## **NCG Endometrium Resource Stratified Guidelines**

		Optimal management		Optional	Remarks
	Pre-treatment Workup	Surgery	Adjuvant		
Disease Clinically confined to body of uterus		Approach: Open/ MIS (Laparoscopic or Robotic)/Vaginal  Peritoneal Cytology  Type I Histology; gr 1/2 without deep myommertial involvement: Extrafascial Type I Hysterectomy with bilateral salphingo- oophorectomy with lymph node assessment +/-BPLND  Type I Histology; gr3 or deep myommertial involvement Extrafascial Type I Hysterectomy with bilateral salphingo-oophorectomy with BPLND +/- retroperitoneal lymphadenectomy  Type II Histology: Extrafascial Type I Hysterectomy with bilateral salphingo-oophorectomy with bilateral salphingo-oophorectomy with pelvic and para-aortic lymph node dissection with infracolicmentectomy.  Retroperitoneal lymphadenectomy-Type II histology, Positive pelvic node, enlarged RP nodes  Vaginal Hysterectomy: In patients not fit for abdominal hysterectomy	Stage IA  Grade I/II with no LVSI: Observation  Grade III with no LVSI: Vaginal Brachytherapy  Grade I-III with LVSI: External beam Radiotherapy to Pelvis  [Status of LVSI not known in view of poor processing/ lack of expertise: To consider as LVSI positive status]  [Type II Histology: Considered as Grade III]  Stage IB  Grade I/II with no LVSI: Vaginal Brachytherapy  Grade I-III with LVSI: External beam Radiotherapy to Pelvis	Sentinel lymph node biopsy  Frozen section examination of uterus for depth of invasion, tumor size and grade and cervical involvement  Image Guided IMRT and brachythera py may be considered.	Medically inoperable: Radical Radiotherapy to Pelvis (External beam Radiotherapy + Intracavitary Brachytherapy)  Fertility Preservation: in young potentially fertile woman with:  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 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
			[Status of LVSI not known in view of poor		

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			processing/ lack		
			of expertise: To		
			consider as LVSI		
			positive status]		
			[Type II		
			Histology:		
			Considered as		
			Grade III]		
Stage II	Endometrial		External beam	Image	Medically / Surgically
July 11	biopsy +/-IHC	Approach: Open (preferred if	Radiotherapy to	Guided	inoperable:
Tumor	Complete	gross cervical involvement)/	Pelvis+/- Vaginal	IMRT and	торогавіо.
invades	Hemogram,	MIS (Laparoscopic or	Brachytherapy	brachythera	Radical
cervical	Renal and	Robotic)	Біаспушетару	py may be	Radiotherapy to
	Liver	(Nobolic)		considered.	Pelvis
stroma,	_	Pariton and Cutalogue		considered.	Pelvis
	Function	Peritoneal Cytology			(External beam
	tests,	Type I Histology			· ·
	Electrocardio	Type I Histology:			Radiotherapy +
	gram	Type I or type II Radical I			Image Based
	lan a min m	Hysterectomy with bilateral			Intracavitary
	Imaging	salphingo-oophorectomy with			Brachytherapy)
	Chest	BPLND +/- retroperitoneal			
	radiograph	lymphadenectomy			
	MRI				
	(abdomen	Type II Histology: Type I or			
	+Pelvis)	type II Radical I			
	or	Hysterectomy with bilateral			
	CT scan	salphingo-oophorectomy with			
	(abdomen	pelvic and para-aortic lymph			
	+Pelvis)	node dissection with			
	or	infracolicmentectomy.			
	Whole body	g.			
