



National Comprehensive  
Cancer Network®

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

# Uterine Neoplasms

Version 1.2025 — December 16, 2024

**NCCN.org**

**NCCN recognizes the importance of clinical trials and encourages participation when applicable and available. Trials should be designed to maximize inclusiveness and broad representative enrollment.**

**NCCN Guidelines for Patients® available at [www.nccn.org/patients](http://www.nccn.org/patients)**

**Continue**



**\*Nadeem R. Abu-Rustum, MD Ω/Chair**  
Memorial Sloan Kettering Cancer Center

**\*Susana M. Campos, MD, MPH, MS †/  
Vice Chair**  
Dana-Farber/Brigham and Women's  
Cancer Center

**Rebecca Arend, MD Ω**  
O'Neal Comprehensive  
Cancer Center at UAB

**Emma Barber, MD Ω**  
Robert H. Lurie Comprehensive Cancer  
Center of Northwestern University

**Kristin Bradley, MD §**  
University of Wisconsin  
Carbone Cancer Center

**Rebecca Brooks, MD Ω**  
UC Davis Comprehensive Cancer Center

**Junzo Chino, MD §**  
Duke Cancer Institute

**Hye Sook Chon, MD Ω**  
Moffitt Cancer Center

**Marta Ann Crispens, MD Ω**  
Vanderbilt-Ingram Cancer Center

**Shari Damast, MD §**  
Yale Cancer Center/  
Smilow Cancer Hospital

**Christine M. Fisher, MD, MPH §**  
University of Colorado Cancer Center

**Peter Frederick, MD Ω**  
Roswell Park Comprehensive  
Cancer Center

**David K. Gaffney, MD, PhD §**  
Huntsman Cancer Institute  
at the University of Utah

**Stephanie Gaillard, MD, PhD †**  
Johns Hopkins Kimmel Cancer Center

**Robert Giuntoli II, MD Ω**  
Abramson Cancer Center  
at the University of Pennsylvania

**Scott Glaser, MD §**  
City of Hope  
National Medical Center

**Brooke E. Howitt, MD ≠**  
Stanford Cancer Institute

**Lisa Landrum, MD, PhD Ω**  
Indiana University Melvin and Bren Simon  
Comprehensive Cancer Center

**Jayanthi Lea, MD Ω**  
UT Southwestern Simmons  
Comprehensive Cancer Center

**Nita Lee, MD, MPH Ω**  
The UChicago Medicine  
Comprehensive Cancer Center

**Gina Mantia-Smaldone, MD Ω**  
Fox Chase Cancer Center

**Andrea Mariani, MD Ω**  
Mayo Clinic  
Comprehensive Cancer Center

**David Mutch, MD Ω**  
Siteman Cancer Center at Barnes-  
Jewish Hospital and Washington  
University School of Medicine

**Christa Nagel, MD Ω**  
The Ohio State University Comprehensive  
Cancer Center - James Cancer Hospital  
and Solove Research Institute

**Larissa Nekhlyudov, MD, MPH Þ**  
Dana-Farber/Brigham and Women's  
Cancer Center

**Karina Nieto, MD §**  
Case Comprehensive Cancer Center/  
University Hospitals Seidman Cancer Center  
and Cleveland Clinic Taussig Cancer Institute

**Mirna Podoll, MD ≠**  
Vanderbilt-Ingram Cancer Center

**Kerry Rodabaugh, MD Ω**  
Fred & Pamela Buffett Cancer Center

**Ritu Salani, MD, MBA Ω**  
UCLA Jonsson Comprehensive Cancer Center

**John Schorge, MD Ω**  
St. Jude Children's Research Hospital/  
The University of Tennessee Health Science Center

**Scott Schuetze, MD, PhD †/Liaison**  
University of Michigan Rogel Cancer Center

**Jean Siedel, DO, MS Ω**  
University of Michigan  
Rogel Cancer Center

**Rachel Sisodia, MD Ω**  
Mass General Cancer Center

**Pamela Soliman, MD, MPH Ω**  
The University of Texas MD Anderson Cancer Center

**Stefanie Ueda, MD Ω**  
UCSF Helen Diller Family  
Comprehensive Cancer Center

**Renata Urban, MD Ω**  
Fred Hutchinson Cancer Center

**Emily Wyse ¥**  
Patient advocate

**NCCN**  
**Nicole McMillian, MS**  
**Vaishnavi Sambandam, PhD**

Ω Gynecologic oncology	§ Radiotherapy/Radiation oncology
Þ Internal medicine	*Discussion Section Writing Committee
† Medical oncology	
≠ Pathology	
¥ Patient advocacy	

**Continue**



[NCCN Uterine Neoplasms Panel Members](#)  
[Summary of the Guidelines Updates](#)

### Uterine Neoplasms

[Uterine Neoplasms \(UN-1\)](#)

### Endometrial Carcinoma

[Disease Limited to the Uterus \(ENDO-1\)](#)

[Suspected or Gross Cervical Involvement \(ENDO-2\)](#)

[Suspected Extrauterine Disease \(ENDO-3\)](#)

[Adjuvant Treatment for Surgically Staged Disease](#)

[\(ENDO-4\), \(ENDO-5\), \(ENDO-6\)](#)

[Incompletely Surgically Staged \(ENDO-7\)](#)

[Criteria for Considering Fertility-Sparing Options \(ENDO-8\)](#)

[Surveillance \(ENDO-9\)](#)

[Locoregional Recurrence \(ENDO-10\)](#)

[Serous Carcinoma \(ENDO-11\)](#)

[Clear Cell Carcinoma \(ENDO-12\)](#)

[Undifferentiated/Dedifferentiated Carcinoma \(ENDO-13\)](#)

[Carcinosarcoma \(ENDO-14\)](#)

[Principles of Pathology and Molecular Analysis \(ENDO-A\)](#)

[Principles of Imaging \(ENDO-B\)](#)

[Principles of Evaluation and Surgical Staging \(ENDO-C\)](#)

[Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#)

### Uterine Sarcoma

[Diagnosed After Total Hysterectomy or Supracervical Hysterectomy ± Bilateral Salpingo-Oophorectomy \(UTSARC-1\)](#)

[Diagnosed by Biopsy or Myomectomy \(UTSARC-1\) Low-Grade Endometrial Stromal Sarcoma \(ESS\) or Adenosarcoma Without Sarcomatous Overgrowth \(UTSARC-2\)](#)

[Adenosarcoma With Sarcomatous Overgrowth \(UTSARC-2\)](#)

[High-Grade ESS, Undifferentiated Uterine Sarcoma, Leiomyosarcoma, and Other Sarcomas Such as Perivascular epithelioid cell tumor \(PEComa\) \(UTSARC-3\)](#)

[Surveillance \(UTSARC-4\)](#)

[Recurrence \(UTSARC-5\)](#)

[Principles of Pathology and Molecular Analysis \(UTSARC-A\)](#)

[Principles of Imaging \(UTSARC-B\)](#)

[Systemic Therapy for Uterine Sarcoma \(UTSARC-C\)](#)

### Uterine Neoplasms

[Principles of Radiation Therapy \(UN-A\)](#)

[Principles of Gynecologic Survivorship \(UN-B\)](#)

[Staging \(ST-1\)](#)

[Abbreviations \(ABBR-1\)](#)

Find an NCCN Member Institution:  
<https://www.nccn.org/home/member-institutions>.

**NCCN Categories of Evidence and Consensus:** All recommendations are category 2A unless otherwise indicated.

See [NCCN Categories of Evidence and Consensus](#).

**NCCN Categories of Preference:** All recommendations are considered appropriate.

See [NCCN Categories of Preference](#).

The NCCN Guidelines® are a statement of evidence and consensus of the authors regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult the NCCN Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient's care or treatment. The National Comprehensive Cancer Network® (NCCN®) makes no representations or warranties of any kind regarding their content, use or application and disclaims any responsibility for their application or use in any way. The NCCN Guidelines are copyrighted by National Comprehensive Cancer Network®. All rights reserved. The NCCN Guidelines and the illustrations herein may not be reproduced in any form without the express written permission of NCCN. ©2024.



### Updates in Version 1.2025 of the NCCN Guidelines for Uterine Neoplasms from Version 3.2024 include:

#### Uterine Neoplasms

##### General

- The staging text box noted throughout the algorithm was revised: "All staging in guideline is based on ~~updated~~ 2009 FIGO staging..."

##### UN-1

- Initial evaluation; 2nd bullet revised: "Complete blood count (CBC) (~~including platelets~~), liver function test..."
- Footnote c: "... Principles of Pathology for ~~Uterine Sarcoma~~ and Molecular Analysis for Uterine Sarcoma (UTSARC-A)"

#### Endometrial Carcinoma

##### ENDO-2

- Additional Workup: Cervical biopsy or ~~pelvic~~ *pelvis* MRI (if not previously done)

##### ENDO-7

- The page for incompletely surgically staged was extensively revised.

##### ENDO-7A

- Footnote h added: Systemic Therapy for Endometrial Carcinoma (ENDO-D).
- Footnote t is new: Consider omitting imaging for stage IA, grade 1–2 endometrium-limited carcinoma.

##### ENDO-8

- Primary Treatment; New bullet added: Consider dual-progestin therapy [(megestrol or medroxyprogesterone) + levonorgestrel IUD]
- Endometrial cancer present at 6–12 mo pathway; Recommendation revised: TH/BSO with staging (*preferred by 12 months*)
- Footnote removed: Gunderson CC, et al. *Gynecol Oncol* 2012;125:477-482 and Hubbs JL, et al. *Obstet Gynecol* 2013;121:1172-1180.

##### ENDO-9

- Surveillance
  - ▶ 2nd bullet revised: CA-125 if initially elevated *or serous histology*
  - ▶ 4th bullet revised: "~~Patient education regarding symptoms of potential recurrence, lifestyle, obesity, exercise, smoking cessation, sexual health (including vaginal dilator use and lubricants/moisturizers), nutrition counseling, and Clinical evaluation and management of potential long-term and late effects of treatment (Also see Principles of Gynecologic Survivorship (UN-B)...~~"
- Footnote v revised: ~~Principles of Gynecologic Survivorship (UN-B): Patient education should include symptoms of potential recurrence, lifestyle, obesity, exercise, sexual health (including vaginal dilator use, lubricants/moisturizers, and local estrogen and hormone therapy for menopause), smoking cessation, and nutrition counseling.~~



### Updates in Version 1.2025 of the NCCN Guidelines for Uterine Neoplasms from Version 3.2024 include:

#### [ENDO-A Principles of Pathology](#)

##### [ENDO-A 1 of 4](#)

- Pathologic assessment for carcinoma; Sub-bullets removed
  - ▶ HER2 immunohistochemistry (IHC) testing (with reflex to HER2 fluorescence in situ hybridization [FISH] for equivocal IHC) is recommended for all serous and carcinosarcoma tumors. Consider HER2 testing for p53 abnormal carcinomas regardless of histology.
  - ▶ Estrogen receptor (ER) and progesterone receptor (PR) testing is recommended in the settings of stage III, stage IV, and recurrent disease.

#### [ENDO-A 2 of 4 Principles of Molecular Analysis](#)

- Bullets revised as follows:
  - ▶ 1st bullet: "...no specific molecular profile (NSMP), and p53 ~~abnormal~~ *aberrant*."
  - ▶ 3rd bullet: "Ancillary studies for *POLE* mutations (~~hotspot pathogenic~~ mutations in the exonuclease domain), immunohistochemical (IHC) staining for mismatch repair (MMR) or MSI testing, and p53 IHC are ~~strongly encouraged~~ *recommended* to complement morphologic assessment regardless of histologic tumor type..."
  - ▶ 5th bullet: For tumors that are *POLE*-mutated, MSI-H, ~~or copy number high~~ *p53 aberrant, or NMSP*, clinical trial enrollment is strongly encouraged.
  - ▶ 7th bullet: ~~Universal testing of endometrial carcinomas for MMR proteins is recommended. Evaluation for MMR status is commonly done using IHC. Molecular profiling via NGS panels or MSI PCR assay are acceptable alternatives is an acceptable alternative.~~
    - ◇ 1st arrow sub-bullet: MSI testing is recommended if *IHC* results are equivocal.
    - ◇ 3rd arrow sub-bullet: ~~Genetic counseling, molecular analysis, and testing for all other MMR abnormalities is recommended. Genetic counseling for any suspected germline mutation is strongly recommended.~~
    - ◇ 4th arrow sub-bullet: "...testing are recommended regardless of MMR or MLH1 promoter methylation results [see *Lynch Syndrome (LS-1)* (~~Hereditary Nonpolyposis Colorectal Cancer Syndrome~~) in the [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal, Endometrial, and Gastric](#)].
- New bullets added
  - ▶ HER2 IHC testing (with or without reflex to HER2 fluorescence in situ hybridization [FISH] for equivocal IHC) is recommended for all p53 aberrant carcinomas regardless of histology.
  - ▶ Estrogen receptor (ER) and progesterone receptor (PR) testing is recommended in the settings of stage III, stage IV, and recurrent disease.

