Chapter 2: Initial treatment for endometrial cancer (including histologic variant type)

CQ01

Which surgical techniques for hysterectomy are recommended for patients considered to be stage I preoperatively?

Recommendations:

1. Abdominal total hysterectomy (extrafascial technique) is recommended (Grade B).
2. Modified radical (extended) hysterectomy is also considered (Grade C1).

[See Fig. 1]

CQ02.

Which surgical hysterectomy techniques are recommended for patients considered to be stage II?

Recommendations:

Either radical hysterectomy or modified radical hysterectomy should be considered for patients with clinically apparent cervical stromal involvement (Grade C1).

[See Fig. 1]

CQ03

What are the benefits of pelvic lymphadenectomy?

Recommendations:

1. The diagnostic significance of pelvic lymph node dissection in the determination of correct surgical staging has been established (Grade A).
2. The therapeutic benefits of pelvic lymphadenectomy are not established. However, this procedure should be considered in intermediate-risk or high-risk patients (Grade C1).
   [See Fig. 1]

CQ04

What are the benefits of para-aortic lymphadenectomy (biopsy)?

Recommendations:

1. Para-aortic lymphadenectomy (biopsy) is necessary to determine correct surgical staging (Grade A).
2. The therapeutic benefits of paraaortic lymphadenectomy (lymph node biopsy) are not

established. However, this procedure should be considered in intermediate-risk or high-risk patients (Grade C1).
[See Fig. 1]

CQ05

Is omentectomy necessary?

Recommendations:

1. Searching the omentum by careful ocular inspection and palpation is necessary in all cases. When metastasis is suspected, omentectomy should be performed to determine the correct stage (Grade A).
2. Omentectomy is considered when deep myometrial invasion, positive intraoperative peritoneal cytology, Grade 3 endometrial carcinoma, serous or clear cell adenocarcinoma, or macroscopic extrauterine disease is present, even if no gross abnormalities are detected in the omentum (Grade C1).
   [See Fig. 1]

CQ06

Is ovarian preservation possible?

Recommendations:

1. In principle, bilateral adnexectomy is conducted to determine the correct surgical stage during initial treatment (Grade A).
2. Ovarian preservation is considered after having explained the risks to young patients with well-differentiated tumors and shallow myometrial invasion (Grade C1).
   [See Fig. 1]

CQ07

What surgical technique is recommended for serous adenocarcinoma and clear-cell adenocarcinoma?

Recommendations:

1. Total hysterectomy with bilateral salpingo-oophorectomy is recommended (Grade B).
2. Additionally, pelvic and para-aortic lymphadenectomy (lymph node biopsy) and omentectomy are considered (Grade C1).
   [See Fig. 1]

CQ08

Is an inguinal lymph node biopsy noted in the surgical staging guidelines necessary?

Recommendations:

1. When an enlarged inguinal lymph node is detected in preoperative imaging such as a CT scan, then a biopsy is recommended to determine the surgical stage (Grade A).
2. When an enlarged inguinal lymph node is not detected, the benefits of biopsy are not evident. Therefore, routine inguinal lymph node biopsy is not recommended (Grade C2).
   [See Fig. 1]

CQ09

What is a significance of preoperative diagnostic imaging?

Recommendations:

1. Evaluation for myometrial invasion and cervical invasion by preoperative MRI is recommended (Grade A).
2. Evaluation for lymph node metastases or distant metastases by preoperative imaging such as CT scan or MRI is recommended (Grade C1).
   [See Fig. 1, 3, and 6]

CQ10

Is intraoperative frozen-section diagnosis useful to determine the optimal operative method?

Recommendations:

1. Intraoperative frozen-section diagnosis may be useful for predicting high-risk disease for which pelvic and para-aortic lymphadenectomy or omentectomy would be appropriate (Grade C1).
2. Intraoperative frozen-section diagnosis is not recommended for the definite diagnosis in terms of histological type, histologic differentiation, and myometrial invasion (Grade C2).

CQ11

Should intraoperative frozen-section diagnosis be performed to detect lymph node metastases?

Recommendations:

1. Intraoperative frozen-section diagnosis is useful in the diagnosis of metastasis when apparent lymph node enlargement is detected (Grade C1).
2. There is insufficient evidence to recommend modification of the surgical technique based on the

lymph node metastasis status assessed with intraoperative frozen sections. It is not recommended in daily practice (Grade C2).

CQ12

Can lymphadenectomy be omitted if a sentinel node biopsy is performed?

Recommendations:

There is insufficient evidence to omit retroperitoneal lymphadenectomy (lymph node biopsy) based on the sentinel lymph node status. It is not recommended in daily practice (Grade C2).

