Complete Summary

GUIDELINE TITLE

Management of endometrial cancer.

BIBLIOGRAPHIC SOURCE(S)

American College of Obstetricians and Gynecologists (ACOG). Management of endometrial cancer. Washington (DC): American College of Obstetricians and Gynecologists (ACOG); 2005 Aug. 13 p. (ACOG practice bulletin; no. 65). [82 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

- Endometrial cancer
- Atypical endometrial hyperplasia

GUIDELINE CATEGORY

Evaluation
Management
Treatment

CLINICAL SPECIALTY

Obstetrics and Gynecology
Oncology
Radiation Oncology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To aid practitioners in making decisions about appropriate obstetric and gynecologic care
- To review the risks and benefits of current treatment options to optimize treatment for women with endometrial cancer

TARGET POPULATION

Women with endometrial cancer or atypical hyperplasia

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation

1. Physical examination, including functional status and comorbidities
2. Chest radiograph
3. Histologic staging
4. Differential diagnosis (including human papillomavirus testing and cervical immunohistochemistry)
5. Cancer antigen (CA) 125 levels

Management

1. Surgical staging (pelvic washing, bilateral pelvic and paraaortic lymphadenectomy, retroperitoneal lymph node assessment)
2. Laparoscopic surgical restaging
3. Post-operative imaging (computed tomography, positron emission tomography)
4. Individualized care for comorbid conditions (e.g., long instrumentation, thromboembolic prophylaxis, postoperative pulmonary function care, panniculectomy, surgical procedure)
5. Frequency of post-treatment follow-up
6. Referral to or consultation with a gynecologic oncologist

Treatment

1. Surgery (complete resection of disease, hysterectomy, bilateral salphingo-oophorectomy, bilateral pelvic and paraaortic lymphandenectomy)
2. Preoperative radiation therapy
3. Adjuvant radiation therapy (whole pelvic radiation therapy, vaginal brachytherapy)
4. Systemic cytotoxic therapy may be used alone or in combination

5. Hormonal therapy (oral, parenteral, or intrauterine progestational agents; continuous versus cyclical therapy)
6. Concomitant versus sequential systemic therapy
7. Primary therapeutic radiation therapy (for poor surgical candidates)

MAJOR OUTCOMES CONSIDERED

- Survival rate
- Complication rate
- Cost
- Recurrence rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The MEDLINE database, the Cochrane Library, and the American College of Obstetricians and Gynecologists' own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 1985 and April 2005. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.

II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Analysis of available evidence was given priority in formulating recommendations. When reliable research was not available, expert opinions from obstetrician–gynecologists were used. See also the "Rating Scheme for the Strength of Recommendations" field regarding Grade C recommendations.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A — Recommendations are based on good and consistent scientific evidence.

Level B — Recommendations are based on limited or inconsistent scientific evidence.

Level C — Recommendations are based primarily on consensus and expert opinion.

COST ANALYSIS

Published cost analyses were reviewed.

A published cost analysis of treatment option of intermediate-risk patients (surgical stage I, grade 2 to 3, deep myometrial invasion) who underwent complete staging made the following assumptions: 1) lymph node status is the most important prognostic factor, 2) removal of lymph nodes testing negative for disease improves survival, 3) lymphadenectomy has minimal morbidity, 4) lymphadenectomy improves the cost effectiveness, and 5) teletherapy can be eliminated for stage I–II disease. The analysis demonstrated a 12% cost reduction with routine lymphadenectomy by avoiding teletherapy and substituting brachytherapy. The same analysts also report a 31% cost reduction by avoiding routine brachytherapy and treating the high-risk women only when they develop recurrent disease.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Practice Bulletins are validated by two internal clinical review panels composed of practicing obstetrician-gynecologists generalists and sub-specialists. The final guidelines are also reviewed and approved by the American College of Obstetricians and Gynecologists (ACOG) Executive Board.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of evidence (I-III) and levels of recommendation (A-C) are defined at the end of the "Major Recommendations" field.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Most women with endometrial cancer should undergo systematic surgical staging, including pelvic washings, bilateral pelvic and paraaortic lymphadenectomy, and complete resection of all disease. Exceptions to this include young or perimenopausal women with grade 1 endometrioid adenocarcinoma associated with atypical endometrial hyperplasia and those at increased risk of mortality secondary to comorbidities.
- Women with atypical endometrial hyperplasia and endometrial cancer who desire to maintain their fertility may be treated with progestin therapy. Following therapy they should undergo serial complete intrauterine evaluation approximately every 3 months to document response. Hysterectomy should be recommended for women who do not desire future fertility.
- 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.
- For those women who have not received radiation therapy, pelvic examinations every 3 to 4 months for 2 to 3 years, then twice yearly

following surgical treatment of endometrial cancer are recommended for detection and treatment of recurrent disease.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Women who cannot undergo systematic surgical staging because of comorbidities may be candidates for vaginal hysterectomy.
- Only a physical examination and a chest radiograph are required for preoperative staging of the usual (type I endometrioid grade 1) histology, clinical stage I patient. All other preoperative testing should be directed toward optimizing the surgical outcome.

Definitions:

Grades of Evidence

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.

II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Levels of Recommendations

Level A — Recommendations are based on good and consistent scientific evidence.

Level B — Recommendations are based on limited or inconsistent scientific evidence.

Level C — Recommendations are based primarily on consensus and expert opinion.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate screening and management of endometrial cancer

POTENTIAL HARMS

- Of patients treated with radiation, 2% have major complications, and 20% have minor complaints that affect quality of life.
- Complications and risks associated with surgery

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Aug

GUIDELINE DEVELOPER(S)

American College of Obstetricians and Gynecologists - Medical Specialty Society

SOURCE(S) OF FUNDING

American College of Obstetricians and Gynecologists (ACOG)

GUIDELINE COMMITTEE

American College of Obstetricians and Gynecologists (ACOG) Committee on Practice Bulletins-Gynecology

Society of Gynecologic Oncologists

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: None available

Print copies: Available for purchase from the American College of Obstetricians and Gynecologists (ACOG) Distribution Center, PO Box 4500, Kearneysville, WV 25430-4500; telephone, 800-762-2264, ext. 192; e-mail: sales@acog.org. The ACOG Bookstore is available online at the ACOG Web site.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

The following is available:

- Cancer of the uterus. How it can affect your pregnancy. Atlanta (GA): American College of Obstetricians and Gynecologists (ACOG); 2006.

Electronic copies: Available from the American College of Obstetricians and Gynecologists (ACOG) Web site. Copies are also available in Spanish.

Print copies: Available for purchase from the American College of Obstetricians and Gynecologists (ACOG) Distribution Center, PO Box 4500, Kearneysville, WV 25430-4500; telephone, 800-762-2264, ext. 192; e-mail: sales@acog.org. The ACOG Bookstore is available online at the ACOG Web site.

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NGC STATUS

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