorly understood [21].

The majority of the published studies on endometriosis-associated ovarian cancer have reported that ovarian cancer (OC) risk among endometriosis patients is moderately increased (RR, SIR or OR 1.32–1.92) (Table 1). The strongest association between OC and endometriosis was reported by Brinton et al. (SIR = 2.48) [8], Stewart et al. [22] (HR = 2.33) and Buis et al. [23] (HR = 12.4); interestingly, these three studies included only women suffering from infertility, which may be a potential confounding factor for their results. Moreover, a remarkably high increase of ovarian cancer risk (SIR = 8.95) has been demonstrated by Kobayashi et al. [24]. In their retrospective cohort study ovarian cancer risk was analysed in women with sonographically diagnosed endometriomas based on time periods from first diagnosis of endometrioma to first diagnosis of ovarian cancer. Since endometriomas were histologically confirmed in only one-third of the cases, whereas the majority of diagnoses was made based on ultrasound image, the ovarian cancer risk has been possibly overestimated in this analysis: some of ovarian cysts identified as endometriomas might have in fact been ovarian cancers. In summary, there are a number of epidemiological studies, in which at least a modest association between endometriosis and ovarian cancer has been consistently demonstrated. Despite epidemiological evidence, a direct causal association between endometriosis and ovarian cancer has not been elucidated so far [25].

Histological Findings

The histological link between endometriosis and cancer has first been postulated as early as 1925 [26]. Sampson et al., based on microscopic observations, speculated that endometrial ovarian cancers may develop from endometriotic tissue and described the criteria for diagnosis of endometriosis-associated OC: (1) evidence of endometriosis close to the tumor, (2) exclusion of invasion from other sources, (3) presence of tissue resembling endometrial stoma surrounding characteristic epithelial glands [26]. Scott et al., in their analysis from 1953, added a fourth criterion:

**Table 1** Epidemiological studies on association between endometriosis and ovarian cancer.

<table>
<thead>
<tr>
<th>Author</th>
<th>Type of study</th>
<th>Number of endometriosis cases</th>
<th>Number of cancer cases</th>
<th>Number of controls</th>
<th>OR, SIR, HR or RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brinton 1997 [8]</td>
<td>cohort</td>
<td>20686</td>
<td>29</td>
<td>1.92 (1.3–2.8)</td>
<td></td>
</tr>
<tr>
<td>Ness 2000 [10]</td>
<td>case control</td>
<td>66 (85 CG)</td>
<td>767</td>
<td>1.7 (1.2–2.4)</td>
<td></td>
</tr>
<tr>
<td>Olson 2002 [12]</td>
<td>cohort</td>
<td>1392</td>
<td>3</td>
<td>0.78 (0.25–2.44)</td>
<td></td>
</tr>
<tr>
<td>Brinton 2004 [13]</td>
<td>cohort</td>
<td>12193</td>
<td>45</td>
<td>2.48 (1.3–4.2)</td>
<td></td>
</tr>
<tr>
<td>Borgenfeldt and Andolf 2004 [14]</td>
<td>nested case control</td>
<td>28163</td>
<td>81</td>
<td>1.34 (1.03–1.75)</td>
<td></td>
</tr>
<tr>
<td>Modugno 2004 [15]</td>
<td>cohort</td>
<td>177 (184 CG)</td>
<td>2098</td>
<td>1.32 (1.06–1.65)</td>
<td></td>
</tr>
<tr>
<td>Melin 2006 [16]</td>
<td>cohort</td>
<td>64992</td>
<td>122</td>
<td>1.43 (1.19–1.71)</td>
<td></td>
</tr>
<tr>
<td>Pearson 2012 [18]</td>
<td>case control</td>
<td>738 (818 CG)</td>
<td>7911</td>
<td>1.49 (1.24–1.65)</td>
<td></td>
</tr>
<tr>
<td>Stewart 2012 [22]</td>
<td>cohort</td>
<td>2978</td>
<td>38</td>
<td>2.33 (1.02–5.35)</td>
<td></td>
</tr>
<tr>
<td>Buis 2013 [23]</td>
<td>cohort</td>
<td>3657</td>
<td>34</td>
<td>12.4 (2.8–54.2)</td>
<td></td>
</tr>
<tr>
<td>Kok 2015 [20]</td>
<td>cohort</td>
<td>2266</td>
<td>13</td>
<td>4.56 (1.72–12.11)</td>
<td></td>
</tr>
</tbody>
</table>

