

Guideline for the Management of Endometrial Cancer
Formerly the Guideline for Post Menopausal Bleeding and Endometrial Cancer

Date Approved by Network Governance	May 2012
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Date for Review	May 2015
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Changes made during review in 2011

- Separation of the guidelines for post menopausal bleeding (PMB) and for endometrial cancer
- The results of the PORTEC 2 publication and several audits have been utilised – see bibliography
- All cases of high grade endometrioid, advanced endometrial cancers and those with unusual histological types should be discussed by the Specialist Multi Disciplinary Team (SMDT) before definitive treatment.
- Incorporation of new International Federation of Gynaecology and Obstetrics (FIGO) staging.

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1. Scope of the guideline

This guideline has been produced to support the management of patients diagnosed with endometrial cancer.

2. Guideline background

All Trusts undertaking gynaecological surgery in the Pan Birmingham Cancer Network are recognised as cancer units. One hospital (Sandwell and West Birmingham Hospitals NHS Trusts: City Hospital site) is recognised as the gynaecological cancer centre and hosts the Specialist MDT.

Guideline statements

3. Referral – by secondary care and primary care

3.1 Please refer to the please refer to the PBCN Guideline for the Management of Post Menopausal Bleeding (PMB) at <http://www.birminghamcancer.nhs.uk/staff/clinical-guidelines/gynaecology>.

3.2 Patients that are diagnosed incidentally either in secondary care or primary care should be referred directly to the gynaecology cancer team at the local hospital.

4. Initial assessment by the gynaecology cancer team (please see appendix 1 for patient pathways)

4.1 The clinician who takes the endometrial biopsy that shows endometrial cancer should arrange to inform the patient of their diagnosis in the presence of a gynae oncology clinical nurse specialist.

4.2 If the diagnostic endometrial biopsy shows endometrioid G1/2 the patient should be referred to the gynaecology cancer **unit** lead clinician for assessment.

4.3 If the diagnostic endometrial biopsy shows endometrioid G3 or non-endometrioid cancer, the patient should be referred for assessment by the gynaecological cancer **centre oncologist**.

4.4 Initial assessment by whoever sees the patient in gynae cancer unit or centre should include a history and examination and answer three questions:

- i. Is the patient fit for surgery?
- ii. Is there clinical evidence of metastatic disease?
- iii. Is the patient suitable for laparoscopic hysterectomy?

4.5 All patients should be discussed at the local MDT; those requiring discussion at the specialist MDT are identified within the text of the guideline.

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5. Patients considered unfit for surgery

Patients considered unfit for surgery at the initial assessment should have an anaesthetic assessment. If this confirms they are unfit for surgery they should be discussed by the MDT with consideration given to palliative radiotherapy, palliative chemotherapy, hormonal therapy, best supportive care or a clinical trial.

6. Patients fit for surgery with clinical evidence of metastatic disease.

These patients fall into two groups:

- 6.1 Cervical involvement only: A chest x-ray and MRI of the pelvis/abdomen should be requested and the results discussed by the specialist MDT.
- a: If the uterus appears resectable and
 - i. Cervical stromal invasion is less than 50%, **a simple** hysterectomy/BSO/pelvic lymphadenectomy should be undertaken at the cancer centre.
 - ii. Cervical stromal invasion is greater than 50%, **a radical** hysterectomy/BSO/pelvic lymphadenectomy should be undertaken at the cancer centre.
 - b: If the uterus appears irresectable, the patient should be considered for the following:
 - i. neoadjuvant chemotherapy and possible delayed debulking surgery
 - ii. primary radiotherapy
 - iii. hormonal treatment
 - iv. a trial
- 6.2 Vaginal and/or upper abdominal involvement: A chest x-ray and CT of the pelvis/abdomen should be requested and discussed at the specialist MDT (a local audit has failed to show a role of CT thorax).
- a: If the metastatic disease appears resectable, primary debulking surgery should be attempted at the cancer centre.
 - b: If the metastatic disease appears irresectable, the patient should be considered for the following:
 - i. neoadjuvant chemotherapy and possible delayed debulking surgery
 - ii. primary radiotherapy
 - iii. hormonal treatment
 - iv. a clinical trial

7. Patients fit for surgery without clinical evidence of metastatic disease who are unsuitable for pelvic lymphadenectomy:

These patients should have a simple hysterectomy and BSO if the chest x-ray is negative at the **cancer unit**.

