Optimal care pathway for women with endometrial cancer

Quick reference guide

Step 1: Prevention and early detection

**Prevention**
Recommendations for reducing the risk of developing endometrial cancer include:
- maintaining a healthy weight
- taking birth control pills (especially over an extended period)
- having progesterone therapy as part of hormone replacement therapy for women with an intact uterus.

**Risk factors**
- Age
- Obesity
- Diabetes
- Endometrial hyperplasia
- Lynch syndrome (40–60 per cent lifetime risk of endometrial cancer)
- Family history of endometrial cancer in a first-degree relative
- PTEN gene mutations
- Unopposed postmenopausal oestrogen therapy
- Endometrial hyperplasia
- Nulliparity
- Anovulation
- Early menarche and late menopause
- Tamoxifen use in postmenopausal women
- Hormone secreting tumour of the ovary (granulosa cell tumour)

**Risk-reducing surgery**
Risk-reducing surgery may be considered for women with:
- non-genetic conditions where there is an increased risk of endometrial cancer such as atypical hyperplasia
- genetic conditions (e.g. Lynch syndrome or PTEN mutation).

Women considering risk-reducing surgery should have a thorough family history taken, including male relatives, and consider referral to a familial cancer service to try to define the actual risk, not only for the individual but also for other family members.

**Screening recommendations**
Screening in asymptomatic women is not appropriate for the early detection of endometrial cancer.

**Checklist**
- Recent weight changes discussed and the patient’s weight recorded
- Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate
- Smoking status discussed and recorded and brief smoking cessation advice offered to smokers
- Physical activity recorded
- Referral to a dietician considered
- Referral to a physiotherapist or exercise physiologist considered
- Education on being sun smart considered

Step 2: Presentation, initial investigations and referral

The following signs and symptoms should be investigated:
- vaginal bleeding after menopause
- bleeding between periods
- abnormal, watery or blood-tinged vaginal discharge
- unexplained weight loss
- pelvic pain
- difficult or painful urination.

**Initial examinations and investigations include:**
- a general and pelvic examination (including a speculum examination and cervical screening test)
- referral to an experienced gynaecological ultrasonographer for a transvaginal pelvic ultrasound.

**Checklist**
- Signs and symptoms recorded
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient notified of support services such as Cancer Council 13 11 20
Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 2: Presentation, initial investigations and referral continued

Referral options
At the referral stage, the patient’s GP or other referring doctor should advise the patient about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service.

Communication
The GP’s responsibilities include:
• explaining to the patient and/or carer who they are being referred to and why
• supporting the patient and/or carer while waiting for specialist appointments
• informing the patient and/or carer that they can contact Cancer Council on 13 11 20.

Checklist
☐ Referral options discussed with the patient and/or carer including cost implications

Timeframe
Any bleeding or abnormal vaginal discharge after menopause (more than 12 months after the last period) should be investigated without delay.

Any new, persistent or progressive symptoms in patients over the age of 40 should be investigated within 4 weeks of presenting with symptoms.

Symptoms that do not respond to treatment initiated by the GP (e.g. oral contraception or progesterone) should be evaluated within 3 months of treatment beginning.

Test results should be provided to the patient within 2 weeks of initial presentation.

If any investigations cannot be provided locally, then referral to a specialist for investigation and diagnosis should occur within 4 weeks of initial presentation to the GP.

Step 3: Diagnosis, staging and treatment planning

Diagnosis
The following investigations should be considered:
• transvaginal pelvic ultrasound (if not already done)
• outpatient endometrial biopsy
• endometrial biopsy (if diagnosis of malignancy not already obtained)
• abdomino-pelvic-chest CT scan
• MRI scans
• routine blood tests.

Staging
Staging is based on pathological and surgical findings. Where surgery is not performed, a clinical stage may be determined based on physical examination and imaging-related information.

Treatment planning
All newly diagnosed patients should be discussed in a gynaecology oncology multidisciplinary team meeting (MDM) before definitive treatment.

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

Research and clinical trials
Consider enrolment where available and appropriate. Search for a trial <www.australiancancertrials.gov.au>.

