Kent and Medway Cancer Collaborative

The Management of Endometrial Cancer

Pathway of Care

Publication date	August 2022
Expected review date	August 2024
Version number	10.0
Version status	FINAL

Table of Contents

1.0 Pathway Overview

Primary Care Refer if:

- ❒ There is more than one or a single heavy episode of post-menopausal bleeding in women who are not on HRT
- ❒ On HRT – unexpected or prolonged bleeding which is persistent for more than 4 weeks after stopping HRT
- ❒ On HRT and wishes to continue then further investigation is warranted. USS is not helpful and a hysteroscopy and endometrial biopsy need to be performed not as 2ww referral although within 4 weeks

GP decision to refer to first appointment no more than 14 days

2WW Referral

Secondary Care

(Specialist or Affiliated Designated Stand Alone Diagnostic Units)

- ❒ Assessment
- ❒ Diagnosis
- ❒ Imaging

} Described in sections 4.2, 4.3, 4.5 & 4.6 below

- ❒ The CNS should always be present when bad news is given
- ❒ Regardless of whether diagnostic assessments are undertaken in a specialist or designated stand alone units all diagnosed Endometrial cancers are to be discussed at the Specialist **MDM**

Stand Alone Diagnostic Units

Low risk Grade 1 Endometrial Cancer may have their surgery undertaken in the hospital hosting the Diagnostic Service providing the surgeon is a full and active member of the Specialist MDT

Specialist MDT

Women with **any** Endometrial Cancer other than a Stage 1 (i.e. cervical extension or uterinefixity on a pelvic examination) **must** have their surgery undertaken at the Specialist Centre

Date of decision to treat to date of first treatment – no more than 31 days

- ❒ Regardless of where surgery is undertaken any post surgical upstaging must be discussed at the Specialist MDM and treatment plans modified if appropriate
- ❒ All cases of endometrial cancer to be considered for entry into an appropriate clinical trial
- ❒ Patients will be followed up according to the Gynae TSSG agreed protocols set out in section 7
- ❒ Women with recurrent/metastatic disease will have their cases reviewed by the MDT in order to optimise their treatment options
- ❒ Women who fall into the age categories specified by the Children's and Young Peoples IOG will be managed in association with designated CYP MDTs

GP Decision to refer to first treatment no more than 62 days

2.0 Purpose

To describe the process for ensuring that all Endometrial Cancer cases diagnosed within the Kent & Medway region are managed by the East and West Kent Gynaecological Oncology Centres, achieving a coordinated seamless patient pathway in accordance with the best possible evidence based practice and to facilitate advancement in the specialty in the field of endometrial cancer management.

3.0 Scope

This Pathway of Care (PoC) applies to all cases and suspected cases of endometrial malignancy within Kent & Medway. The Kent & Medway Cancer Collaborative (KMCC) Endometrial Cancer specification of delivery of care requires all Trusts within Kent & Medway (K&M) to adopt an agreed policy. The aim of the guidelines is to ensure that all patients with suspected endometrial carcinoma are appropriately referred and investigated and any patient with a confirmed endometrial carcinoma receives care and treatment in accordance with the best possible evidence based practice available within the region.

The policy covers the following:

- Access
- Initial Assessment
- Investigations
- Gynaecological oncology multidisciplinary meeting
- Surgical and non-surgical treatment.
- Recurrent disease
- Follow up

4.0 Policy

4.1 Access

All patients with suspected endometrial cancer to be referred within 24 hours to a gynaecology rapid assessment clinic, based in each major acute hospital within K&M. Patients will be seen within 2 weeks of decision to refer.