#### [ENDO-A 3 of 4 Principles of Molecular Analysis](#)

- Term revised in figure: Pole ~~hotspot pathogenic~~ mutation

##### [ENDO-A 4 of 4](#)

- Reference 2 updated: *Crothers BA Harik LR, Krishnamurti UG, Turashvilli G Movahedi-Lankarani S, Birdsong GG, et al. Protocol for the examination of specimens from patients with carcinoma and carcinosarcoma of the endometrium. (Version 4.4.0.0) College of American Pathologists 2019 2023.*

#### [ENDO-B Principles of Imaging](#)

- Follow-up/Surveillance; 2nd bullet; New arrow sub-bullet added: Consider pelvic ultrasound surveillance for patients with ovarian preservation.



### Updates in Version 1.2025 of the NCCN Guidelines for Uterine Neoplasms from Version 3.2024 include:

#### Endometrial Carcinoma—continued

##### ENDO-C Principles of Evaluation and Surgical Staging

###### ENDO-C 1 of 6

- Principles of Surgical Staging for Endometrial Cancer

- ▶ 4th bullet revised: "... and often comprises *either SLN mapping and resection of sentinel nodes or a pelvic nodal dissection with or without para-aortic nodal dissection...*"
- ▶ 5th bullet: "SLN mapping is preferred (see pages 2–6 of ENDO-C)" reordered to be the 5th bullet. Previously it was the 7th bullet.

###### ENDO-C 2 of 6

- Principles of Sentinel Lymph Node(s) Mapping for Endometrial Cancer Staging; Bullets revised

- ▶ New bullet added: Indocyanine green (ICG) is the preferred imaging dye for SLN mapping
- ▶ 12th bullet revised: For cases of failed SLN mapping, reinjection of the cervix may be considered. *An additional 1 mL in the non-detected side can be infiltrated in the superficial cervical area.*
- ▶ Bullet removed: Indocyanine green (ICG) recently emerged as a useful imaging dye that requires a near-infrared camera for localization, provides a very high SLN detection rate, and is commonly used in many practices at the present time

###### ENDO-C 5 of 6

- Retroperitoneal evaluation text box revised: Excision of ~~all mapped~~ SLN with ultrastaging

#### ENDO-D Systemic Therapy for Endometrial Carcinoma

##### ENDO-D 1 of 5

- Chemoradiation Therapy

- ▶ Other Recommended Regimens; The following agents changed from category 2A to category 2B
  - ◊ Capecitabine/mitomycin
  - ◊ Gemcitabine
  - ◊ Paclitaxel

- Primary or Adjuvant Therapy (Stage I–IV); Preferred Regimens revised

- ▶ The 4th and 5th bullets were combined as follows: Carboplatin/paclitaxel/trastuzumab (for stage III–IV HER2-positive uterine serous carcinoma *or carcinosarcoma*)
- ▶ Carboplatin/paclitaxel/bevacizumab (stage III–IV with measurable disease) added as an option
- ▶ Carboplatin/paclitaxel moved down the list to be the last regimen

- Footnotes revised

- ▶ Footnote a is new: An FDA-approved biosimilar is an appropriate substitute for any recommended systemic biologic therapy in the NCCN Guidelines.
- ▶ Footnote b: For stage III or IVA with measurable disease *post surgery* or stage IVB with or without measurable disease. *For patients not meeting the eligibility criteria for NRG-GY018, carboplatin/paclitaxel + pembrolizumab should be considered for stage III–IV dMMR tumors (Van Gorp T, et al. Ann Oncol. Published online August 23, 2024).*
- ▶ Footnote e: *For adult patients with primary advanced endometrial carcinoma (post surgery):* stage IIIA, IIIB, or IIIC1 with measurable disease, stage IIIC1 with carcinosarcoma, clear-cell, serous, or mixed histology regardless of the presence of measurable disease, and stage IIIC2 or stage IV regardless of the presence of measurable disease.
- ▶ Footnote f is new: For stage III with measurable disease post surgery and stage IV with or without measurable disease.
- ▶ Footnote removed: An FDA-approved biosimilar is an appropriate substitute for trastuzumab.

[Continued](#)

**UPDATES**



### Updates in Version 1.2025 of the NCCN Guidelines for Uterine Neoplasms from Version 3.2024 include:

#### Endometrial Carcinoma—continued

##### ENDO-D 2 of 5

- First-Line Therapy for Recurrent Disease; Preferred Regimens
  - ▶ The 4th and 5th bullets were combined as follows: Carboplatin/paclitaxel/trastuzumab (for HER2-positive serous carcinoma *or carcinosarcoma*)
  - ▶ Carboplatin/paclitaxel (category 1 for carcinosarcoma) moved down the list to be the last regimen
- Second-Line or Subsequent Therapy
  - ▶ Other Recommended Regimens; Two agents added as options:
    - ◊ Lenvatinib
    - ◊ Gemcitabine
  - ▶ Useful in Certain Circumstances (Biomarker-directed therapy)
    - ◊ *NTRK* gene fusion-positive tumors: Repotrectinib added as an option

##### ENDO-D 2A of 5

- The following footnote changes were made:
  - ▶ Footnote n revised: NCCN recommends TMB-H testing if not previously done. Pembrolizumab is indicated for patients with unresectable or metastatic tumors with TMB-H [ $\geq 10$  mutations/megabase (mut/Mb)], ~~as determined by an FDA-approved assay, or a validated test performed in a CLIA-certified laboratory~~; whose disease has progressed following prior treatment and who have no satisfactory alternative treatment options.
  - ▶ Footnote s is new: *NTRK*-positive tumors that are naïve to prior *NTRK*-targeted therapy or have progressed on prior *NTRK* therapy.
  - ▶ Footnotes removed:
    - ◊ An FDA-approved biosimilar is an appropriate substitute for bevacizumab.
    - ◊ An FDA-approved biosimilar is an appropriate substitute for trastuzumab.

##### ENDO-D 3 of 5

- Hormonal Therapy for Recurrent or Metastatic Endometrial Carcinoma; Other Recommended Regimens
  - ▶ 3rd bullet; Aromatase inhibitors; Added:
    - ◊ Anastrozole
    - ◊ Letrozole
    - ◊ Exemestane
- Hormonal Therapy for Uterine-Limited Disease Not Suitable for Primary Surgery or for Those Desiring Uterine Preservation for Fertility; Other Recommended Regimens; Added the following new bullet and sub-bullets
  - ▶ Dual progestin agents
    - ◊ Megestrol acetate + levonorgestrel IUD
    - ◊ Medroxyprogesterone acetate + levonorgestrel IUD

##### ENDO-D 4 of 5

- References updated to reflect changes in the algorithm



### Updates in Version 1.2025 of the NCCN Guidelines for Uterine Neoplasms from Version 3.2024 include:

#### Uterine Sarcoma

##### UTSARC-2

- Low-grade ESS or Adenosarcoma without sarcomatous overgrowth (SO)
  - ▶ Additional Therapy for Stage I; Revised: BSO (*preferred*)

##### UTSARC-4

- Surveillance revised
  - ▶ 1st bullet: H&P exam every 3–4 mo (*consider every 6 months for low-grade, early-stage sarcomas*) for 2–3 y, then every 6–12 mo
  - ▶ 3rd bullet: "~~Patient education regarding symptoms of potential recurrence, lifestyle, obesity, exercise, nutrition, sexual health (including vaginal dilator use and lubricants/moisturizers), smoking cessation, nutrition counseling, and Clinical evaluation and management of potential long-term and late effects of treatment (also see Principles of Gynecologic Survivorship (UN-B))...~~"
- Footnote m revised: ~~Principles of Gynecologic Survivorship (UN-B)~~: Patient education should include symptoms of potential recurrence, lifestyle, obesity, exercise, sexual health (including vaginal dilator use, lubricants/moisturizers, and local estrogen and hormone therapy for menopause), smoking cessation, and nutrition counseling.

#### UTSARC-A Principles of Pathology and Molecular Analysis

##### UTSARC-A 1 of 8

- Molecular Analysis for Sarcoma 2nd bullet revised: "... is informative for predicting rare pan-tumor targeted therapy opportunities and should include at least NTRK, MSI, *RET-fusion*, and TMB. *Preferred on tissue; if tissue is not available, blood-based assays may be considered....*"

##### UTSARC-A 2 of 8 through UTSARC-A 7 of 8

- Table 1 was extensively revised.

##### UTSARC-A 8 of 8

- New references added
  - ▶ Chapel DB, Nucci MR, Quade BJ, Parra-Herran C. Epithelioid leiomyosarcoma of the uterus: Modern outcome-based appraisal of diagnostic criteria in a large institutional series. *Am J Surg Pathol* 2022;46:464-475.
  - ▶ Chiang S, Vasudevaraja V, Serrano J, et al. TSC2-mutant uterine sarcomas with JAZF1-SUZ12 fusions demonstrate hybrid features of endometrial stromal sarcoma and PEComa and are responsive to mTOR inhibition. *Mod Pathol* 2022;35:117-127.

#### UTSARC-B 1 of 2 Principles of Imaging

- Follow-up/Surveillance; 2nd bullet revised: "~~Optional abdominal/pelvic~~ *abdomen/pelvis* MRI and chest CT without contrast every 3–6 months..."



### Updates in Version 1.2025 of the NCCN Guidelines for Uterine Neoplasms from Version 3.2024 include:

#### [UTSARC-C Systemic Therapy for Uterine Sarcoma](#)

##### [UTSARC-C 1 of 3](#)

- First-Line Therapy
  - ▶ Preferred Regimens revised: Doxorubicin/dacarbazine (*for LMS or ifosfamide ineligible*)
  - ▶ Useful in Certain Circumstances
    - ◊ Biomarker-directed therapy; *NTRK* gene fusion-positive tumors: Repotrectinib added as an option
    - ◊ Selpercatinib added for RET-fusion positive tumors
- Second-Line or Subsequent Therapy
  - ▶ Preferred Regimens revised: Trabectedin (*for LMS*)
  - ▶ Other Recommended Regimens: Regorafenib added as an option.
- Footnote c is new: *NTRK*-positive tumors that are naïve to prior *NTRK*-targeted therapy or have progressed on prior *NTRK* therapy.
- Footnote d revised: For the treatment of patients with unresectable or metastatic TMB-high (TMB-H) ( $\geq 10$  mut/Mb) tumors, ~~as determined by an FDA-approved assay, or a validated test performed in a CLIA-certified laboratory~~, that have progressed following prior treatment and have no satisfactory alternative treatment options.
- Footnote removed: For LMS that has been treated with a prior anthracycline-containing regimen.

##### [UTSARC-C 2 of 3](#)

- Anti-Estrogen Hormone Therapy for Low-Grade ESS or Adenosarcoma Without SO or Hormone Receptor-Positive (ER/PR) Uterine Sarcomas
  - ▶ Preferred Regimens
    - ◊ 1st bullet; For "Aromatase inhibitors for low-grade ESS or adenosarcoma without SO" the following agents added
      - Anastrozole
      - Letrozole
      - Exemestane
    - ◊ New bullet added: Consider gonadotropin-releasing hormone (GnRH) analogs with aromatase inhibitors in patients who are premenopausal and not suitable for surgery (BSO)
  - ▶ Other recommended Regimens revised
    - ◊ 1st bullet; For "Aromatase inhibitors (for ER/PR-positive uterine sarcomas)" the following agents added:
      - Anastrozole
      - Letrozole
      - Exemestane
    - ◊ Bullet removed: GnRH analogs (category 2B for low-grade ESS, adenosarcoma without SO, and ER/PR-positive uterine sarcomas)

##### [UTSARC-C 3 of 3](#)

- New References added:
  - ▶ Solomon BJ, Drilon A, Lin JJ, et al. 1372P Repotrectinib in patients (pts) with NTRK fusion-positive (NTRK+) advanced solid tumors, including NSCLC: Update from the phase I/II TRIDENT-1 trial [abstract]. *Ann Oncol* 2023;34:S787-S788.
  - ▶ Subbiah V, Wolf J, Konda B, et al. Tumor-agnostic efficacy and safety of selpercatinib in patients with RET fusion-positive solid tumours other than lung or thyroid tumours (LIBRETTO-001): a phase 1/2, open-label, basket trial. *Lancet Oncol* 2022;23:1261-1273.
  - ▶ Berry V, Basson L, Bogart E, et al. REGOSARC: Regorafenib versus placebo in doxorubicin-refractory soft-tissue sarcoma-A quality-adjusted time without symptoms of progression or toxicity analysis. *Cancer* 2017;123:2294-2302.

