Endometrial Cancer

Disclaimer

This pathway is for patients with suspected or diagnosed endometrial cancer. See also:
Heavy Menstrual Bleeding
Persistent Pelvic Pain

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Red Flags

- Postmenopausal bleeding

Assessment

1. History – Check for:
   - postmenopausal bleeding.
   - intermenstrual bleeding.
   - abnormal vaginal discharge, usually watery or blood-tinged.
   - pelvic pain including dypareunia.
   - unexplained haematuria.
   - unexplained weight loss.

2. Check risk factors for endometrial cancer or hyperplasia. Patients at higher risk are either aged ≥ 40 years, or aged > 35 years with one or more of:
   - BMI > 35
   - **Unopposed oestrogen exposure**

   Unopposed oestrogen exposure
   - Chronic anovulation e.g., polycystic ovarian syndrome (PCOS)
   - Nulliparity, early menarche, late menopause
   - HRT without progesterone support, including natural or bioidentical hormones (oral or topical)
   - Tamoxifen or other hormonal treatments of malignancy

   - Family history of endometrial cancer in first degree relative or known Lynch syndrome—see Familial Cancer Syndromes pathway.

3. Examination:
   - Perform abdominal examination, speculum, and bimanual pelvic examination.
   - Check for inguinal lymphadenopathy.

4. Arrange investigations:
   - FBE, iron studies, liver function tests, and thyroid-stimulating hormone (TSH)
   - Transvaginal pelvic ultrasound (on day 5 or 6 of cycle if premenopausal or on cyclical hormone treatment)
   - Cervical screening test
Management

Suspicion of endometrial cancer

1. Address the patient’s understanding and engagement. Consider barriers to effective care.

   **Barriers to effective care**

   Factors that could stop the patient from getting further tests or treatment:
   - Complexity of cancer care pathway – not knowing when or where to go next
   - Family, and social network dynamics
     - Family history
     - Family obligations including dependents
     - Work responsibilities
     - Community engagement and obligations or responsibilities
   - Locality and geographical access to health and hospital services
   - Socio-economic factors, including source of income.

2. If diagnosis made on ultrasound, refer for gynaecology assessment.

3. If normal investigation results, arrange review at 2 months.
   - If appropriate, consider treatment for vaginal atrophy.
   - If symptoms are persisting at 2 months, refer for urgent or routine gynaecology referral.

4. Consider high suspicion of cancer and refer for urgent or routine gynaecology referral within 2 weeks if:
   - thickened endometrium:
     - Post menopausal (with and without tamoxifen) and an endometrial thickness > 5 mm.
     - Premenopausal early proliferative phase and endometrial thickness > 7 mm.
   - abnormal vaginal bleeding, discharge, or pelvic pain and abnormal clinical examination findings consistent with gynaecological malignancy.
   - evidence of a rapidly growing uterine mass.

Initial treatment of confirmed endometrial cancer

1. If endometrial cancer is already diagnosed:
   - refer to the cancer treatment summary letter from the multidisciplinary disease management team.

   **Cancer treatment summary letter**

   Most importantly should include:
   - risk of recurrence and intentions of treatment.
   - goals and quantitative benefit of proposed treatment.
   - what the patient has been told.

   Usually includes:
   - diagnostic tests performed and results.
   - tumour characteristics and other factors determining prognosis.
➢ type and date of treatments and a treatment summary.
➢ expectations of disease course, including expected discharge from oncology services.
➢ interventions and treatment plans from other health professionals.
➢ a process for rapid re-entry to specialist medical services for suspected recurrence.
➢ a list of symptoms that might need prompt investigation.
➢ a list of supportive care services provided and a plan for community care services, including what each service is to provide.
➢ contact information for key care providers.

• contact the **GP Liaison Unit** for queries about specialist to general practitioner correspondence.

See also [Low-risk Endometrial Cancer Follow-Up](#).