	PET-CT				
	1 2 1 0 1				
Stage III	Endometrial	Approach: Open / MIS	Chamatharani		Inonorable: Systemia
Stage III		• • • • • • • • • • • • • • • • • • •	Chemotherapy	lmago	Inoperable: Systemic
Local	biopsy +/-IHC	(Laparoscopic or Robotic)	(Paclitaxel and	Image	Chemotherapy 4-6
Local	Complete	only in selected cases with small volume extra-uterine	Carboplatin): 4- 6	Guided	Cycles followed by
and/or	Hemogram,		Cycles +/-	IMRT may	re-assessment for
regional	Renal and	disease	Radiation	be considered	debulking surgery
spread	Liver	Type I Hyptoroete my with	therapy +/-	considered	Chemotherapy
of the	Function	Type-I Hysterectomy with	concurrent		Regimen:
tumor	tests, CA125	bilateral salphingo-	chemotherapy		Paclitaxel 175mg/m²
ша.	Electrocardio	oophorectomy with pelvic and	(Sequencing can		+ Carboplatin AUC
IIIA:	gram	para-aortic lymph node	be as per		5-6:: 3 weekly
Tumor	Lance and	dissection +/-Omentectomy.	Institutional		regimen
invades	Imaging	Marriaga I Out	Practice)		Not 60 for
the	Chest	Maximal Cytoreductive			Not fit for
serosa of	radiograph	Surgery may be considered			Chemotherapy
the	SOS CT	in the presence of bulky	To supplement		5
corpus	thorax	disease.	with vaginal		Radical
uteri			brachytherapy		Radiotherapy to
and/or	MRI		depending on the		Pelvis +/- Para-Aortic
adnexae	(abdomen		following factors:		Region

IIIB   Care					
IIIB: OT scan (dabdomen and/or parametric al many parametric al positive per per parametric al many per per parametric al many per		+Pelvis) or			(External beam
Vaginal and/or Parametri al positive ent Whole body involvem ent Whole body involvement ent Whole body involvement ent Whole body involvement ent whole body ent ent whole body involvement ent whole body ent	IIIB:			1. Vaginal	`
and/or parametri al or whole body involvem ent ent PET-CT   Positive nodes   IIIC1: Positive pelvic nodes   IIIC2-Posi tive para- aortic per pelvic nodes   IIIC2-Posi tive para- aortic pymph nodes with or without pelvic podes with or without positive produces with or positive pelvic nodes   IIIC2-Posi tive para- aortic pymph nodes   IIIC3   IIIC4   IIIC5   IIIC5   IIIC5   IIIC5   IIIC5   IIIC6   IIIC6   IIIC6   IIIC7	Vaginal	(abdomen			
Parametri al Whole body   PET-CT   PET-CT   PET-CT   PET-CT   PET-CT   PET-CT   PET-CT   Positive ent   PET-CT   Positive pelvic   Positive parametri al margins are not reported in view of poor poor processing of poor poor processing of poor poor processing of poor without positive parametri al margins are not reported in view of poor processing of poor poor processing of processing of poor processing of processing o				Parametri	Brachytherapy)
all involvem ent	Parametri	· '		al positive	137
involvement ent ent ent ent ent ent ent ent ent		Whole body		-	
ent   IIIC1:   Positive pelvic   parametri   al margins   are not   reported   in view of poor   processin   patients not fit for patients not fit for patients   poor poor positive pelvic   poor   poor   poor positive pelvic   poor   poor   poor positive pelvic   poor   poor	involvem				To use image based
IIIC1: Positive pelvic nodes   Positive para-aoric lymph nodes   Positive pelvic lymph nodes   Positive lymph node disease   Positive lymph	ent				•
Positive pelvic nodes    IIIC2:Positive pelvic nodes				parametri	approach for
Positive pelvic unodes  IIIC2-Posi tive para-aortic lymph nodes without positive pelvic lymph nodes  Stage IVA Endometrial IVA Estage IVA Regiand and/or Electrocardio of Function of Function and/or and/or lates and/or lates and/or an				al	improved control
pelvic nodes  IIIC2:Posi tive para- aortic lymph nodes with or without pelvic nodes  IIIC3:Posi tive para- aortic lymph nodes  With or without positive pelvic lymph nodes  IVA  Stage IVA  IVA  IVA  Complete Hemogram, Turnor Invasion of Function of Punction of Invasion of Invasion of Invasion of Invasion of Invasion of Punction Diadder lasts, CA125 and/or bowel mucosa  IIIC2:Posi tive para- aortic lymph node dissection H-maging Invasion of Chest radiograph Sook CT scan  IIIC2:Posi tive para- aortic lymph node dissection H-maging Chest radiograph Sook CT scan  IIIC2:Posi tive para- aortic lymph node dissection the presence of bulky disease  IIIC2:Posi tive para- avortic lymph node dissection the presence of bulky disease  IIIC2:Posi tive para- avortic lymph node dissection the para- avortic lymph node dissection the presence of bulky disease  IIIC2:Posi tive para- avortic lymph node dissection the para- avortic lymph node dissection the presence of bulky disease  IIIC2:Posi tive para- avortic para- avortic lymph node dissection the para- avortic lymph node dissection the presence of bulky disease  IIIC2:Posi tive para- avortic para- avortic para- avortic lymph node dissection the para- avortic lymph node node not para- avortic lymph node node not para- avortic lymph n	IIIC1:			margins	rates