[Continued](#)

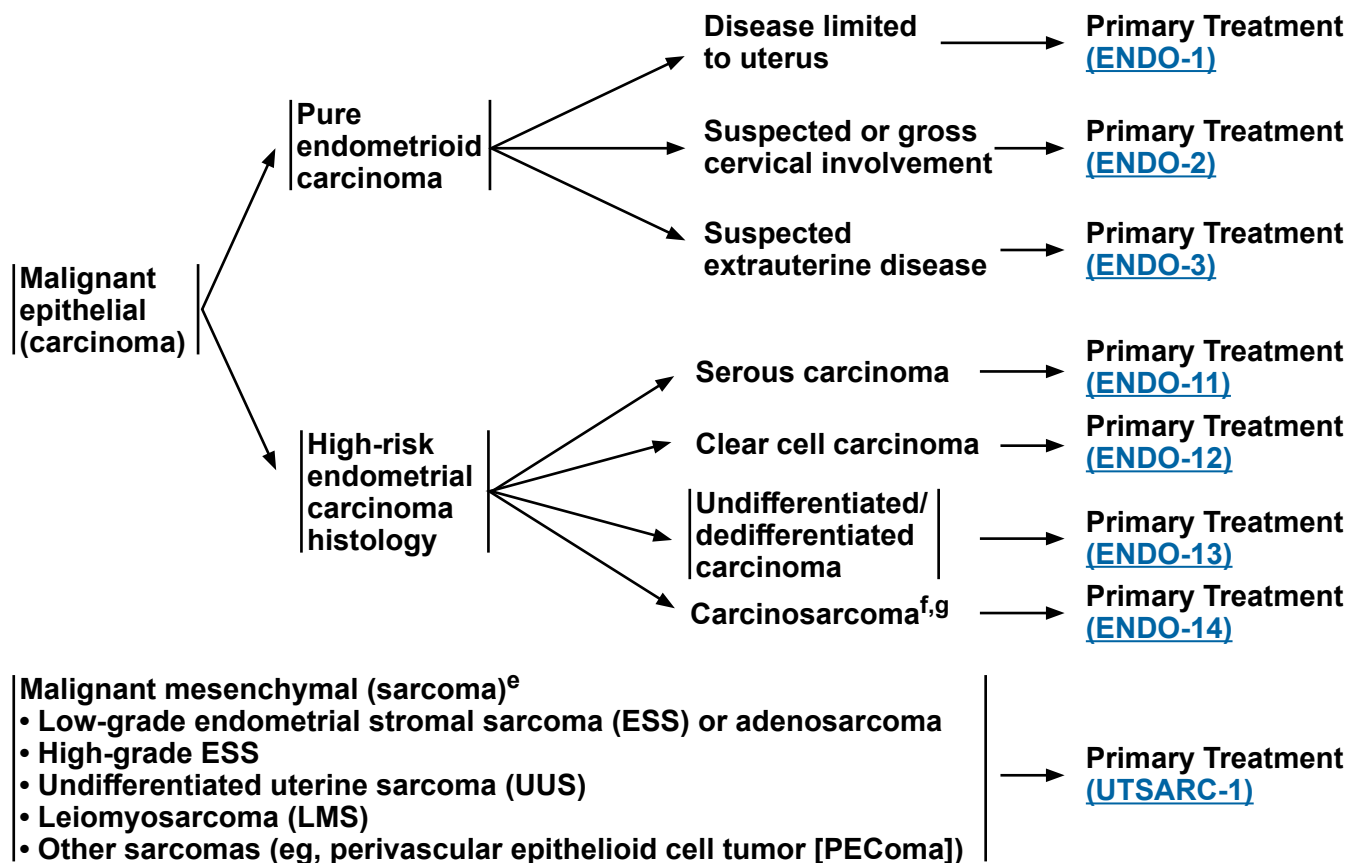
**UPDATES**

All staging in guideline is based on 2009 FIGO staging. ([ST-1](#), [ST-2](#), [ST-3](#) and [ST-4](#))

### INITIAL EVALUATION<sup>a</sup>

- History and physical (H&P)
- Complete blood count (CBC), liver function test [LFT], renal function tests, chemistry profile; and consider CA-125
- Expert pathology review with additional endometrial biopsy as clinically indicated<sup>b,c</sup>
- Imaging<sup>d</sup>
- Recommend molecular evaluation of tumor and evaluation for inherited cancer risk ([ENDO-A](#) and [UTSARC-A](#))
- For patients who are older with uterine cancer also see the [NCCN Guidelines for Older Adult Oncology](#)
- Consider germline and/or multigene panel testing

### INITIAL CLINICAL FINDINGS<sup>c</sup>



<sup>a</sup> Initial preoperative evaluation for known or suspected malignancy.

<sup>b</sup> Preoperative imaging and biopsy may help to identify uterine sarcomas, although biopsy sensitivity is less than for endometrial cancer. If there is suspicion of malignancy, fragmentation/morcellation should be avoided.

<sup>c</sup> See [Principles of Pathology for Endometrial Carcinoma \(ENDO-A\)](#) and [Principles of Pathology and Molecular Analysis for Uterine Sarcoma \(UTSARC-A\)](#).

<sup>d</sup> See [Principles of Imaging for Endometrial Carcinoma \(ENDO-B\)](#) and [Principles of Imaging for Uterine Sarcoma \(UTSARC-B\)](#).

<sup>e</sup> Consider referral to a center of expertise that specializes in the treatment of malignant mesenchymal tumors (sarcoma).

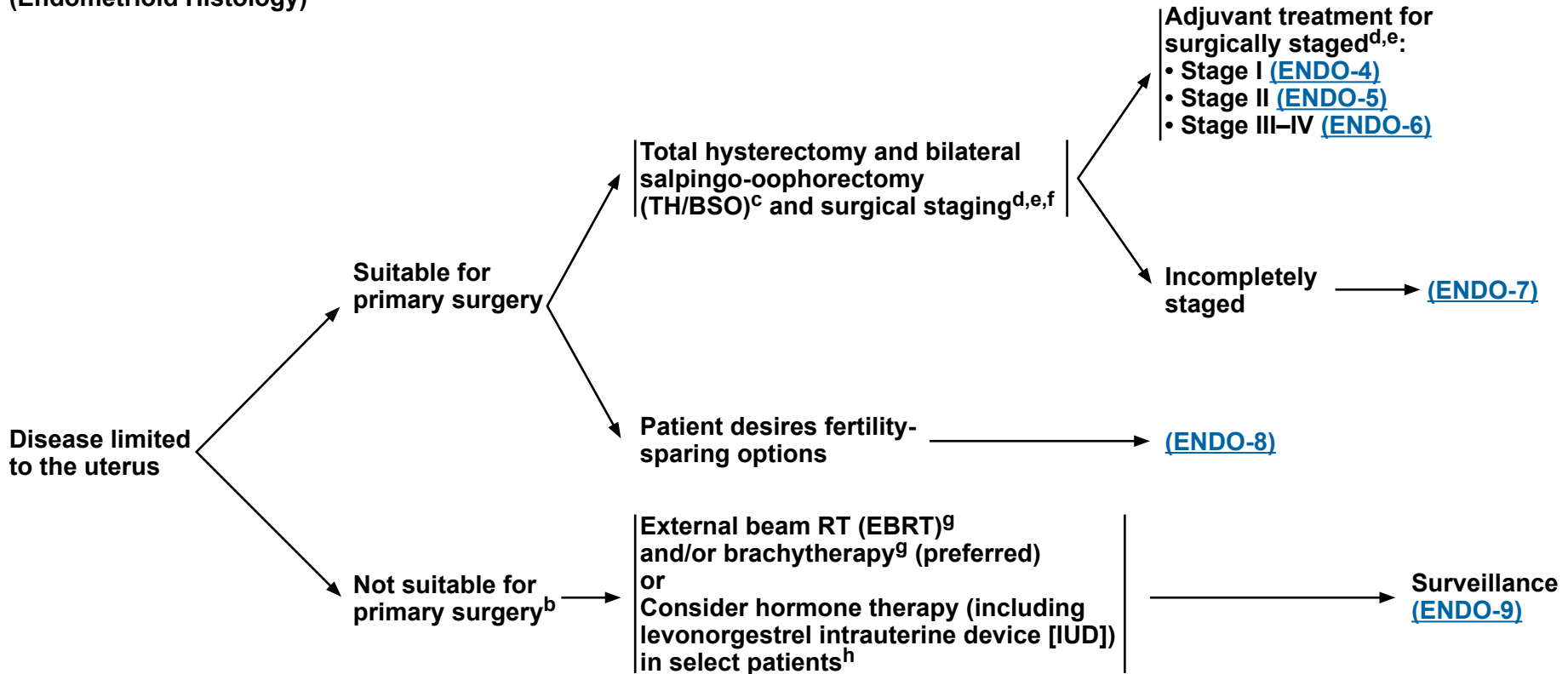
<sup>f</sup> Should be treated as a high-grade endometrial cancer.

<sup>g</sup> Also known as malignant mixed mesodermal tumor or malignant mixed Müllerian tumor, and including those with either homologous or heterologous stromal elements.

Note: All recommendations are category 2A unless otherwise indicated.

## INITIAL CLINICAL FINDINGS (Endometrioid Histology)<sup>a</sup>

## PRIMARY TREATMENT



<sup>a</sup> [\(UN-1\)](#) for classification of uterine neoplasms.

<sup>b</sup> Disease is not amenable to resection or patient is not suitable for surgery based on comorbidities.

<sup>c</sup> [Principles of Pathology and Molecular Analysis \(ENDO-A\)](#).

<sup>d</sup> Minimally invasive surgery (MIS) is the preferred approach when technically feasible. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

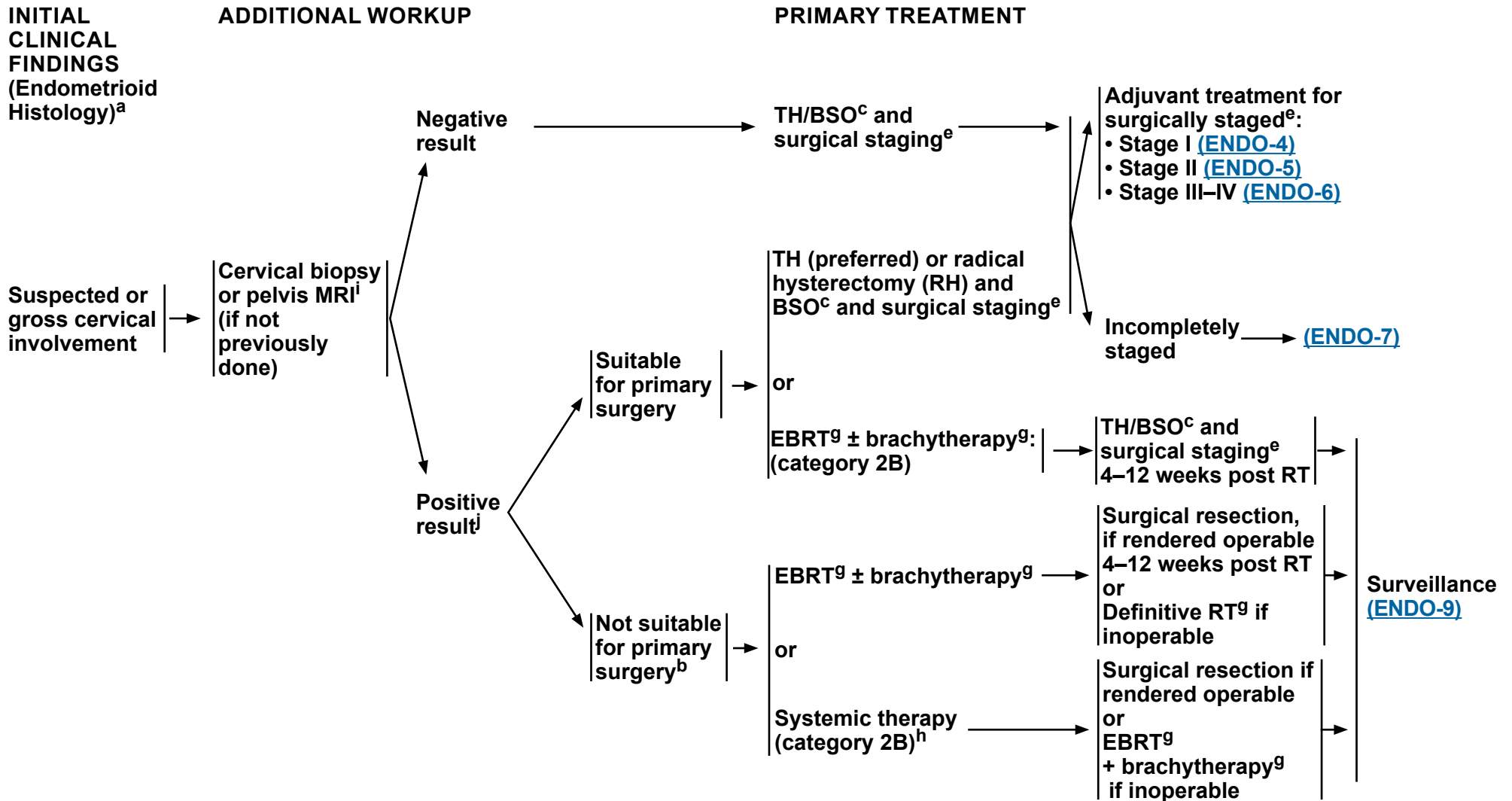
<sup>e</sup> The degree of surgical staging to assess disease status depends on preoperative and intraoperative findings. Multidisciplinary expertise is recommended. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>f</sup> Ovarian preservation may be safe in select patients who are premenopausal with early-stage endometrioid cancer, normal-appearing ovaries, and no family history of breast/ovarian cancer or Lynch syndrome. Salpingectomy is recommended.

