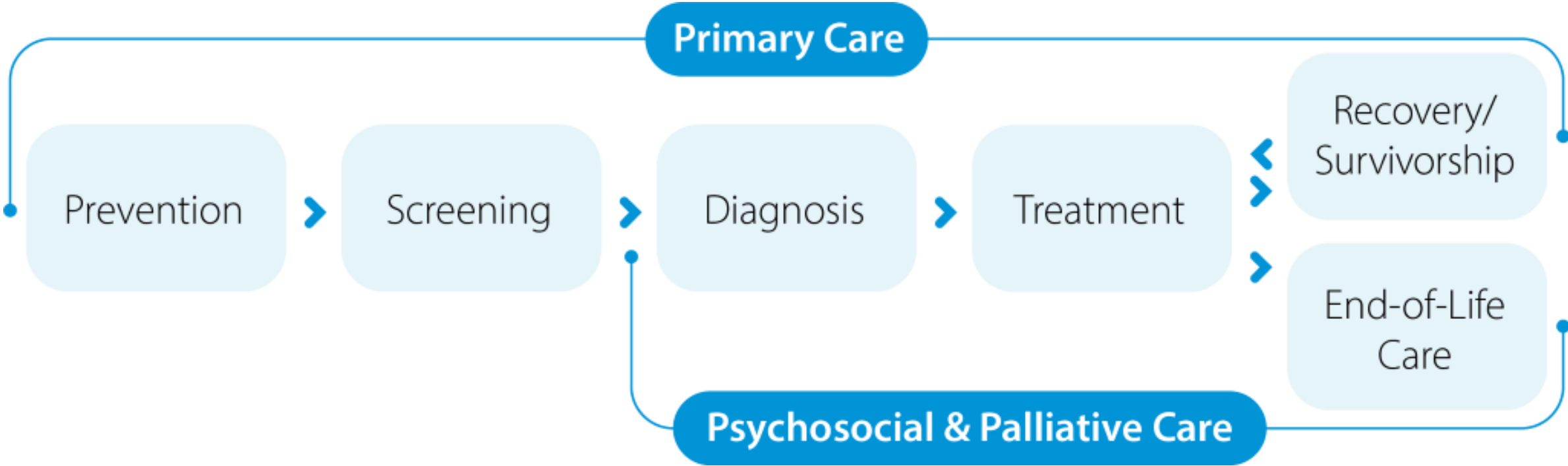


Endometrial Cancer Treatment and Follow Up Pathway Map

Version 2021.11



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Pathway Map Considerations

- For more information about the optimal organization of gynecologic oncology services in Ontario, refer to [EBS #4-11](#).
- All patients with grade 2 endometrioid cancers and all high-grade histology should be referred to a gynecologic oncology center (GOC).
- Pathology:**
 - All endometrial cancers reviewed at a non-gynecologic oncology centre (non-GOC) and believed to be grade 1 endometrioid must have the diagnosis confirmed by 2 pathologists. If there is discordance between pathologists, the patient and pathology should be referred to a GOC.
 - All grade 2 endometrioid and high-grade (grade 3 endometrioid, serous, clear cell, carcinosarcoma, undifferentiated and mixed histologies) endometrial cancer should be reviewed at a GOC by a pathologist with an interest in gynecologic pathology.
 - All endometrial cancers should have reflex mismatch repair (R) immunohistochemistry (IHC) testing to screen for Lynch syndrome. If M1 deficient, reflex hypermethylation should be performed.
 - All endometrial cancers should have p53 IHC performed.
 - IHC for M and p53 should ideally be performed on diagnostic endometrial biopsy.
- Genetics:** All tumours with M2/M6, M6, P52 and M1 (without hypermethylation) deficiency and patients with family history consistent with Lynch syndrome are candidates for genetic testing and should be referred for genetic counselling. Visit [Hereditary Cancer Testing Eligibility](#)
- Treatment:** Stage II patients who are not candidates for surgery (due to poor performance status, surgical resectability, and patient comorbidities) should be referred to a radiation oncology centre with ≥ 10 intracavitary brachytherapy cases per year.
- Sexual health should be considered throughout the care continuum. Healthcare providers should discuss sexual health with patients before, during and after treatment as part of informed decision-making and symptom management. See [Psychosocial Oncology Guidelines Resources](#).
- Before initiating gonadotoxic therapy (e.g. surgery, systemic, radiation), healthcare providers should discuss potential effects on fertility with patients and arrange referral to a fertility specialist if appropriate. See [Ontario Fertility Program](#).
- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway map. For patients who do not have a primary care provider, [Health Care Connect](#) is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway map, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see [Person-Centered Care Guideline](#) and [EBS #19-2 Provider-Patient Communication](#).*
- Hyperlinks are used throughout the pathway map to provide information about relevant CCO tools, resources and guidance documents.
- The term ‘healthcare provider’, used throughout the pathway map, includes primary care providers and specialists, e.g. family doctors, nurse practitioners, and emergency physicians.
- For more information on wait time prioritization, visit [Surgery](#).
- Multidisciplinary Cancer Conferences (MCCs) may be considered for all phases of the pathway map. For more information on MCCs, visit [MCC Tools](#).
- Clinical trials should be considered for all phases of the pathway map.
- Psychosocial oncology (PSO) is the interprofessional specialty concerned with understanding and treating the social, practical, psychological, emotional, spiritual and functional needs and quality-of-life impact that cancer has on patients and their families. Psychosocial care should be considered an integral and standardized part of cancer care for patients and their families at all stages of the illness trajectory. For more information, visit [EBS #19-3](#).*
- The following should be considered when weighing the treatment options described in this pathway map for patients with potentially life-limiting illness:
 - Palliative care may be of benefit at any stage of the cancer journey, and may enhance other types of care – including restorative or rehabilitative care – or may become the total focus of care.
 - Ongoing discussions regarding goals of care is central to palliative care, and is an important part of the decision-making process. Goals of care discussions include the type, extent and goal of a treatment or care plan, where care will be provided, which health care providers will provide the care, and the patient’s overall approach to care.



