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

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<th>Date Approved by Network Governance</th>
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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.
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**


3.2 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**

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-endometriod 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.
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](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.
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](mailto: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**


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Appendix 1

POSITIVE ENDOMETRIAL BX

BREAK BAD NEWS WITH CNS PRESENT

ENDOMETRIOID G1/2
UNIT LEAD

ENDOMETRIOID G3 NON-ENDOMETRIOID
CENTRE GYNAE ONCOLOGIST

UNDERTAKE CLINICAL ASSESSMENT & ANSWER 3 QUESTIONS

FIT FOR SURGERY? Yes / No
CLINICAL METASTATIC DISEASE? Yes / No
SUITABLE FOR LAPAROSCOPIC SURGERY? Yes / No

REQUEST CXR

ENDORSED BY THE GOVERNANCE COMMITTEE
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?
CLINICAL METASTATIC DISEASE?
FIT FOR SURGERY?

YES

CERVIX

MRI ABD & PELVIS / CXR & DISCUSS AT sMDT

RESECTABLE

CERVICAL STROMAL INVASION <50%
SIMPLE HYST BSO NODES AT CENTRE

CERVICAL STROMAL INVASION >50%
RH BSO NODES AT CENTRE

IRRESECTABLE

VAGINA/ UPPER ABDOMEN

CT ABD & PELVIS / CXR & DISCUSS AT sMDT

RESECTABLE

PDS

Abbreviations:
PDS = primary debulking surgery
NACT = neoadjuvant chemotherapy
DDS = delayed debulking surgery
MI = myometrial invasion
NON-ENDOMETRIOID (SEROUS, CLEAR CELL, MMMT)

FIT FOR SURGERY? YES
METASTATIC DISEASE? NO

CT ABD & PELVIS** /CXR AND DISCUSS AT MDT

NO UPPER ABD METS

SIMPLE HYST BSO
OMENTAL BX
NODES*

UPPER ABD METS

RESECTABLE

IRESECTABLE

PDS

NACT/DDS

*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