<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

**Note: All recommendations are category 2A unless otherwise indicated.**



<sup>a</sup> ([UN-1](#)) for classification of uterine neoplasms.

<sup>b</sup> Disease is not amenable to resection or patient is not suitable for surgery based on comorbidities.

<sup>c</sup> [Principles of Pathology and Molecular Analysis \(ENDO-A\)](#).

<sup>e</sup> The degree of surgical staging to assess disease status depends on preoperative and intraoperative findings. Multidisciplinary expertise is recommended. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

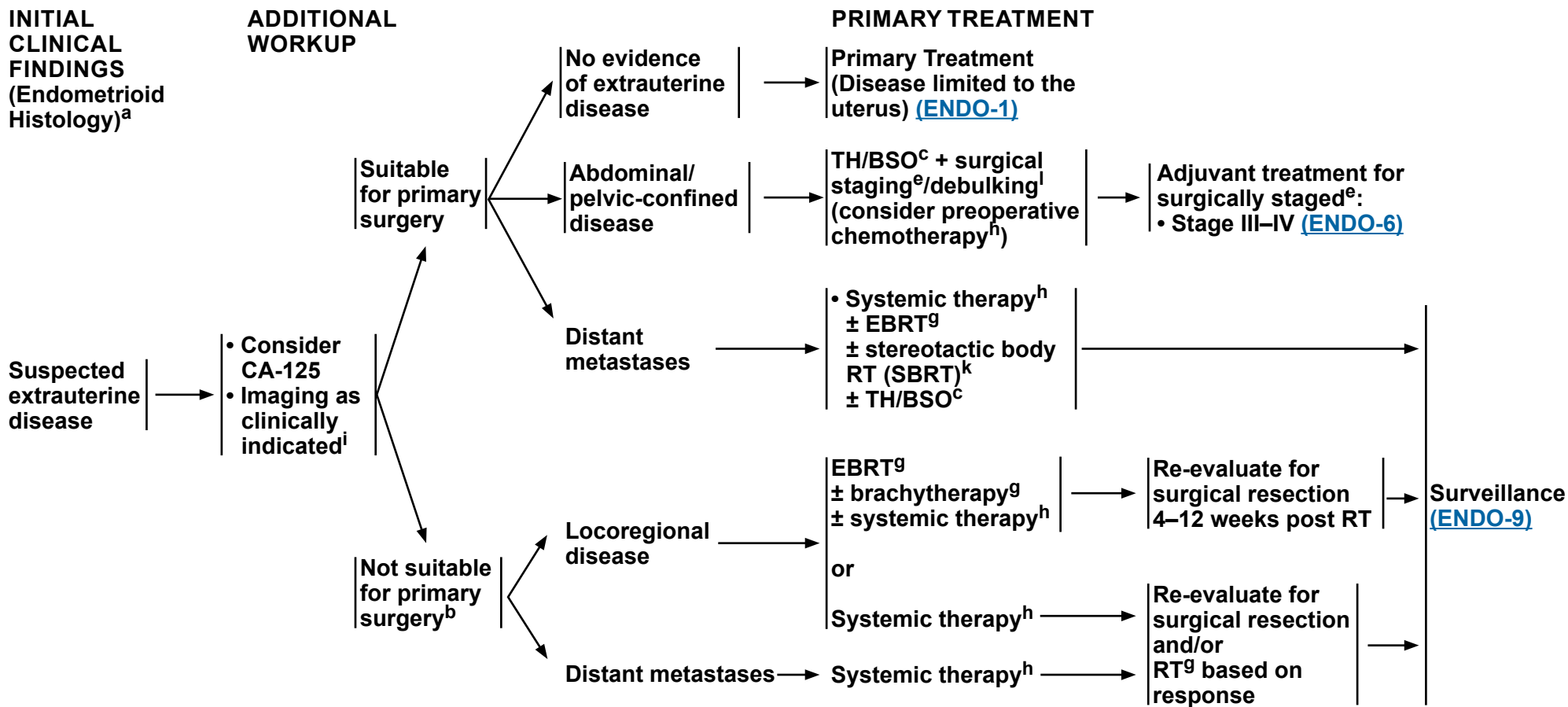
<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>i</sup> [Principles of Imaging \(ENDO-B\)](#).

<sup>j</sup> Clear demonstration of cervical stromal involvement.

**Note: All recommendations are category 2A unless otherwise indicated.**



<sup>a</sup> [\(UN-1\)](#) for classification of uterine neoplasms.

<sup>b</sup> Disease is not amenable to resection or patient is not suitable for surgery based on comorbidities.

<sup>c</sup> [Principles of Pathology and Molecular Analysis \(ENDO-A\)](#).

<sup>e</sup> The degree of surgical staging to assess disease status depends on preoperative and intraoperative findings. Multidisciplinary expertise is recommended.

See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>i</sup> [Principles of Imaging \(ENDO-B\)](#).

<sup>k</sup> Consider ablative RT for 1–5 metastatic lesions if hysterectomy is performed (category 2B) (Palma DA, et al. Lancet 2019;393:2051-2058).

<sup>l</sup> The surgical goal is to have no measurable residual disease.

**Note: All recommendations are category 2A unless otherwise indicated.**



All staging in guideline is based on 2009 FIGO staging. [\(ST-1\)](#)

**CLINICAL FINDINGS**  
(Endometrioid  
Histology)<sup>a</sup>

**HISTOLOGIC GRADE/ADJUVANT TREATMENT<sup>g,h,m</sup>**

Surgically staged:  
Stage I<sup>e</sup> →

FIGO Stage	Histologic Grade	Adjuvant Treatment
IA	G1, G2	Observation preferred or Consider vaginal brachytherapy if lymphovascular space invasion (LVSI) and/or age ≥60 y <sup>n</sup>
	G3	Vaginal brachytherapy preferred or Consider observation if no myoinvasion or Consider EBRT if either age ≥70 y or LVSI (category 2B)
IB	G1	Vaginal brachytherapy preferred or Consider observation if age <60 y and no LVSI
	G2	Vaginal brachytherapy preferred or Consider EBRT if ≥60 y and/or LVSI or Consider observation if age <60 y and no LVSI
	G3	RT (EBRT and/or vaginal brachytherapy) ± systemic therapy (category 2B for systemic therapy)

<sup>a</sup> [\(UN-1\)](#) for classification of uterine neoplasms.

<sup>e</sup> The degree of surgical staging to assess disease status depends on preoperative and intraoperative findings. Multidisciplinary expertise is recommended. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>m</sup> Initiate EBRT as soon as the vaginal cuff is healed, preferably no later than 12 weeks after surgery.

<sup>n</sup> Vaginal brachytherapy is strongly suggested if two risk factors are present.

**Note: All recommendations are category 2A unless otherwise indicated.**

All staging in guideline is based on 2009 FIGO staging. [\(ST-1\)](#)

**CLINICAL FINDINGS**  
(Endometrioid Histology)<sup>a</sup>

**HISTOLOGIC GRADE/ADJUVANT TREATMENT<sup>g,h,m</sup>**

Surgically staged<sup>e</sup>:  
Stage II<sup>o,p</sup>

FIGO Stage	Histologic Grade	Adjuvant Treatment
II	G1–G3	EBRT (preferred) and/or vaginal brachytherapy <sup>q</sup> ± systemic therapy (category 2B for systemic therapy)

Surveillance [\(ENDO-9\)](#)

<sup>a</sup> [\(UN-1\)](#) for classification of uterine neoplasms.

<sup>e</sup> The degree of surgical staging to assess disease status depends on preoperative and intraoperative findings. Multidisciplinary expertise is recommended. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>m</sup> Initiate EBRT as soon as the vaginal cuff is healed, preferably no later than 12 weeks after surgery.

<sup>o</sup> Consider additional imaging if not previously done. See [Principles of Imaging \(ENDO-B\)](#).

<sup>p</sup> Adverse cervical risk factors including depth of stromal invasion, grade, LVSI, and adverse fundal risk factors influencing therapy decisions for stage I disease [\(ENDO-4\)](#), such as depth of myometrial invasion and LVSI, may also impact the choice of adjuvant therapy for stage II disease.

<sup>q</sup> Vaginal brachytherapy is also an option for grade 1 or 2, ≤50% myometrial invasion, no LVSI, and microscopic cervical invasion (Harkenrider MM, et al. Int J Radiat Oncol Biol Phys 2018;101:1069-1077).

**Note: All recommendations are category 2A unless otherwise indicated.**



All staging in guideline is based on 2009 FIGO staging. [\(ST-1\)](#)

## CLINICAL FINDINGS (Endometrioid Histology)<sup>a</sup>

## ADJUVANT TREATMENT<sup>g,h</sup>

Surgically staged<sup>e</sup>:  
Stage III, IV<sup>r</sup>



Systemic therapy  
± EBRT<sup>s</sup>  
± vaginal brachytherapy<sup>s</sup>

<sup>a</sup> [\(UN-1\)](#) for classification of uterine neoplasms.

<sup>e</sup> The degree of surgical staging to assess disease status depends on preoperative and intraoperative findings. Multidisciplinary expertise is recommended. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>r</sup> Additional imaging if not previously done. See [Principles of Imaging \(ENDO-B\)](#).

<sup>s</sup> Combination therapy depends on assessment of both locoregional and distant metastatic risk. Consider combination therapy for stage IIIB and IIIC disease.