8. Patients fit for surgery without clinical evidence of metastatic disease who are suitable for lymphadenectomy fall into two groups:

8.1 Endometrial biopsy shows endometrioid carcinoma: these patients should have a chest x-ray, MRI and be discussed by at the **cancer unit MDT**.

a. If the chest x-ray is positive see section 5 (patients considered unfit for surgery).

b. If the chest x-ray is negative:

- i. G1/2, < 50% myometrial invasion, no cervical stromal invasion and no extrauterine disease – simple hysterectomy and BSO at **cancer unit**.
- ii. G1/2, > 50% myometrial invasion, no cervical stromal invasion and no extrauterine disease – simple hysterectomy and BSO at **cancer centre** after discussion at the specialist MDT.
- iii. G3, no cervical stromal invasion and no extrauterine disease – simple hysterectomy BSO and pelvic lymphadenectomy at **cancer centre** after discussion at the specialist MDT.
- iv. G1/2/3 and inner half cervical stromal involvement - simple hysterectomy, BSO and pelvic lymphadenectomy at **cancer centre** after discussion at the specialist MDT.
- v. G2/3 and outer half cervical stromal involvement - radical hysterectomy, BSO and pelvic lymphadenectomy at **cancer centre** after discussion at the specialist MDT.

8.2. Endometrial biopsy shows non-endometrioid carcinoma. In the absence of clinical evidence of metastatic disease, these patients should have chest x-ray, CT abdomen/pelvis (a local audit has failed to show a role of CT thorax) and MDT discussion.

a. If the chest x-ray is positive see section 5 (patients considered unfit for surgery)

b. If the chest x-ray and CT are negative – simple hysterectomy, BSO, pelvic lymphadenectomy (unless unfit for this) and omental biopsy at the cancer centre.

c. If the chest x-ray is negative and the CT is positive – see section 6.2

9. Adjuvant treatment

VBT = vaginal brachytherapy

EBRT = external beam radiotherapy

9.1 Endometrioid

Stage 1A G1/2 – no adjuvant treatment

Stage 1B G1/2 – VBT irrespective of whether nodes done or not

Stage 1 A/B G3 – VBT if nodes negative, EBRT if nodes not done

Stage 2 – VBT if nodes negative, EBRT if nodes not done

Stage 3 – chemotherapy & EBRT

Stage 4 – Chemotherapy / hormonal therapy / EBRT / recruitment to trial / best supportive care

9.2 Non-endometrioid (serous, clear cell, MMMT)

Stage 1A – no adjuvant treatment of no residual disease in surgical specimens

Stage 1A with residual disease /B – chemotherapy, VBT if nodes negative, EBRT if nodes not done

Stage 2 A/B/C – chemotherapy, VBT if nodes negative, EBRT if nodes not done

Stage 3 A/B/C – chemotherapy, VBT if nodes negative, EBRT if nodes not done

Stage 4 A/B – chemotherapy, VBT if nodes negative, EBRT if nodes not done
recruitment to trial / best supportive care

10. Follow up

10.1 Please see PBCN Guideline for the follow-up of patients with gynaecological cancer. (<http://www.birminghamcancer.nhs.uk/staff/clinical-guidelines/gynaecology>) for the follow up of patients with gynaecological cancer. In summary:

10.2 Cases with no adjuvant treatment

a. Stage 1a G1 – patient initiated follow up

b. Stage 1a G2 – follow-up at 3, 6 and 12 months and then patient initiated follow up

10.3 Cases with any adjuvant treatment – follow up at 3, 6, 12 and 24 months and then patient initiated follow up.

11. Recurrent disease

11.1 All patients with recurrent disease should be discussed at the specialist MDT.

11.2 Decisions should be made by the specialist MDT on an individual patient basis. Options for management include palliative radiotherapy, chemotherapy or hormone therapy. Consider early referral of patients to specialist MDT if there are complex symptom control or psycho-social issues. Patients requiring surgery for the management of recurrent cancer should be managed by the gynaecological cancer centre team.

