North of Scotland Cancer Network
Clinical Management Guideline
for
Endometrial Cancer

UNCONTROLLED WHEN PRINTED
Clinical Management Guideline for Endometrial Cancer: Initial Diagnosis and Staging

General Principles:
The following information should only be used to guide the management of adult patients (ie aged over 18 years) with endometrial cancer and who have not been entered into a clinical trial.

All patients (including those who decline, or are considered clinically not suitable for active treatment) should be registered with the North of Scotland regional Gynaecological cancer MDT in order to ensure accurate data capture and an opportunity for peer review.

In advance of any patient being discussed at the above specialist weekly MDT, it is important to have taken steps earliest to establish i) a definitive diagnosis, as well as ii) an indication of FIGO* clinical staging (see page 7).

Where available clinical trials should always be considered the preferred option for all eligible patients.

Clinical judgement should ultimately determine which diagnostic tests require performed for each patient. However, as a general rule this will include:

Initial Investigation:
- Full Medical History
- Physical Examination (including an examination of the pelvis)
- Routine Blood Screen: Full Blood Count (FBC), Biochemistry (U&E’s) + bone profile

Diagnosis & Staging
- Trans vaginal Ultrasound Scan and biopsy
- CT of Chest, Abdomen & Pelvis for Grade 2 & 3*
- MRI pelvis * in selected patients for whom it may alter surgical management

* as per local /Board protocols: NOSCAN Guideline on Imaging of Gynaecological Malignancy currently still under development

Other considerations
In addition to above,
- all patients should be referred or made aware earliest to the service identified Clinical Nurse Specialist (CNS) for assessment and ongoing specialist advice education, support and co-ordination of care for both the patient and their relatives throughout the treatment pathway: this is in addition to any other specialist referrals that may also be clinically warranted depending on individual patient circumstances.
- fertility expectations /childbearing potential should be discussed

*FIGO – The International Federation of Gynaecology and Obstetrics
Clinical Management Guideline for Endometrial Cancer: Evaluation and primary treatment

Clinical Stage

Primary Treatment

Adjuvant Treatment

Follow-up

Confirmed Diagnosis of Endometrial Cancer

(See page 2)

All patients initially discussed at weekly MDT to identify suitable imaging or any further imaging requirements.

Primary Surgery

Further intervention determined as per risk stratification (see page 4)

Review of post-operative pathology at MDT

Routine Follow-up (See page 6)

Individualised treatment plan according to patient circumstance

Additional imaging completed

Patient declines/ unfit for Surgery

Where available, clinical trials should always be considered the preferred option for eligible patients

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LOW RISK
(Stage IA: Grade 1-2 LVI –ve)

No adjuvant treatment

INTERMEDIATE RISK
(Stage IB: Grade 1-2 LVI –ve)

VB T or No treatment an option

HIGH INTERMEDIATE RISK
(Stage IA: Grade 3 LVI +/-ve
Stage IA/B: Grade 1-2 LVI +ve)

Surgically Staged

VBT or No treatment an option

Not Surgically Staged

LVI -ve

VBT

LVI +ve

EBRT
discuss SACT in context of PORTEC-3

HIGH RISK Stage I
(Stage IB: Grade 3)

Surgically Staged

VBT

Not Surgically Staged

EBRT + consider SACT

HIGH RISK Stage II

Surgically Staged

VBT + consider SACT if Grade 3 or LVI +ve

Not Surgically Staged

HIGH RISK Stage III

VB T (+ EBRT if outer half invasion) + consider SACT if Grade 3 or LVI +ve

EBRT (+ VBT if cervical stromal invasion) + consider SACT

Key:
EBRT – External Beam Radiotherapy
SACT – Systemic Anti-Cancer Therapy
VBT – Vault Brachytherapy
LVI – LymphoVascular Invasion
PORTEC 3 - A Clinical Trial [Identifier NCT00411138]


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Relapsed Endometrial Cancer

- Presence of Local Relapse
  - Confined to vagina only
    - No
      - Consider SACT or EBRT + hormone therapy
    - Yes
      - EBRT + VBT (where previously not received radiation)

- Any presence of Distant Relapse
  - Individualised treatment plan according to patient circumstance

Notes:
- EBRT - External Beam Radiotherapy
- SACT - Systemic Anti Cancer Therapy
- VBT - Vault Brachytherapy

*SACT – See separate document for regimen details

Where available, clinical trials should always be considered the preferred option for eligible patients
Excepting for patients who are enrolled in a clinical trial (who should be followed up according to the study protocol), the following should be referred to when planning follow up and aftercare for patients with a diagnosis of endometrial cancer.