**Note: All recommendations are category 2A unless otherwise indicated.**

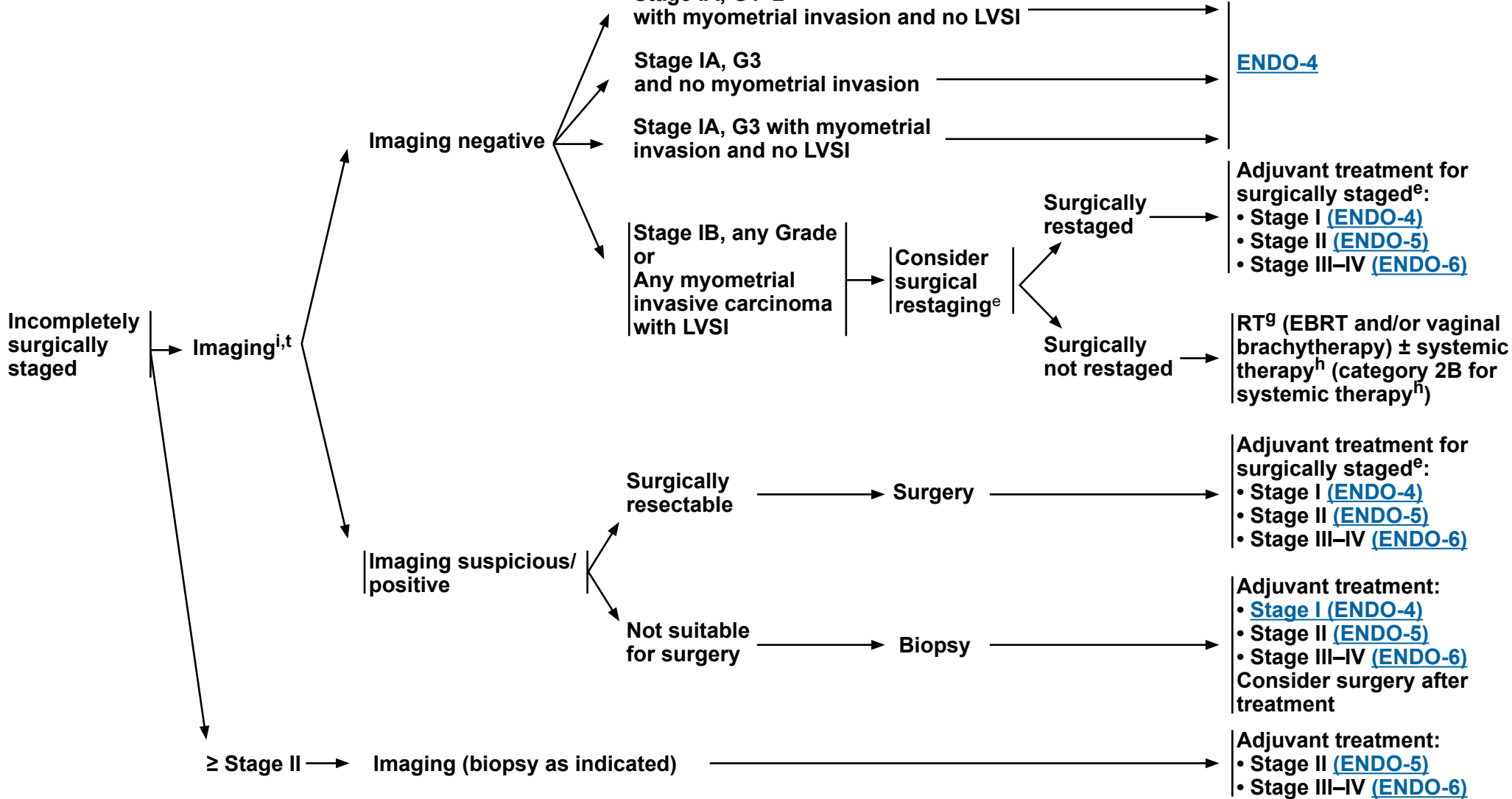
**Surveillance**  
**[\(ENDO-9\)](#)**

**ENDO-6**

All staging in guideline is based on 2009 FIGO staging. [\(ST-1\)](#)

**CLINICAL INTRAUTERINE FINDINGS**  
(Endometrioid Histology)<sup>a</sup>

**ADJUVANT TREATMENT**



Note: All recommendations are category 2A unless otherwise indicated.

Surveillance  
[\(ENDO-9\)](#)

**ENDO-7**



## FOOTNOTES FOR ENDO-7

<sup>a</sup> [\(UN-1\)](#) for classification of uterine neoplasms.

<sup>e</sup> The degree of surgical staging to assess disease status depends on preoperative and intraoperative findings. Multidisciplinary expertise is recommended. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>i</sup> [Principles of Imaging \(ENDO-B\)](#).

<sup>t</sup> Consider omitting imaging for stage IA, grade 1–2 endometrium-limited carcinoma.

**Note: All recommendations are category 2A unless otherwise indicated.**

## CRITERIA FOR CONSIDERING FERTILITY-SPARING OPTIONS FOR MANAGEMENT OF ENDOMETRIAL CARCINOMA (All criteria must be met)

- Well-differentiated (grade 1) endometrioid adenocarcinoma on dilation and curettage (D&C) confirmed by expert pathology review
- Disease limited to the endometrium on MRI (preferred) or transvaginal ultrasound<sup>i</sup>
- Absence of suspicious or metastatic disease on imaging
- No contraindications to medical therapy or pregnancy
- Patients should undergo counseling that fertility-sparing option is NOT standard of care for the treatment of endometrial carcinoma

- Consultation with a fertility expert prior to therapy
- Recommend molecular evaluation of tumor and evaluation for inherited cancer risk (UN-1)
- Ensure negative pregnancy test

## PRIMARY TREATMENT

- Continuous progestin-based therapy:
  - ▶ Megestrol
  - ▶ Medroxyprogesterone
  - ▶ Levonorgestrel IUD (preferred for fertility preservation)
- Consider dual-progestin therapy [(megestrol or medroxyprogesterone) + levonorgestrel IUD]
- Weight management/lifestyle modification counseling<sup>u</sup>

## SURVEILLANCE

Endometrial evaluation every 3–6 mo (either D&C or endometrial biopsy)

Complete response by 6 mo

Encourage conception (with continued surveillance/endometrial sampling every 6–12 mo and consider maintenance progestin-based therapy if patient is not actively trying to conceive)

Endometrial cancer present at 6–12 mo<sup>i</sup>

TH/BSO with staging<sup>d,e</sup> after childbearing complete or progression of disease on endometrial sampling (ENDO-1)

- Ovarian preservation may be considered in select patients who are premenopausal

TH/BSO with staging<sup>d,e</sup> (preferred by 12 months) (ENDO-1)

- Ovarian preservation may be considered in select patients

<sup>d</sup> MIS is the preferred approach when technically feasible. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>e</sup> The degree of surgical staging to assess disease status depends on intraoperative findings. Multidisciplinary expertise is recommended. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>i</sup> [Principles of Imaging \(ENDO-B\)](#).

<sup>u</sup> See Healthy Lifestyles (HL-1) and Nutrition and Weight Management (SNWM-1) in the [NCCN Guidelines for Survivorship](#).

**Note: All recommendations are category 2A unless otherwise indicated.**

## SURVEILLANCE

- Physical exam (including pelvis)
  - ▶ every 3–6 mo for 2–3 y,
  - ▶ then every 6–12 mo for up to year 5,
  - ▶ then annually
- CA-125 if initially elevated or serous histology
- Imaging as indicated based on symptoms or examination findings suspicious for recurrence<sup>i</sup>
- Clinical evaluation and management of potential long-term and late effects of treatment<sup>v</sup>  
(Also see [Principles of Gynecologic Survivorship \(UN-B\)](#), [NCCN Guidelines for Survivorship](#) and [NCCN Guidelines for Smoking Cessation](#))

## CLINICAL PRESENTATION

Locoregional recurrence  
• Negative for distant metastases on radiologic imaging<sup>i</sup>

Isolated metastases

Disseminated metastases

## THERAPY FOR RELAPSE

Therapy for Relapse ([ENDO-10](#))

- Consider resection and/or EBRT<sup>g</sup> or Ablative therapy<sup>w</sup>
- Consider systemic therapy<sup>h</sup> (category 2B)

Not amenable to local treatment or Further recurrence

Treat as disseminated metastases (See below)

Systemic therapy<sup>h</sup> ± palliative EBRT<sup>g</sup>

If progression, Best supportive care ([NCCN Guidelines for Palliative Care](#))

<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>i</sup> [Principles of Imaging \(ENDO-B\)](#).

<sup>v</sup> Patient education should include symptoms of potential recurrence, lifestyle, obesity, exercise, sexual health (including vaginal dilator use, lubricants/moisturizers, and local estrogen and hormone therapy for menopause), smoking cessation, and nutrition counseling.

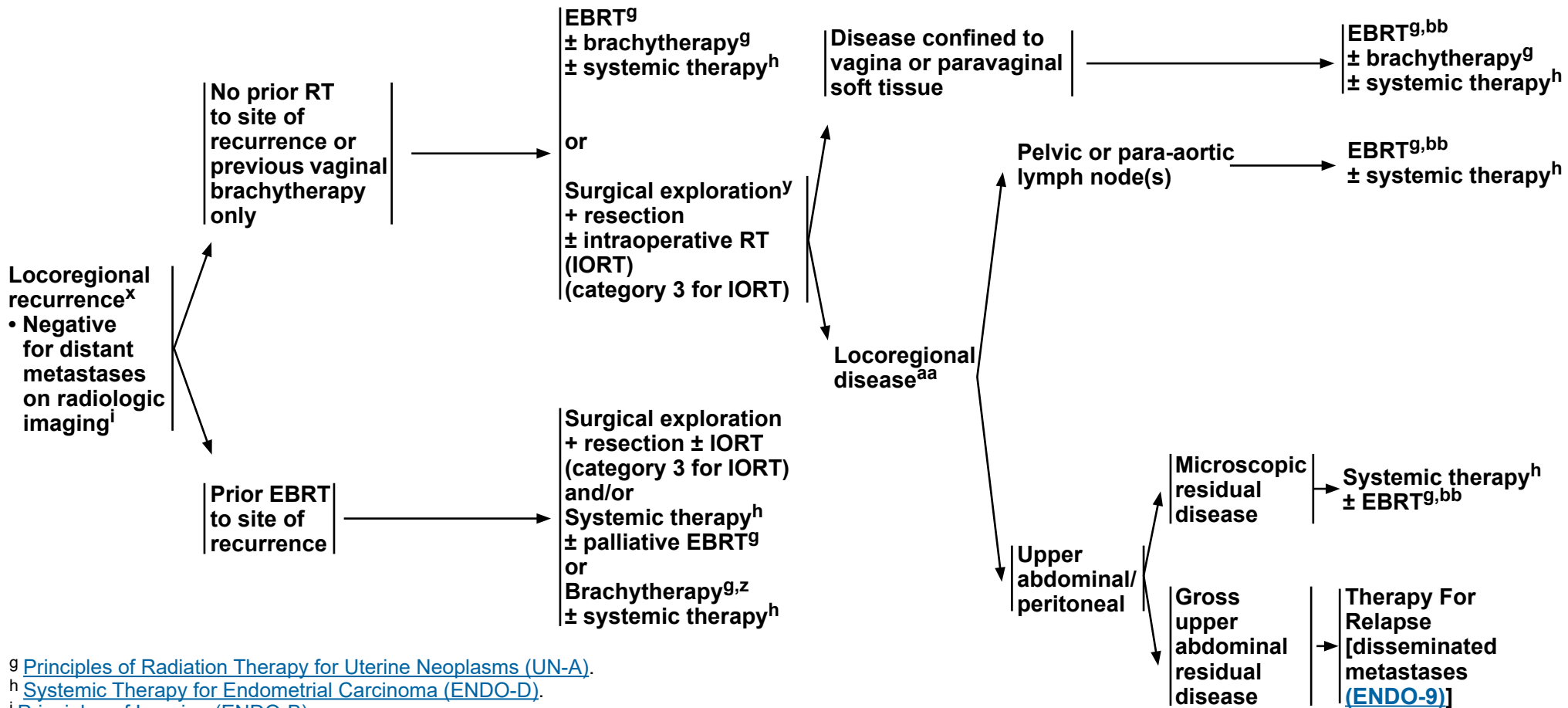
<sup>w</sup> Consider ablative RT for 1–5 metastatic lesions if the primary cancer has been controlled (category 2B) (Palma DA, et al. Lancet 2019;393:2051-2058).

**Note: All recommendations are category 2A unless otherwise indicated.**

## CLINICAL PRESENTATION

## THERAPY FOR RELAPSE

## ADDITIONAL THERAPY



<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>i</sup> [Principles of Imaging \(ENDO-B\)](#).

<sup>x</sup> May include patients with isolated common iliac or para-aortic lymph node recurrence.

