Optimal care pathway for women with endometrial cancer

Quick reference guide

Please note that not all women will follow every step of this pathway:

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 1

Prevention and early detection

Risk factors for endometrial cancer:

- obesity (including hypertension and diabetes)
- polycystic ovarian syndrome
- Lynch syndrome (40–60 per cent lifetime risk of endometrial cancer)
- a family history of endometrial cancer in a first-degree relative
- unopposed postmenopausal oestrogen therapy
- endometrial hyperplasia
- nulliparity
- anovulation
- early menarche and late menopause
- tamoxifen use.

Prevention: Maintaining a healthy weight and taking birth control pills (especially over a long period) can lower risk.

All women with an intact uterus using hormone replacement therapy should have progesterone therapy as part of their regimen to reduce the risk of developing endometrial cancer.

Preventative surgery: For women with a hereditable risk factor, surgery to remove the uterus (hysterectomy) or treatment with hormones (progesterone) may prevent endometrial hyperplasia from developing into endometrial cancer.

All women considering risk-reducing surgery should have a thorough family history taken, and consider referral to a familial cancer clinic to try to define the actual risk, not only for the woman herself, but also for other family members.

Step 2

Presentation, initial investigations and referral

Signs and symptoms include:

- vaginal bleeding after menopause
- bleeding between periods
- abnormal, watery or blood-tinged vaginal discharge
- pelvic pain or pain during intercourse
- unexplained weight loss.

General/primary practitioner investigations:

- a general and pelvic examination (including a speculum and Pap smear)
- referral for a transvaginal pelvic ultrasound by an experienced gynaecological ultrasonographer.

Results should be available and the woman reviewed by the general practitioner within four weeks.

Referral: If the diagnosis is suspected, then referral to a specialist gynaecologist for further investigation is required. If the diagnosis is confirmed with initial tests, then referral to or consultation with a gynaecological oncologist or service is required.

Communication – lead clinician to:[1]

- provide the woman with information that clearly describes who they are being referred to, the reason for referral and the expected timeframe for appointments
- support the woman while waiting for the specialist appointment.

Step 3

Diagnosis, staging and treatment planning

Diagnosis: The following sequence of preoperative investigations should be considered:

- transvaginal pelvic ultrasound (if not already done)
- routine blood tests
- other imaging as indicated by clinical assessment.

Investigations should be completed within two weeks of specialist review.

Staging: Staging is generally pathological following surgery.

Treatment planning: All newly diagnosed women should be discussed in a gynaeoncology multidisciplinary team meeting before definitive treatment.

Special considerations that need to be addressed at this stage may include issues around obesity, diabetes, early menopause and hormonal changes.

Research and clinical trials: Consider enrolment where available and appropriate.

Communication – lead clinician to:

- discuss a timeframe for diagnosis and treatment with the woman/carer
- explain the role of the multidisciplinary team in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

1 Lead clinician – the clinician who is responsible for managing patient care.
The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

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Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 4

Treatment:

Establish intent of treatment:

- curative
- anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- symptom palliation.

Treatment options

Surgery: For early-stage endometrial cancer hysterectomy and bilateral salpingo-oophorectomy with or without lymph node dissection. Lymphadenectomy may be considered in select patients.

Radiation therapy: For women with higher risk factors, adjuvant radiation may be offered. In selected cases radiation therapy may also be considered as part of primary treatment or for symptomatic relief and palliation of metastatic disease.

Chemotherapy and other systemic therapy: Chemotherapy may be considered after further discussion at a multidisciplinary team meeting:

- following surgery in women at high risk , usually in conjunction with radiation therapy
- as primary treatment for metastatic disease where the patient is not suitable for surgery
- where there is residual disease at the completion of surgery or the disease has spread.

Hormonal therapy: May be appropriate for young women who wish to retain fertility or for symptom management.

Refer to the endometrial optimal care pathway for recommendations for screening for Lynch syndrome

Palliative care: Early referral can improve quality of life and, in some cases, survival. Referral should be based on need, not prognosis.

Communication – lead clinician to:

- discuss treatment options with the woman/carer including the intent of treatment and expected outcomes
- discuss advance care planning with the woman/carer where appropriate
- discuss the treatment plan with the woman's general practitioner.

For detailed information see <http://wiki.cancer.org.au/australia/Guidelines:Endometrial_cancer/Treatment/Early_stage>.

Step 5

Care after initial treatment and recovery

For premenopausal women, ongoing assessment of the effects of surgical menopause is required after surgery.

Cancer survivors should be provided with the following to guide care after initial treatment.

Treatment summary (provide a copy to the woman/carer and her general practitioner) outlining:

- diagnostic tests performed and results
- tumour characteristics
- type and date of treatment(s)
- interventions and treatment plans from other health professionals
- supportive care services provided
- contact information for key care providers.

Follow-up care plan (provide a copy to the woman/carer and her general practitioner) outlining:

- medical follow-up required (tests, surveillance)
- care plans for managing late effects
- a process for rapid re-entry to medical services for suspected recurrence.

Communication – lead clinician to:

- explain the treatment summary and follow-up care plan to the woman/carer
- inform the woman/carer about secondary prevention and healthy living
- discuss the follow-up care plan with the general practitioner.

Step 6

Managing recurrent, residual and metastatic disease

Detection of recurrent disease: Some cases of recurrent disease will be detected by routine follow-up in a woman who is asymptomatic.

Treatment: Where possible, refer the woman to the original multidisciplinary team. Treatment will depend on the location, the extent of recurrence, previous management and patient preferences.

Palliative care: Early referral can improve quality of life and, in some cases, survival. Referral should be based on need, not prognosis.

Communication – lead clinician to:

- explain the treatment intent, likely outcomes and side effects to the woman/carer.

Step 7

End-of-life care

Palliative care: Consider referral to palliative care if not already involved. Ensure that an advance care plan is in place.

Communication – lead clinician to:

- be open about the prognosis and discuss palliative care options with the woman/carer
- establish transition plans to ensure the woman's needs and goals are addressed in the appropriate environment.

Visit www.cancerpathways.org.au for consumer friendly guides. Visit www.cancer.org.au/OCP for the full clinical version and instructions on how to import these guides into your GP software.