IIIC2:Posi tive para- aortic typmh nodes with or without positive pelvic tymph nodes  IIIC2:Posi tive para- aortic tymph nodes with or without positive pelvic tymph nodes  IIIC2:Posi tive para- aortic tymph node	Positive			are not	
IIIC2:Posi tive para- aortic lymph  nodes without or  without  positive  pelvic  lymph  nodes	pelvic			reported	
IIIC2-Posi tive para- aortic typmph nodes without positive pelvic tymph nodes  IVA  Stage IVA  Tumor Tumor Industrian of Function of Pendia and or invasion of Invas	nodes				
IIIC2-Posi tive para- aortic lymph nodes with or without positive pelvic lymph nodes  IVA    Diagos					
tive para- aortic lymph nodes with or without positive pelvic lymph nodes  Stage lymph nodes  Endometrial biopsy +/-IHC complete Hemogram, rivasion of bladder pof livasion of pof libadder pof limaging				-	
aortic lymph nodes with or without positive pelvic lymph nodes  Stage liva					
Imaging   Imag					•
nodes with out positive pelvic lymph nodes  Stage IVA Endometrial Liver of Function bladder and/or place in tests, CA125 and/or bladder and/or bladder and/or bladder and/or bladder and/or blowel mucosa  Name of the prosence of bulky disease  CT scan Endometrial Chemotherapy  Approach: Open / MIS (Laparoscopic or Robotic) only in selected cases with sanily volume extra-uterine disease  Name of the prosence of bulky disease  CT scan  Chemotherapy Regimen: Pacilitate Pacilitate Systemic for patients not fit for Systemic chemotherapy.  IMRT to be considerd for patients receiving extended Field RT  Fleid RT  Pallitative Chemotherapy: 4-6 cycles. To consider apy  Pelvic Operable:: Radical Hysterectomy with bilateral salphingo-cophorectomy with pelvic and para-aortic lymph node dissection +/- bladder/bowel resection  Maximal Cytoreductive Surgery may be considered in the presence of bulky disease  CT scan  CT scan  Hormone therapy may be considered for patients not fit for Systemic Chemotherapy.  IMRT to be considerd for patients not fit for patients				al surgery	Surgery.
with or without positive pelvic lymph nodes  Stage IVA  Tumor Complete Hemogram, Renal and liver invasion of for Function Panal and Diadder and or invasion of for Function Dadder and or invasion of for Function Chemother and pelvic and pelvic and/or blowel mucosa  IVA  IVA  Stage IVA  IVA  Approach: Open / MIS (Laparoscopic or Robotic) only in selected cases with small volume extra-uterine disease  IVA  Operable:: Radical Hysterectomy with bilateral salphingo-opohorectomy with pelvic and para-aortic lymph node dissection +/- bladder/bowel resection  IVA  Operable:: Radical Hysterectomy with bilateral salphingo-opohorectomy with pelvic and para-aortic lymph node dissection +/- bladder/bowel resection  IVA  Operable:: Radical Hysterectomy with bilateral salphingo-opohorectomy with pelvic and para-aortic lymph node dissection +/- bladder/bowel resection  IVA  Operable:: Radical Hysterectomy with bilateral salphingo-opohorectomy with pelvic and para-aortic lymph node dissection +/- bladder/bowel resection  IVA  Operable:: Radical Hysterectomy with bilateral salphingo-opohorectomy with pelvic and para-aortic lymph node dissection +/- bladder/bowel resection  IVA  Operable:: Radical Hysterectomy with bilateral salphingo-opohorectomy with pelvic and para-aortic lymph node dissection +/- bladder/bowel resection  IVA  Operable:: Approach: Open / MIS  Innoperable:: Systemic chemotherapy  Innoperable:: Systemic chemotherapy  Innoperable:: Systemic Chemother apy  Innoperable:: Approach: Open / MIS  Innoperable:: Approac					
without positive pelvic lymph nodes  Stage IVA Diopsy +/-IHC Complete Compl				01 (1	
positive pelvic lymph nodes  Stage   Indometrial biopsy +/-IHC   Complete Hemogram, Ranal and invasion of Function bladder and/or blowel gram mucosa   Imaging Chest radiograph mucosa   Imaging Chest radiograph so SOS CT thorax   Imaging CT scan					
pelvic lymph nodes    Part					
Imaging Chest radiograph Novel Palliary Program   Imaging Chest radiograph SOS CT Son Sugery may be considered in the presence of bulky disease   CT scan   Imaging CT scan   CT scan   Imaging CT scan   Imagin					
nodes    Stage	•				cnemotnerapy.
