Survivorship – Endometrial Cancer

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

**ELIGIBILITY**

**CONCURRENT COMPONENTS OF VISIT**

**SURVEILLANCE**

Annual physical exam with:
- Pelvic exam
- CA-125 based on pathology

New primary or recurrent disease?

Yes

- Return to primary treating physician

No

- Continue survivorship monitoring

**MONITORING FOR LATE EFFECTS**

Consider the following:
- Bone Health (see Gynecologic Cancer Survivorship: Bone Health algorithm)
- Patient education regarding symptoms including radiation therapy complications if appropriate
- Sexual health

Patient education, counseling, and screening:
- Lifestyle risk assessment
- Cancer screening
- HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis Screening and Management – HBV and HCV algorithm)
- Consider cardiovascular risk reduction
- Genetic screening (see Genetic Counseling algorithm)

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Social support
- Financial stressors

**RISK REDUCTION/EARLY DETECTION**

Endometrial carcinoma post-treatment
- Low or High Risk and NED

**PSYCHOSOCIAL FUNCTIONING**

New primary or recurrent disease?

Yes

- Return to primary treating physician

No

- Continue survivorship monitoring

**DISPOSITION**

NED = no evidence of disease

1 Low risk endometrial cancer is defined as any patient who did not receive chemotherapy or radiation therapy as adjuvant treatment after their initial surgery. Survivorship begins 3 years post-treatment and NED.
2 High risk defined as patients who received chemotherapy or radiation therapy as adjuvant treatment after their surgery. Survivorship begins 5 years post-treatment and NED.
3 Uterine carcinosarcoma – CA-125 annually
4 High grade, serous types – CA-125 annually, if previously elevated
5 See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
6 Includes breast, cervical (if appropriate), colorectal, liver, lung, pancreatic, and skin cancer screening
7 Consider use of Vanderbilt’s ABCDE’s approach to cardiovascular health
8 Consider genetic counseling if there has been a significant family history change since the last genetic consult, or if the patient has not previously had genetic counseling and has Lynch Syndrome risk factors. Lynch Syndrome risk factors: personal history of colon or rectal cancer; immediate family (first degree relatives such as parent, child, or sibling) with colorectal or endometrial cancer; immediate or extended family (first, second or third degree relatives including parent, child, sibling, aunt, uncle, nieces, nephews, grandparents, and first cousins) diagnosed before age 50 with colon, rectal or uterine cancer; any relatives tested positive for a Lynch Syndrome mutation (EPCAM, MLH1, MSH2, MSH6, PMS2 genes).

Lynch Syndrome risk factors: personal history of colon or rectal cancer; immediate family (first degree relatives such as parent, child, or sibling) with colorectal or endometrial cancer; immediate or extended family (first, second or third degree relatives including parent, child, sibling, aunt, uncle, nieces, nephews, grandparents, and first cousins) diagnosed before age 50 with colon, rectal or uterine cancer; any relatives tested positive for a Lynch Syndrome mutation (EPCAM, MLH1, MSH2, MSH6, PMS2 genes).

Copyright 2019 The University of Texas MD Anderson Cancer Center

Approved by the Executive Committee of the Medical Staff on 08/27/2019
Survivorship – Endometrial Cancer

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

SUGGESTED READINGS


Continued on next page
SUGGESTED READINGS - continued


This survivorship algorithm is based on majority expert opinion of the Gynecologic Survivorship work group at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

Therese Bevers, MD (Cancer Prevention)
Diane C. Bodurka, MD (Education)
Robin Coyne, FNP, RN (Cancer Prevention)
Molly S. Daniels, MS, CGC (Clinical Cancer Genetics)
Terri Earles, WHNP-BC (Gyn Onc & Reproductive Med)
David M. Gershenson, MD (Gyn Onc & Reproductive Med)
Thoa Kazantsev, BSN, RN, OCN*
Shiney Kurian, WHNP-BC (Gyn Onc & Reproductive Med)
Marita Lazzaro, RN, MS, ANP (Cancer Prevention)
Paula Lewis-Patterson, DNP, RN, NEA-BC (Cancer Survivorship)
Karen H. Lu, MD (Gyn Onc & Reproductive Med)

* Clinical Effectiveness Development Team

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.