

NCG Endometrium Resource Stratified Guidelines

| | Optimal management | | | Optional | Remarks |
|--|---|---|--|--|--|
| | Pre-treatment Workup | Surgery | Adjuvant | | |
| Disease Clinically confined to body of uterus | <p>Endometrial biopsy +/-IHC Complete Hemogram, Renal and Liver Function tests, Electrocardiogram</p> <p>Imaging Chest radiograph USG(TAS+TVS) abdomen+pelvis or CT scan (abdomen +Pelvis) or MRI (abdomen +Pelvis)</p> | <p><i>Approach:</i> Open/ MIS (Laparoscopic or Robotic)/Vaginal</p> <p>Peritoneal Cytology</p> <p>Type I Histology; gr 1/2 without deep myometrial involvement: Extrafascial Type I Hysterectomy with bilateral salphingo-oophorectomy with lymph node assessment +/-BPLND</p> <p>Type I Histology; gr3 or deep myometrial involvement Extrafascial Type I Hysterectomy with bilateral salphingo-oophorectomy with BPLND +/- retroperitoneal lymphadenectomy</p> <p>Type II Histology: Extrafascial Type I Hysterectomy with bilateral salphingo-oophorectomy with pelvic and para-aortic lymph node dissection with infracolicmentectomy.</p> <p>Retroperitoneal lymphadenectomy- Type II histology, Positive pelvic node, enlarged RP nodes</p> <p>Vaginal Hysterectomy: In patients not fit for abdominal hysterectomy</p> | <p>Stage IA</p> <p>Grade I/II with no LVSI: Observation</p> <p>Grade III with no LVSI: Vaginal Brachytherapy</p> <p>Grade I-III with LVSI: External beam Radiotherapy to Pelvis</p> <p>[Status of LVSI not known in view of poor processing/ lack of expertise: To consider as LVSI positive status]</p> <p>[Type II Histology: Considered as Grade III]</p> <p>Stage IB</p> <p>Grade I/II with no LVSI: Vaginal Brachytherapy</p> <p>Grade I-III with LVSI: External beam Radiotherapy to Pelvis</p> <p>[Status of LVSI not known in view of poor</p> | <p>Sentinel lymph node biopsy</p> <p>Frozen section examination of uterus for depth of invasion, tumor size and grade and cervical involvement</p> <p>Image Guided IMRT and brachytherapy may be considered.</p> | <p>Medically inoperable: Radical Radiotherapy to Pelvis (External beam Radiotherapy + Intracavitary Brachytherapy)</p> <p>Fertility Preservation: in young potentially fertile woman with:</p> <ol style="list-style-type: none"> 1. Disease confined to endometrium or with minimum myometrial invasion 2. Grade I, Well Differentiated Endometriod Histology 3. ER/PR Positive Status/P53 Wild type <p>MRI is a must in the above. Counselling regarding associated risks to be explained. Treatment is by high dose progesterone therapy with periodic r evaluation for response</p> |

| | | | | | |
|--|---|---|--|--|--|
| | | | processing/ lack of expertise: To consider as LVSI positive status] [Type II Histology: Considered as Grade III] | | |
| Stage II Tumor invades cervical stroma, | Endometrial biopsy +/-IHC Complete Hemogram, Renal and Liver Function tests, Electrocardiogram Imaging Chest radiograph MRI (abdomen +Pelvis) or CT scan (abdomen +Pelvis) or Whole body PET-CT | Approach: Open (preferred if gross cervical involvement)/ MIS (Laparoscopic or Robotic) Peritoneal Cytology Type I Histology: Type I or type II Radical I Hysterectomy with bilateral salphingo-oophorectomy with BPLND +/- retroperitoneal lymphadenectomy Type II Histology: Type I or type II Radical I Hysterectomy with bilateral salphingo-oophorectomy with pelvic and para-aortic lymph node dissection with infracolicmentectomy. | External beam Radiotherapy to Pelvis+/- Vaginal Brachytherapy | Image Guided IMRT and brachytherapy may be considered. | Medically / Surgically inoperable: Radical Radiotherapy to Pelvis (External beam Radiotherapy + Image Based Intracavitary Brachytherapy) |
| Stage III Local and/or regional spread of the tumor IIIA: Tumor invades the serosa of the corpus uteri and/or adnexae | Endometrial biopsy +/-IHC Complete Hemogram, Renal and Liver Function tests, CA125 Electrocardiogram Imaging Chest radiograph SOS CT thorax MRI (abdomen | Approach: Open / MIS (Laparoscopic or Robotic) only in selected cases with small volume extra-uterine disease Type-I Hysterectomy with bilateral salphingo-oophorectomy with pelvic and para-aortic lymph node dissection +/-Omentectomy. Maximal Cytoreductive Surgery may be considered in the presence of bulky disease. | Chemotherapy (Paclitaxel and Carboplatin): 4- 6 Cycles +/- Radiation therapy +/- concurrent chemotherapy (Sequencing can be as per Institutional Practice) To supplement with vaginal brachytherapy depending on the following factors: | . Image Guided IMRT may be considered | <i>Inoperable:</i> Systemic Chemotherapy 4-6 Cycles followed by re-assessment for debulking surgery Chemotherapy Regimen: Paclitaxel 175mg/m ² + Carboplatin AUC 5-6:: 3 weekly regimen Not fit for Chemotherapy Radical Radiotherapy to Pelvis +/- Para-Aortic Region |

