

S2k Guideline on the Diagnosis and Treatment of Endometrial Carcinoma

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Methodological report: S2k Guideline on Endometrial Carcinoma

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Methodological report: key recommendations

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In formulating the recommendations, three different qualities were distinguished whenever possible:

- “Must/must not,” corresponding to a strong recommendation for/against an intervention
- “Should/should not,” corresponding to a recommendation for/against an intervention
- “Can/may,” corresponding to an optional action with some uncertainty

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Specialist society/organization	Representative
Working Group on Psycho-Oncology (<i>Arbeitsgemeinschaft für Psychoonkologie, PSO</i>)	Prof. J. Weis Dr. M. Keller
Working Group on Gynecological Oncology (<i>Arbeitsgemeinschaft Gynäkologische Onkologie, AGO</i>)	Prof. M.W. Beckmann Prof. G. Emons
Working Group on Radiological Oncology (<i>Arbeitsgemeinschaft Radiologische Onkologie, ARO</i>)	Prof. G. Hänsgen
German Society for Radio-Oncology (<i>Deutsche Gesellschaft für Radioonkologie, DEGRO</i>)	Prof. W. Harms
Working Group on Rehabilitation, Follow-Up, and Social Medicine (<i>Arbeitsgemeinschaft Rehabilitation, Nachsorge und Sozialmedizin, ARNS</i>)	Prof. R. Schröck
Working Group on Supportive Measures (<i>Arbeitskreis Supportivmassnahmen, ASO</i>)	Prof. P. Feyer Dr. K. Jordan
Association of Gynecologists (<i>Berufsverband der Frauenärzte e.V.</i>)	Dr. K. König
German Society for Gynecology and Obstetrics (<i>Deutsche Gesellschaft für Gynäkologie und Geburtshilfe, DGGG</i>)	Prof. P. Mallmann Prof. R. Kimmig
Working Group on Oncological Pathology (<i>Arbeitsgemeinschaft onkologische Pathologie, AOP</i>)	Prof. D. Schmidt
German Society for Pathology (<i>Deutsche Gesellschaft für Pathologie, DGP</i>)	Prof. L.-C. Horn
German Radiology Society (<i>Deutsche Röntgengesellschaft, DRG</i>)	Prof. B. Hamm
Women's Self-Help after Cancer (<i>Frauenselbsthilfe nach Krebs e.V.</i>)	Ms. B. Reckers
Conference of Oncological and Pediatric Nurses (<i>Konferenz onkologischer Kranken- und Kinderkrankenpflege, KOK</i>)	Ms. K. Paradis

Statements:

Early recognition and screening

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- 1. General screening cannot be recommended.**
- 2. There is no evidence that screening of high-risk populations leads to reduced mortality.**

Statements: Diagnosis

1. Obtaining a histological sample is necessary in order to confirm the diagnosis.
3. There are no machine-aided measures that are capable of replacing surgical staging in endometrial carcinoma. In patients who are inoperable due to comorbid conditions, magnetic resonance imaging may be helpful for treatment planning.
5. The histological classification of endometrial carcinoma and its precursor lesions is carried out in accordance with the WHO guidelines.
7. The minimum requirements for a report on histopathological findings in endometrial carcinoma are: tumor type, grade, vascular invasion, depth of invasion into the myometrium, cervical infiltration and lymph-node involvement, R classification, vascular and lymphatic invasion.

Statements:

Patient information I

Information materials (print or Internet media) that are of high quality and produced with appropriate specialist competence must be provided, in accordance with the quality requirements set out in the Guideline on Gynecological Information. By communicating the risks in a comprehensible way (including details of incidences, rather than relative percentages), these materials should provide patients with support in taking independent decisions for or against medical procedures.

Statements: Patient information II

Information should be communicated to the patient both comprehensively and accurately, observing the following basic principles of patient-centered communication:

- Expression of empathy and active listening
- Direct and sensitive ways of touching on difficult subjects
- If possible, avoidance of specialized medical terms, or with explanations of specialist terms being given if necessary
- Strategies for improving understanding (repetition, summing up of important information, use of graphics, etc.)
- Encouraging the patient to ask questions
- Permission and encouragement to express emotions
- Offering further assistance (e.g., from self-help groups, psycho-oncology, psychosocial cancer counseling)

Statements:

Treatment for precursors of endometrial carcinoma

1. Hyperplasia of the endometrium without atypia can be treated conservatively.
2. Hyperplasia of the endometrium with atypia has a high risk of malignant transformation. An attempt at conservative treatment should only be considered if the patient wishes to have children and a high degree of compliance can be expected.