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12. Patient information and counselling

- 12.1 All patients, and (with their consent) their partners will be given access to appropriate written information during their investigation and treatment. On diagnosis they will be given the opportunity to discuss their management with a clinical nurse specialist who is a member of the relevant MDT. The patient should have a method of access to the gynae team at all times.
- 12.2 Access to psychological support will be available if required. All patients should undergo a holistic needs assessment and onward referral as required.

13. Palliative care

Palliative care services will be made available to all patients as deemed appropriate by the MDT.

14. Clinical trials

- 14.1 Wherever possible, patients who are eligible should be offered the opportunity to participate in National Institute for Health Research portfolio clinical trials and other well designed studies.
- 14.2 Where a study is only open at one Trust in the Network, patients should be referred for trial entry. A list of studies available at each Trust is available from Pan Birmingham Cancer Research Network.
Email: PBCRN@westmidlands.nhs.uk .
- 14.3 Patients who have been recruited into a clinical trial will be followed up as defined in the protocol.

Monitoring of the Guideline

Adherence to the Network guidelines may from time to time be formally monitored.

References

- 1 The International Federation of Gynaecology and Obstetrics (FIGO), 2006. Staging classifications and clinical practice guidelines of gynaecological cancers.
<http://www.figo.org>
- 2 Randall ME, [J Clin Oncol](#). 2006 Jan 1;24(1):36-44. Epub 2005 Dec 5

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Approval Signatures

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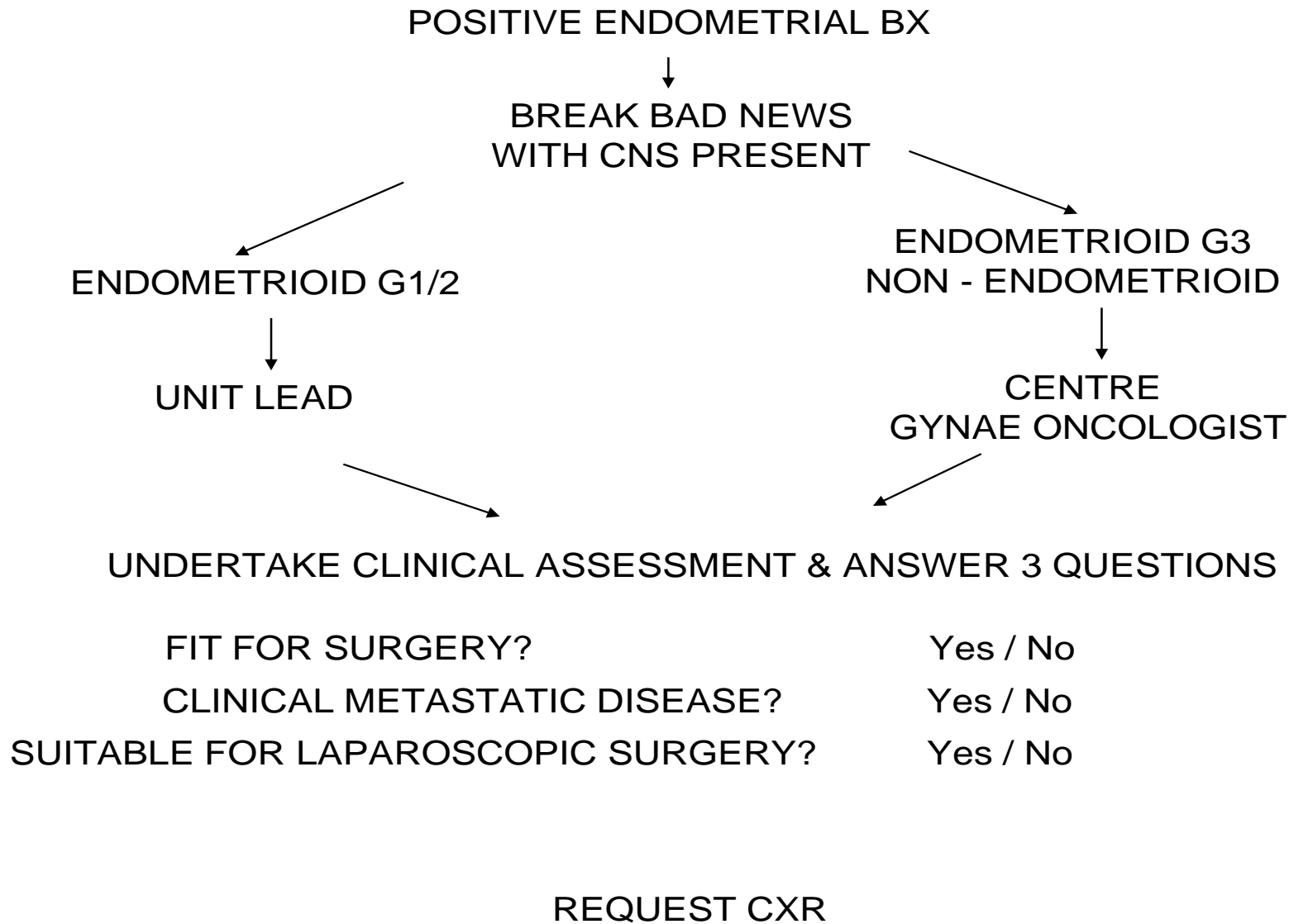
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Date: June 2012