* **Note:** [EBS #19-2](#) and [EBS #19-3](#) are older than 3 years and are currently listed as ‘For Education and Information Purposes’. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes. [GL #19-6](#) and [GL #4-11](#) are currently listed as “In Review.”

Pathway Map Legend









Colour Guide

	Primary Care
	Palliative Care
	Pathology
	Organized Diagnostic Assessment
	Gynecologic Oncology
	Radiation Oncology
	Medical Oncology
	Radiology
	Gynecology
	Multidisciplinary Cancer Conference (MCC)
	Genetics
	Psychosocial Oncology (PSO)

Line Guide

	Required
	Possible

Shape Guide

	Intervention
	Decision or assessment point
	Patient (disease) characteristics
	Consultation with specialist
	Exit pathway
 or 	Off page reference
	Referral

Pathway Map Disclaimer

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While care has been taken in the preparation of the information contained in the pathway map, such information is provided on an “as-is” basis, without any representation, warranty, or condition, whether express, or implied, statutory or otherwise, as to the information’s quality, accuracy, currency, completeness, or reliability.

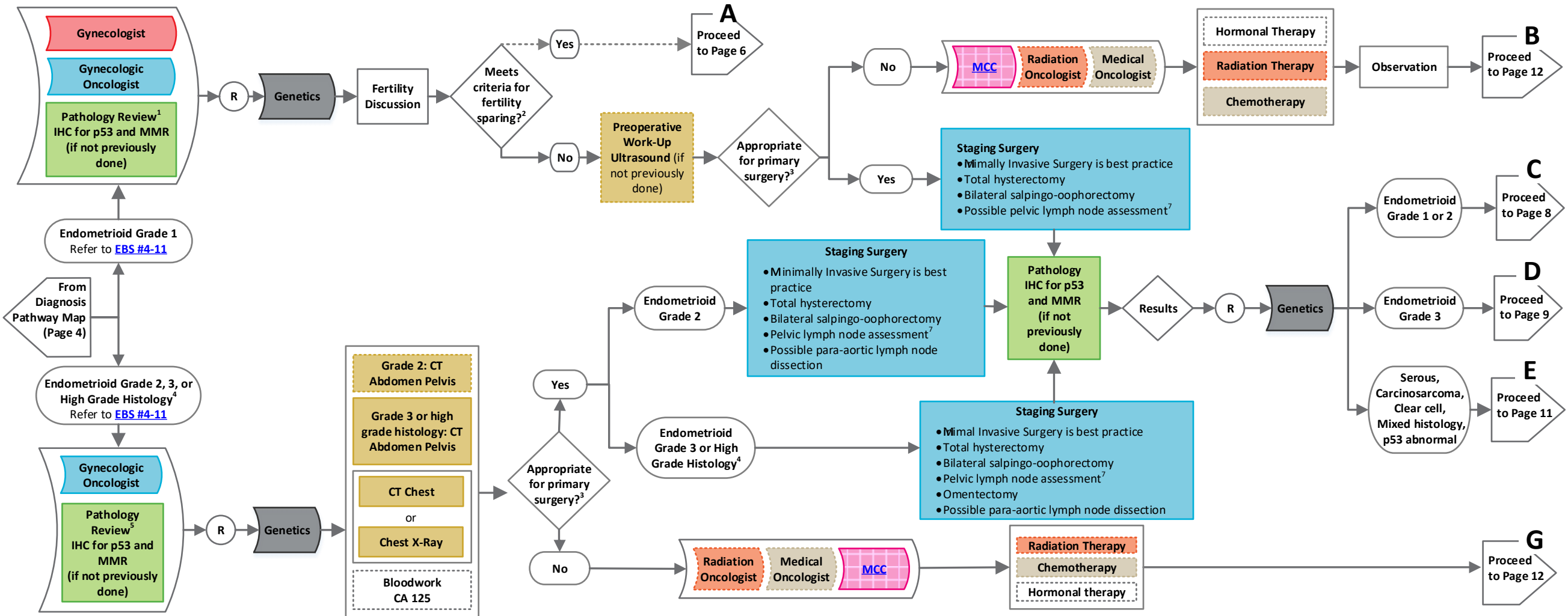
Ontario Health (Cancer Care Ontario) and the pathway map’s content providers (including the physicians who contributed to the information in the pathway map) shall have no liability, whether direct, indirect, consequential, contingent, special, or incidental, related to or arising from the information in the pathway map or its use thereof, whether based on breach of contract or tort (including negligence), and even if advised of the possibility thereof. Anyone using the information in the pathway map does so at his or her own risk, and by using such information, agrees to indemnify Ontario Health (Cancer Care Ontario) and its content providers from any and all liability, loss, damages, costs and expenses (including legal fees and expenses) arising from such person’s use of the information in the pathway map.

This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. Ontario Health (Cancer Care Ontario) and its content providers assume no responsibility for omissions or incomplete information in this pathway map. It is possible that other relevant scientific findings may have been reported since completion of this pathway map. This pathway map may be superseded by an updated pathway map on the same topic.

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Screen for psychosocial needs, and assessment and management of symptoms. [Click here for more information about symptom assessment and management tools](#)

Consider the introduction of palliative care, early and across the cancer journey. [Click here for more information about palliative care](#)



¹ Throughout the pathway map, all endometrial cancers reviewed at a non-gynecologic oncology centre (non-GOC) and believed to be grade 1 endometrioid must have the diagnosis confirmed by 2 pathologists. If there is discordance between pathologists, the patient and pathology should be referred to a GOC.

² Patients should undergo counseling that fertility sparing treatment is for highly selected and motivated patients who meet strict criteria for progestin therapy: 1) Grade 1 endometrioid adenocarcinoma, 2) no myometrial invasion on IM, 3) no metastatic disease, 4) no contraindications to progesterone therapy, 5) desire for future fertility.

³ The following should be taken into consideration: performance status, surgical resectability, and patient comorbidities.

⁴ High grade histology: serous, clear cell, carcinosarcoma, grade III endometrioid, undifferentiated, mixed high grade.

⁵ Throughout the pathway map, all grade 2 endometrioid and high-grade (grade 3 endometrioid, serous, clear cell, carcinosarcoma, undifferentiated and mixed histologies) endometrial cancer should be reviewed at a GOC by a pathologist with an interest in gynecologic pathology.

