Optimal care pathway for women with endometrial cancer

Quick reference guide

The optimal care pathways describe the standard of care that should be available to all cancer patients treated in Australia. The pathways support patients and carers, health systems, health professionals and services, and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance provided in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

This quick reference guide provides a summary of the *Optimal care pathway for women with endometrial cancer.*

Please note that not all patients will follow every step of the 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

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 dietitian 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

SECOND EDITION

Australian Government
Cancer Australia

Cancer Council

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

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

Step 3: Diagnosis, staging and treatment planning continued

Communication

The lead clinician's[1] 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

- ❑ Patient referred to support services (such as Cancer Council) as required
- ❑ Treatment costs discussed with the patient and/or carer

Timeframe

Diagnostic investigations and relevant staging should be completed **within 2 weeks** of the initial specialist appointment.

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

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

Surgery

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.

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.

Systemic therapy

A number of patients may benefit from systemic therapy:

- patients with adverse risk factors (systemic therapy may be offered in conjunction with adjuvant radiotherapy to improve local control and, in selected cases, survival)
- as primary treatment, where the patient is not suitable for surgery
- to manage recurrent/metastatic or residual disease following surgery.

Hormonal therapy

Hormonal therapy may be appropriate for: fertility preservation in young patients; intrauterine and/or high-dose oral progestins in well-differentiated early-stage disease for patients who are unfit for surgery; or for symptom management in patients with recurrent/metastatic disease.

Palliative care

Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis. For more, visit the Palliative Care Australia website <www.palliativecare.org.au>.

Communication

The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate
- communicating the treatment plan to the patient's GP
- helping patients to find appropriate support for exercise programs where appropriate to improve treatment outcomes.

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.

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.

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

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.

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

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

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.

Checklist

- ❑ Treatment intent, likely outcomes and side effects explained 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
- ❑ Advance care planning discussed with the patient and/or carer
- ❑ Patient referred to palliative care if appropriate
- ❑ Routine follow-up visits scheduled

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

- ❑ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❑ Patient referred to palliative care
- ❑ Advance care directive discussed and recommended

Visit our guides to best cancer care webpage <www.cancercareguides.org.au> for consumer guides. Visit our OCP webpage <www.cancer.org.au/OCP> for the optimal care pathway and instructions on how to import these guides into your GP software.

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