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FIT FOR SURGERY?



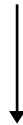
NO



ANAESTHETIC OPINION (WITH REQUEST FOR % RISK OF DEATH)

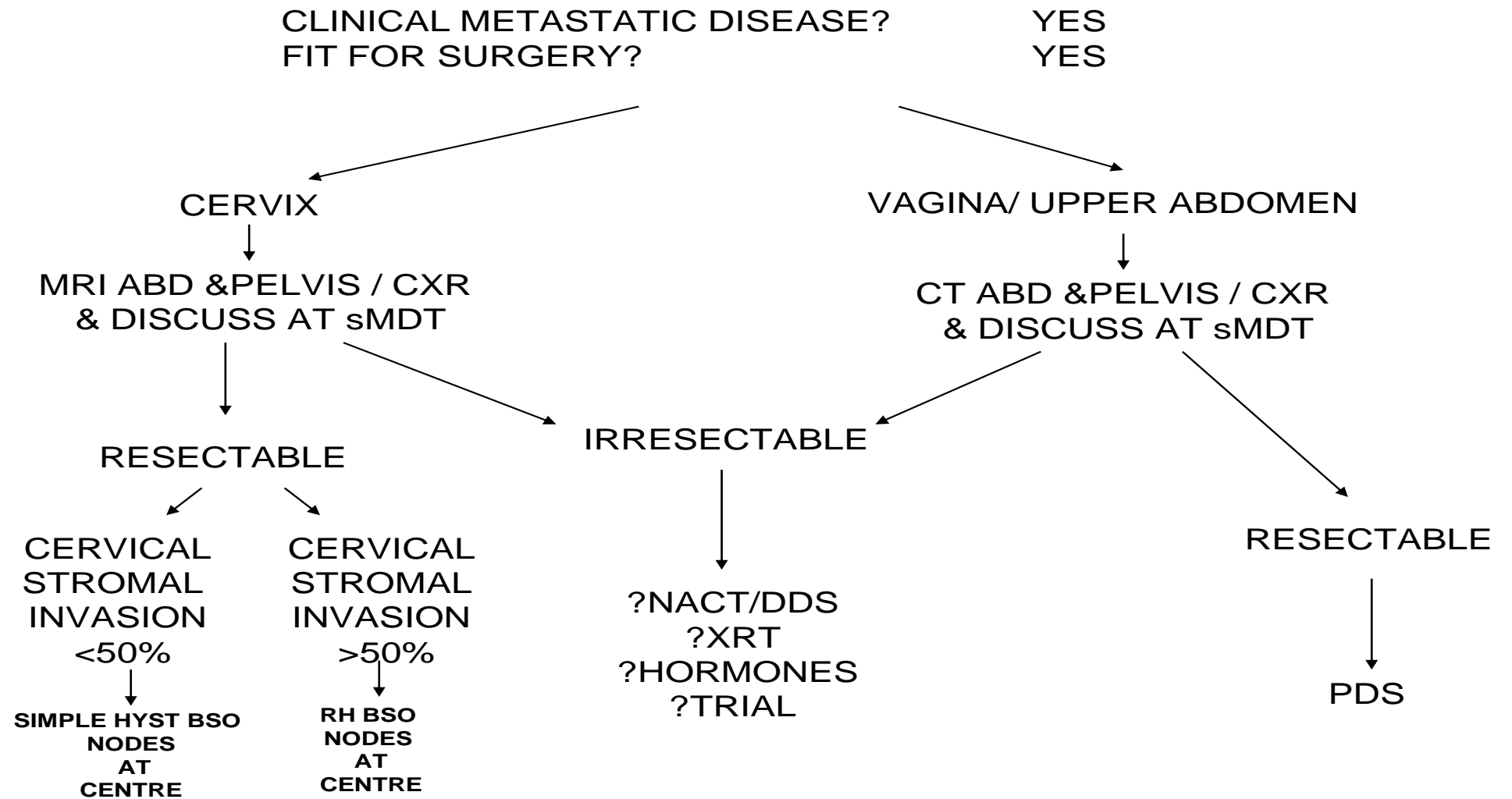


REVIEW AT MDT



PROGESTERONE THERAPY
AROMATASE INHIBITOR
XRT
PALLIATIVE CHEMO
BEST SUPPORTIVE CARE
SUITABLE FOR TRIAL?