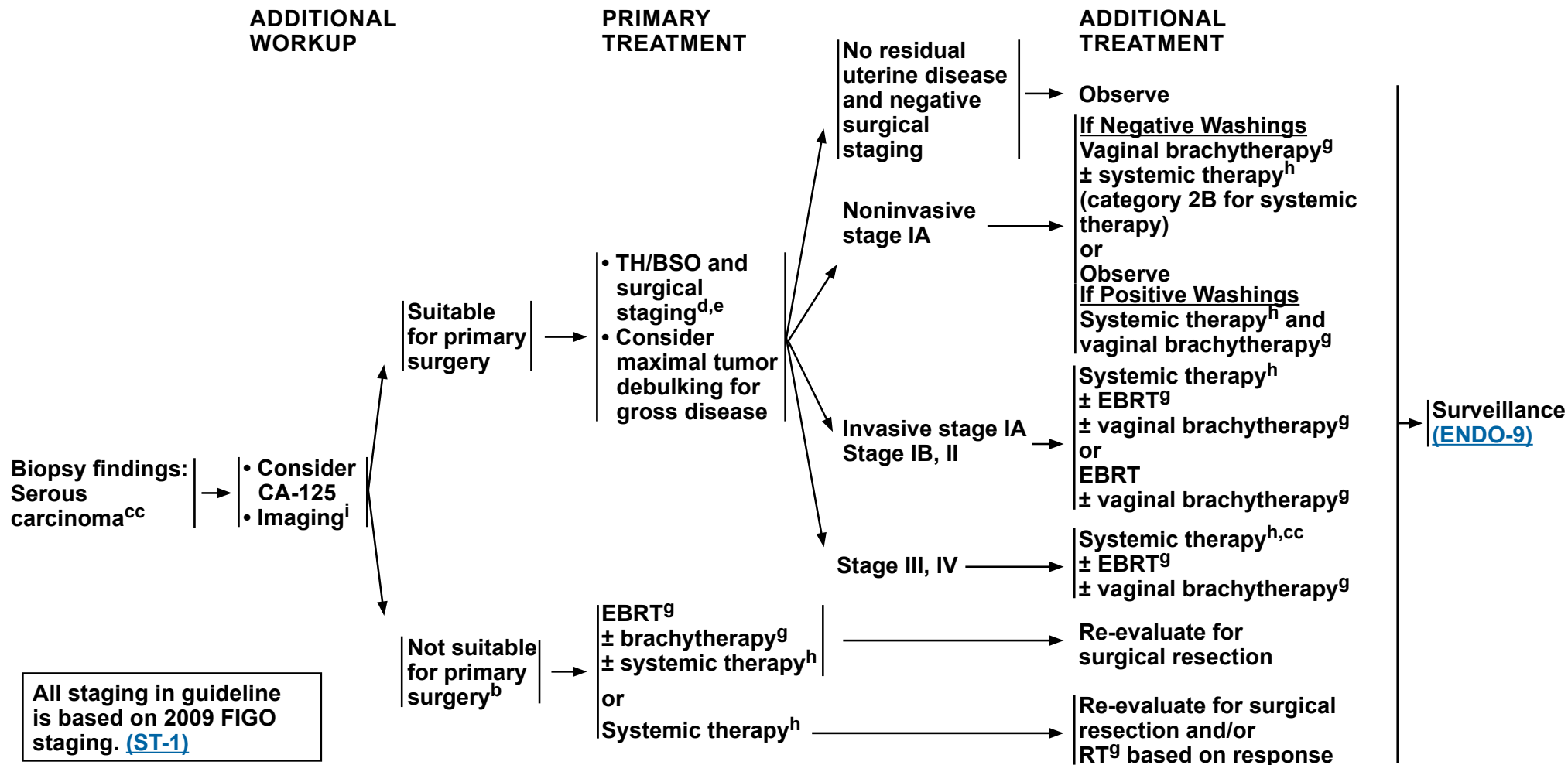
<sup>y</sup> Consider preoperative EBRT in select patients.

<sup>z</sup> Recommended for small-volume vaginal and/or paravaginal disease.

<sup>aa</sup> Consider brachytherapy for locoregional disease with a vaginal component.

<sup>bb</sup> Post-resection consolidation EBRT can be considered in patients who were not previously irradiated or who are deemed to have additional tolerance for radiation.

**Note: All recommendations are category 2A unless otherwise indicated.**



<sup>b</sup> Disease is not amenable to resection or patient is not suitable for surgery based on comorbidities.

<sup>d</sup> MIS is the preferred approach when technically feasible. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>e</sup> The degree of surgical staging to assess disease status depends on intraoperative findings. Multidisciplinary expertise is recommended. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

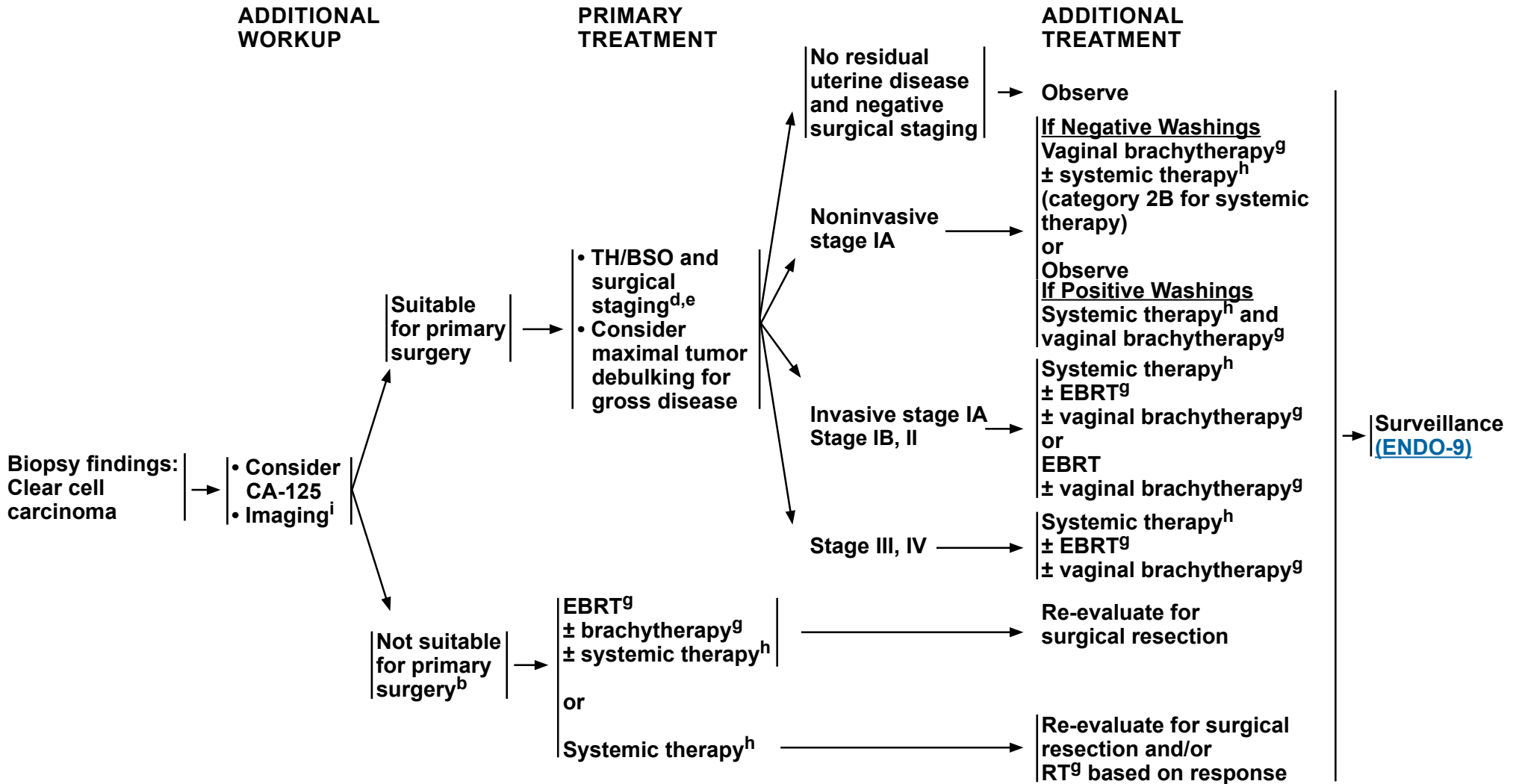
<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>i</sup> [Principles of Imaging \(ENDO-B\)](#).

<sup>cc</sup> HER2 testing is recommended for advanced or metastatic disease.

**Note: All recommendations are category 2A unless otherwise indicated.**



All staging in guideline is based on 2009 FIGO staging. (ST-1)

<sup>b</sup> Disease is not amenable to resection or patient is not suitable for surgery based on comorbidities.

<sup>d</sup> MIS is the preferred approach when technically feasible. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>e</sup> The degree of surgical staging to assess disease status depends on intraoperative findings. Multidisciplinary expertise is recommended.

See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

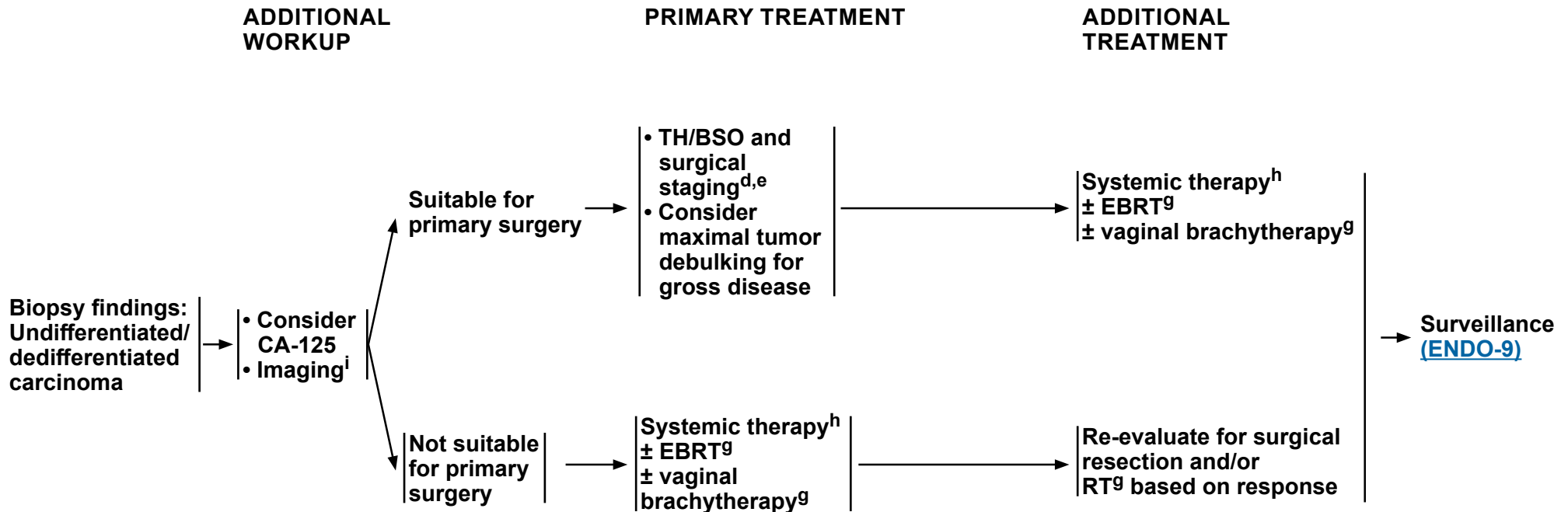
<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>i</sup> [Principles of Imaging \(ENDO-B\)](#).

Note: All recommendations are category 2A unless otherwise indicated.

All staging in guideline is based on 2009 FIGO staging. [\(ST-1\)](#)



<sup>d</sup> MIS is the preferred approach when technically feasible. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>e</sup> The degree of surgical staging to assess disease status depends on intraoperative findings. Multidisciplinary expertise is recommended. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

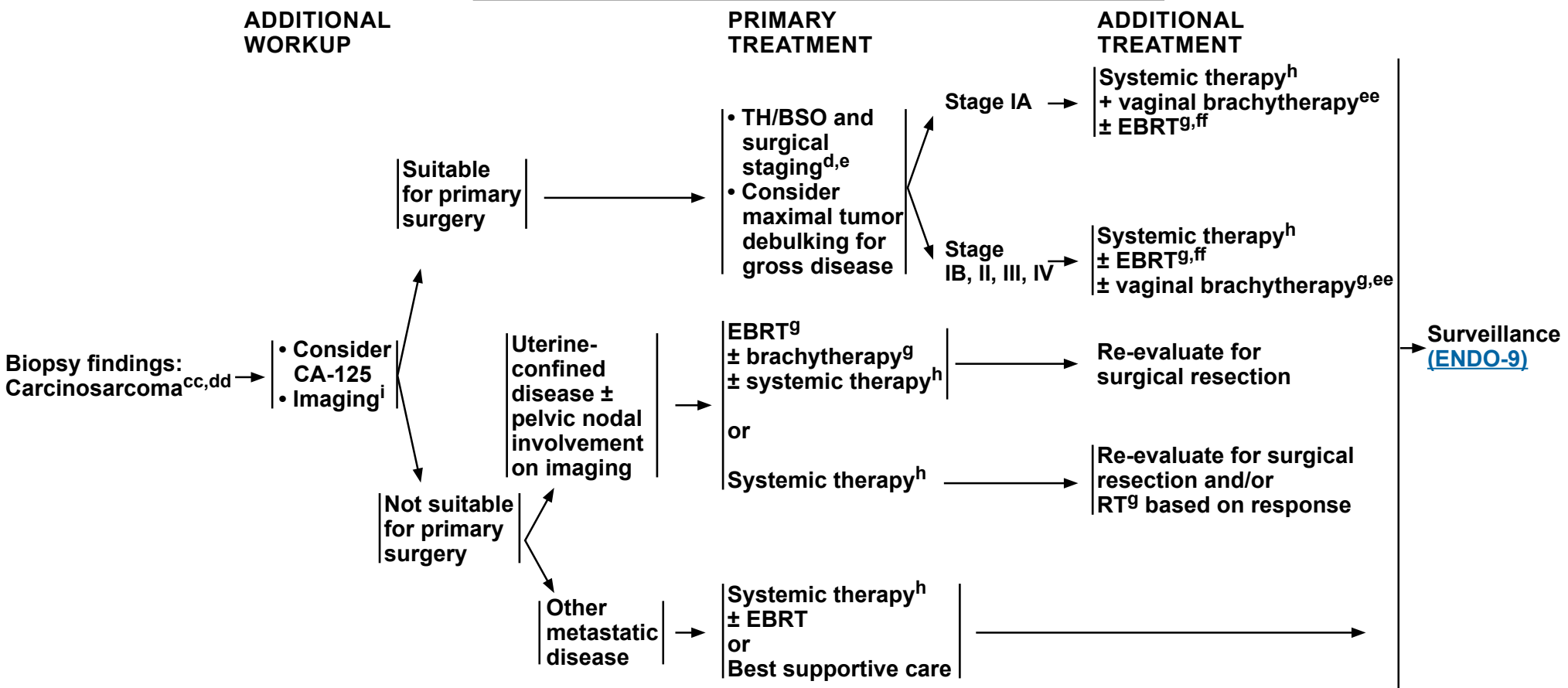
<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>i</sup> [Principles of Imaging \(ENDO-B\)](#).