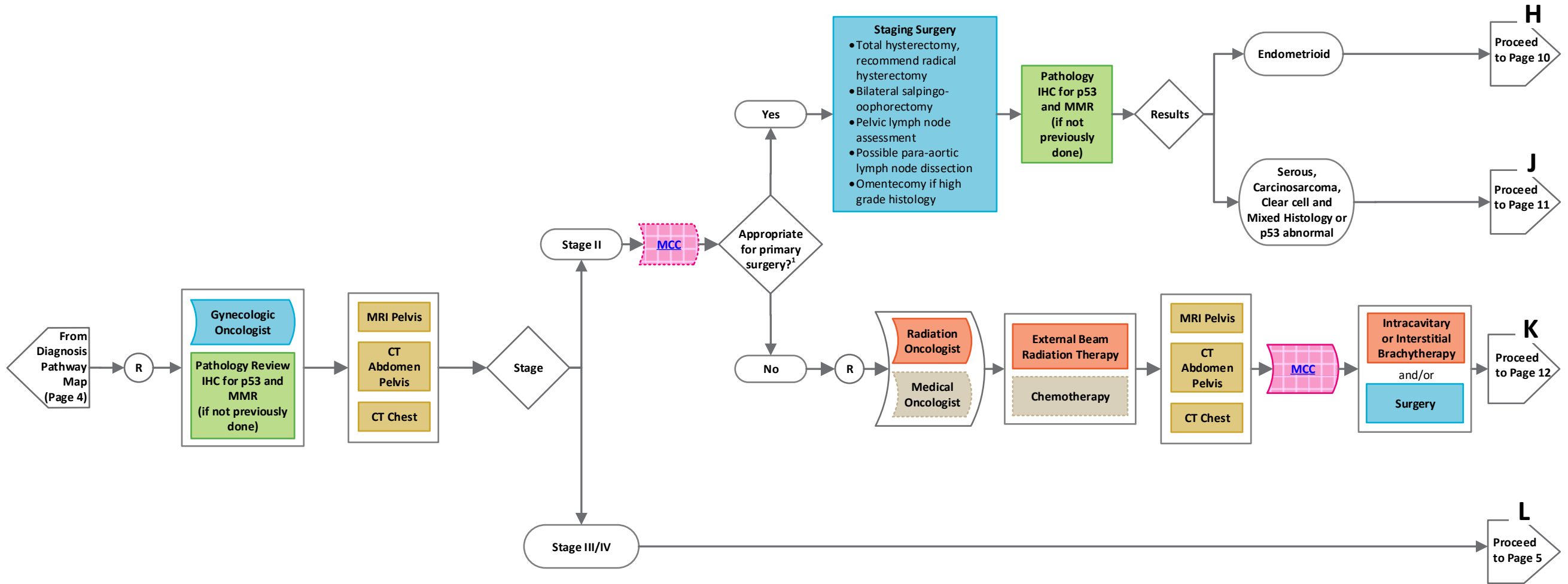
⁷ Sentinel lymph node dissection or pelvic lymphadenectomy

Endometrial Cancer Treatment and Follow Up Pathway Map

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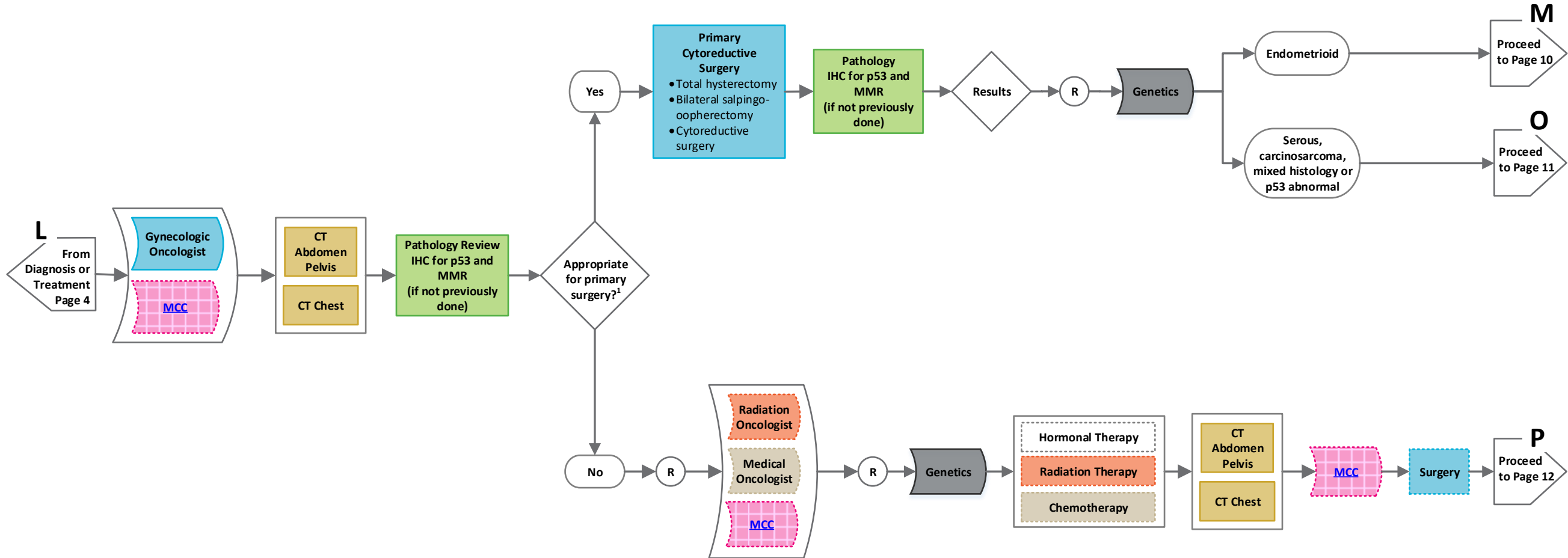
Endometrial Cancer Treatment and Follow Up Pathway Map

Clinical Stage III/IV Extrauterine Disease (Metastasis)

