No. 291, April 2013 (Replaces no. 51, November 1996, Reaffirmed September 2018)

No. 291-Epidemiology and Investigations for Suspected Endometrial Cancer

This clinical practice guideline has been prepared by the SOGC-GOC-SCC Policy and Practice Guidelines Committee, reviewed by the Clinical Practice Gynaecology Committee and approved by the executive and Council of the Society of Gynecologic oncology of Canada and the executive and Council of the Society of obstetricians and Gynaecologists of Canada.

Marie-Claude Renaud, MD, Québec City, QC

Tien Le, MD, Ottawa, ON

SOGC-GOC-SCC Policy and Practice Guidelines Committee: Tien Le, MD (Chair), Ottawa, ON; James Bentley, MB ChB, Halifax, NS; Scott Farrell, MD, Halifax, NS; Michel P. Fortier, MD, Québec City, QC; Christopher Giede, MD, Saskatoon, SK; Rachel Kupets, MD, Toronto, ON; Marie Plante, MD, Québec City, QC; Patti Power, MD, St. John's, NL; Marie-Claude Renaud, MD, Québec City, QC; Alexandra Schepansky, MD, Edmonton, AB; Vyta Senikas, MD, Ottawa, ON. Special contributors: Janice Kwon, MD, Vancouver, BC; Michel Préfontaine, MD, London, ON; Isabelle Germain, MD, Montréal, QC; Robert Pearcey, MD, Edmonton, AB; David D'Souza, MD, London, ON; Mary Senterman, MD, Ottawa, ON; Paul Hoskins, MA, Vancouver, BC. Disclosure statements have been received from all contributors.

The literature searches and bibliographic support for this guideline were undertaken by Becky Skidmore, Medical Research Analyst, Society of Obstetricians and Gynaecologists of Canada.

Key Words: Endometrial cancer, diagnostic workup, endometrial evaluation, ultrasound, magnetic resonance imaging, MRI, postmenopausal bleeding

Abstract

Objective: To review the evidence relating to the epidemiology of endometrial cancer and its diagnostic workups.

Options: Women with possible endometrial cancer can undergo an endometrial evaluation by office biopsy, hysteroscopy, or dilatation and curettage. To assist in treatment planning, pelvic ultrasound, CT scan, or MRI may be considered.

Outcomes: The identification of optimal diagnostic tests to evaluate patients with possible endometrial cancer.

Evidence: Published literature was retrieved through searches of PubMed, CINAHL, and The Cochrane Library, using appropriate controlled vocabulary (e.g., endometrial neoplasms) and key words (e.g., endometrium cancer, endometrial carcinoma). Results were restricted to systematic reviews, randomized control trials/controlled clinical trials, and observational studies. There were no date or language restrictions. Searches were updated on a regular basis and incorporated in the guideline to December 31, 2011. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology assessment-related agencies, clinical practice guideline collections, clinical trial registries, national and international medical specialty societies, and recent conference abstracts.

J Obstet Gynaecol Can 2018;40(9):e703–e711

https://doi.org/10.1016/j.jogc.2018.07.005

Women have the right and responsibility to make informed decisions about their care in partnership with their health care providers. In order to facilitate informed choice women should be provided with information and support that is evidence based, culturally appropriate and tailored to their needs. The values, beliefs and individual needs of each woman and her family should be sought and the final decision about the care and treatment options chosen by the woman should be respected.

Table 1. Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment*	Classification of recommendations†
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case–control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
	E. There is good evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

* The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

† Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Adapted from: Woolf SH, et al. Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. CMAJ 2003;169:207–8.

Values: The quality of evidence was rated using the criteria described in the Report of the Canadian Task Force on Preventive Health Care (Table 1).

Benefits, harms, and costs: This document is intended to guide the development of a standardized cost-effective investigation of patients with suspected endometrial cancer.

Validation: The guideline was reviewed for accuracy by experts in pathology, radiation oncology, and medical oncology. Guideline content was also compared with relevant documents from the American Congress of Obstetricians and Gynecologists.

RECOMMENDATIONS:

1. A complete focused history should be taken and a physical examination carried out in patients with suspected endometrial cancer. Attention should be paid to predisposing factors for excess estrogen stimulation of the endometrium such as long history of anovulation, obesity, menstrual irregularity, or long-term use of unopposed estrogen or tamoxifen. Patients with a strong family history of endometrial, ovarian, and colorectal cancers might have inherited Lynch syndrome (hereditary non-polyposis colorectal cancer syndrome) that increases their lifetime risk of developing endometrial cancer. Genetic counselling and testing can be used to individualize risk-management interventions including screening strategies and treatment options (III-B).

2. Endometrial cancer should be ruled out in perimenopausal and postmenopausal patients with abnormal vaginal bleeding (II-1A).

3. Depending on access, histologic endometrial evaluation and transvaginal ultrasound are the preferred initial diagnostic investigations for patients with suspected endometrial cancer (II-1B).

4. Histologic evaluation of the endometrium should be done in all patients in whom endometrial cancer is suspected (II-1A).

5. Hysteroscopic examination should be considered in patients with persistent uterine bleeding with benign endometrial sampling or insufficient endometrial sampling after ultrasound (II-2B).

6. Formal review of the histopathology should be considered in patients with high grade tumours or rare histologic types such as serous, clear cell, or mucinous types (III-B).

7. Additional tumour markers, CT scan, and MRI scan should not be used routinely (III-D).