Survivorship – Endometrial Cancer

Endometrial carcinoma post-treatment
Low1 or High2 Risk and NED

ELIGIBILITY

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

MONITORING FOR LATE EFFECTS

RISK REDUCTION/EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

New primary or recurrent disease?

Yes

See appropriate cancer treatment algorithm

No

Continue survivorship monitoring

Refer or consult as indicated

Annual physical exam with:

● Pelvic exam
● CA-125 based on pathology

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

Survivorship begins 3 years post-treatment and NED.

● 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.

● High risk defined as women who received chemotherapy or radiotherapy as adjuvant treatment after their surgery. Survivorship begins 5 years post-treatment and NED.

1 Uterine carcinosarcoma – Annual CA-125
2 High grade, serous types – CA-125 if done while followed in Gynecologic Oncology
3 Includes breast, cervical (if appropriate), colo结rectal, liver, lung, pancreatic, and skin cancer screening
4 Consider use of Vanderbilt’s ABCDE’s approach to cardiovascular health
5 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).

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.
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SUGGESTED READINGS


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SUGGESTED READINGS - continued


NCCN Clinical Practice Guidelines in Oncology, Uterine Neoplasm V1.2014


DEVELOPMENT CREDITS

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:

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