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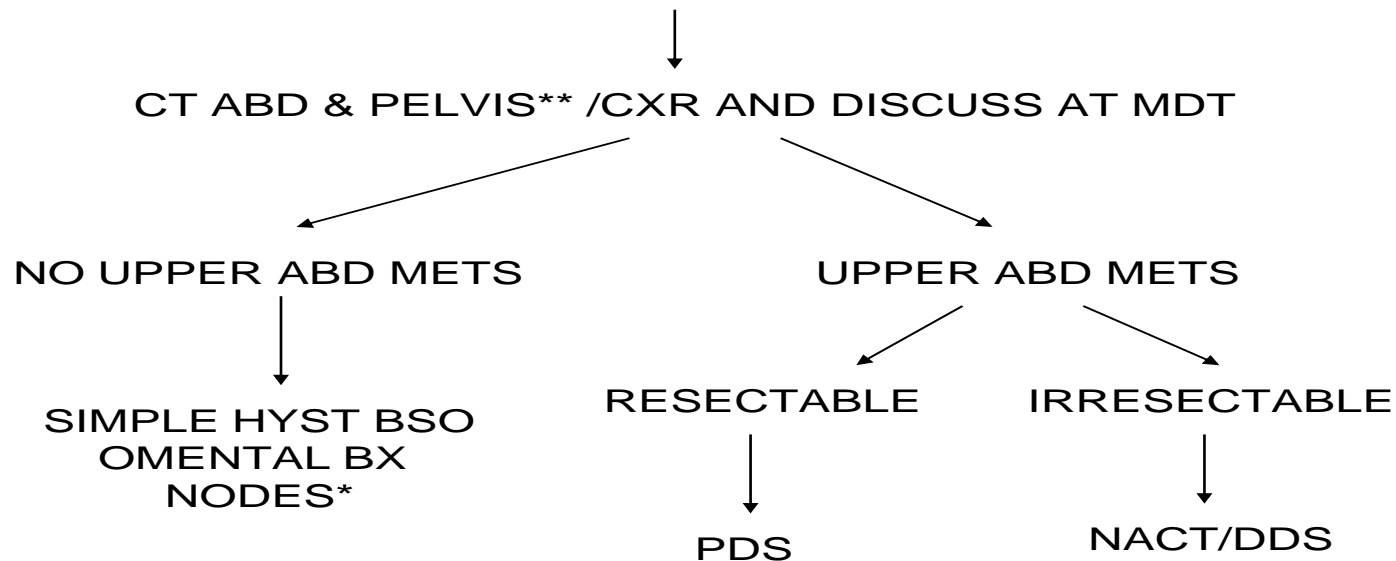
Abbreviations: PDS = primary debulking surgery NACT = neoadjuvant chemotherapy DDS = delayed debulking surgery
 MI = myometrial invasion

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NON-ENDOMETRIOID (SEROUS, CLEAR CELL, MMMT)

