Patient presents with abnormal vaginal bleeding
(to general practitioner or gynecologist)

Endometrial Biopsy or
D & C +/- Hysteroscopy
OR
Incidental Finding
(General Practitioner or Gynecologist)

Complex Hyperplasia
with Cytologic Atypia

Tissue Diagnosis of
Endometrioid Carcinoma

Tissue Diagnosis of
Endometrial Serous,
Clear Cell or
Carcinosarcoma
Endometrial Cancer

Referral to Gynecologic Oncologist

Conservative
fertility sparing

Surgical Staging (if not yet completed)
Hysterectomy + Bilateral Salpingo Oophorectomy,
+/- Lymph Node Dissection, +/‐ Omenectomy, + Peritoneal Washing(s)

** Imaging may be indicated**

Endometrioid Carcinoma

Endometrial Serous, Clear Cell,
Carcinosarcoma

Incompletely Staged

Observation and follow-up based on clinical characteristics

See Algorithm for Endometrioid Carcinoma

See Algorithm for Endometrial Serous,
Clear Cell, and Carcinosarcoma

Version date: 2015 Aug 05
Algorithm for the Management of Endometrioid Carcinoma (GYNE-002)

Endometrioid Carcinoma

Lynch Syndrome Screening (See Algorithm for Lynch Syndrome Screening)

Stage IA
- Grade 1
- Grade 2

Stage IB
- Grade 1 & 2

Stage II
- Observation (Grade 1 only, and if Radical HYS, BSO, Pelvic LND)

Stage III
- BIIA / IIIB
- IIIC

Stage IVA and IVB

Adverse risk factors?

LVSI?

No

YES

Vaginal Brachy

No adjuvant treatment

Vaginal Brachy

+= Pelvic RT

Follow-up and Surveillance
Counsel patients about potential recurrence symptoms. Patients who are symptomatic should undergo appropriate investigations to rule out recurrence, as many local recurrences are potentially curable with additional therapy.

Follow-up by the treating gynecologic oncologist, general oncologist, or general practitioner could be based on the risk of recurrence. The majority of recurrences are symptomatic and occur within 5 years.

General examination, including a complete history, speculum, and a pelvic-rectal examination should be given as follows:
- For low-risk patients (stage IA/IB, grade 1/2): every 6 months during years 1-3, then once yearly during years 4-5;
- For high-risk patients (stage IA/IB, grade 3, or stage II or higher): every 4 months during years 1-3, then every 6 months during years 4-5.

Chemotherapy (CT) & Hormone Therapy (HT) Regimens:
- CT:
  - Carboplatin (AUC 5) + paclitaxel (175 mg/m²) x 4-6 cycles, if hypersensitivity to paclitaxel, docetaxel (75 mg/m²) should be considered.
- HT:
  - Provera (200-400 mg/d) or Megace (160 mg/d).

Chemotherapy (CT) & Hormone Therapy (HT) Regimens:
- CT:
  - Carboplatin (AUC 5) + paclitaxel (175 mg/m²) x 4-6 cycles, if hypersensitivity to paclitaxel, docetaxel (75 mg/m²) should be considered.
- HT:
  - Provera (200-400 mg/d) or Megace (160 mg/d).

Version date: 2016Jan 05

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Algorithm for the Management of Endometrial Serous, Clear Cell, and Carcinosarcoma (GYNE-002)

Endometrial Serous, Clear Cell Carcinoma, and Carcinosarcoma

Positive peritoneal fluid?

No

Yes

Consider Adjuvant Chemotherapy (below)
RT not considered

Stage IA

Myometrial invasion?

NO

YES

Stage IB/ Stage II

CT +/- Vaginal Brachy

CT +/- RT

Stage III/ Stage IV (Adequately Debulked)

CT +/- RT

Follow-up and Surveillance

Counsel patients about potential recurrence symptoms. Patients who are symptomatic should undergo appropriate investigations to rule out recurrence, as many local recurrences are potentially curable with additional therapy.

Follow-up by the treating gynecologic oncologist, general oncologist, or general practitioner could be based on the risk of recurrence. The majority of recurrences are symptomatic and occur within 5 years.

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Chemotherapy (CT) Regimens:
Chemotherapy: carboplatin (AUC 5) + paclitaxel (175 mg/m²) x 4-6 cycles; if hypersensitivity to paclitaxel, docetaxel (75 mg/m²) should be considered.
Algorithm for Example Lynch Syndrome Screening for Endometrial Cancer (GYNE-002)

Endometrial Cancer

IHC Testing for MMR

MLH1, PMS2, MSH2, MSH6 Normal*

Stop**

PMS2 Absent

MSH2/MSH6 Absent

MSH6 Absent

MLH1/PMS2 Absent

Referral for Genetic Counseling

Negative

MLH1 Promoter Hypermethylation Testing

Positive

Stop**

*If your lab reports MSH6 and PMS2 present, this infers that all four proteins are normal in expression.

**Patients with significant personal or family history suggestive of hereditary cancer syndromes should be considered for genetic referral regardless of normal screening studies.

Version date: 2015 Nov 26