4.2 Initial Assessment

- Full history and pelvic examination.
- Assessment of endometrium (trans vaginal ultrasound / outpatient hysteroscopy / pipelle)
- Abdominal scan if trans vaginal scan is not possible

4.3 Diagnostic Biopsy – Endometrial Tumours

- Endometrial sampling (with or without hysteroscopy) can be performed in the consultant led clinic as an outpatient procedure if the endometrial thickness is more than 4mm (BGCS recommendation) and further sampling needs to be undertaken. If the cavity view was suboptimal or the biopsy inadequate, this procedure can be repeated under a general anaesthetic.
- Biopsy at a later time, if bleeding persists and endometrial thickness less than 4mm, or proceed with endometrial sampling at initial episode regardless of endometrial thickness depending on patient preference, particularly if other risk factors for endometrial malignancy.
- Patients who do not wish to have an outpatient endometrial biopsy should be given the option of undergoing hysteroscopy under general anaesthesia.

4.4 Gynaecological Oncology Multidisciplinary Meeting

All endometrial cancer patients should be referred to the Cancer Centre and reviewed at the Multi-Disciplinary Meeting (MDM), where possible prior to undergoing first definitive treatment. Case discussion should include review of:

- Histology from biopsy.
- Imaging – CXR or CT (Grade 1) or CT chest abdomen and pelvis (for all Grade 2 + 3).
- Discussion of management options (i.e. radical surgery / radiotherapy), and discussion of suitability for recruitment into clinical trials.
- Cases should also be discussed following surgery to review histology and management plan, and in the event of disease recurrence.

4.5 Investigations

- FBC
- U&E
- LFTs
- + Ca 125 (if serous papillary sub type)

4.6 Imaging

This is organised in local diagnostic unit: dependent on histology grade (endometrial adenocarcinoma) and subtype:

- Endometrial adenocarcinoma Grade 1: CXR +/- CT chest / abdomen / pelvis or MRI pelvis as per local protocol.
- Endometrial adenocarcinoma Grade 2: CT chest / abdomen / pelvis or MRI abdopelvis and CXR.
- Grade 3 Endometrioid Adenocarcinoma, Mixed Mesodermal Tumour (MMMT), Papillary serous, Clear Cell tumours: CT chest / abdomen / pelvis or CT chest and MRI abdo/pelvis.
- Leiomyosarcoma: CT chest / abdomen / pelvis.
- Imaging-guided biopsy where appropriate.

Note: Full details of the KMCC Imaging Guidance can be found on the KMCC website:-
http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/diagnostics-group/

4.7 Where surgery may be undertaken

Grade alone will determine treatment at the centre or the hospital hosting the affiliated "Stand Alone Diagnostic Unit" unless examination demonstrates obvious stage greater than stage I (e.g. cervical extension or uterine fixity on pelvic examination, or deep myometrial invasion on MRI). All surgery will be performed by a core member of the Centre Multi-Disciplinary Team (MDT) regardless of locality. The provision for low risk Grade 1 endometrial cancer surgery in the former "cancer units" in West Kent by core members of the West Kent Gynaecological Cancer Centre MDT is compliant with the revised Gynaecological Cancer Peer Review Measures.

4.8 Pathology

All KMCC reporting pathologists follow The Royal College of Pathologists Histopathology Reporting on Cancers guidelines – a copy of which is available through the KMCC website:-

http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/pathology-group/

Pathology specimens will be processed and reported in accordance with the guidelines set out Royal College of Physicians (RCP) minimum data set.

See Appendix 1 for FIGO staging system, incorporated into clinical practice in the United Kingdom on January 1, 2010.

4.9 Genetic testing for endometrial cancers

Prevalence of Lynch syndrome in endometrial cancers is 3.2%. The lifetime risk of developing endometrial cancer is 40 to 60% in people with a Lynch syndrome mutation. Immunohistochemistry (IHC) to identify mismatch repair (MMR) deficiency should be carried out. If there is evidence of MMR deficiency in the tumour, then such patients should subsequently be referred to genetics for germline testing for Lynch Syndrome as per NICE recommendations (2021).

5.0 Treatment – Endometrial Cancers

Surgical treatment should be tailored with the aims of local clearance of tumour.

Patients who are to have radical treatment (surgery and / or radiotherapy) should receive advice concerning lymphoedema.