**FIT FOR SURGERY?
METASTATIC DISEASE?**

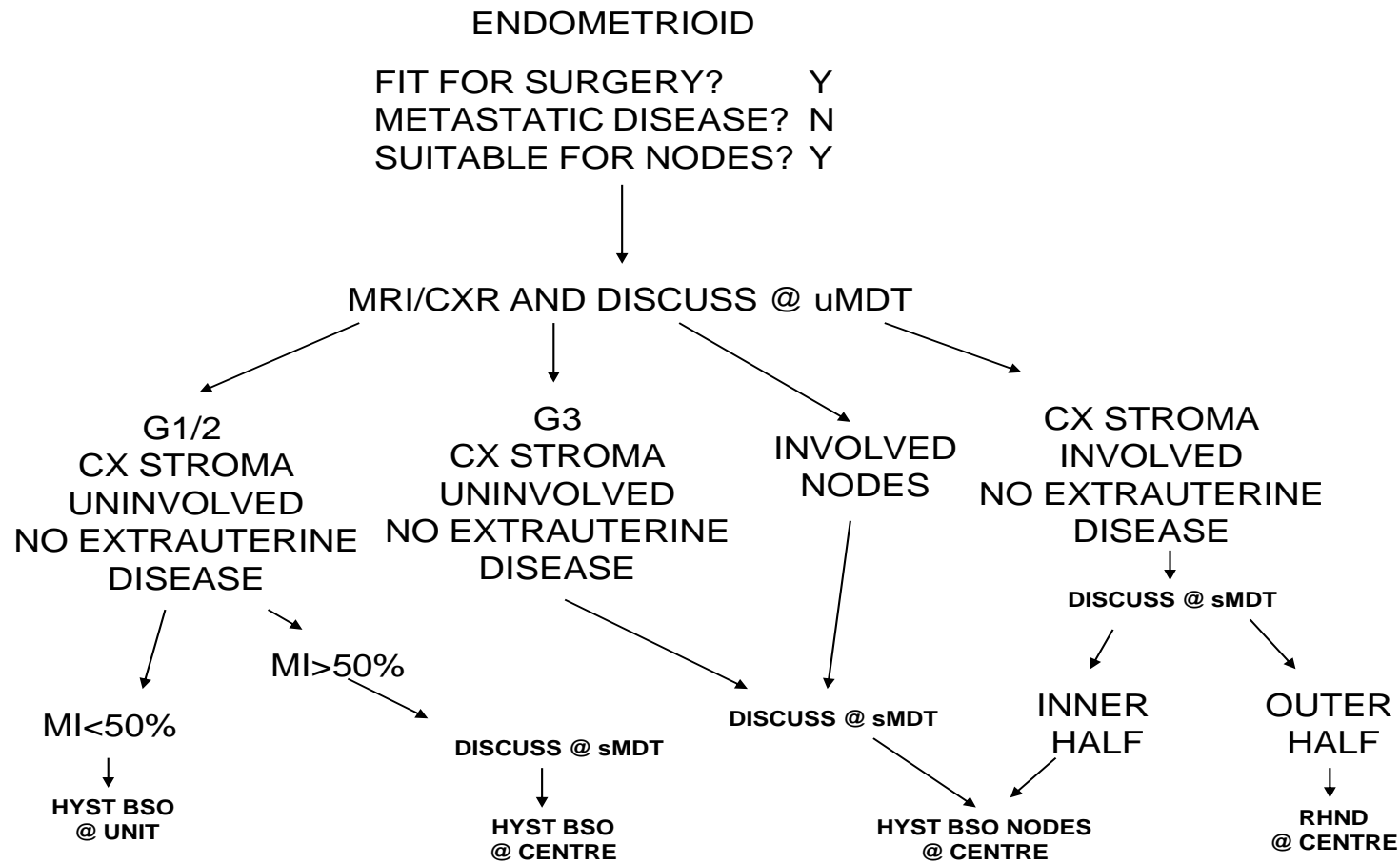
**YES
NO**



**•NODES NOT TO BE DONE IF PATIENT UNFIT / UNSUITABLE OR IF ANY OVERT SEROSAL OR PERITONEAL DISEASE
VISIBLE AT LAPAROTOMY/LAPAROSCOPY. LATTER SHOULD BE DEBULKED**

****A LOCAL AUDIT HAS FAILED TO SUPPORT THE USE OF CT CHEST IN THESE PATIENTS**

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