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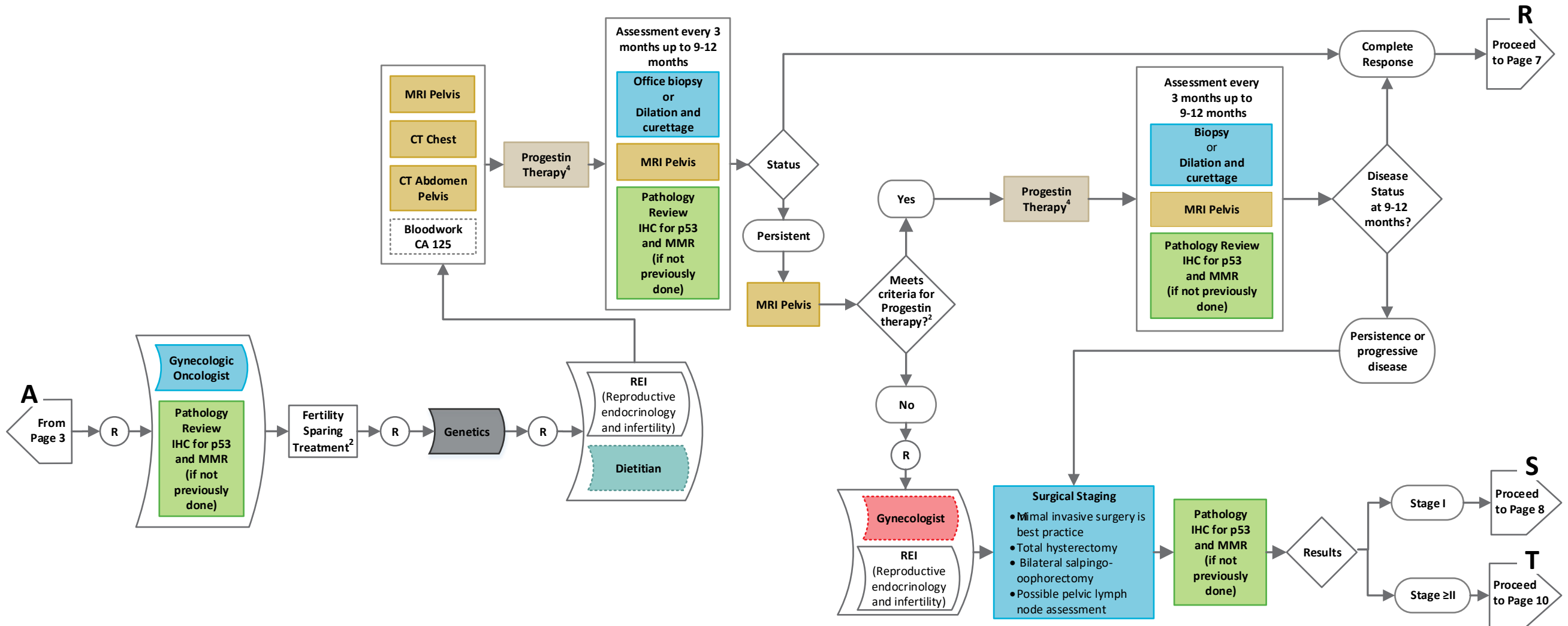


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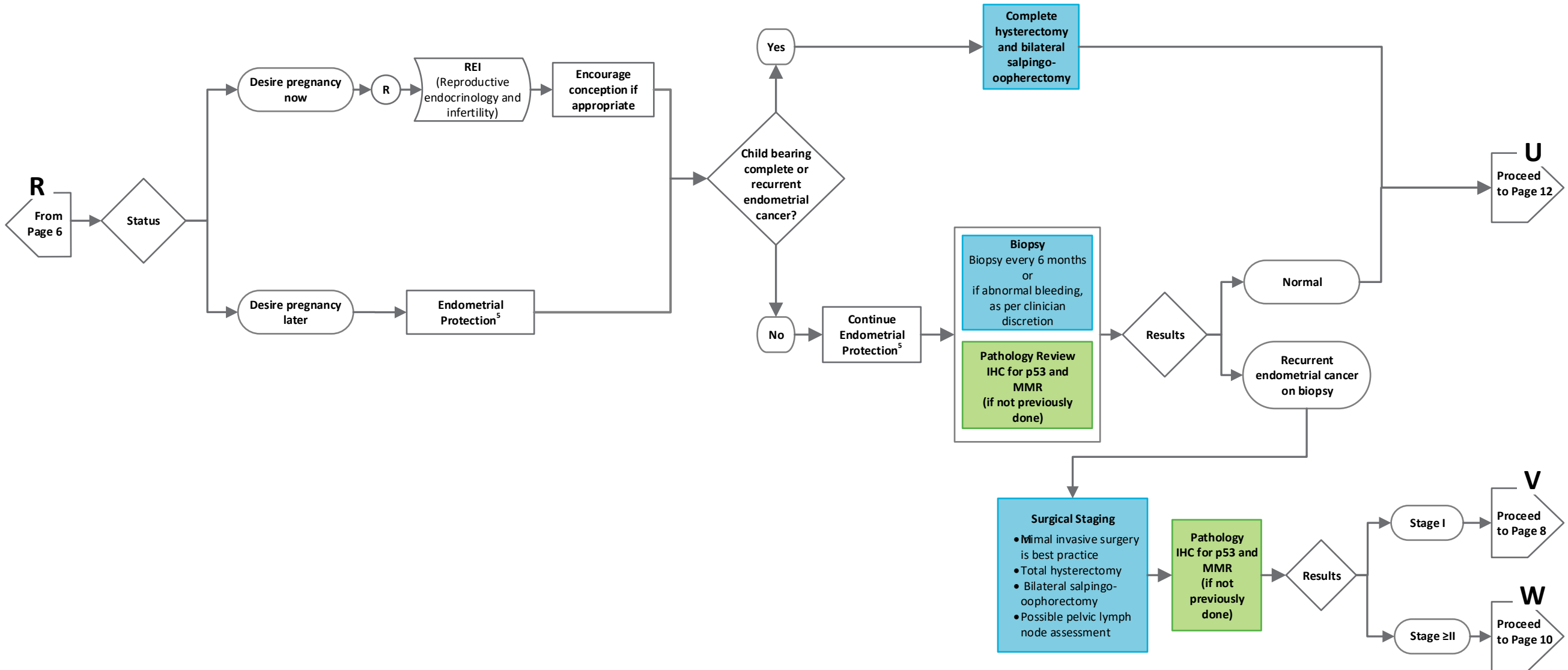
² Patients should undergo counseling that fertility sparing is for highly selected and motivated patients who meet strict criteria for progestin therapy: 1) Grade 1 endometrioid adenocarcinoma, 2) no myometrial invasion on **M**, 3) no metastatic disease, 4) no contraindications to progesterone therapy, 5) desire for future fertility.