Note: Full details of the KMCC oncology guidance can be found on the KMCC website:
http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/gynae-tssg/

5.1 Stage 1 (Ref: Appendix 1)

Women undergoing surgery should have either an abdominal or laparoscopic route of surgery depending on the surgeon's preference and patient suitability. Where suitable facilities and expertise exist, and there is no clinical contra-indication, a laparoscopic approach is preferred. The choice of abdominal incision rests with the surgeon.

Kent consists of two surgical Centres: East and West Kent Gynaecological Cancer Centres (EKGCC and WKGCC respectively). In EKGCC, all endometrial cancers of all grades are operated on centrally. In WKGCC most Grade 1 endometrial adenocarcinomas presumed Stage I with apparent superficial

myometrial invasion are operated on in the local hospital (former “cancer unit”) by a gynaecologist who is also a core member of the Centre MDT; all other grades of endometrial adenocarcinoma and sub types MMMT, Papillary serous, Clear Cell tumours and Leiomyosarcoma undergo surgery/managed in the Centre by sub specialist gynae oncologists**.**

5.1.1 Surgery at the unit

Surgery for grade 1 presumed Stage I should involve:

- Peritoneal washings for cytology
- Total hysterectomy
- Bilateral salpingo oophorectomy

Surgery for Grade 1 tumours with deep myometrial invasion demonstrated on MRI or on frozen section histology should be offered completion of surgical staging with pelvic (+/- para-aortic) lymphadenectomy following clear discussion of the potential benefits and complications as demonstrated by review of the recent published peer reviewed literature.

5.1.2 Surgery at the Centre (WKGCC and EKGCC)

Surgery for grade 2 + 3 tumours should involve:

- Peritoneal washings for cytology
- Total hysterectomy
- Bilateral salpingo oophorectomy
- Bilateral pelvic lymphadenectomy (BPLND) is offered for grade 2 and grade 3 presumed early stage endometrial adenocarcinoma unless clinically inappropriate.

If endometrial curettage histology suggests the presence of high-risk serous papillary or clear cell subtypes, then an infracolic omentectomy should be performed and debulking of visible disease.

Where preoperative imaging or intraoperative assessment suggests bulky pelvic or para aortic nodal disease, debulking lymphadenectomy should be considered by the MDT and offered to the patient if appropriate.

Sentinel node mapping in endometrial cancer:

Studies have demonstrated a high negative predictive value for sentinel lymph node (SLN) algorithms for surgical staging of endometrial cancers. For women with endometrial cancer where lymph node dissection is indicated, the use of sentinel lymph node (SLN) algorithms can be considered for surgical staging in the absence of metastatic disease on pre-operative imaging or extra uterine disease noted at surgery. SLN mapping is associated with a lower risk of postoperative morbidity such as lymphocysts and lymphoedema. The use of an intracervical injection of a tracer or dye has been found to be the most suitable technique with the use of Indocyanine green (ICG) or a combination of Tc99m labelled colloid and blue dye having higher detection rates than blue dye alone. In cases where a sentinel node has not been detected, a full lymphadenectomy must be performed on that hemipelvis. Sentinel nodes must be ultrastaged as this improves the detection of metastases.

5.2 Advanced Disease

- Pelvic radiotherapy for palliation symptoms. Consideration of appropriate systemic treatment.
- Appropriate surgery may be considered for palliation of bleeding, bulk reduction and symptom relief.
- The palliative care team should be involved.

5.3 Adjuvant Disease

Knowledge of the pelvic lymph nodal status is helpful in deciding on the benefits of adjuvant radiotherapy. The following table outlines the Risk status with respect to stage, myometrial invasion lymphovascular space invasion (LVSI), lymph nodal status and age. These recommendations have been taken from the ESMO-ESGO-ESTRO Consensus Guidelines for Endometrial Cancer (December 2015 Annals of Oncology 0: 1–26, 2015).