Checklist
☐ Diagnosis confirmed
☐ Full histology obtained
☐ Performance status and comorbidities measured and recorded
☐ Patient discussed at an MDM and decisions provided to the patient and/or carer
☐ Clinical trial enrolment considered
☐ Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
### Step 4: Treatment

<table>
<thead>
<tr>
<th>Establish intent of treatment</th>
<th>Surgery</th>
<th>Systemic therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Curative</td>
<td>Surgery is the primary treatment for endometrial cancer. The type of surgery offered will depend on several factors such as the extent and grade of disease, the patient's age, medical comorbidities, performance status and desire to retain fertility.</td>
<td>A number of patients may benefit from systemic therapy:</td>
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<tr>
<td>• Anti-cancer therapy to improve quality of life and/or longevity without expectation of cure</td>
<td>Radiation therapy For patients with adverse risk factors, adjuvant radiation may be offered. In selected cases, where surgery is inappropriate, radiation therapy may be offered as part of primary treatment or for symptomatic relief and palliation of metastatic or recurrent disease.</td>
<td>• patients with adverse risk factors (systemic therapy may be offered in conjunction with adjuvant radiotherapy to improve local control and, in selected cases, survival)</td>
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<tr>
<td>• Symptom palliation</td>
<td>Radiation therapy should begin within 6 weeks of the MDM if used for primary treatment and within 8 weeks after surgery if being used as adjuvant treatment.</td>
<td>• as primary treatment, where the patient is not suitable for surgery</td>
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#### Communication

The lead clinician's responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care
- encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication
- providing appropriate information and referral to support services as required
- communicating with the patient's GP about the diagnosis, treatment plan and recommendations from MDMs.

#### Checklist

- Intent of treatment established
- Risks and benefits of treatments discussed with the patient and/or carer
- Treatment plan discussed with the patient and/or carer
- Treatment plan provided to the patient's GP
- Treating specialist has adequate qualifications, experience and expertise
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Early referral to palliative care considered
- Advance care planning discussed with the patient and/or carer

#### Timeframe

Surgery should occur within 4 weeks of the MDM, provided the patient is medically fit. Radiation therapy or systemic therapy should begin within 6 weeks of the MDM if used for primary treatment and within 8 weeks after surgery if being used as adjuvant treatment.
Step 5: Care after initial treatment and recovery

**Provide a treatment and follow-up summary to the patient, carer and GP outlining:**
- the diagnosis, including tests performed and results
- tumour characteristics
- treatment received (types and date)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of these
- supportive care services provided
- a follow-up schedule, including tests required and timing
- contact information for key healthcare providers who can offer support for lifestyle modification
- a process for rapid re-entry to medical services for suspected recurrence.

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

**Communication**
The lead clinician’s responsibilities include:
- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient’s GP.

**Detection of recurrent disease**
Most patients with recurrent disease will usually present with symptoms. A small percentage of cases will be detected by routine follow-up.

**Treatment**
Evaluate each patient for whether referral to the original multidisciplinary team is appropriate. Treatment will depend on the location and extent of disease, previous management and the patient’s preferences.

**Advance care planning**
Advance care planning is important for all patients but especially those with advanced disease. It allows them to plan for their future health and personal care by thinking about their values and preferences. This can guide future treatment if the patient is unable to speak for themselves.

**Survivorship and palliative care**
Survivorship and palliative care should be addressed and offered early. Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

**Communication**
The lead clinician and team’s responsibilities include:
- explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient’s GP.

**Step 6: Managing recurrent, residual or metastatic disease**

**Detection of recurrent disease**
Most patients with recurrent disease will usually present with symptoms. A small percentage of cases will be detected by routine follow-up.

**Treatment**
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**Communication**
The lead clinician and team’s responsibilities include:
- explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient’s GP.

**Step 7: End-of-life care**

**Palliative care**
Consider a referral to palliative care. Ensure an advance care directive has been discussed and recommended.

**Communication**
The lead clinician’s responsibilities include:
- being open about the prognosis and discussing palliative care options with the patient
- establishing transition plans to ensure the patient’s needs and goals are considered in the appropriate environment

**Checklist**
- Treatment and follow-up summary provided to the patient and/or carer and the patient’s GP
- Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- Patient-reported outcome measures recorded
- Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- Patient referred to palliative care if appropriate
- Routine follow-up visits scheduled