**Note: All recommendations are category 2A unless otherwise indicated.**

All staging in guideline is based on 2009 FIGO staging. (ST-1)



<sup>d</sup> MIS is the preferred approach when technically feasible. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>e</sup> The degree of surgical staging to assess disease status depends on intraoperative findings. Multidisciplinary expertise is recommended. See [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>g</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>h</sup> [Systemic Therapy for Endometrial Carcinoma \(ENDO-D\)](#).

<sup>i</sup> [Principles of Imaging \(ENDO-B\)](#).

<sup>cc</sup> HER2 testing is recommended for advanced or metastatic disease.

<sup>dd</sup> Also known as malignant mixed mesodermal tumor or malignant mixed Müllerian tumor.

<sup>ee</sup> Initiation of chemotherapy within 3–6 weeks postoperatively should be considered. Vaginal brachytherapy can be interdigitated with chemotherapy starting 6 weeks postoperatively.

<sup>ff</sup> Consider EBRT if both high-grade epithelial components and sarcoma are dominant (>50% of sarcoma component in uterine tumor) (Matsuo K, et al. Surg Oncol 2018;27:433-440).

**Note: All recommendations are category 2A unless otherwise indicated.**



### PRINCIPLES OF PATHOLOGY<sup>a,1,2,3</sup>

#### **Procedure:**

- TH/BSO: Total hysterectomy + bilateral salpingo-oophorectomy
- RH: Radical hysterectomy

#### **Pathologic Assessment for Carcinoma (including carcinoma, carcinosarcoma, and neuroendocrine carcinoma):**

- Uterus
  - ▶ Hysterectomy type
  - ▶ Specimen integrity (intact, opened, morcellated, other)
  - ▶ Tumor site (endometrium, lower uterine segment, polyp)
  - ▶ Tumor size
  - ▶ Histologic type
  - ▶ Histologic grade (if applicable)
  - ▶ Myometrial invasion (depth of invasion in mm/myometrial thickness in mm)
  - ▶ Cervical stromal involvement<sup>b</sup>
  - ▶ LVSI<sup>c</sup>
- Other tissue/organ involvement (fallopian tubes, ovaries, vagina, parametrium, peritoneum, omentum, other)
- Peritoneal/ascitic fluid cytology<sup>d</sup>
- Lymph nodes (when resected)
  - ▶ Sentinel lymph nodes (SLNs) should undergo ultrastaging for detection of low-volume metastasis.<sup>e</sup>
  - ▶ Isolated tumor cells are staged N0(i+) and should not upstage patients, but should be considered in the discussion of adjuvant therapy.
  - ▶ Level of nodal involvement (ie, pelvic, common iliac, para-aortic)
  - ▶ Number of lymph nodes with isolated tumor cells, micrometastasis, and macrometastasis
  - ▶ Thorough gross evaluation of the SLN tissue specimen is recommended to ensure that lymph node tissue is included. This could be performed either by the surgeon (depending on experience/comfort level with gross evaluation) or by seeking an intraoperative pathology consultation.
- Morphologic evaluation of endometrial carcinoma to determine histologic type—especially in high-grade cancers—is challenging and issues exist regarding diagnostic reproducibility.<sup>4,5</sup>

<sup>a</sup> [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>b</sup> Additional information including depth of invasion in mm/cervical wall thickness in mm may be requested by radiation oncologists to aid in the decision for EBRT.

<sup>c</sup> Pathologists may be asked to quantify LVSI. The current definition of substantial LVSI is  $\geq 4$  (LVSI-involved vessels in at least one hematoxylin and eosin [H&E] slide) for defining clinically relevant LVSI in endometrial cancer (Peters EEM, et al. Int J Gynecol Path 2022;41:220-226).

<sup>d</sup> Although cytology by itself does not affect FIGO staging, cytology results should still be obtained because positive cytology is an adverse risk factor.

<sup>e</sup> Ultrastaging commonly entails thin serial sectioning of the gross SLN and review of multiple H&E-stained sections with or without cytokeratin immunohistochemistry (IHC) for all blocks of SLN. There is no standard protocol for lymph node ultrastaging.

**Note: All recommendations are category 2A unless otherwise indicated.**

[References](#)  
[Continued](#)

**ENDO-A**  
**1 OF 4**

## PRINCIPLES OF MOLECULAR ANALYSIS

- Molecular analysis of endometrial carcinoma has identified four clinically significant molecular subgroups associated with differing clinical prognoses: *POLE* mutations, microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), no specific molecular profile (NSMP), and p53 aberrant.<sup>6,7</sup>
- Retrospective analyses indicate that these four molecular subgroups may respond to therapy differently and therefore may require escalation or de-escalation of therapy compared to previous guidelines. Prospective randomized trials are ongoing to determine the role of a molecular profile–guided treatment strategy in the management of high-intermediate-risk and high-risk endometrial carcinomas.
- Ancillary studies for *POLE* mutations (pathogenic mutations in the exonuclease domain), immunohistochemical (IHC) staining for mismatch repair (MMR) or MSI testing, and p53 IHC are recommended to complement morphologic assessment regardless of histologic tumor type.<sup>8</sup> See [Figure 1: Pathology and Genomics in Endometrial Carcinoma \(ENDO-A 3 of 4\)](#).
- Comprehensive molecular profiling is strongly encouraged via an FDA-approved assay, or a validated test performed in a Clinical Laboratory Improvement Amendment (CLIA)-certified laboratory, in the initial evaluation of uterine neoplasms.
- For tumors that are *POLE*-mutated, MSI-H, p53 aberrant, or NSMP, clinical trial enrollment is strongly encouraged.
- Molecular testing may be performed on the initial biopsy or D&C material or the final hysterectomy specimen.
- Evaluation for MMR status is commonly done using IHC. Molecular profiling via NGS panels or MSI PCR assay are acceptable alternatives.
  - ▶ MSI testing is recommended if IHC results are equivocal.
  - ▶ *MLH1* loss should be further evaluated for promoter methylation to assess for an epigenetic mechanism.
  - ▶ Genetic counseling for any suspected germline mutation is strongly recommended.
  - ▶ For those who have a strong family history of endometrial and/or colorectal cancer, genetic counseling and testing are recommended regardless of MMR or *MLH1* promoter methylation results [see Lynch Syndrome (LS-1) in the [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal, Endometrial, and Gastric](#)].
- HER2 IHC testing (with or without reflex to HER2 fluorescence in situ hybridization [FISH] for equivocal IHC) is recommended for all p53 aberrant carcinomas regardless of histology.<sup>9-12</sup>
- Estrogen receptor (ER) and progesterone receptor (PR) testing is recommended in the settings of stage III, stage IV, and recurrent disease.
- Consider *NTRK* gene fusion testing for metastatic or recurrent endometrial carcinoma.
- Consider tumor mutational burden (TMB) testing through an FDA-approved assay, or a validated test performed in a CLIA-certified laboratory.<sup>13</sup>

Note: All recommendations are category 2A unless otherwise indicated.

[References](#)

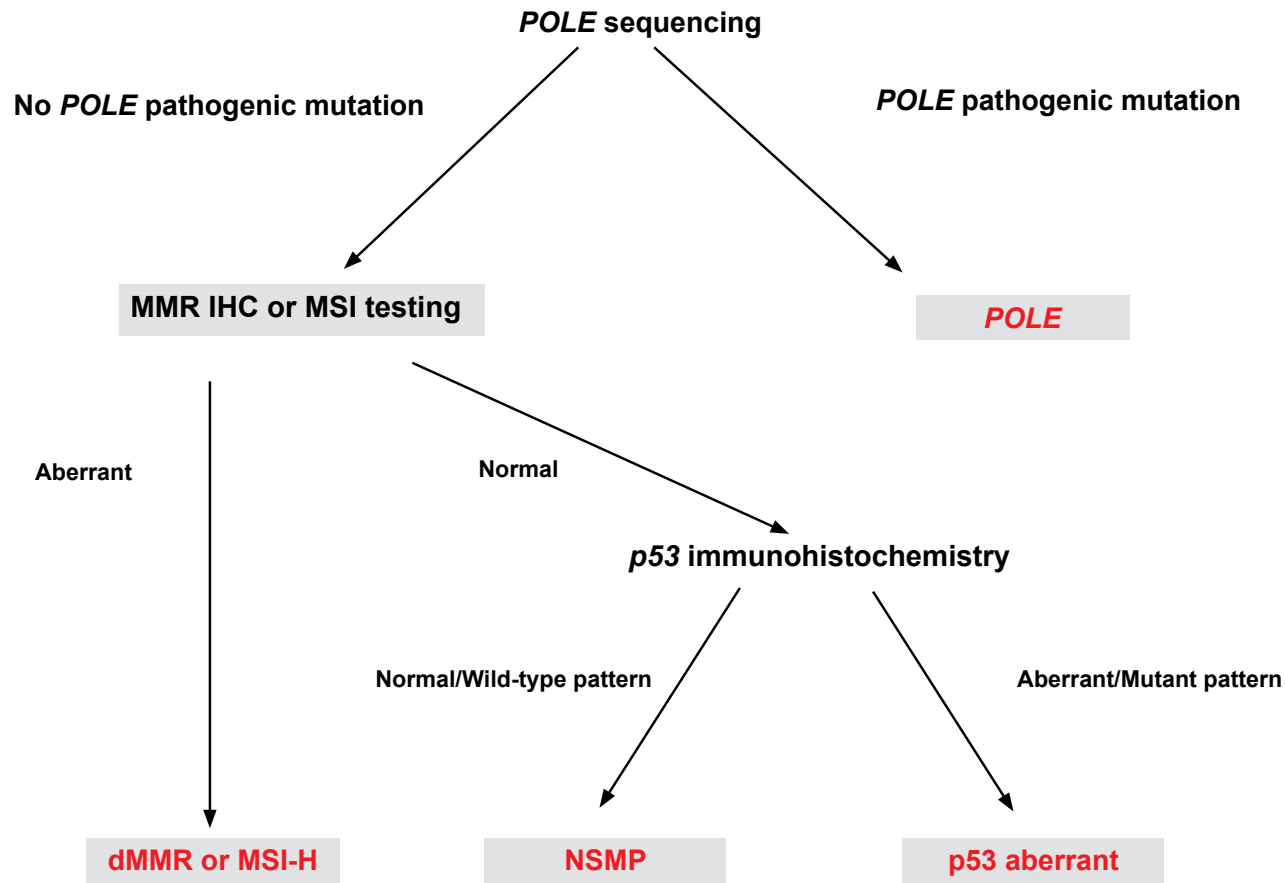
[Continued](#)

ENDO-A  
2 OF 4

## PRINCIPLES OF MOLECULAR ANALYSIS

**FIGURE 1: PATHOLOGY AND GENOMICS IN ENDOMETRIAL CARCINOMA**

(The decision to use molecular testing/classification depends on the availability of resources and the multidisciplinary team of each center.)<sup>f,9</sup>



<sup>f</sup> Adapted with permission from Murali R, Delair DF, Bean SM, et al. Evolving roles of histologic evaluation and molecular/genomic profiling in the management of endometrial cancer. *J Nat Compr Canc Netw* 2018;16:201-209.