Summary of Adjuvant Treatment Recommendations

	STAGE	Grade	50% Myometrial Invasion	LVSI	Lymph nodal status	Adjuvant Rx	<60yrs
Low Risk	I	1-2	<	No		None	
Intermediate Risk	I	1-2	≥	No		Adj VBT or nil	None
High Risk Intermediate	I	1-2	Any MI	+	Negative	VBT or nil	
					Unknown	EBRT	
	I	3	<	+/-	Negative	VBT or nil	
				No	Unknown	VBT	
	I	3		+	Unknown	EBRT	
High Risk	I	3	≥	+/-	Negative	EBRT limited fields Vs VBT alone	
					Unknown	EBRT+/- Chemo	
	II	1-2		No	Negative	VBT	
	II	3			Negative	EBRT + VBT	
	II			+	Negative	EBRT + VBT	
	II	3		+/-	Unknown	EBRT + VBT Consider chemo+RT	
	III					Adj Chemo + EBRT	
High Risk		Serous clear cell				Consider chemo	
Non endometrioid	Ia		<	No		Consider VBT alone	
	Ib		≥	No		EBRT + consider chemo	
		MMMT /undifferentiated				Consider chemo + EBRT	

If para aortic nodes are enlarged on post-operative CT scan (suspected Stage 3C2), then treatment with a para aortic strip and/or chemotherapy may be considered.

5.4 Recurrent Disease

- Multidisciplinary discussion to optimise management regime.
- Radiotherapy if not suitable for excision and maximum dose not already given.
- Radiotherapy or palliation for inoperable disease.
- Hormone therapy with Progestogens if receptor positive.
- In rare circumstances exenterative surgery may be considered.
- Standard default adjuvant chemotherapy

5.5 Sarcoma

See FIGO staging system (appendix 1)
Patients with leiomyosarcoma will be referred to Royal Marsden Hospital (RMH) sarcoma MDT for discussion and advice regarding chemotherapy and radiotherapy. Surgical care will be performed in the East or West Kent Gynaecological Oncology Centre and in most cases chemotherapy / radiotherapy will also be administered locally by the local cancer centre teams. This arrangement is compliant with the Sarcoma IOG guidance. Referrals to RMH Sarcoma MDT may also be made for cases of endometrial stromal sarcoma at the discretion of the local MDTs but will not generally be performed for cases of carcinosarcoma.

6.0 Oncological Provision

The Non Surgical Oncology Sub Group (NOG) of the Gynae Tumour Site Specific Group (TSSG) will be responsible for defining chemotherapy and radiotherapy treatment protocols. These will be formally signed off by the full TSSG.

All patients will be considered for entry into a clinical trial where possible.

Note: Full details of the KMCC oncology guidance can be found on the KMCC website:-
http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/gynae-tssg/

Note: The Terms of Reference for the NOG can be found on the KMCC website:-
http://kmcc.nhs.uk/tumour-sites/terms-of-reference/

7.0 Follow Up

Note: Please see gynaecological follow up guidelines which can be found on the KMCC website:-
http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/gynae-tssg/

8.0 Supportive and Palliative Care

Palliative care provision should be made for all patients:
- Hospital teams, including the Clinical Nurse Specialists for gynae cancer patients.
- Primary Health Care Team would provide for palliative care at home.
- General Practitioner should be informed of management decision changes as soon as possible.

The management of symptoms, psychological, social and spiritual issues, and the communication of the diagnosis and any associated problems, should be within the domain of all health care professionals.

Open and frank discussions with patients should take place with patients at all stages of their journey so that patients are not confused about their prognosis or have unrealistic expectations of any of the forms of treatment offered to them.

Relatives and carers will need to be appropriately supported and given appropriate information. However, in accord with the recommendations set out in various revised Improving Outcomes Guidance, relatives and carers should not be given information different to that given to the patient.

Referral to specialist palliative care services should be considered when these issues have not been resolved and in particular for patients with:
- Complex symptom management issues, which are difficult to manage
- Difficulties in adjusting to the diagnosis or disease progression
- Psychological and family issues – such as communication problems within the family
- Spiritual issues, such as the challenging of belief system/faith/cultural values as a result of the cancer

Consideration of specialist palliative care or support should be given throughout the patient pathway, particularly:
- At the MDT Meeting
- When no active treatment is considered
- After active treatment
- At relapse
- In the terminal stages

9.0 Data Collection

Collection of data at each stage of the pathway is the responsibility of the team looking after the patient at that time. The minimum dataset agreed by the TSSG will be a combination of those data items that meet national requirements, and additional items as agreed by the TSSG.

