Survivorship – Endometrial Cancer

ELIGIBILITY

Endometrial carcinoma post-treatment of Low[1] or High[2] Risk and NED

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

Annual history and physical exam with:
- Pelvic exam
- CA-125 based on pathology[3]

Suspected new primary or recurrent disease?

Yes

Return to primary treating physician
- **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative[4]

No

Continue survivorship monitoring

MONITORING FOR LATE EFFECTS

Consider the following:
- Bone Health (see Survivorship - Gynecologic Cancer: Bone Health algorithm)
- Sexual health (see Ovarian Toxicity Monitoring algorithm)
- Pelvic floor dysfunction
- Genitourinary assessment (*e.g.,* vasomotor symptoms, vulvovaginal dryness, urinary incontinence)
  - Consideration of hormone therapy (HT) if medically appropriate
- Bowel dysfunction assessment for radiation proctitis, adhesions, and/or fibrosis
- Lymphedema assessment

Refer or consult as indicated

RISK REDUCTION/EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

CHRONIC HEALTH MAINTENANCE

See Page 2

DISPOSITION

NED = no evidence of disease

[1] Low risk endometrial cancer is defined as any patient who did not receive chemotherapy or radiotherapy 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 radiotherapy as adjuvant treatment after their surgery. Survivorship begins 5 years post-treatment and NED.

[3] • Uterine carcinosarcoma – CA-125 annually • High grade, uterine serous types – CA-125 annually

[4] GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

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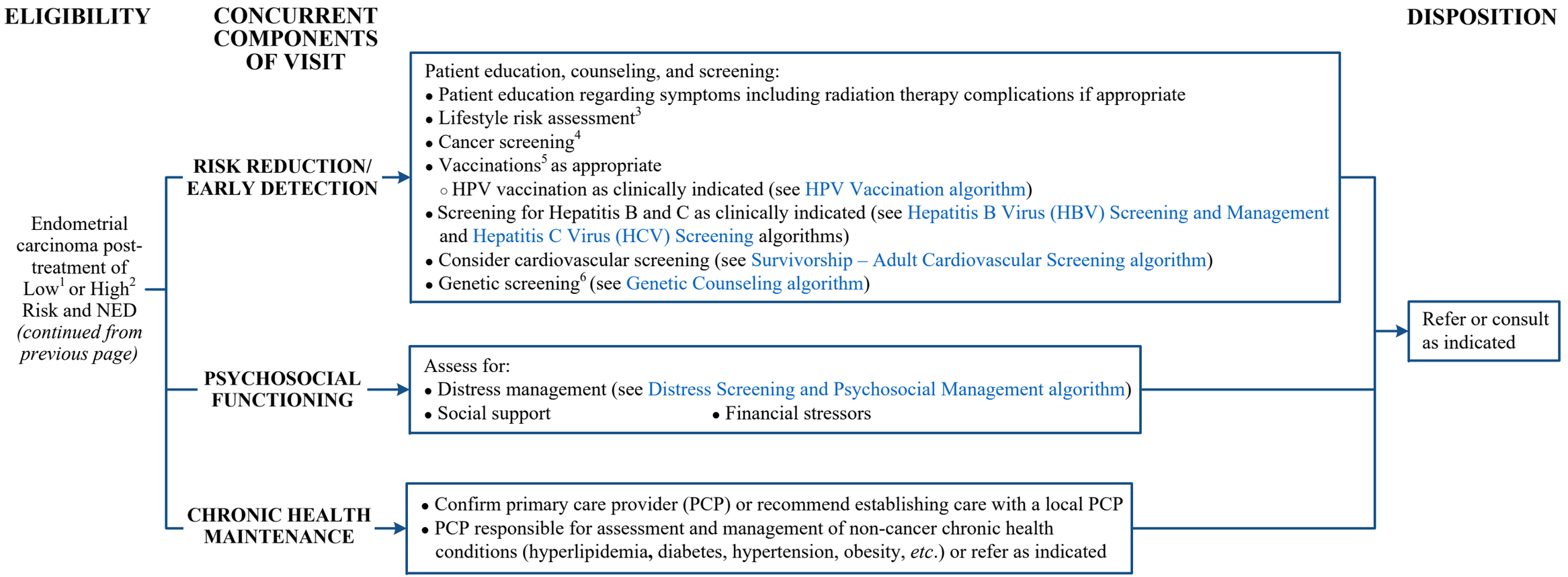

[1] Low risk endometrial cancer is defined as any patient who did not receive chemotherapy or radiotherapy as adjuvant treatment after their initial surgery. Survivorship begins 3 years post-treatment and NED.
[2] High risk defined as patients who received chemotherapy or radiotherapy as adjuvant treatment after their surgery. Survivorship begins 5 years post-treatment and NED.
[3] See Physical Activity, Nutrition, Obesity Screening and Management and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[4] Includes breast, cervical, colorectal, liver, lung, pancreatic, and skin cancer screening
[5] Based on American Society of Clinical Oncology (ASCO) guidelines
[6] 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).

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MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy

Advance Care Planning (ACP) Conversation Workflow (ATT1925)

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DEVELOPMENT CREDITS

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