Endometrial Cancer Treatment & Follow-Up Pathway Map
Disease Pathway Management
Version 2018.12

Disclaimer
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Target Patient Population

- Women presenting with endometrial cancer

Pathway Map Considerations

- For more information about the optimal organization of gynecologic oncology services in Ontario refer to EBS #4-11
- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway map. For patients who do not have a primary care provider, Health Care Connect, is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway map, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see Person-Centered Care Guideline and EBS #19-2 Provider-Patient Communication.
- Hyperlinks are used throughout the pathway map to provide information about relevant CCO tools, resources and guidance documents.
- The term ‘healthcare provider’, used throughout the pathway map, includes primary care providers, specialists, midwives, nurse practitioners, gynecologists, emergency physicians or other healthcare providers.
- For more information on Multidisciplinary Cancer Conferences visit MCC Tools.
- For more information on wait time prioritization, visit: Surgery, Systemic Treatment, Radiation Treatment Wait Times, prioritizations.
- Clinical trials should be considered for all phases of the pathway map.
- Psychosocial oncology (PSO) is the interprofessional specialty concerned with understanding and treating the social, practical, psychological, emotional, spiritual and functional needs and quality-of-life impact that cancer has on patients and their families. Psychosocial care should be considered an integral and standardized part of cancer care for patients and their families.
- The following should be considered when weighing the treatment options described in this pathway map for patients with potentially life-limiting illness:
  - Palliative care may be of benefit at any stage of the cancer journey, and may enhance other types of care - including restorative or rehabilitative care - or may become the total focus of care.
  - Ongoing discussions regarding goals of care is central to palliative care, and is an important part of the decision-making process. Goals of care discussions include the type, extent and goal of a treatment or care plan, where care will be provided, which health care providers will provide the care, and the patient’s overall approach to care.

Pathway Map Disclaimers

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- This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. CCO and its content providers assume no responsibility for omissions or incomplete information in this pathway map, even if advised of the possibility thereof. While care has been taken in the preparation of the information contained in the pathway map, such information is provided on an “as-is” basis, without any representation, warranty, or condition, whether express, implied, statutory or otherwise, as to the information’s quality, accuracy, currency, completeness, or reliability.

- EBS #19-2 and EBS #19-3 are older than 3 years and is currently listed as ‘For Education and Information Purposes.’ This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes.
Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools.

Consider the introduction of palliative care, early and across the cancer journey. Click here for more information about palliative care.

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Clinical Stage II

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*Note. EBS 21-2 is older than 3 years and is currently listed as ‘For Education and Information Purposes’. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes.

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**Primary Staging Surgery**
- Minimally Invasive Surgery is best practice
- Total Hysterectomy, recommend radical hysterectomy
- Bilateral Salpingo-oophorectomy
- Cytology
- Pelvic Lymph Node Assessment
- Possible Para-aortic Lymph Node Dissection
- Peritoneal washings
- Omentectomy if high grade histology

**Pathology**

From Diagnosis to Pathway Map (Page 4)
- MRI Pelvis
- CT Abdomen Pelvis
- CT Chest

**Stage**
- Yes
  - **Appropriate for primary surgery?**
  - **MCC**

**Stage II**

**Pathology16**

Results

**Endometrioid**
- Grade 1 or 2
- Grade 3
- Serous, Carcinosarcoma, Clear cell and Mixed Histology

**Stage III/IV**

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1 Endometrioid Grade 1: If grade I endometrial cancer diagnosed at a non-gynecologic oncology center (GOC), the pathology must be reviewed by a second pathologist. Both pathologists must be in agreement with diagnosis of grade I endometriod cancer: otherwise, referral of patient to a GOC is necessary.