National data requirements will include:

- Cancer Waiting Times monitoring, including Going Further on Cancer Waits. The data items required will be as defined in ISB0147 at the time of referral and/or treatment.

  Details of the Cancer Waiting Times dataset are available from:
  http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/national_cancer_waiting_times_monitoring_data_set_fr.asp

  Cancer Waiting Times data will be submitted according to the timetable set out in the National Contract for Acute Services.

- The Cancer Outcomes and Services Dataset. The data items will be as defined in ISB1521, and any subsequent versions, at the time of diagnosis and/or treatment. The requirement will include those fields listed in the “Core” section of the dataset, and any additional tumour site specific sections, as applicable.

  Details of the COSD are available from:
  http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd.aspx

  Cancer Registration and Cancer Outcomes and Services (COSD) data will be submitted according to the timetable set out by the National Cancer Registration Service.

- Where applicable, teams will also collect additional data items as defined in any corresponding National Clinical Audit Support Programme (NCASP) audit dataset.

  Details of these datasets are available from:

http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/cancer

Data for NCASP audits will be submitted, where applicable, according to timetables as agreed by the TSSG, and within the overall submission deadlines for each audit.

Submission of data to meet these national requirements will be the responsibility of each individual Trust.

Note that these standards are subject to variation from time to time, and where these requirements change, the data items required to be collected by the team will also change in line with national requirements.

Local data requirements will include any additional data items as agreed by the TSSG. These must be selected to avoid overlap with any existing data items, and where possible must use standard coding as defined in the NHS Data Dictionary.

Where possible and applicable, InfoFlex will be used for the collection and storage of data.

Additional areas of the COSD, relating to pathology, radiotherapy, SACT, diagnostic imaging and basic procedure details will feed into the dataset from other nationally mandated sources. It is the responsibility of each team to ensure that the whole of the relevant dataset is collected, and it is acknowledged that this may come from a variety of sources.

10.0 Children, Teenagers and Young Adults

Children and Young People (CYP) and Teenage and Young Adults with Gynaecological Cancers will be treated in accordance with principles set out in the CYP & TYA IOG.

All children and Young People up to 18 years + 364 days must be referred to the CYP Principal Treatment Centre (PTC) which for KMCC is based at the Royal Marsden Hospital.

Referral to a CYP / TYA Principal Treatment Centre does not necessarily mean that treatment will be undertaken at that centre; shared care management protocols may allow some treatments to be undertaken locally.

All Young Adults between 19 and 24 years of age must be offered a referral to the TYA Principal Treatment Centre which for KMCC is the Royal Marsden Hospital.

11.0 Personnel and Contact Information

A comprehensive, up to date list of MDM contact details can be found on the KMCC website via the following link: http://kmcc.nhs.uk/tumour-sites/terms-of-reference/

12.0 References

1. Improving Outcomes in Gynaecological Cancers: The Research Evidence NHS Executive. DOH, July 1999.
2. Guidance for Purchasers: Improving Outcomes in Gynaecological Cancers – The Manual
3. Clinical Recommendations for the Management of Vulval Cancer; “Setting Standards to Improve Women’s Health”. The Royal College of Obstericians and Gynaecologists, July 1999
4. NHS Cancer Referral Guidelines HSC2000/013
5. Sentinal Consensus Document for Vulval, Endometrial and Cervical Cancer BGCS January 2019
6. Testing strategies for Lynch syndrome in people with endometrial cancer, NICE DG42 2021

13.0 Appendix 1

Endometrial cancer can be grouped with regard to the degree of differentiation of the adenocarcinoma, as follows:

- G1: 5% or less of a nonsquamous or nonmorular solid growth pattern.
- G2: 6% to 50% of a nonsquamous or nonmorular solid growth pattern.
- G3: more than 50% of a nonsquamous or nonmorular solid growth pattern.

