Endometrial Cancer

All women with endometrial cancer should undergo systematic surgical staging, including pelvic washings, total hysterectomy (including cervix), bilateral salpingo-oophorectomy, bilateral pelvic and paraaortic lymphadenectomy, and complete resection of all disease. This could be completed via laparoscopy or laparotomy.

The minimum preoperative evaluation must include a pelvic examination, chest x-ray, and serum Ca 125 measurement. Other investigations such as CT scans or MRI etc. should be ordered on an individual basis.

Women with atypical endometrial hyperplasia and endometrial cancer who desire to maintain their fertility may be treated with progestin therapy (Megace 180mg BID +/- Mirena IUD). These patients should have a pelvic MRI to rule out muscle invasive disease. Following therapy they should undergo serial complete intrauterine evaluation approximately every 3 months to document response. Hysterectomy should be recommended for women who fail medical therapy and whom do not desire future fertility.

Adjuvant postoperative therapy (after complete FIGO surgical staging):

- Stage IA-IB grades 1-2 require surveillance and no adjuvant radiotherapy
  Stage IC, IIA or grade 3 adenocarcinoma require adjuvant radiotherapy (brachytherapy)
- Stage IIB require adjuvant pelvic radiotherapy if patient had extrafascial hysterectomy (teletherapy and brachytherapy) and brachytherapy if patient had radical hysterectomy
- Stage III-IV and all papillary serous adenocarcinoma of any stage require combination chemotherapy (Paclitaxel 175mg/m2 and Carboplatin AUC 5-6 Q3weeks X 6 cycles) followed by adjuvant pelvic +/- extended field radiotherapy

Patients with surgical stage I disease may be counseled that postoperative radiation therapy can reduce the risk of local recurrence, but the cost and toxicity should be balanced with the evidence that it does not improve survival or reduce distant metastasis.
When to refer:

- When the ability to completely and adequately surgically stage the patient is not readily available at the time of her initial procedure
- Preoperative histology of grade 3, papillary serous, clear cell, carcinosarcoma) suggests a high risk for extrauterine spread
- Preoperative Ca 125 elevated above the normal range suggests a high risk for extrauterine spread
- The final pathology test result reveals an unexpected endometrial cancer following hysterectomy performed for other indications
- There is evidence of cervical or extrauterine disease
- The pelvic washings are positive for malignant cells
- Recurrent disease is diagnosed or suspected
- Nonoperative therapy is contemplated

Follow-up:

- Every 3-4 months with pelvic examinations for 2-3 years, then twice yearly until the 5th year, and thereafter on a yearly basis
- Shared-care with the referring physician is strongly encouraged. It involves alternating the follow-up visits between the gynecologic oncology team and the referring physician.

Relevant Clinical Trials:

1. NCIC IND.160: A phase II study of CCI-779 in patients with metastatic and/or locally advanced recurrent endometrial cancer
2. RTOG 0418: A phase II study of intensity modulated radiation therapy (IMRT) to the pelvis +/- chemotherapy for post-operative patients with either endometrial or cervical carcinoma

Reference:
ACOG Practice Bulletin Number 65, August 2005.