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Endometrial Carcinoma is showing increasing incidence in frequency and occurrence at earlier ages. It has been estimated by Meunzer in 1974 that 700,000 of 45,000,000 women aged 35 years and above will develop carcinoma of endometrium. Improvement in survival figures will require earlier diagnosis with use of an effective screening approach prior to onset of symptoms of abnormal or post menopausal bleeding.

According to Kistner (1973), endometrial carcinoma is a disease of menopausal and post-menopausal women with seventy four percent of the cases occurring between the ages of fifty to sixty nine years and sixteen per cent at age of seventy years or older. Recent reports suggest an increase in the frequency of the lesion and occurrence at an earlier age with four per cent of the cases occurring before age of forty, twenty per cent cases occurring between forty and fifty years and seventy five per cent of the cases occurring after age of fifty years.

Endometrial carcinoma is an easily curable disease which is true only if it is localized early. Therefore attempts have been made to identify women who are at risk for developing endometrial carcinoma,
asymptomatic women with early disease and women with precursors of the disease.

The age at which menopause occurs is also a risk factor. As the incidence of endometrial carcinoma and the proportion of menopausal adults continue to increase, the need for early diagnosis will become intensified and greater emphasis will be placed on screening.

Any screening technique must fulfill certain criteria because it gains widespread acceptance. The technique must be safe and easily tolerated by the patients so that there is maximum co-operation and participation. Most detection methods suffer from this problem because any intrauterine manipulation will cause discomfort to the patient. Use of any anaesthesia increases potential morbidity and inconvenience to the patient.

Diagnostic dilatation and curettage is a reliable method to detect early endometrial carcinoma and pre-cancerous lesions of the endometrium but curettage makes up a considerable portion of the operative work for the gynaecologist. Inconvenience is caused to patients by the need for admission. In addition many centres have long waiting lists for admission which means that diagnosis and treatment are delayed to the patient's
disadvantage. In cases of endometrial cancer delayed treatment may risk the patient's life.

Percentage of vaginal and percentage of cervical smears have a low accuracy in the diagnosis of endometrial cancer because before the endometrial cells reach the vagina and posterior fornix they are desquamated and tend to degenerate.

Endometrial aspiration is a simple technique which provides abundant cellular material for early diagnosis of carcinoma in females. Application of endometrial aspiration cytology to detect clinically unsuspected endometrial carcinoma and pre-malignant lesions of endometrium has been demonstrated to be worthwhile. Hecht (1952) has quoted examples of six cases which repeatedly showed positive endometrial smears and negative curettings and in which hysterectomy confirmed the presence of carcinoma.

Normal endometrial cells are very cohesive and thus, exfoliation of them is limited. Fortunately, since malignant and hyperplastic cells are less cohesive they are more likely to exfoliate and be detected by cytology.

Jordan (1956) states that cytologic studies should be considered a routine part of every pelvic examination and an easily accomplished procedure for screening large groups of apparently normal patients. By endometrial
smears formerly it was possible to diagnose only well differentiated carcinoma. It is now possible to recognize as separate entities the various metaplasias as well as definite atypias which are caused by hyperplasia, polyps, myomata, metritis and squamous cell metaplasia of the endo cervix. The need for early diagnosis is important because the prognosis in endometrial carcinoma is chiefly dependent on early diagnosis.

When a tumour is small and the uterine cavity otherwise empty the vacuum aspiration ensures that all material obtained reaches the operator (Mathews, 1973) while in conventional curettage material, the site of lesion may be missed especially if the lesion is in initial stages and is small.

Earlier diagnosis and quick definitive therapy are the only effective means of reducing the mortality from this disease, until such a time when a method for its prevention is also discovered.

Endometrial aspiration is acceptable to patients, it has a place in the detection of endometrial carcinoma as an office procedure and more in cases where at operation absence of curettings denied histological examination.

With the endometrial aspiration technique the endometrium has been brought simply, painlessly and practically into the realm of the accessible.
The discomfort produced by vacuum aspiration was very slight and could be compared with dysmenorrhoea or insertion of an intra uterine contraceptive device.

So realising that there is recent rise in the proportion of endometrial cancers with respect to cervical cancer, augmentation indicates necessity of effective diagnosis of both early and asymptomatic forms. The sampling should be performed from the endometrial cavity, thus this present study is conducted specially in symptomatic cases or high risk individuals.