Statements:

Treatment of early endometrial carcinoma

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1. For women with well-differentiated, progesterone receptor–positive endometrioid endometrial carcinoma in clinical stage 1a who have a strong desire for children, conservative therapy can be considered.

Statements:

Surgical Treatment for Endometrial Carcinoma

1. Surgical treatment for endometrial carcinoma should include cytological sampling from the abdominal cavity, hysterectomy, bilateral adnexectomy, and pelvic and para-aortic lymphadenectomy as far as the renal pedicle.
2. In the presence of serous or clear cell carcinoma, multiple peritoneal biopsies should be taken and omentectomy should also be carried out.
3. In stages pT1a, pT1b, and in the presence of G1 or G2, lymphadenectomy is optional.
4. In stage pT2b, the parametria should also be resected.
5. In advanced stages, as complete a resection of the tumor as possible should take place in order to improve the effectiveness of adjuvant systemic and radiotherapeutic measures.

Statements:

Radiotherapy for endometrial carcinoma

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1. Primary radiotherapy for endometrial carcinoma is indicated if the patient is not operable due to a comorbid condition.
2. In patients with a high risk of local recurrence, adjuvant radiotherapy should be administered in order to reduce the risk of locoregional recurrence.
3. In stages I and II, adjuvant radiotherapy has no effect on the overall survival.

There are no adequate data on this topic for more advanced stages.

Statements:

Systemic adjuvant therapy for endometrial carcinoma

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1. Adjuvant endocrine therapy with gestagens has no therapeutic effect.
2. In optimally operated endometrial carcinoma in stages III and IV, chemotherapy is an alternative to radiotherapy.
3. In endometrial carcinomas in stages Ic G3, II G3, and III, adjuvant chemotherapy may represent an alternative to radiotherapy.

Statements:

Systemic palliative therapy for endometrial carcinoma

1. If surgery and/or radiotherapy are no longer possible in patients with recurrences or metastases, gestagen treatment is recommended for patients with progesterone receptor–positive carcinomas and asymptomatic metastases.
3. If progression occurs during endocrine therapy, in receptor-negative tumors, and when there are symptomatic and life-threatening tumor signs, palliative chemotherapy may be useful.
5. The indication for systemic combination chemotherapy regimens needs to be established strictly, in view of their lack of effect or only marginal effect on the overall survival.

Statements:

Recurrences, metastases

1. Resectable recurrences of endometrial carcinoma should be treated surgically.
2. In inoperable patients, radiotherapy should be carried out.
3. If neither surgery nor radiotherapy is possible, palliative systemic treatment should be carried out.

Statements: Supportive therapy

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1. Supportive therapy in accordance with the guidelines is required for prophylaxis against and minimization of treatment-related or tumor-related symptoms.

Statements: Psycho-oncology

1. Psycho-oncological care for patients with endometrial carcinoma is an integral component of oncological diagnosis, treatment, rehabilitation, and follow-up and represents an interdisciplinary task.
2. The patient should be informed at an early stage about the availability of in-patient and outpatient psycho-oncological assistance and should receive skilled psycho-oncological care if needed.
3. The patient's quality of life must be regularly assessed during treatment, rehabilitation, and follow-up, also in order to assess the potential need for psycho-oncological support.

Statements: Rehabilitation

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1. All patients should be informed and advised in detail by the attending physician regarding the statutory facilities for subsequent treatment, regular therapy, and outpatient rehabilitation.

Statements: Follow-up

1. Since a curative approach is possible if a local recurrence is recognized at an early stage, a 3-month follow-up interval should be observed in the first 2–3 years after primary therapy, with speculum examination, vaginal and rectal examination, and ultrasonography if appropriate.
3. More detailed imaging diagnosis is only required in symptomatic patients.
5. The following points should be addressed in discussion with the patient during the follow-up:
 - Transient and long-term effects of the disease and treatment
 - Psycho-oncological/psychotherapeutic treatment facilities
 - Sexuality and relationship
 - Quality of life