| | | | | | |
|--|---|--|--|--|---|
| <p>IIIB: Vaginal and/or Parametrial involvement</p> <p>IIIC1: Positive pelvic nodes</p> <p>IIIC2: Positive para-aortic lymph nodes with or without positive pelvic lymph nodes</p> | <p>+Pelvis) or CT scan (abdomen +Pelvis) or Whole body PET-CT</p> | | <ol style="list-style-type: none"> 1. Vaginal cuff/ Parametrial positive margins 2. Vaginal cuff/ parametrial margins are not reported in view of poor processing/ suboptimal surgery <p>Chemotherapy Regimen: Paclitaxel 175mg/m² + Carboplatin AUC 5-6:: 3 weekly regimen</p> <p>IMRT to be considered for patients receiving extended Field RT</p> | | <p>(External beam Radiotherapy + Intracavitary Brachytherapy)</p> <p>To use image based brachytherapy approach for improved control rates</p> <p>*To consider tumour directed RT after Chemotherapy in patients not fit for Surgery.</p> <p>Hormone therapy may be considered for patients not fit for Systemic chemotherapy.</p> |
| <p>Stage IVA</p> <p>Tumor invasion of bladder and/or bowel mucosa</p> | <p>Endometrial biopsy +/-IHC Complete Hemogram, Renal and Liver Function tests, CA125 Electrocardiogram</p> <p>Imaging Chest radiograph SOS CT thorax</p> <p>CT scan (abdomen</p> | <p>Approach: Open / MIS (Laparoscopic or Robotic) only in selected cases with small volume extra-uterine disease</p> <p><i>Operable::</i> Radical Hysterectomy with bilateral salphingo-oophorectomy with pelvic and para-aortic lymph node dissection +/- bladder/bowel resection</p> <p>Maximal Cytoreductive Surgery may be considered in the presence of bulky disease</p> | <p>Palliative Chemotherapy</p> <p>Pelvic RT+/- Brachytherapy</p> <p>Hormonal therapy in patients not fit for Chemotherapy</p> | | <p><i>Inoperable:</i> Systemic Chemotherapy:4-6 cycles. To consider Palliative Surgery after Chemotherapy in responders</p> |

| | | | | | |
|--|--|--|---|---|--|
| | +Pelvis) or MRI (abdomen +Pelvis) | | | | |
| Stage IVB Distant metastases, including intra- abdominal metastases and/or inguinal lymphnodes | Endometrial biopsy +/-IHC Complete Hemogram, Renal and Liver Function tests, CA125 Electrocardio gram Imaging Chest radiograph SOS CT thorax Whole body PET-CT Or MRI (abdomen +Pelvis) or CT scan (abdomen +Pelvis) | To consider upfront surgery in highly selected patients | Systemic Chemotherapy: 6 Cycles To consider Palliative Surgery after Chemotherapy in responders Palliative RT for symptom relief Hormonal therapy only in patients not fit for Chemotherapy | Stereotactic RT may be considered for oligometastatic disease Immunotherapy in patients with MSI high | |

| Imaging | Optimal | Optional | Remarks |
|----------|--|---|--|
| Early | Transvaginal Ultrasound with Endometrial Biopsy Grade I: No further investigation Chest X Ray | MRI: Pelvis to evaluate endometrial thickness and depth of myometrial involvement | |
| Advanced | CECT Thorax+Abdomen MRI Pelvis | PETCT | To assess for operability w.r.t primary tumour and burden of lymph nodes |