Post Treatment Surveillance for Women with Endometrial Cancer

Goal: Prognosis for recurrent disease is poor and treatment options limited. Early detection of recurrence does not change outcome. Aggressive surveillance is not indicated and a twice a year schedule is suggested.

- These guidelines apply to women who have completed primary therapy (surgery with or without adjuvant radiation) and are without evidence of disease.
- Sarcomas of the uterus are rare and have different treatment options and prognosis. Those patients will require modification of the guideline.
- The tumor marker Ca-125 is not specific to endometrial cancer but can be useful.
- Endometrial cancer is the most common gynecologic malignancy but it is also the most curable. (>75% 5-year survival for stage 1)
- Endometrial cancer usually presents as abnormal (postmenopausal) bleeding while the tumor is confined to the uterus (stage 1) and readily treated surgically.
- If endometrial cancer recurs the vagina (cuff) is the most common location though pelvic, pulmonary and distant mets are also possible.
- Curative treatment for recurrent disease is often not possible but both radiation and hormonal therapy offer significant palliative benefit.
- Most patients with low stage disease will never recur.
- Most recurrences happen in the first three years. Late recurrences are possible.
- Most recurrences are found from symptoms. Patients should be instructed to come in for bleeding, weight loss, pain in the abdomen, pelvis or back, cough or shortness of breath, nausea, vomiting or swelling of the abdomen or legs.
- The patients need for support and reassurance may require more frequent contact than is recommended below.
- Estrogen can promote tumor growth and hormone replacement must be individualized.
- Colon cancer and breast cancer screening is indicated.

Scheduled follow up

Clinical Exam 2 times each year for the first 3 years then yearly

1. Physical to include pelvic, rectal and lymph nodes.
2. History and ROS focused on abdominal, pelvic and respiratory symptoms.
3. Pap and Ca-125

Imaging Studies

1. Chest X-ray for symptoms
2. CT of Abd/Pelvis based on Clinical Exam

Consultation with Gynecologist

1. OB/Gyn staff is available for follow up visits in field clinics and at ANMC X 2years
2. At least yearly for patients with no evidence of disease for the first 5 years
3. When recurrence is diagnosed or suspected
4. Whenever treatment plan or follow up is changed

Reference:

Johnson, FE, Virgo KS, Edge SB. *Cancer Patient Follow-up*. St. Louis: Mosby Yearbook. 1997