CQ13

Should peritoneal cytology be conducted on the occasion of surgery?

Recommendations:

The performance of peritoneal cytology should be continued regardless of whether it is a prognostic factor. Positive cases should be reported separately from surgical staging (Grade A).
[See Fig. 1 and 3]

CQ14

Can laparoscopic surgery become a standard surgical technique?

Recommendations:

1. Laparoscopic surgery is considered for patients with atypical endometrial hyperplasia or an early endometrial cancer limited to the uterus (stage I) (Grade B).
2. Laparoscopic surgery is not recommended for patients with advanced endometrial cancer (Grade C2).
   [See Fig. 1]

Additional statement

1. It is desirable to decide operative method and to operate by the team including qualified surgeon of the Japan Society of Gynecologic and Obstetric Endoscopy and Minimally Invasive Therapy or the Japan Society for Endoscopic Surgery, and board-certified gynecologic oncologists of the JSGO. Otherwise it is desirable to be carried out by the instruction system of these physicians.
2. The decision of the operative method of the laparoscopic surgery is carried out according to a basic policy described in CQ01, CQ03, and CQ04.

CQ15

How should patients who are confirmed to be endometrial cancer after hysterectomy be treated?

Recommendations:

1. Follow-up is possible when an extrauterine lesion is negative for myometrial invasion less than 1/2, G1, or G2. However, adjuvant therapy is considered when vascular invasion is detected (Grade C1).
2. Reoperation is considered when an extrauterine lesion is suspected or when G3, a variant histologic type, or stage >IB disease is present, even if myometrial invasion is less than 1/2. Based on it, it is desirable restaging, metastasis is confirmed, and to examine necessity of the adjuvant therapy.
   [See Fig. 2]

CQ16

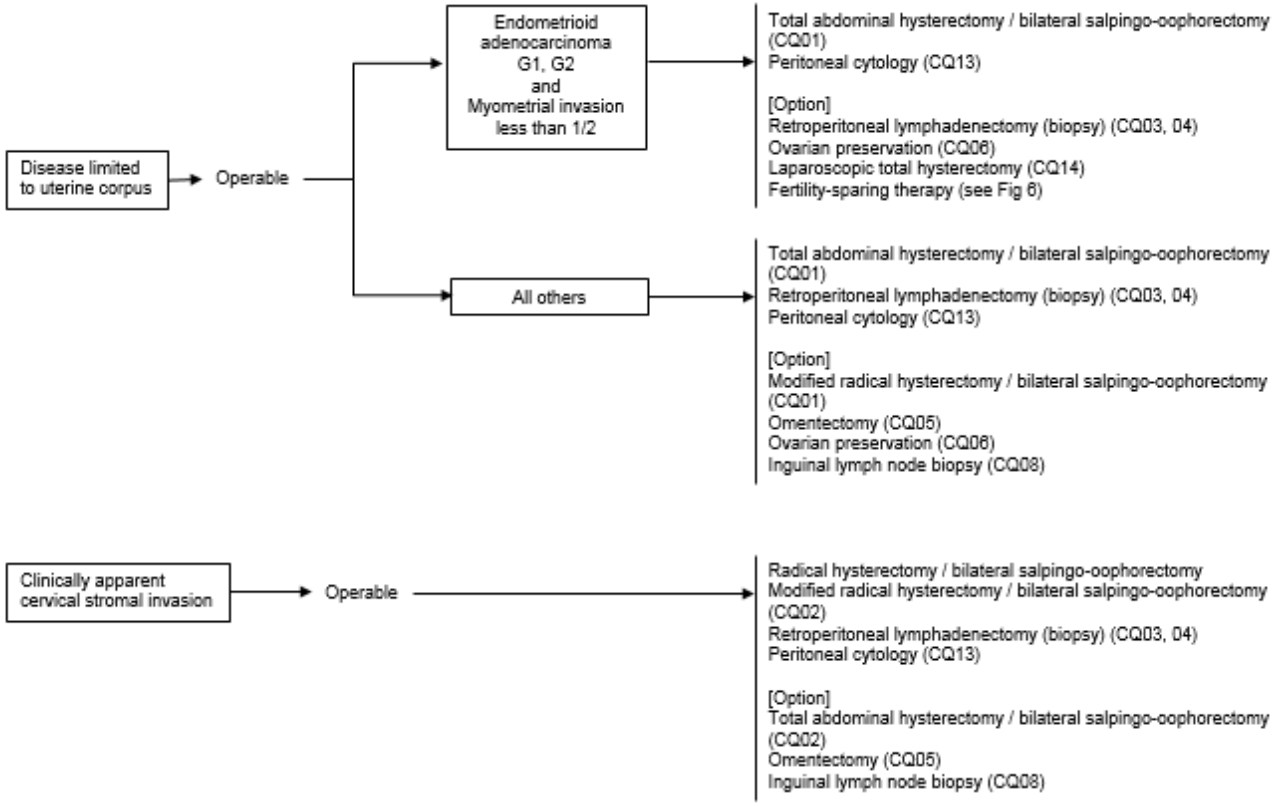
What is the indication for the definitive radiation therapy?