Stage   Endometrial biopsy +/-IHC   Laparoscopic or Robotic)   Complete   Hemogram, rinvasion of Electrocardio bowel mucosa   Imaging Chest radiograph SOS CT throat and content or content of the content or content or thorax   Imaging CT scan   Im					
Stage IVA Endometrial biopsy +/-IHC (Laparoscopic or Robotic) Complete Hemogram, small volume extra-uterine disease invasion of Function bladder and/or blowel gram mucosa  IMRT to be considerd for patients receiving extended Field RT  Approach: Open / MIS (Laparoscopic or Robotic) Chemother apy; 4-6 cycles. To consider Palliative Chemother apy or cycles. To consider Palliative Surgery after Chemotherapy in responders  Imaging Chest radiograph SOS CT surgery may be considered in the presence of bulky disease  IMRT to be considerd for patients receiving extended Field RT  Palliative Chemother apy or cycles. To consider Palliative Surgery after Chemotherapy in responders  Imaging Chest radiograph SOS CT Surgery may be considered in the presence of bulky disease  IMRT to be considerd for patients receiving extended Field RT  Palliative Chemother apy or cycles. To consider Palliative Surgery after Chemotherapy in responders  Imaging Chest radiograph SOS CT Surgery may be considered in the presence of bulky disease  CT scan	noues			,	
Stage IVA Biology +/-IHC (Laparoscopic or Robotic) Complete Only in selected cases with Hemogram, Sinvasion of Function Bladder and/or and/or Bowel gram Pelvic and para-aortic lymph mucosa  Imaging Chest radiograph SOS CT thorax in the presence of bulky of the formation of the formation of the presence of bulky of the presence of bulky of the presence of the p				regimen	
Stage IVA Biology +/-IHC (Laparoscopic or Robotic) Complete Only in selected cases with Hemogram, Sinvasion of Function Bladder and/or and/or Bowel gram Pelvic and para-aortic lymph mucosa  Imaging Chest radiograph SOS CT thorax in the presence of bulky of the formation of the formation of the presence of bulky of the presence of bulky of the presence of the p				IMRT to be	
Stage   Endometrial   Approach: Open / MIS   Field RT					
Stage   Endometrial   Approach: Open / MIS   Field RT					
Stage IVA Endometrial biopsy +/-IHC (Laparoscopic or Robotic) (Laparoscopic or Robotic) (Laparoscopic or Robotic) (Complete biopsy +/-IHC (Laparoscopic or Robotic) (Chemother apy in responders) (Chemother apy in responders)  Tumor Renal and disease (Iver of Electrocardio gram pelvic and para-aortic lymph mucosa (Imaging Chest radiograph SOS CT thorax in the presence of bulky disease (CT scan)    Field RT   Field RT   Field RT     Palliative (Chemother apy in patients not fit for the responders) (Inoperable: Systemic Chemotherapy: 4-6 cycles. To consider apy apy (Chemotherapy: 4-6 cycles. To consider Palliative Surgery after Chemotherapy: 4-6 cycles. To consider Palliative Surgery after Chemotherapy: 4-6 cycles. To consider Apy (Chemother apy apy (Chemother apy in patients not fit for Chemother apy (Chemother apy in the presence of bulky disease)				-	
Stage   Endometrial   Diopsy +/-IHC   Diopsy +/-IHC   Complete   Hemogram, and invasion   Liver   Pelvic   Electrocardio   Gram   Pelvic and/or bowel   Imaging Chest radiograph   SOS CT   SOS CT thorax   CT scan   Sos CT sca				extended	
biopsy +/-IHC Complete Hemogram, Tumor Renal and Liver Of Function bladder and/or bowel mucosa  Imaging Chest radiograph SOS CT thorax  CT scan  biopsy +/-IHC Complete Only in selected cases with small volume extra-uterine disease  Chemother apy Apy  After Chemotherapy in responders  Chemother apy After Chemotherapy in responders  Hormonal therapy in patients not SOS CT thorax  In the presence of bulky disease  CT scan				Field RT	
