Chapter 1: Overview of guidelines

1. *How to use these guidelines*

These guidelines are intended for doctors (general practitioners and specialists) who provide medical care for patients with uterine tumors and are meant to provide useful treatment methods by integrating previous evidence of benefit. However, the guidelines are not intended to be limited to the therapies listed. The main purposes of the guidelines are as follows: (1) to indicate current treatment that is considered appropriate for endometrial cancer, carcinosarcoma/sarcoma, and trophoblastic diseases; (2) to reduce differences in therapy among institutions; (3) to improve the prognosis and safety of treatments; (4) to reduce the economic and psychosomatic burden of patients by promoting the performance of appropriate treatment; and (5) to aid mutual understanding of healthcare professionals and patients.

2. *Intended audience*

These guidelines are intended for practicing physicians engaged in the treatment of patients with endometrial cancer, carcinosarcoma/sarcoma, and trophoblastic diseases.

3. *Diseases addressed by these guidelines*

Endometrial cancer was mainly described in the first edition. Variant histologic types of uterine cancer and carcinosarcoma/sarcoma were added in the revised edition. Trophoblastic disease was added to the newest revised edition, and these tumors and their recurrence are described in these guidelines. The characteristics of these guidelines are as follows. A variant histologic type was incorporated in both chapters of an initial treatment, the postoperative treatment and advanced/recurrent treatment. Lymph node dissection and laparoscopic surgery are described in detail. In addition, postoperative hormone adjuvant therapy is described in the chapter regarding post-treatment follow-up. Atypical endometrial hyperplasia is included in the chapter regarding fertility-sparing therapy. The chapter regarding treatment of trophoblastic disease is based on the third edition of the trophoblastic disease handling convention published in 2011.

4. *Basic policies in creating the guidelines*

To create these guidelines, the Guidelines Formulation Committee and Evaluation Committee were independently established within the Committee for Treatment Guidelines for Uterine Body Neoplasms. The initial draft was created after a thorough evaluation. Opinions from within and outside the JSGO were incorporated into the final draft. The guidelines were published after their approval by the JSGO. Much of the evidence that formed the basis for the Japanese guidelines was obtained from clinical trials in Western countries. However, given the

differences between practice in Japan and other countries, the consensus regarding clinical practice in Japan took priority in the event of discrepancies. Wherever possible, high-level Japanese evidence was used to formulate these guidelines. The following items are assumed to underlie the basic policy of the guidelines:

1) These guidelines were created in accordance with the principles of evidence-based medicine, considered to be the international standard for creating clinical practice guidelines.
2) Searches were performed of data and literature published until December 2011, including Japanese and non-Japanese studies in Japan and overseas.
3) The collected evidence was evaluated for quality using the criteria of the Japan Society of Clinical Oncology and its Formulation Committee of Clinical Practice Guidelines for the Use of Anticancer Agents [4,5]. However, some of the contents were modified in line with these guidelines (Table 1).

Table 1
Classification of evaluation criteria for evidence quality

Level I Evidence from meta-analyses of multiple randomized controlled trials or evidence from multiple randomized controlled trials.
Level II Evidence from at least one randomized controlled trial or evidence from multiple well-designed controlled studies without randomization.
Level III Evidence obtained from at least one other type of well-designed quasi-experimental study, or evidence obtained from well-designed, nonexperimental descriptive studies such as comparative studies, correlation studies, or case studies.
Level IV Expert committee reports or opinions and/or clinical experiences of respected authorities.

4) The strengths of the recommendations in our guidelines were also determined by the recommendation criteria of the Japan Society of Clinical Oncology and its Formulation Committee of Clinical Practice Guidelines for the Use of Anticancer Agents. These were modified while referring to the “Guide 2007 Minds practice guidelines” [6] (Table 2).

Table 2
Classification of recommendation categories

Grade A The treatment is strongly recommended if there is at least one piece of level I evidence indicating validity.
Grade B The treatment is recommended if there is at least one piece of level II evidence indicating validity.

Grade C1　The treatment can be considered, but the evidence is insufficient; for example, there are several reports of level III evidence, which shows validity with generally consistent results.
Grade C2　The treatment is not recommended without sufficient scientific evidence.
Grade D　The treatment is not recommended because utility and effectiveness have not been shown and the treatment may be harmful.

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5) The surgical staging criteria described in the 2013 edition were based on the surgical staging system developed in 2008 by the International Federation of Gynecology and Obstetrics.
In the text, we didn't use the clinical stage (JSOG 1983, FIGO1982), and used in a description "considered to be stage X preoperatively" instead.

6) Therapy is often difficult to administer under the Japanese medical care insurance system. In this regard, the present guidelines follow the Formulation Committee of Clinical Practice Guidelines for the Use of Anticancer Agents.

5. ***Disclosure of information***

These guidelines are published as a pamphlet and are shown on the homepage of JSCO to facilitate widespread use.

6. Responsibility for treatment

The JSGO bears the responsibility for the content and descriptions of these guidelines. However, the final decision to use these guidelines should be made by the individual user. Thus, the responsibility for the treatment outcomes should be directly attributed to the person in charge.

7. ***Revision***

1) These guidelines are continuously being revised by the Committee for Treatment Guidelines for Uterine Body Neoplasms with a medical advance and a medical change.
2) Newly accumulated evidence after the making of these guidelines is saved in a database.
3) Any associated information regarding clinical inconvenience occurring with the use of these guidelines is collected.
4) Revision work is conducted by the Guidelines Formulation Committee and Evaluation Committee based on new evidence and information. And sufficient opinion from the associated academic societies, groups or JSGO members are gained widely.
5) After the above-mentioned process, the Committee for Treatment Guidelines for Uterine Body Neoplasms provides a revised version with the approval of the JSGO.

8. Funding

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9. Conflicts of interest

The Board of the Society Conflict of Interest Committee confirmed the absence of any conflicts of interest. Although some committees had conflicts of interest through the study or lecture activity with the company, the contents of these guidelines are based on scientific bases and thus unaffected by any interest with specific groups or products.

10. Summary of recommendations

In general, each chapter comprises a clinical question (CQ), recommendations, background, objectives, explanations, and references. This article summarizes these guidelines in a question-and-answer format. Recommendations from each chapter are listed below under their respective chapter titles.

11. Algorithms

These guidelines contain the following nine algorithms:

1. Initial treatment for the patients with endometrial cancer considered to be stage I or II preoperatively (Fig. 1).
2. Initial treatment for the patients who are confirmed to be endometrial cancer after hysterectomy (Fig. 2).
3. Initial treatment for the patients with endometrial cancer considered to be stage III or IV preoperatively (Fig. 3).
4. Postoperative adjuvant treatment for endometrial cancer (Fig. 4).
5. Treatment of recurrent endometrial cancer (Fig. 5).
6. Strategies for fertility-sparing therapy (atypical endometrial hyperplasia and endometrioid adenocarcinoma (corresponding to G1)) (Fig. 6).
7. Treatment for uterine carcinosarcoma (Fig. 7).
8. Treatment for uterine sarcoma (Fig. 8).
9. Treatment for choriocarcinoma (Fig. 9).