

Clinical Features of Uterine Tumors in Epithelial Ovarian Cancer

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DESCRIPTION

One of the most prevalent gynecological malignant tumors that can develop at any age is Ovarian Cancer (OC). The National Comprehensive Cancer Network (NCCN) recommends that surgery be the primary form of treatment for ovarian cancer, and that this be reserved for a select group of patients who have specific indications, such as those with early-stage ovarian cancer who wish to preserve their fertility or those who have low-risk malignant tumors (early epithelial ovarian cancer, low-grade malignant potential tumors, germ cell tumors, or malignant stromal tumors). This primarily takes into account the fact that ovarian cancer is distinguished by considerable dispersion in the abdominal cavity, which can metastatically expand through direct spread to surrounding tissues and organs, seeding dissemination, and lymph node metastases. Therefore, the most frequently affected organs are the uterus, fallopian tube, larger momentum, retroperitoneal lymph nodes, and other organs.

Hysterectomy is frequently carried out for both patients who have thorough staging surgery in the early stage and patients who undergo tumor cell reduction in the middle and late phases in order to achieve the goal of tumor reduction. However, some patients may receive a diagnosis of malignant ovarian tumors prior to childbearing, making severe surgery difficult for them to accept. This is due to the postponement of reproductive age. Also hysterectomy causes a variety of additional problems that negatively effect women's quality of life, as well as their physical and mental health. Patients who have has a hysterectomy will experience abnormal urination, defecation, and pelvic organ prolapse as a result of altered pelvic floor function. Additionally, it will affect women psychologically and lead to psychogenic sexual dysfunction in them. Chinese women, particularly premenopausal women, are more unsatisfied with their self-image following hysterectomy because of the cultural disparities between China and the West, which causes negative psychological reactions. This implies that medical practitioners are constantly looking for methods to provide

patients more care while yet presearving their oncological prognosis. According to several research, Functional Somatic Syndrome (FSS) is now less dangerous for individuals with 1-2 stage I EOC who are of reproductive age. However, we also discovered in clinical practice that in certain patients in the middle and late stages, even when a probable uterine metastasis was discovered by imaging and intraoperative surveillance prior to surgery, no microscopic metastasis could still be found by postoperative inspection.

The location of the ovarian lesions, oviduct metastasis, and pelvic metastasis are the three clinically significant independent risk factors for uterine metastasis of ovarian cancer.

There are two stages of ovarian cancer: Surgical and pathological. Based on surgical pathology, it is staged. Stage IIA, as defined by FIGO staging in 2014, describes a tumor that has progressed to or implanted itself in the uterus, fallopian tube, or ovary. Stage II ovarian cancer is still debatable and challenging to characterize.

There are certain individuals with ovarian cancer whose tumors have directly spread to other pelvic organs, but there is no sign of this spreading, and the findings of the abnormality examination following surgery cannot corroborate it. Ultrasound, Computed Tomography (CT), or Magnetic Resonance Imaging (MRI) were reliable judgement bases prior to surgery. During surgery, the extent of pelvic and peritoneal lesions was described. For example, lesions on the serous surface of the uterus were typically present, as were lesions in the posterior wall of the uterus, the rectum, and the uterine recess. There was also dense adhesion between the uterine ligaments and the lesions, which thickened and shrunk. Ovarian lesions site, oviduct metastasis, and pelvic metastasis are the main independent risk factors for uterine metastasis of ovarian cancer. The incidence of uterine myometrial metastasis of ovarian cancer is 4.96%.

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