⁴ Suggested progestin therapy includes medroxyprogesterone, megestrol acetate, and levonorgestrel IUD.

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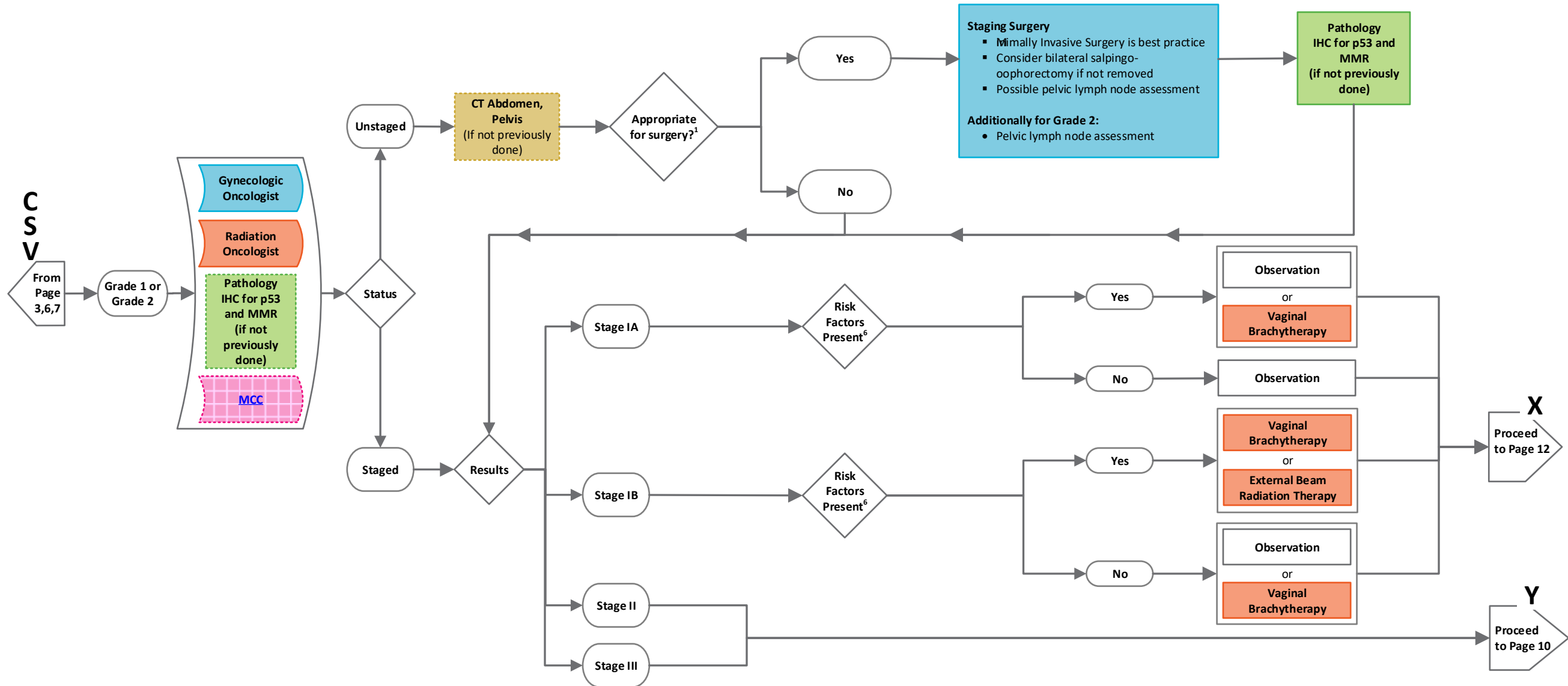


⁵ IUD levonorgestrel, oral contraceptive pill.

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⁶ Risk factors include: age greater than 60 years (based on the PORTEC-1 trial), positive lymphovascular invasion, deep myometrial invasion more than or equal to 50%, and high grade histology. Myer LA, Bohlke K, Powell M, Fader AN, Franklin GE, Lee LJ, Mei D, Coallier L, Wright AA. Postoperative Radiation Therapy for Endometrial Cancer: American Society of Clinical Oncology Clinical Practice Guideline Endorsement of the American Society for Radiation Oncology Evidence-Based Guideline. J Clin Oncol. 2015 Sep 10;33(26):2908-13.