CG: control group, RR: relative risk, OR: odds ratio, HR: hazard ratio, SIR: standardized incidence ratio

Abbreviations

- CCC: Clear cell carcinoma
- DFS: Disease-free survival
- EAM: Endometriosis-associated malignancy
- EAOC: Endometriosis-associated ovarian cancer
- HR: Hazard ratio
- LOH: Loss of heterozygosity
- OC: Ovarian cancer
- OR: Odds ratio
- OS: Overall survival
- PTEN: Phosphatase and tensin homolog
- RR: Relative risk
- SIR: Standardized incidence ratio

Introduction

Endometriosis is a common condition in women in which endometrium-like tissue is detected outside the uterine cavity [1]. The incidence of the disease in females of reproductive age is estimated at 5 to 15% [2]; the main symptoms are dysmenorrhea, pelvic pain and infertility [3]. Despite extensive research in this field, the exact pathogenesis of endometriosis remains not fully understood but one widely accepted hypothesis is the implantation of endometrial tissue in the peritoneal cavity due to retrograde menstruation [4]. Although endometriosis is considered a benign condition, it has been demonstrated to share some characteristics with malignant tumors such as tissue invasion and damage, neoangiogenesis or spread to distant organs [5]. Current knowledge about endometriosis-associated malignancies will be presented in this review.
(4) histological proof of transition from benign changes in endometriosis to malignant changes in cancer [27]; all four criteria are still in use to define an endometriosis-associated malignancy (EAM).

About 80% of EAMs are localized in the ovary, whereas extragonadal sites are affected in one-fourth to one-fifth of all cases [9, 28]. In two large reviews of endometriosis-related neoplasms (222 and 205 cases, respectively), extragonadal tumors were reported in 21–24% of women [29,30]. Since the malignant transformation can take place in every site affected by endometriosis, extragonadal EAMs can be found in the lower pelvis, gastrointestinal tract, abdominal wall, umbilicus, pleura and others [31]. The most common localisations of extragonadal EAMs are the recto-sigmoid, colon, rectovaginal septum and pelvic peritoneum; these sites are commonly involved by deep infiltrating endometriosis [31].

Based on histopathology and molecular features, ovarian cancers are divided into five main categories: high-grade serous, endometrioid, clear cell, mucinous, and low-grade serous carcinomas [32]. The most common subtype is the high-grade serous cancer (70%), followed by the endometrioid (10%) and clear cell (10%) type. Endometrioid and clear cell carcinomas usually present as low-stage disease; the former is typically well differentiated [33]. Endometriosis-associated malignancies are most commonly cancers of these two histologic subtypes, rarely other ovarian malignancy types like borderline tumors, endometrial stromal sarcoma or adenosarcoma [18, 25, 28, 31]. Recently published pooled analysis of case-controlled studies by Pearce et al. reported an increased risk for low-grade serous ovarian cancer among endometriosis patients as well (RR 2.11; 95% CI 1.39–3.20, p < 0.0001) [18]. No association between endometriosis and high-grade serous ovarian cancer or mucinous ovarian cancer has been reported to date [18,28].

Theories of Pathogenesis

There are two main theories which attempt to explain the origin of endometriosis-associated malignancies. According to a number of histopathological studies endometriosis-associated ovarian cancer (EAO) may arise from atypical endometriosis of the ovary [34,35]. This heterogeneous condition is histologically characterized by hyperplasia of endometrial glands with cytological atypia or presence of atypical hobnail cells within ovarian endometriosis [25, 36, 37]. A direct association between atypical endometriosis and ovarian cancer was first demonstrated by La Grenade and Silverberg in 1988 [34]; in five cases of ovarian cancer (three clear cell carcinomas and two endometroid carcinomas) accompanying atypical endometriosis was found in the ovary and in four out of five cases atypical changes were in contiguity with ovarian neoplasm [34]. Furthermore, a significantly higher rate of cytological atypia within endometriotic lesion was demonstrated in cases of EAO compared with endometriosis alone [38]. Although the hypothesis that atypical endometriosis may be a premalignant condition is supported by the fact that it can be detected in up to 80% of EAO, there are still not enough data proving this model [35,39,40].

According to the other theory endometriosis is not a real precancerous lesion, but there is an indirect link involving common environmental, histological, immunological and genetic factors. Several studies have demonstrated that microenvironment of endometriosis and EAO share similar mediators and cytokines [40, 41]. Whether EAM arise by malignant transformation of endometriotic cells through intermediary lesions (atypical endometriosis) or similarity of microenvironment represents a link between these both entities has not been definitely understood [40,42].