Recommendations:

Radiation therapy is considered when surgery is undesirable because of advanced age, complications, or when the patients have unresectable tumors (Grade C1).

[See Fig. 3]

Fig. 1 Initial treatment for the patients with endometrial cancer considered to be stage I or II preoperatively.

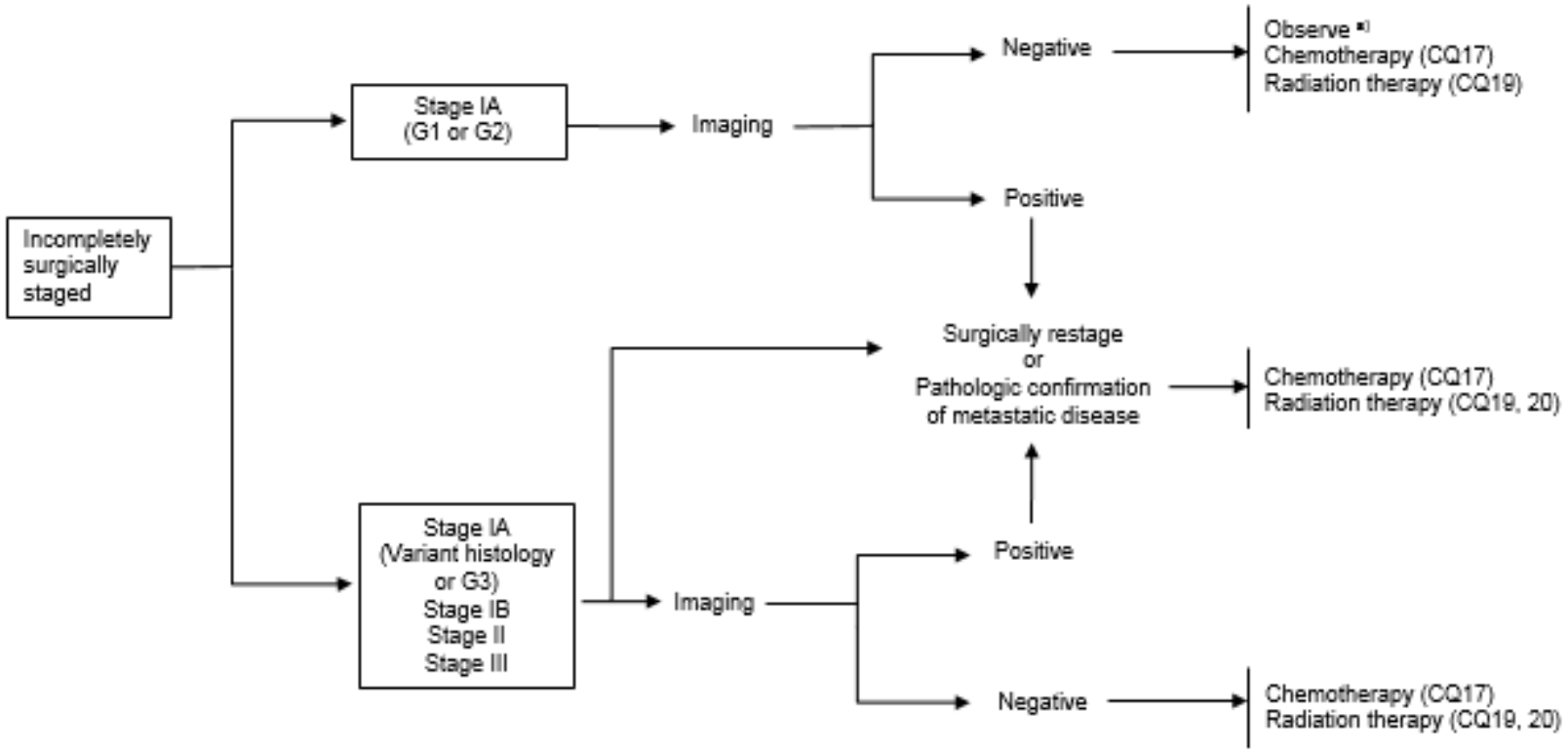


a) Radiation therapy or chemotherapy are considered when surgery is impossible.

b) Pelvic and para-aortic lymphadenectomy/lymph node biopsy and omentectomy are considered in addition to total hysterectomy with bilateral salpingo-oophorectomy for the patients with serous adenocarcinoma or clear-cell adenocarcinoma.