FIGO staging for endometrial cancer (UK revision adopted January 01, 2010):

Carcinoma of the endometrium.

Stage I*	Tumor confined to the corpus uteri
IA*	No or less than half myometrial invasion
IB*	Invasion equal to or more than half of the myometrium
Stage II*	Tumor invades cervical stroma, but does not extend beyond the uterus**
Stage III*	Local and/or regional spread of the tumor
IIIA*	Tumor invades the serosa of the corpus uteri and/or adnexae#
IIIB*	Vaginal and/or parametrial involvement#
IIIC*	Metastases to pelvic and/or para-aortic lymph nodes#
IIIC1*	Positive pelvic nodes
IIIC2*	Positive para-aortic lymph nodes with or without positive pelvic lymph nodes
Stage IV*	Tumor invades bladder and/or bowel mucosa, and/or distant metastases
IVA*	Tumor invasion of bladder and/or bowel mucosa
IVB*	Distant metastases, including intra-abdominal metastases and/or inguinal lymph nodes

*Either G1, G2, or G3.

**Endocervical glandular involvement only should be considered as Stage I and no longer as Stage II.

#Positive cytology has to be reported separately without changing the stage.

Staging for uterine sarcomas (leiomyosarcomas, endometrial stromal sarcomas, adenosarcomas, and carcinosarcomas).

(1) Leiomyosarcomas and endometrial stromal sarcomas (ESS)*

Stage		Definition
I		Tumor limited to uterus
	IA	≤5 cm
	IB	>5 cm
II		Tumor extends beyond the uterus, within the pelvis
	IIA	Adnexal involvement
	IIB	Involvement of other pelvic tissues
III		Tumor invades abdominal tissues (not just protruding into the abdomen).
	IIIA	One site
	IIIB	>one site
	IIIC	Metastasis to pelvic and/or para-aortic lymph nodes
IV	IVA	Tumor invades bladder and/or rectum
	IVB	Distant metastasis

(2) Adenosarcomas

Stage		Definition
I		Tumor limited to uterus
	IA	Tumor limited to endometrium/endocervix with no myometrial invasion
	IB	Less than or equal to half myometrial invasion
	IC	More than half myometrial invasion
II		Tumor extends beyond the uterus, within the pelvis
	IIA	Adnexal involvement
	IIB	Involvement of other pelvic tissues
III		Tumor invades abdominal tissues (not just protruding into the abdomen).
	IIIA	One site
	IIIB	>one site
	IIIC	Metastasis to pelvic and/or para-aortic lymph nodes
IV	IVA	Tumor invades bladder and/or rectum
	IVB	Distant metastasis

(3) Carcinosarcomas

Carcinosarcomas should be staged as carcinomas of the endometrium.

*Note:
Simultaneous endometrial stromal sarcomas of the uterine corpus and ovary/pelvis in association with ovarian/pelvic endometriosis should be classified as independent primary tumors.

14.0 Glossary

Acronyms in common usage throughout KMCC documentation:

CNB	Cancer Network Board
CYP	Children & Young People (in relation to the IOG)
DCCAG	Diagnostic Cross Cutting Advisory Group
DOG	Disease Orientated Group (NSSG/TSSG/TWG)
DVH	Darent Valley Hospital
EK	East Kent
EKGCC	East Kent Gynaecological Oncology Centre
EKHUFT	East Kent Hospitals University Foundation Trust
HoP	High Level Operational Policy
IOSC	Improving Outcomes: A Strategy for Cancer
K&C	Kent & Canterbury Hospital, Canterbury, (EKHUFT)
KMCA	Kent & Medway Cancer Alliance
KMCC	Kent & Medway Cancer Collaborative
LSESN	London & South East Sarcoma Network
MDM	Multi Disciplinary Meeting
MDT	Multi Disciplinary Team
MFT	Medway Foundation Trust
MMMT	Mixed Mesodermal Tumour
MTW	Maidstone & Tunbridge Wells NHS Trust
NOG	Non Surgical Oncology Group *(Permanent oncologist sub group of the TSSGs with a specific responsibility for chemo/rad pathways and advice to the TSSGs, KMCC and geographical locations on new drugs)*
PoC	Pathway of Care *(K&M agreed disease site specific clinical guidelines)*
RCP	Royal College of Physicians
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of life
RCP	Royal College of Physicians
RMH	Royal Marsden Hospital
RNOH	Royal National Orthopaedic Hospital
SACT	Systemic Anti-Cancer Therapy
TSSG	Tumour Site Specific Group
TYA	Teenagers & Young Adults
QVH	Queen Victoria Foundation Trust Hospital East Grinstead
UCLH	University College Hospital London
WHH	William Harvey Hospital, Ashford (EKHUFT)
WK	West Kent
WKGCC	West Kent Gynaecological Oncology Centre