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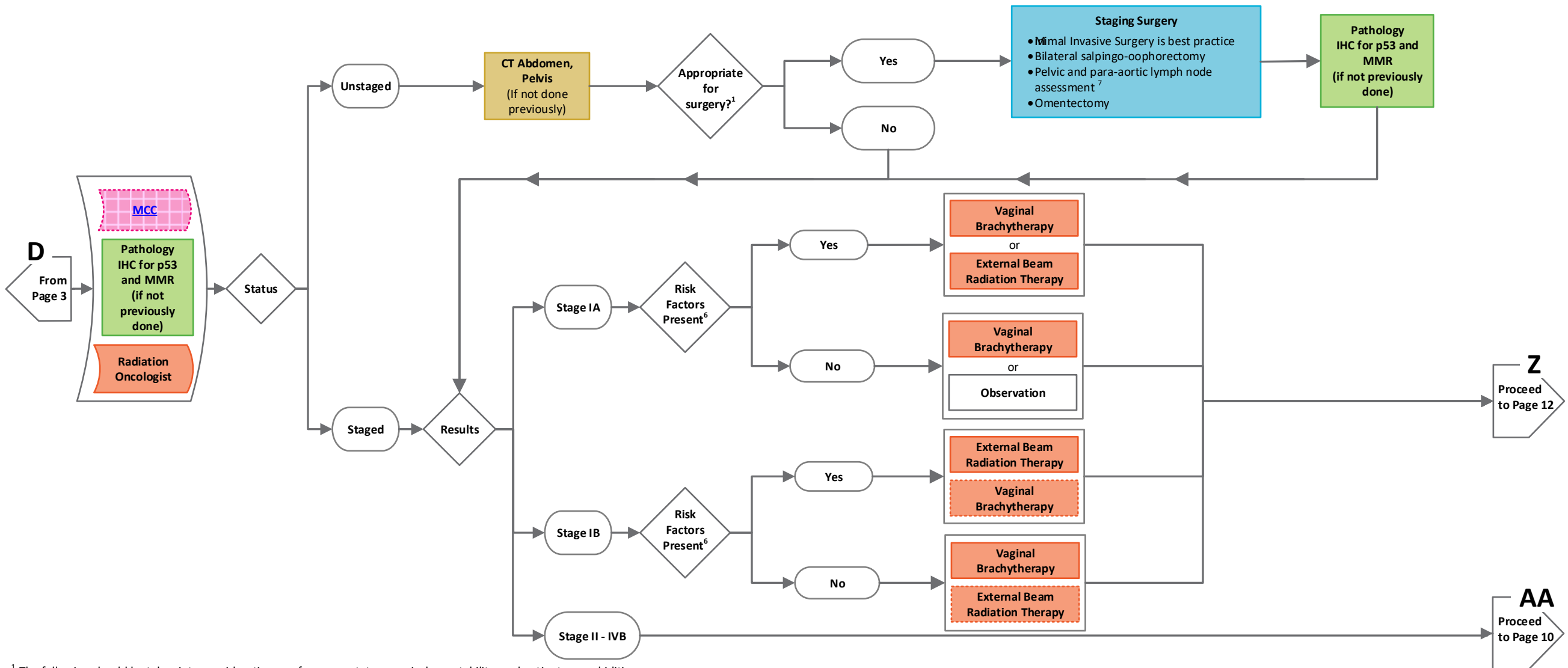
Grade 3 Endometrioid (p53 wild type) Stage I

Version 2021.11 Page 9 of 15

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⁷ Sentinel lymph node dissection or pelvic and para-aortic lymphadenectomy

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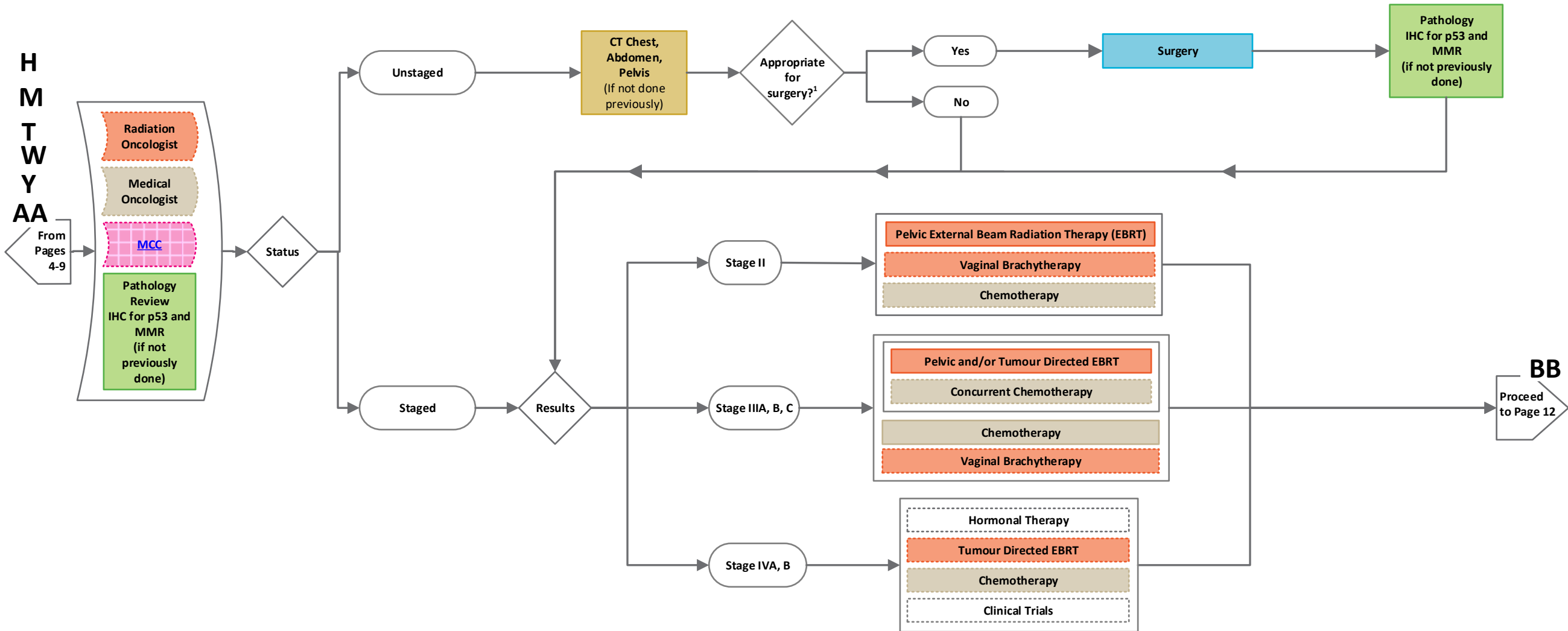
Grade 1, 2, 3 Endometrioid (p53 wild type), Stage II - IVB