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Tumor Renal and disease  Tumor Palliative Surgery after Chemotherapy in responders  Operable:: Radical Pelvic Function Operable:: Radical Practical Brachyther and/or Electrocardio Salphingo-oophorectomy with pelvic and para-aortic lymph node dissection +/- Imaging Chest radiograph SOS CT Surgery may be considered fit for thorax in the presence of bulky disease  Hemogram, Renal and disease  Pelvic RT+/- Brachyther apy  Brachyther apy  Hormonal therapy in patients not fit for Chemother apy  Chemother apy  Chemother apy  Falliative Surgery after Chemotherapy in responders  Hormonal therapy in patients not fit for Chemother apy  Chemother apy  CT scan	IVA				
Tumor invasion				ару	
invasion of Function of Electrocardio gram pelvic and para-aortic lymph node dissection +/- bladder/bowel resection Facility and graph SOS CT thorax in the presence of bulky of the state	_	1 0			0 ,
of bladder tests, CA125 Hysterectomy with bilateral and/or Electrocardio gram pelvic and para-aortic lymph node dissection +/-  Imaging Chest radiograph SOS CT thorax in the presence of bulky CT scan    Function tests, CA125 Hysterectomy with bilateral salphingo-oophorectomy with parachyther apy			disease		
bladder and/or Electrocardio salphingo-oophorectomy with bilateral salphingo-oophorectomy with pelvic and para-aortic lymph node dissection +/- bladder/bowel resection Chest radiograph SOS CT thorax in the presence of bulky CT scan  Tysterectomy with bilateral salphingo-oophorectomy with pelvic and para-aortic lymph node dissection +/- thormonal therapy in patients not fit for Chemother apy  Tormonal therapy in patients not fit for Chemother apy  Chemother apy			On a walk last Dealthank		in responders
and/or bowel gram salphingo-oophorectomy with pelvic and para-aortic lymph node dissection +/- Imaging Chest radiograph SOS CT Surgery may be considered thorax in the presence of bulky CT scan salphingo-oophorectomy with pelvic and para-aortic lymph node dissection +/- Imaging Chest therapy in patients not fit for Chemother apy  CT scan  Salphingo-oophorectomy with pelvic and para-aortic lymph node dissection +/- Imaging Chest therapy in patients not fit for Chemother apy	-				
bowel gram pelvic and para-aortic lymph node dissection +/- Imaging bladder/bowel resection Hormonal therapy in patients not SOS CT Surgery may be considered in the presence of bulky disease CT scan  pelvic and para-aortic lymph node dissection +/-  Hormonal therapy in patients not fit for Chemother apy		•		•	
mucosa  Imaging bladder/bowel resection Chest radiograph SOS CT Surgery may be considered thorax  In the presence of bulky disease  Total Cytoreductive patients not fit for Chemother apy			, , , , ,	ару	
Imaging Chest radiograph SOS CT thorax  CT scan    Dladder/bowel resection		yraili			
Chest radiograph SOS CT Surgery may be considered in the presence of bulky disease CT scan therapy in patients not fit for Chemother apy	mucosa	Imaging		Hormonal	
radiograph SOS CT Surgery may be considered in the presence of bulky disease CT scan patients not fit for Chemother apy			biaddei/bowei iesection		
SOS CT thorax Surgery may be considered in the presence of bulky disease CT scan fit for Chemother apy			Maximal Cytoreductive		
thorax in the presence of bulky disease CT scan Chemother apy				•	
CT scan disease apy					
CT scan					
		CT scan		-17	

	+Pelvis) or MRI (abdomen +Pelvis)				
Stage IVB  Distant metastas es, including intra-abdomina I metastas es and/or inguinal lymphnod es	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 Chemother apy: 6 Cycles To consider Palliative Surgery after Chemother apy in responders  Palliative RT for symptom relief  Hormonal therapy only in patients not fit for Chemother apy	Stereotactic RT may be considered for oligometast atic disease Immunother apy 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