2. If diagnosis made on ultrasound, refer directly to **urgent or routine gynaecology referral**.

3. Discuss with patient their understanding of treatment options:

  • **Treatment options** depend on stage, grade, and co-morbidities.

    **Treatment options**
    - All patients are recommended a hysterectomy and bilateral salpingo-oophrectomy with or without lymph node resection.
    - For most endometrial cancers, laparoscopic procedure is preferred where possible.
    - Other therapies that can be considered through multidisciplinary meeting (MDM) and in discussion with patient include:
      - radiotherapy – external radiation treatment or brachytherapy
      - chemotherapy and cytotoxics
      - hormone therapy – Provera, tamoxifen

  • Fertility-sparing options, if patient is of child-bearing age.

4. Ensure follow-up and surveillance. After initial diagnosis and treatment, the gynaecology service will design an individual follow-up plan according to level of risk of recurrence. The plan may involve regular general practitioner visits, which will detail:

  • the frequency of visits.
  • tests required and designated providers.
  • a nominated point-of-contact, if clinical concern.
  • regular assessment of **post-treatment sequelae** and lifestyle behaviours, and appropriate support requests e.g., dietitian, lymphoedema specialist.

**Post-treatment sequelae**

Side-effects of radiation or chemotherapy:

  - Gastrointestinal sequelae, nausea, vomiting, diarrhoea, rectal bleeding, proctitis, incontinence.
  - Hair loss (not carboplatin), skin rashes, mouth ulcers.
  - Bladder problems, irritability, incontinence, haematuria.
  - General symptoms, fatigue, lethargy, anorexia, mood, and cognition disturbance.
  - Easy bruising or bleeding (consider FBE).

• evidence-based advice about a healthy lifestyle.

Patients assessed as having a low risk of recurrence (< 10%) can be solely followed in general practice. See [Low-risk Endometrial Cancer – Follow-up](#).
Ongoing care and support

1. Provide ongoing care and support:
   - See Cancer Supportive Care for general advice on:
     - lifestyle changes
     - psychological needs
     - financial, legal, and practical needs
     - managing physical sequelae
     - support groups and referral services.

2. For Aboriginal and Torres Strait Islander patients:
   - provide culturally appropriate care.
   - advise the hospital of the patient's Aboriginal and Torres Strait Islander status.
   - ensure follow-up by a culturally appropriate healthcare professional.

3. Consider:
   - referral to palliative care services
   - advance care planning,
   - counselling support,
   - GP Management Plan and Team Care Arrangement,
   - hair loss in cancer therapies.

Referral

1. If diagnosis made on ultrasound, refer for gynae-oncology assessment.
2. Refer for urgent or routine gynaecology referral within 2 weeks if high suspicion of endometrial cancer e.g.:
   - normal investigations, but family history of endometrial cancer in first degree relative or known Lynch syndrome.
   - thickened endometrium:
     - postmenopausal (with and without tamoxifen) and an endometrial thickness > 5 mm.
     - premenopausal early proliferative phase and endometrial thickness > 7 mm.
   - abnormal vaginal bleeding, discharge, or pelvic pain and abnormal clinical examination findings consistent with gynaecological malignancy.
   - evidence of a rapidly growing uterine mass.
   - If normal investigations and symptoms are persisting at 2 month review, refer for urgent or routine gynaecology referral.
   - Consider referral to palliative care services or counselling support.
Information

For health professionals

Further information

Cancer Council Australia – Optimal Cancer Care Pathway for Women with Endometrial Cancer: Quick Reference Guide

For patients

- Cancer Australia:
  - Intimacy and Sexuality for Women with Gynaecological Cancer: Starting a Conversation
  - What are the Risk Factors for Endometrial Cancer?

- Cancer Council:
  - Cancer of the Uterus
  - Cancer: What to expect
  - Endometrial Cancer: What to Expect

- Cancer Council Victoria – Aboriginal Communities: Information
- National Indigenous Cancer Network – About Cancer

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