Version 2021.11 Page 10 of 15

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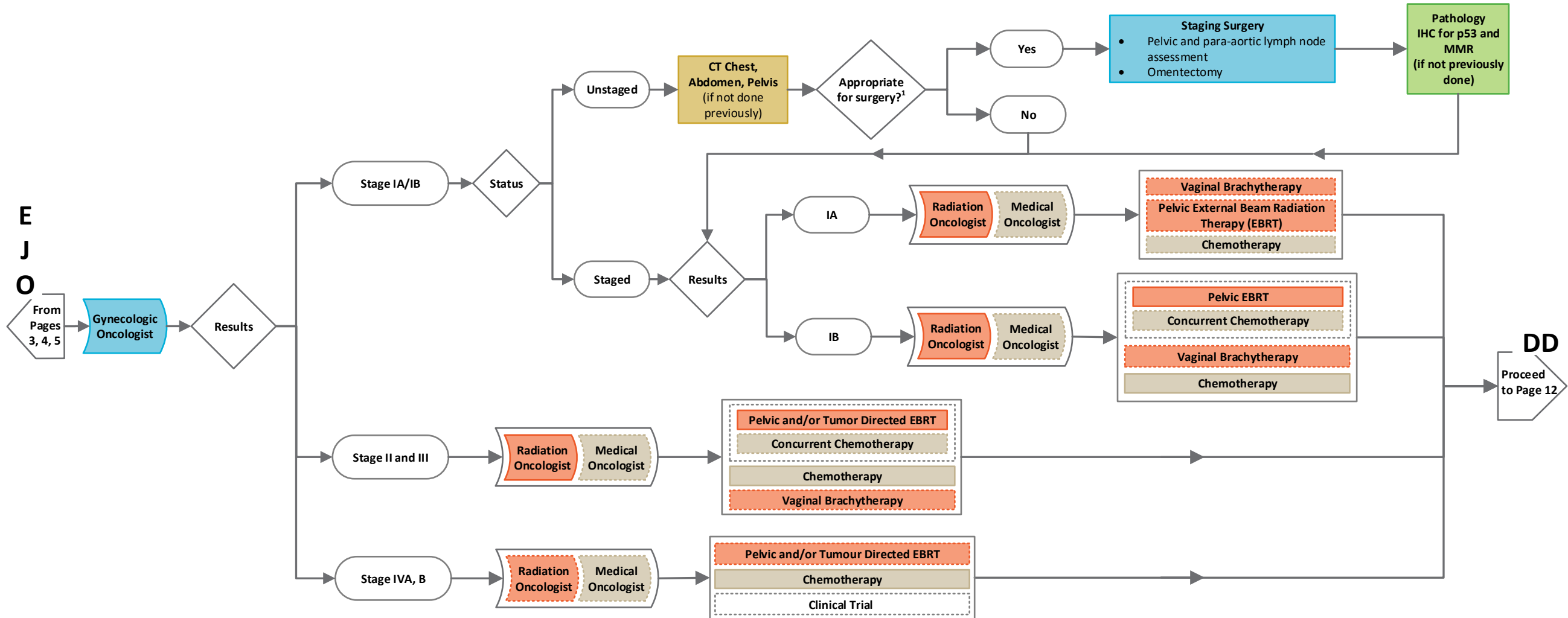
Serous, Carcinosarcoma, Mixed Histology, and p53 abnormal

Version 2021.11 Page 11 of 15

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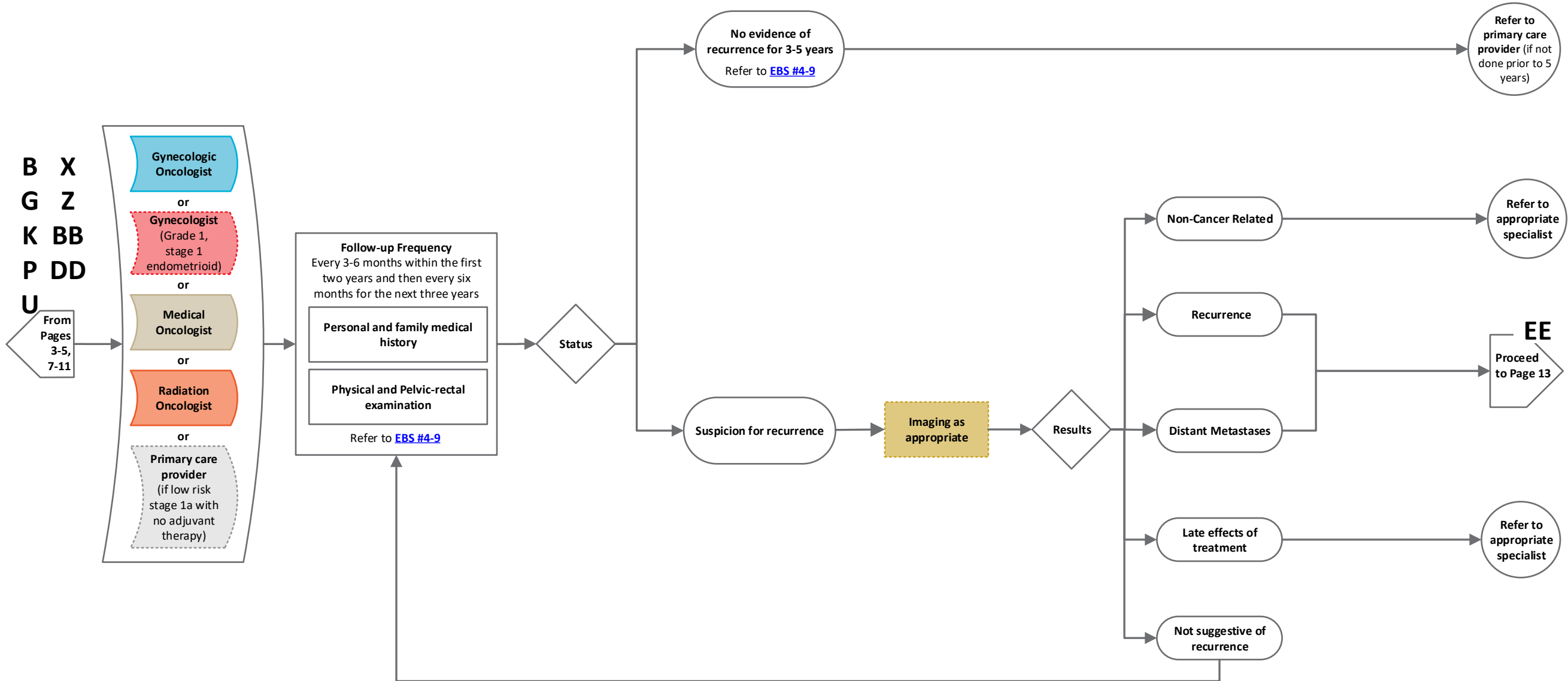


