S3 Guidelines 2018
Endometrium Cancer

P.Mallmann
Cologne
Erklärung der COI

Implementierung und Disseminierung der Leitlinie

- Externe Begutachtung
- Extraktion von Qualitätsindikatoren
- Verfassung einer Lang-, Kurz- und PatientInnen
- Konsentierung der Schlüsselfempfehlungen und Hintergrundtexte
- + englische Version der LL

Dokumentation im Methodenreport

- Konsens
- EbM
- Logik
- Entscheidungsanalyse
- Outcome-Analyse

Formulierung der Zielsetzung

Leitlinienrecherche und -synopse

Konsentierung der Schlüsselfragen

Priorisierung der Schlüsselfragen und Festlegung der Strategie

Formulierung der Schlüsselfempfehlungen und Hintergrundtexte

Literaturrecherche u. kritische Bewertung
A routine case from the daily practice:
A 56-year-old woman with postmenopausal bleeding.
Vaginal ultrasound:
Do all patients with postmenopausal bleeding need a D&C?
No!

- For patients with endometrial thickness of >3mm, the probability of endometrial pathology is less than 2%

z.B. Wong BJOG 2015, Timmermanns 2010
Early Detection

For women with first postmenopausal bleeding and an endometrial thickness of <3mm, a clinical and sonographoc control should be performed within 3 months after diagnosis.

In case of repeated bleeding or an increase of endometrial thickness a D&C is indicated.
Early Detection

For women with postmenopausal bleeding and an endometrial thickness of <3-5mm or inhomogeneous endometrium a D&C is indicated
Operative Therapy
Operative Therapy

Hysterectomy, in premenopausal patients stage IA G 1-2 with salpingectomy, stage IB with adnexectomy.

Cytologic examination of the peritoneal fluid
There is no indication for a radical hysterectomy in endometrium cancer patients
Is a lymphonodectomy indicated?
It depends on the type of endometrium cancer:

Type I
Lymphonodectomy

In case of type 1 endometrial cancer pT1a G1/2 a lymphonodectomy should not be performed
Lymphonodectomy

In case of type 1 endometrial cancer pT1a G3, pT1b G1-2 a lymphonodectomy can be performed
Lymphonodectomy

In case of type 1 endometrial cancer pT2-T4 G1-3 a lymphonodectomy should be performed
In all cases of type 2 endometrial cancer a lymphonodectomy should be performed.
Can those patients who need an lymphonodectomy be identified preoperativly?

- Grading?
- Type 1 or 2 endometrial cancer
- Myometrial infiltration (IB?)
Can those patients who need an lymphonodectomy be identified preoperatively?

- Grading?
- Type 1 or 2 endometrial cancer
- Myometrial infiltration (IB?)
Does this patient need a lymphonodectomy?

- Is this a Stage IB?
Intraoperative quick section

• 166 women with endometrium cancer. Vaginale ultrasound versus MRI versus intraoperative quick section. Comparison of the sensitivity concerning infiltration of the myometrium
  • - vaginale ultrasound 51%
  • - MRI 54%
  • - intraoperative quick section 92%

• Savelli et al. Gynecol Oncol 124(3) 2012 549
Recommendation for the practice:

• The most reliable parameter for the evaluation of the infiltration depth is the intraoperative quick section.

• Intraoperative quick section can prevent the morbidity and mortality of a two-step procedure.
Up to now, there is no reliable data concerning the sentinel node biopsy in endometrial cancer patients. Therefore, SNL biopsy cannot be recommended.
III. Adjuvant therapy
Adjuvant Therapy of endometrial cancer

Half of all patients have a low risk. There is no need for any adjuvant therapy:

Stage I A G 1-2

5-year recurrence-free survival >95%
Adjuvant Therapy of endometrial cancer

One third of all patients have a medium risk. They need a vaginal brachytherapy:

Stage I A G 3, I B G 1-2 N0 L0 V0

5-year recurrence-free survival 80-85%
Adjuvant Therapy of endometrial cancer

20 % of all patients have a high risk that means a risk of relapse of > 50%. They need an adjuvant chemotherapy.

FIGO Stage IB G3 N+
Stage II and III
Papillary and clear cell carcinoma
Adjuvant chemotherapy

For all patients with type II endometrial cancer and patients with type I endometrial cancer pT1b G3 and pT2 an adjuvant chemotherapy can be performed

LoE 2
Adjuvant Chemotherapy

For all patients with endometrial cancer \( pT3 \) and/or \( pN1 \) and all patients with non-endometrial pathology an adjuvant chemotherapy should be performed

LoE 2
There is conflicting data concerning the effect of an adjuvant chemotherapy: positive

Cochrane Data Base 2011
And negative data

Survival (OS and FFS)

- 5 yr OS: 82% (CTRT) versus 77% (RT)
- 5 yr FFS: 76% (CTRT) versus 69% (RT)

HR 0.79 [0.57-1.12], p=0.18

HR 0.77 [0.58-1.03], p=0.078
Adjuvant Radiotherapy

There is no consistent data concerning the effectiveness of a percutaneous radiotherapy in endometrial cancer
IV. Palliative therapy
Palliative therapy of endometrial cancer

➢ First local therapy if possible (e.g. RFA, radiotherapy)
➢ If there are no severe complains endocrine therapy with MPA
➢ In all other cases chemotherapy carboplatin and paclitaxel
Guidelines endometrial cancer 2018

• Standard for all patients with hysterectomy and salpingectomy or adnexectomy, cytologic examination of the abdominal fluid

In
• Typ II endometrial cancer or
• G3 or
• non-endometrioid histology or
• pT1b

simultane pelvic and paraaortal LNE
Stage-adapted surgical staging of endometrium cancer

- For all N+ adjuvant chemotherapy with carboplatin and paclitaxel and radiotherapy