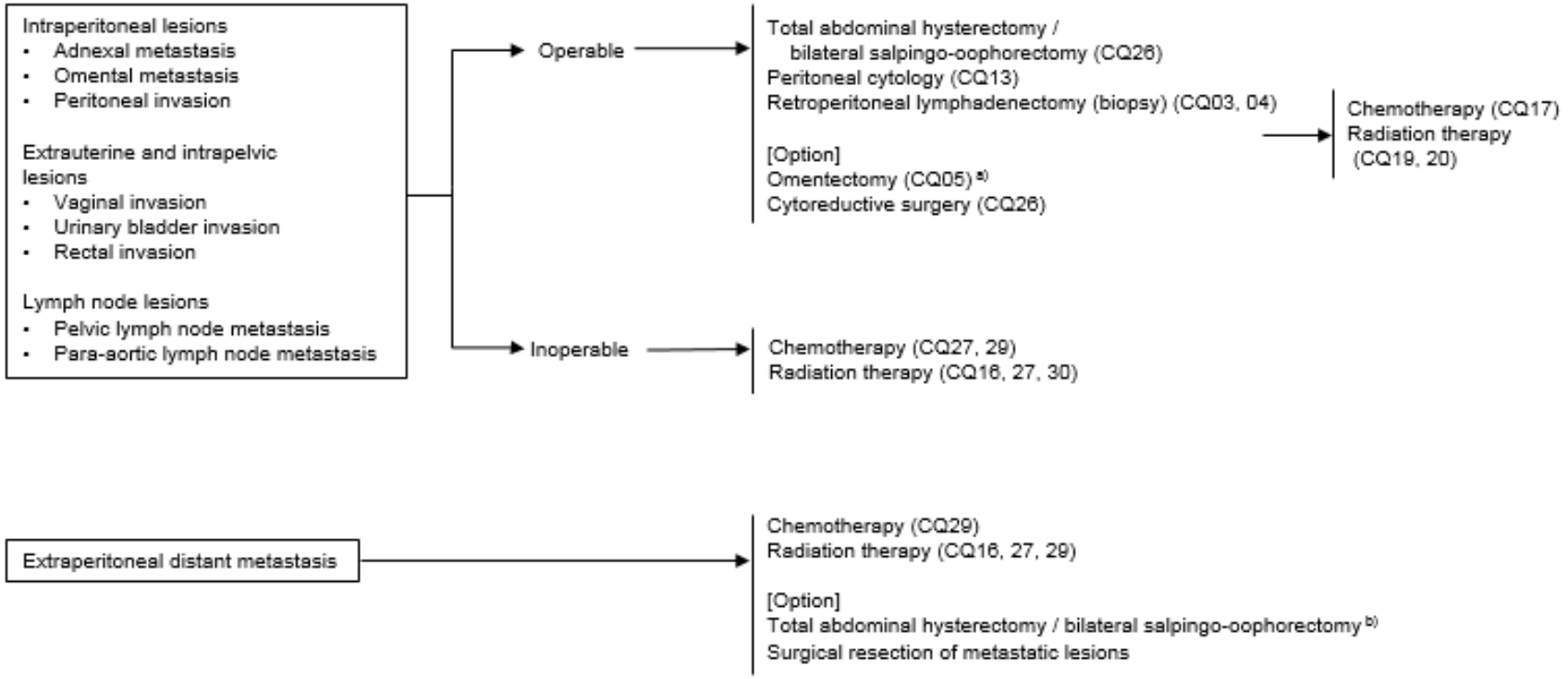
CQ indicates a clinical question.

Fig. 2 Initial treatment for the patients who are confirmed to be endometrial cancer after hysterectomy.



a) Postoperative chemotherapy is considered when positive lymphovascular space invasion.

Fig. 3 Initial treatment for the patients with endometrial cancer considered to be stage III or IV preoperatively.



a) Because the serous adenocarcinoma / clear cell adenocarcinoma is likely to become dissemination, the omentectomy is useful for a diagnosis.

b) Even if there is an extra-peritoneal metastasis or liver metastasis, surgery is considered on for the purpose of hemostasis.

Fig. 6 Strategies for fertility-sparing therapy (atypical endometrial hyperplasia and endometrioid adenocarcinoma (corresponding to G1)