15.0 Document Administration

Document Title	The Management of Endometrial Cancer – Pathway of Care
Principle author	Justin Waters/Omer Devaja/Andreas Papadopoulos/Rema Jyothirmayi
Co-author(s)	Caroline Tsatsaklas/N.Aluwalia
Current version number	10.0
Current status	FINAL
Original publication date	March 2011
Expected review date by	August 2024

Enquiries:	
[1] Rema Iyer [2] Annette Wiltshire	rema.iyer1@nhs.net annette.wiltshire@nhs.net

Revision History			
Date of revision	New Version Number	Nature of Revision	Confirmation of Accuracy by
Aug 05	0.1	Development of Kent document based on (with grateful thanks) the Yorkshire Cancer Network original	O. Devaja/ A.Papadopoulos
Oct 05	0.2	Flow chart update based on revised text set out in draft 1	A.Jackson
Nov 05	0.3	Updated text	A.Papadopoulos
Feb 06	1	Updates agreed at Nov 2005 DOG – Table	A.Jackson/ R.Jyothimayi
Mar 06	2	Oncology provision	A.Jackson/ J.Summers
Sept 08	2.1	Updates as agreed at 10/09/08 Gynae DOG	Gynae DOG
Feb 09	2.1	New Measures Addressed	Gynae DOG
Mar 09	2.2	Draft updated	A.Jackson/ A.Nordin
Mar 09	3.0	Updates	Gynae DOG
Aug 09	3.1	Updates to adjuvant radiotherapy agreed	Gynae DOG
June 2010	3.2	Amendment to guidelines for lymphadenectomy section	A.Nordin
Sept 2011	4.2	Amendment to guidelines for Diagnostic Biopsy	R.MacDermott
Sept 2011	5.0	Final - published	Gynae DOG
Mar 2012	5.1	Draft - changed to new format; updated all weblinks inc. imaging, pathology & contacts; general formatting & content checking	L.Caine/S.Stanley/ C.Tsatsaklas
Sept 2012	6.0	Final – data collection section updated/ final updates made in the Gynae DOG 19/09/12 – agreed/published	A.Brittle/Gynae DOG/ C.Tsatsaklas/I.Vousden
May 2014	6.1	Draft – amendment to surgical guidelines	J. Waters/ Gynae TSSG
May 2014	6.2	Draft – admin text updates (i.e. removal of KMCN, DOGs, replace with KMCC, TSSG etc)	C.Tsatsaklas
May 2014	6.3	Draft – update to reflect current practice to Imaging section 4.6	S.Montalto
May 2014	7.0	Final – agreed changes made in 1/5/2014 Gynae TSSG inc weblink updates etc	J.Waters/Gynae TSSG
June 2014	7.0	Final/Published – ratified by the Operational & Quality Group	Operational & Quality Group

June 2017	7.1	Review underway	Rema Jyothirmayi
July 2017	7.2	Draft updated document circulated for comments to the TSSG group	N.Aluwalia
July 2017	7.3	Comments added, O&Q ratification now due	N.Aluwalia
September 2017	8.0	Final published version following ratification by O&Q Group	N.Aluwalia
February 2020	9.0	Final published version with new chair and updates on 5.12 & 12.0 References	R. Iyer /A. Wiltshire
August 2022	10.0	Final – Revision of document nearing expiry date	R. Iyer /A. Wiltshire