2 Endometrioid Grade 2, 3 or High Risk Histology: Pathology review by a pathologist with an interest in gynecologic pathology at a gynecologic oncology center (GOC)

3 The following should be taken into consideration: performance status, surgical resectability, and patient comorbidities

4 Consider referral to a radiation centre with intracavitary brachytherapy cases ≥ 10 per year EBS 4-11, EBS 21-2

5 All endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MMR deficient, reflex hypermethylation should be performed.
Endometrial Cancer Treatment & Follow Up Pathway Map

Clinical Stage III/IV Extravuterine Disease (Metastasis)  
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1 Discussion to be individualized for each patient; however, may include the following: fertility options, hormone replacement therapy, referral for infertility consultation, etc.
2 All tumours with MSH2/MSH6, MSH5, PMS2 and MLH1 (without hypermethylation) deficiency are candidates for genetic testing and should be referred for genetic counseling.
3 Endometrioid Grade 1: If grade I endometrioid cancer diagnosed at a non-gynecologic oncology center (GOC), the pathology must be reviewed by a second pathologist. Both pathologists must be in agreement with diagnosis of grade I endometrioid cancer; otherwise, referral of patient to a GOC is necessary.
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2 All tumours with MSH2/MSH6, MSH6, PMS2 and MLH1 (without hypermethylation) deficiency are candidates for genetic testing and should be referred for genetic counseling.

3 Endometrioid Grade 1: T1 grade I endometrial cancer diagnosed at a non-gynecologic oncology center (GOC), the pathology must be reviewed by a second pathologist. Both pathologists must be in agreement with diagnosis of grade I endometrioid cancer; otherwise, referral of patient to a GOC is necessary.

4 Endometrioid Grade 2, 3 or High Risk Histology: Pathology review by a pathologist with an interest in gynecologic pathology at a gynecologic oncology center (GOC).

5 Patients should undergo counseling that fertility sparing is for highly selected and motivated patients who meet strict criteria for progestin therapy. Criteria for fertility sparing progestin therapy include: 1) Grade 1 endometrioid adenocarcinoma, 2) no myometrial invasion on MRI, 3) no metastatic disease, 4) no contraindications to progestin therapy, 5) desire for future fertility.

6 Considering requesting IHC for mismatch repair (MSH2, MSH6, PMS2, and MLH1). If a patient has a diagnosis of Lynch syndrome, a recommendation is to perform IHC to screen for Lynch syndrome.

7 Megestrol acetate (Megestatin) is used as a progestin.

8 Suggested progestin therapy includes medroxyprogesterone, megestrol acetate, and levonorgestrel IUD.

9 Consider omitting oophorectomy after thorough preoperative counseling with patient.

10 All endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MMR deficient, reflex hypermethylation should be performed.
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Status

Desire pregnancy now

Desire pregnancy later

Endometrioid Fertility Sparing (contd)

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Desire pregnancy now

R

REI (Reproductive endocrinology and infertility)

Yes

Endometrial Protection

Child bearing complete or recurrent endometrial cancer?

No

Encourage conception if appropriate

Biopsy

Complete Hysterectomy and Bilateral Salpingo-oophorectomy

Results

Normal

Pathology Review

Recurrent endometrial cancer on biopsy

Pathology

Surgical Staging

• Minimal invasive surgery is best practice
• Total hysterectomy
• Bilateral Salpingo-oophorectomy

Results

Proceed to Page 8

From Page 6

Endometrioid Grade 1: If grade I endometrioid cancer diagnosed at a non-gynecologic oncology center (GOC), the pathology must be reviewed by a second pathologist. Both pathologists must be in agreement with diagnosis of grade I endometrioid cancer; otherwise, referral of patient to a GOC is necessary

Endometrioid Grade 2, 3 or High Risk Histology: Pathology review by a pathologist with an interest in gynecologic pathology at a gynecologic oncology center (GOC)

Consider omitting oophorectomy after thorough preoperative counseling with patient

Stage I

Stage II

Proceed to Page 13

Proceed to Page 1

Proceed to Page 12

Proceed to Page 10

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Proceed to Page 11

Proceed to Page 1

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2 Endometrioid Grade 2, 3 or High Risk Histology: Pathology review by a pathologist with an interest in gynecologic pathology at a gynecologic oncology center (GOC)

3 Consider omitting oophorectomy after thorough preoperative counselling with patient

4 IUD levonorgestrel, oral contraceptive pill, cyclical provera, or other progestational agents

5 All endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MLH1 deficient, reflex hypermethylation should be performed.
Endometrial Grade 1, or 2, Stage I