Genetic Alterations

In the last two decades, evidence has been accumulated that endometriosis-associated malignancies may arise within ovarian endometriomas. Possibly, periodic hemorrhage in ovarian endometriomas may lead to iron-triggered oxidative stress and thus induce genetic alterations. Yamaguchi et al. reported that the concentration of free iron in endometriotic cysts was over one hundred times higher than that in nonendometriotic cysts; the level of oxidative stress related markers, such as lactose dehydrogenase, and antioxidants was higher as well [43].

Accumulation of mutations in tumor suppressor genes and oncogenes is a crucial step during tumor development. Interestingly, numerous mutations in genes linked to carcinogenesis have been identified in endometriotic lesions [44–52]. Several studies have reported genetic aberrations in tumor suppression genes, such as p53 and PTEN, in endometriosis specimens [53–55]. Inactivation of DNA mismatch repair genes through hypermethylation has been observed in endometriotic tissue as well [53]. Furthermore, genetic alterations associated with tumorigenesis are encountered more frequently in benign endometriosis samples from patients with synchronous ovarian cancer than in tumor-free patients who were diagnosed with endometriosis alone. Prowse et al. performed microsatellite analysis in ten patients with ovarian cancer and coexisting endometriosis; the tumor and endometriosis samples were analysed for common molecular genetic alterations [56]. 63 events of loss of heterozygosity (LOH) were detected in cancer specimens; one-third of these was also identified in the corresponding endometriosis samples, suggesting that endometriosis might be a clonal precursor to a subtype of ovarian cancer. Hypothetically, endometriosis-associated and endometriosis-independent ovarian cancer may develop through different molecular pathways with distinct genetic alterations (Table 2).

Risk Factors

Several risk factors for EAM in patients with endometriosis have been reported to date. The size of endometrioma as well as postmenopausal status were demonstrated to be independent predictive factors for the development of ovarian cancer among endometriosis patients in the study by Kobayashi et al. [57]. In this prospective cohort trial which assessed the risk of ovarian cancer in 6398 women with ovarian endometriomas, tumor size ≥ 9 cm in diameter was shown to be associated with increased OC risk. However, as mentioned before, one of the limitations of this study is that endometriomas were diagnosed mostly by sonography, and therefore some of the larger tumors might in fact have been ovarian cancers [57]. Another risk factor for EAM is hyperestrogenism, both endo- and exogenous: in the study by Zanetta et al. obesity as well as therapy with unopposed estrogens after hysterectomy were shown to be a significant risk factor for the development of EAM [58]. Similar effects of estrogen were demonstrated by others [40]. On the other hand, hormonal contraception, childhood, tubal ligation or hysterectomy were found

References

triosis patients should, if indicated, receive a combined estrogen-
Conflict of Interest

None.

References

20 Sok VC, Tsai HJ, Su CF et al. The risks for ovarian, endometrial, breast, colorectal, and other cancers in women with newly diagnosed endometriosis or adenomyosis: a population-based study. Int J Gynecol Cancer 2015; 25: 968–976
26 Sampson JA. Endometrial carcinoma of the ovary arising in endome-trial tissue in that organ. Arch Surg 1925; 10: 1–72
27 Scott RB. Malignant changes in endometriosis. Obstet Gynecol 1953; 2: 283–289
33 McCluggage WG. Morphological subtypes of ovarian carcinoma: a review with emphasis on new developments and pathogenesis. Pathology 2011; 43: 420–432
43 Yumuguchi K, Mandai M, Toyokuni S et al. Contents of endometriotic cysts, especially the high concentration of free iron, are a possible cause of carcinogenesis in the cysts through the iron-induced persist-ent oxidative stress. Clin Cancer Res 2008; 14: 32–40


Davis M, Rauh-Hain JA, Andrade C et al. Comparison of clinical outcomes of patients with clear cell and endometrioid ovarian cancer associated with endometriosis to papillary serous carcinoma of the ovary. Gynecol Oncol 2014; 132: 760–766


Erzen M, Rakar S, Klimancik B et al. Endometriosis-associated ovarian carcinoma (EOAC): an entity distinct from other ovarian carcinomas as suggested by a nested case-control study. Gynecol Oncol 2001; 83: 100–108


Soliman NF, Hiliard TC. Hormone replacement therapy in women with past history of endometriosis. Climacteric 2006; 9: 325–335