<table>
<thead>
<tr>
<th>FIGO Stage</th>
<th>Follow-up schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1A</td>
<td>[All Grade 1] Phone consultation every 6 months for 2 years and then discharge if no evidence of disease recurrence</td>
</tr>
<tr>
<td>Stage 1B</td>
<td></td>
</tr>
<tr>
<td>All other patients</td>
<td>1st review @ 6 months Further review every 6 months for 3 years and then discharge if no evidence of disease recurrence</td>
</tr>
</tbody>
</table>

There is increasing evidence to suggest that patients treated for endometrial cancer by surgery alone and identified at low risk of recurrence, do not require regular outpatient review in Secondary care.

Accordingly in the North of Scotland, patients with a diagnosis of endometrial cancer and assessed appropriate are managed through a nurse specialist telephone clinic: the rationale is that as these patients are identified to be at very low risk of disease recurrence, they do not require undergoing routine or regular assessment (which can include a potentially intrusive and/or intimate personal examination). However, as they still require to know what symptoms to be alert to, as well as how to access further assessment and/or advice, they are provided with a dedicated telephone contact. The process adhered to in the NoS is as set out below:

- **Patient completes primary surgery:** assessed to be at ‘low risk’ and not requiring adjuvant therapy
- **Patient advised of diagnosis and planned follow up by Gynaecologist:** – either letter, OPC or GP as requested by GY
- **The Gynaecology Oncologist makes an initial appointment (6 months after surgery) at the CNS Telephone Specialist Revue Clinic**
- **6, 12, 18, and 24 months post surgery, patient is contacted by CNS via telephone to check (using an agreed list of questions) to check if any abnormal symptoms**
<table>
<thead>
<tr>
<th>FIGO stages</th>
<th>Surgical-pathologic findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Tumour confined to corpus uteri</td>
</tr>
<tr>
<td>IA</td>
<td>Tumour limited to endometrium or invades less than one half of the myometrium</td>
</tr>
<tr>
<td>IB</td>
<td>Tumour invades one half or more of the myometrium</td>
</tr>
<tr>
<td>II</td>
<td>Tumour invades stromal connective tissue of the cervix but does not extend beyond uterus**</td>
</tr>
<tr>
<td>IIIA</td>
<td>Tumour involves serosa and/or adnexa (direct extension or metastasis)</td>
</tr>
<tr>
<td>IIIB</td>
<td>Vaginal involvement (direct extension or metastasis) or parametrial involvement</td>
</tr>
<tr>
<td>IIIC</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes</td>
</tr>
<tr>
<td>IIIC1</td>
<td>Regional lymph node metastasis to pelvic lymph nodes</td>
</tr>
<tr>
<td>IIIC2</td>
<td>Regional lymph node metastasis to para-aortic lymph nodes, with or without positive pelvic lymph nodes</td>
</tr>
<tr>
<td>IV</td>
<td>Tumour invades bladder mucosa and/or bowel mucosa, and/or distant metastases</td>
</tr>
<tr>
<td>IVA</td>
<td>Tumour invades bladder mucosa and/or bowel mucosa (bullous edema is not sufficient to classify a tumor as T4)</td>
</tr>
<tr>
<td>IVB</td>
<td>Distant metastasis (includes metastasis to inguinal lymph nodes, intraperitoneal disease, or lung, liver, or bone metastases; it excludes metastasis to para-aortic lymph nodes, vagina, pelvic serosa, or adnexa)</td>
</tr>
</tbody>
</table>

*FIGO – The International Federation of Gynecology and Obstetrics