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Endometrioid Grade 2, 3 or High Risk Histology: Pathology review by a pathologist with an interest in gynecologic pathology at a gynecologic oncology center (GOC)

The following should be taken into consideration: performance status, surgical resectability, and patient comorbidities

Risk factors include: age greater than 60 years based on Portec 1, positive lymphovascular invasion, deep myometrial invasion more than or equal to 50%, all endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MLH1 deficient, reflex hypermethylation should be performed.
Endometrioid Grade 3 Stage I

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16 All endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MLH1 deficient, reflex hypermethylation should be performed.
Endometrial Cancer Treatment & Follow Up Pathway Map

From Page 4-7
Status
Staged

Results

Unstaged

Appropriate for surgery?

CT Abdomen, Pelvis (If not done previously)

Pathology Review

Radiation Oncologist

Medical Oncologist

NCC

MCC

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

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Pathology

Pelvic Radiation Therapy

Vaginal Brachytherapy

Pelvic Radiation Therapy

Concurrent Chemotherapy

Chemotherapy

Vaginal Brachytherapy

Pelvic 4+ Tumour Directed Radiation Therapy

Concurrent Chemotherapy

Chemotherapy

Hormonal Therapy

Tumour Directed Radiation Therapy

Chemotherapy

Hormonal Therapy

Clinical Trials

X

H

N

U

Grade 1 or 2, Stage II - IVB

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4 Endometriod Grade 2, 3 or High Risk Histology: Pathology review by a pathologist with an interest in gynecologic pathology at a gynecologic oncology center (GOC)

5 The following should be taken into consideration: performance status, surgical resectability, and patient comorbidities

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Grade 3, Stage II - IVB

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The following should be taken into consideration:

1. Performance status
2. Surgical resectability
3. Patient comorbidities

Endometrioid Grade 2, 3 or High Risk Histology:
Pathology review by a pathologist with an interest in gynecologic pathology at a gynecologic oncology center (GOC)

From Page 4, 5, 9

CT Chest, Abdomen, Pelvis (If not done previously)

Appropriate for surgery?

Yes

Staging Surgery

Pathology

No

Unstaged

Staged

Status

Results

Stage II

Pelvic Radiation Therapy

Vaginal Brachytherapy

Stage IIIA

Pelvic Radiation Therapy

Concurrent Chemotherapy

Chemotherapy

Stage IIB

Vaginal Brachytherapy

Chemotherapy

Stage IIC

Stage IVA

Pelvic +/- Tumour Directed Radiation Therapy

Chemotherapy

Stage IVB

Clinical Trials

Proceed to Page 13

4 Endometrial Grade 2, 3 or High Risk Histology: Pathology review by a pathologist with an interest in gynecologic pathology at a gynecologic oncology center (GOC)

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16 All endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MLH1 deficient, reflex hypermethylation should be performed.
Serous, Carcinosarcoma, Clear Cell and Mixed Histology

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The following should be taken into consideration: performance status, surgical resectability, and patient comorbidities.

All endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MLH1 deficient, reflex hypermethylation should be performed.
Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care

Follow-up Frequency
Every 3-6 months within the first two years and then every six months for the next three years

Personal and family medical history
Physical and Pelvic-rectal examination
Refer to EBS #4-9

Follow-up Care (All Sub-Types)

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Endometrial Cancer Treatment & Follow Up Pathway Map

Follow-up Frequency
Every 3-6 months within the first two years and then every six months for the next three years

Personal and family medical history
Physical and Pelvic-rectal examination
Refer to EBS #4-9

No evidence of recurrence for 3-5 years
Refer to EBS #4-9

Suspicion for recurrence
Imaging as Appropriate

Results
Distant Metastases
Late Effects of Treatment
Not suggestive of recurrence

Referring to Appropriate Specialist

EE
Proceed to Page 14

Referring to Appropriate Specialist

Non-Cancer Related
Recurrence

Referring to Appropriate Specialist

Relevant to Primary Care Provider if not done prior to 5 years

Refer to Primary Care Provider

B Y G Z L BB R CC V DD

Follow-up Care (All Sub-Types)

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1 Appropriate for low risk stage 1a with no adjuvant therapy

Click here for more information about palliative care
Persistent, Recurrent, Metastatic and Carcinosarcoma (All Sub-Types)

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Endometriod Grade 2, 3 or High Risk Histology:
Pathology review by a pathologist with an interest in gynecologic pathology at a gynecologic oncology center (GOC).

All endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MLH1 deficient, reflex hypermethylation should be performed.

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Pathology Review
Repeat Biopsy
CT Abdomen, Pelvis
MRI Pelvis
CT Chest
Imaging as Appropriate

Gynecologic Oncologist
Radiation Oncologist
Medical Oncologist
Palliative Care
PSO

Clinical Trials
ERB #4-3
Surgery
Chemotherapy
ERB #4-3
Radiation therapy

Appropriate therapy may include one or more of the following:

End of life care planning

Psychosocial oncology and palliative care
Referral to appropriate specialist if additional support is required

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Progression

From Page 13

EE

End of Life (Page 15)

Proceed to

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4 Endometriod Grade 2, 3 or High Risk Histology. Pathology review by a pathologist with an interest in gynecologic pathology at a gynecologic oncology center (GOC).

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End of Life Care

- Revisit Advance Care Planning
  - Ensure the patient has determined who will be their Substitute Decision Maker (SDM)
  - Ensure the patient has communicated to the SDM his/her wishes, values and beliefs to help guide that SDM in future decision making
- Discuss and document goals of care with patient and family
  - Assess and address patient and family’s information needs and understanding of the disease, address gaps between reality and expectation, foster realistic hope and provide opportunity to explore prognosis and life expectancy, and preparedness for death
  - Introduce patient and family to resources in community (e.g., day hospice programs)
- Develop a plan of treatment and obtain consent
  - Determine who the person wants to include in the decision making process (e.g., substitute decision maker if the person is incapable)
  - Develop a plan of treatment related to disease management that takes into account the person’s values and mutually determined goals of care
  - Obtain consent from the capable person or the substitute decision maker if the person is incapable for an end-of-life plan of treatment that includes:
    - Setting for care
    - Resuscitation status
    - Having, withholding and or withdrawing treatments (e.g. lab tests, medications, etc.)
- Screen for specific end of life psychosocial issues
  - Specific examples of psychological needs include: anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
  - Consider referral to available resources and/or specialized services
- Identify patients who could benefit from specialized palliative care services (consultation or transfer)
  - Discuss referral with patients and family
- Proactively develop and implement a plan for expected death
  - Explore place-of-death preferences and assess whether this is realistic
  - Explore the potential settings of dying and the resources required (e.g., home, residential hospice, palliative care unit, long term care or nursing home)
  - Anticipate/Plan for pain & symptom management medications and consider a Symptom Response Kit (SRK) for unexpected pain & symptom management
  - Preparation and support for family to manage
  - Discuss emergency plans with patient and family (who to call if emergency in the home or long-term-care or retirement home)
- Home care planning
  - Connect with Home and Community Care early (not just for last 2 to 4 weeks)
  - Ensure resources and elements in place
  - Consider a Symptom Response Kit (SRK) with access to pain, dyspnea and delirium medication
  - Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources

For more information on the Gold Standards Framework, visit [http://www.goldstandardsframework.org.uk/](http://www.goldstandardsframework.org.uk/)
At the time of death:

- Pronouncement of death
- Completion of death certificate
- Allow family members to spend time with loved one upon death, in such a way that respects individual rituals, cultural diversity and meaning of life and death
- Implement the pre-determined plan for expected death
- Arrange time with the family for a follow-up call or visit
- Provide age-specific bereavement services and resources
- Inform family of grief and bereavement resources/services
- Initiate grief care for family members at risk for complicated grief
- Encourage the bereaved to make an appointment with an appropriate health care provider as required

Bereavement Support and Follow-Up

- Offer psychoeducation and/or counseling to the bereaved
- Screen for complicated and abnormal grief (family members, including children)
- Consider referral of bereaved family member(s) and children to appropriate local resources, spiritual advisor, grief counselor, hospice and other volunteer programs depending on severity of grief

Provide opportunities for debriefing of care team, including volunteers

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