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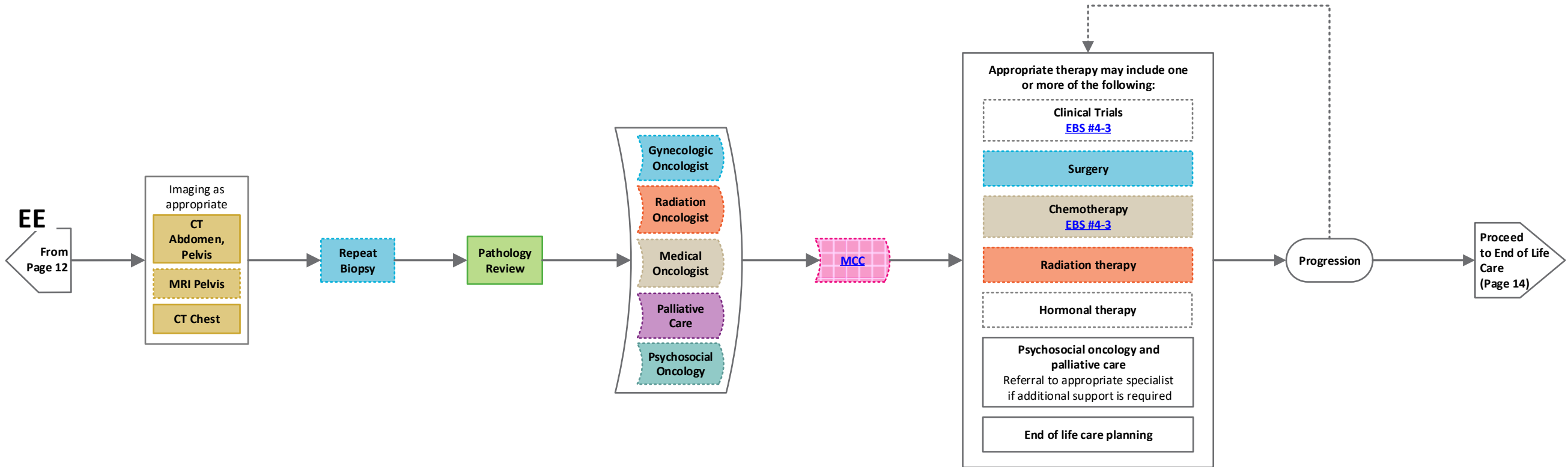
Persistent, Recurrent, and Metastatic (All Sub-Types)

Version 2021.11 Page 13 of 15

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Pathway Map

Target Population:

Individuals with cancer approaching the last 3 months of life and their families.

While this section of the pathway is focused on the care delivered at the **end of life**, palliative care should be initiated much earlier in the illness trajectory. In particular, providers can introduce a palliative approach to care as early as the time of diagnosis.

Triggers that suggest patients are nearing the last few months and weeks of life

- ECOG/Patient-ECOG/PRFS = 4
or
- PPS ≤ 50
- Declining performance status/functional ability

Screen, Assess, Plan, Manage and Follow Up



End of Life Care planning and implementation
Collaboration and consultation between specialist-level care teams and primary care teams



Conversations to determine where care should be provided and who will be responsible for providing the care

End of Life Care

□ Key conversations to revisit Goals of Care and to discuss and document key treatment decisions

- Assess and address patient and family's information needs and understanding of the disease, address gaps between reality and expectation, foster realistic hope and provide opportunity to explore prognosis and life expectancy, and preparedness for death
- Explore the patient's views on medications, tests, resuscitation, intensive care and preferred location of death
- If a patient makes any treatment decisions relevant to their current condition (i.e., provides consent), these decisions can be incorporated into their Plan of Treatment
- Review Goals of Care and patient preferences regularly, particularly when there is a change in clinical status

□ Screen for specific end of life psychosocial issues

- Assess and address patient and families' loss, grief and bereavement needs including anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
- Provide appropriate guidance, support and information to families, caregivers, and others, based on awareness of culture and needs, and make referrals to available resources and/or specialized services to address identified needs as required
- Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources

□ Identify patients who could benefit from specialized palliative care services (consultation or transfer)

- As patient and family/caregiver needs increase and/or change over time consult with palliative care specialists and/or other providers with additional expertise, as required. Transfer care only if/when needs become more extensive or complex than the current team can handle
- Discuss referral with the patient and their family/caregiver

□ Proactively develop and implement a plan for expected death

- Explore place-of-death preferences and the resources required (e.g., home, hospice, palliative care unit, long term care or nursing home) to assess whether this is realistic
- Prepare and support the family to understand what to expect, and plan for when a loved one is actively dying, including understanding probable symptoms, as well as the processes with death certification and how to engage funeral services
- Discuss emergency plans with patient and family (including who to contact, and when to use or avoid Emergency Medical Services)

□ Home care planning (if this is where care will be delivered)

- Contact the patient's primary care and home and community care providers and relevant specialist physicians to ensure an effective transfer of information related to their care. If the patient is transitioning from the hospital, this should include collaborating to develop a transition plan
- Introduce patient and family to resources in community (e.g., respite, day hospice programs, volunteer services, support groups, etc.)
- Connect with home and community care services early (not just in the last 2-4 weeks)
- Ensure resources and services are in place to support the patient and their family/caregiver, and address identified needs
- Anticipate/plan for pain and symptom management, including consideration for a Symptom Response Kit to facilitate access to pain, dyspnea, and delirium medication for emergency purposes
- If the patient consents to withholding cardiopulmonary resuscitation, A 'Do Not Resuscitate' order must be documented in their medical record, and a Do Not Resuscitate Confirmation (DNR-C) Form should be completed. This form should be readily accessible in the home, to ensure that the patient's wishes for a natural death are respected by Emergency Medical Services

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