<sup>9</sup> Diagnostic algorithm for integrated genomic-pathologic classification of endometrial carcinomas.

**Note: All recommendations are category 2A unless otherwise indicated.**



### PRINCIPLES OF PATHOLOGY AND MOLECULAR ANALYSIS REFERENCES

- <sup>1</sup> American College of Obstetricians and Gynecologists. ACOG practice bulletin, clinical management guidelines for obstetrician-gynecologists, number 65, August 2005: management of endometrial cancer. *Obstet Gynecol* 2005;106:413-425.
- <sup>2</sup> Crothers BA, Harik LR, Krishnamurti UG, Turashvilli G, et al. Protocol for the examination of specimens from patients with carcinoma and carcinosarcoma of the endometrium. (Version 4.4.0.0) College of American Pathologists 2023.
- <sup>3</sup> Longacre TA, Broaddus R, Chuang LT, et al. Template for reporting results of biomarker testing of specimens from patients with carcinoma of the endometrium. *Arch Pathol Lab Med* 2017;141:1508-1512.
- <sup>4</sup> Hoang LN, Kinloch MA, Leo JM, et al. Interobserver agreement in endometrial carcinoma histotype diagnosis varies depending on The Cancer Genome Atlas (TCGA)-based molecular subgroup. *Am J Surg Pathol* 2017;41:245-252.
- <sup>5</sup> Thomas S, Hussein Y, Bandyopadhyay S, et al. Interobserver variability in the diagnosis of uterine high-grade endometrioid carcinoma. *Arch Pathol Lab Med* 2016;140:836-843.
- <sup>6</sup> The Cancer Genome Atlas (TCGA) Research Network; Kandoth C, Schultz N, Cherniack AD, et al. Integrated genomic characterization of endometrial carcinoma. *Nature* 2013;497:67-73.
- <sup>7</sup> Rios-Doria E, Momeni-Boroujeni A, Friedman CF, et al. Integration of clinical sequencing and immunohistochemistry for the molecular classification of endometrial carcinoma. *Gynecol Oncol* 2023;174:262-272.
- <sup>8</sup> Murali R, Delair DF, Bean SM, et al. Evolving roles of histologic evaluation and molecular/genomic profiling in the management of endometrial cancer. *J Natl Compr Canc Netw* 2018;16:201-209.
- <sup>9</sup> Fader AN, Roque DM, Siegel E, et al. Randomized phase II trial of carboplatin-paclitaxel versus carboplatin-paclitaxel-trastuzumab in uterine serous carcinomas that overexpress human epidermal growth factor receptor 2/neu. *J Clin Oncol* 2018;36:2044-2051.
- <sup>10</sup> Moukarzel LA, Ferrando L, Da Cruz Paula A, et al. The genetic landscape of metaplastic breast cancers and uterine carcinosarcomas. *Mol Oncol* 2021;15:1024-1039.
- <sup>11</sup> Crane E, Naumann W, Tait D, et al. Molecular variations in uterine carcinosarcomas identify therapeutic opportunities. *Int J Gynecol Cancer* 2020;30:480-484.
- <sup>12</sup> Rottmann D, Snir OL, Wu X, et al. HER2 testing of gynecologic carcinosarcomas: tumor stratification for potential targeted therapy. *Mod Pathol* 2020;33:118-127.
- <sup>13</sup> Merino DM, McShane LM, Fabrizio D, et al. Establishing guidelines to harmonize tumor mutational burden (TMB): in silico assessment of variation in TMB quantification across diagnostic platforms: phase I of the Friends of Cancer Research TMB Harmonization Project. *J Immunother Cancer* 2020;8:e000147.

**Note: All recommendations are category 2A unless otherwise indicated.**



### PRINCIPLES OF IMAGING<sup>a,1-9</sup>

#### Initial Workup

##### • Non–Fertility-Sparing Treatment

- ▶ Consider chest imaging (chest x-ray). If an abnormality is seen, then chest CT without contrast may be performed.
- ▶ Consider pelvis MRI to establish the origin of the tumor (endocervical vs. endometrial) and assess local disease extent.
- ▶ Consider preoperative pelvis ultrasound if uterine size is not clear on exam.
- ▶ For high-grade carcinoma,<sup>b</sup> consider chest/abdomen/pelvis CT (preferred) to evaluate for metastatic disease.
- ▶ For patients who underwent TH with incidental finding of endometrial cancer or whose cancer was incompletely staged ([ENDO-7](#)) with uterine risk factors,<sup>c</sup> consider chest/abdomen/pelvis CT to evaluate for metastatic disease.
- ▶ Consider neck/chest/abdomen/pelvis/groin fluorodeoxyglucose (FDG)-PET/CT if metastasis is suspected in select patients.
- ▶ Other initial imaging should be based on symptomatology and clinical concern for metastatic disease.<sup>d</sup>

##### • Fertility-Sparing Treatment

- ▶ Pelvis MRI (preferred) to exclude myoinvasion and assess local disease extent; pelvic transvaginal ultrasound if MRI is contraindicated or unavailable.
- ▶ Consider chest imaging (chest x-ray). If an abnormality is seen, then chest CT without contrast may be performed.
- ▶ Consider neck/chest/abdomen/pelvis/groin FDG-PET/CT if metastasis is suspected in select patients.
- ▶ Other imaging should be based on symptomatology and clinical concern for metastatic disease.<sup>e</sup>

#### Follow-up/Surveillance

##### • Non–Fertility-Sparing Treatment

- ▶ Imaging should be guided by patient symptoms, risk assessment, and clinical concern for recurrent or metastatic disease.<sup>e</sup>

##### • Fertility-Sparing Treatment

- ▶ Repeat pelvis MRI (preferred) for patients with persistent endometrial carcinoma after 6–9 months of ineffective treatment, especially if considering further fertility-sparing approaches.
- ▶ Other imaging should be based on symptomatology and clinical concern for metastatic disease.<sup>e</sup>
- ▶ Consider pelvis ultrasound surveillance for patients with ovarian preservation.

#### Suspected Recurrence or Metastasis

- Abdomen/pelvis CT and/or chest CT is recommended based on symptoms or physical exam findings.<sup>e</sup>
- Consider whole body FDG-PET/CT and/or abdomen/pelvis MRI in select patients as clinically indicated.

<sup>a</sup> MRI is performed with and without contrast and CT is performed with contrast unless contraindicated. Contrast is not required for screening chest CT.

<sup>b</sup> High-grade endometrial carcinoma includes: poorly differentiated endometrioid, serous, clear cell, undifferentiated carcinoma, and carcinosarcoma.

<sup>c</sup> Uterine risk factors identified post TH include: high-grade carcinomas (above criteria), myoinvasion >50%, cervical stromal involvement, LVSI, and tumor >2 cm.

<sup>d</sup> Indications may include abnormal physical exam findings; bulky uterine tumor; vaginal or extrauterine involvement; delay in presentation or treatment; and abdominal or pulmonary symptoms.

<sup>e</sup> Indications may include abnormal physical exam findings such as vaginal tumor; palpable mass or adenopathy; and new pelvic, abdominal, or pulmonary symptoms.

#### References

**Note:** All recommendations are category 2A unless otherwise indicated.



## PRINCIPLES OF IMAGING REFERENCES

- <sup>1</sup> Salani R, Khanna N, Frimer M, et al. An update on post-treatment surveillance and diagnosis of recurrence in women with gynecologic malignancies: Society of Gynecologic Oncology (SGO) recommendations. *Gynecol Oncol* 2017;146:3-10.
- <sup>2</sup> Haldorsen IS, Salvesen HB. What is the best preoperative imaging for endometrial cancer? *Curr Oncol Rep* 2016;18:25.
- <sup>3</sup> Elit L, Reade CJ. Recommendations for follow-up care for gynecologic cancer survivors. *Obstet Gynecol* 2015;126:1207-1214.
- <sup>4</sup> Vargas HA, Akin O, Zheng J, et al. The value of MR imaging when the site of uterine cancer origin is uncertain. *Radiology* 2011;258:785-792.
- <sup>5</sup> Sohaib SA, Houghton SL, Meroni R, et al. Recurrent endometrial cancer: patterns of recurrent disease and assessment of prognosis. *Clin Radiol* 2007;62:28-34; discussion 35-36.
- <sup>6</sup> Hensley ML, Barrette BA, Baumann K, et al. Gynecologic Cancer InterGroup (GCIG) consensus review: uterine and ovarian leiomyosarcomas. *Int J Gynecol Cancer* 2014;24(9 Suppl 3):S61-S66.
- <sup>7</sup> Lakhman Y, Katz SS, Goldman DA, et al. Diagnostic performance of computed tomography for preoperative staging of patients with non-endometrioid carcinomas of the uterine corpus. *Ann Surg Oncol* 2016;23:1271-1278.
- <sup>8</sup> Colombo N, Creutzberg C, Amant F, et al; ESMO-ESGO-ESTRO Endometrial Consensus Conference Working Group. ESMO-ESGO-ESTRO Consensus Conference on Endometrial Cancer: diagnosis, treatment and follow-up. *Ann Oncol* 2016;27:16-41.
- <sup>9</sup> Sala E, Rockall AG, Freeman SJ, et al. The added role of MR imaging in treatment stratification of patients with gynecologic malignancies: what the radiologist needs to know. *Radiology* 2013;266:717-740.

**Note: All recommendations are category 2A unless otherwise indicated.**



### PRINCIPLES OF EVALUATION AND SURGICAL STAGING

#### Principles of Surgical Staging for Endometrial Cancer<sup>1-15</sup>

- TH/BSO and lymph node assessment is the primary treatment for apparent uterine-confined endometrial carcinoma, unless patients desire (and are candidates for) fertility-sparing options ([ENDO-8](#)).<sup>1-3</sup> Select patients with metastatic endometrial carcinoma are also candidates for hysterectomy ([Principles of Pathology and Molecular Analysis \[ENDO-A\]](#)).
- Endometrial carcinoma should be removed en bloc to optimize outcomes; intraperitoneal morcellation or tumor fragmentation should be avoided.
- TH/BSO and lymph node assessment may be performed by any surgical route (eg, laparoscopic, robotic, vaginal, abdominal), although the standard in those with apparent uterine-confined disease is to perform the procedure via a minimally invasive approach. Randomized trials, a Cochrane Database Systematic Review, and population-based surgical studies support that minimally invasive techniques are preferred in this setting due to a lower rate of surgical site infection, transfusion, venous thromboembolism, decreased hospital stay, and lower cost of care, without compromise in oncologic outcome.<sup>4-9</sup>
- The lymph node assessment includes evaluation of the nodal basins that drain the uterus, and often comprises either SLN mapping and resection of sentinel nodes or a pelvic nodal dissection with or without para-aortic nodal dissection. This continues to be an important aspect of surgical staging in patients with uterine-confined endometrial carcinoma, as the procedure provides important prognostic information that may alter treatment decisions.
- SLN mapping is preferred (see pages 2–6 of [ENDO-C](#)).<sup>15</sup>
- Pelvic lymph nodes from the external iliac, internal iliac, obturator, and common iliac nodes are frequently removed for staging purposes.
- Para-aortic nodal evaluation from the inframesenteric and infrarenal regions may also be utilized for staging in patients with high-risk tumors such as deeply invasive lesions, high-grade histology, and tumors of serous carcinoma, clear cell carcinoma, or carcinosarcoma.
- Excision of suspicious or enlarged lymph nodes in the pelvic or aortic regions is important to exclude nodal metastasis.
- Some patients may not be candidates for lymph node dissection.
- Visual evaluation of the peritoneal, diaphragmatic, and serosal surfaces with biopsy of any suspicious lesions is important to exclude extrauterine disease.
- While peritoneal cytology does not impact staging, FIGO and AJCC nonetheless recommend that surgeons continue to obtain this during the TH/BSO.
- Cytology results should not be taken in isolation to guide adjuvant therapy.
- Omental biopsy is commonly performed in those with serous carcinoma, clear cell carcinoma, or carcinosarcoma histologies.
- For stage II disease, TH/BSO is the standard procedure. RH should only be performed if needed to obtain negative margins.

[Continued](#)

Note: All recommendations are category 2A unless otherwise indicated.

ENDO-C  
1 OF 6



### PRINCIPLES OF EVALUATION AND SURGICAL STAGING WHEN SLN MAPPING IS USED

#### Principles of Sentinel Lymph Node(s) Mapping for Endometrial Cancer Staging<sup>10-26</sup>

- Prospective and retrospective studies demonstrate that compared to systemic lymphadenectomy (LND), SLN mapping with ultrastaging may increase the detection of lymph node metastasis with low false-negative rates in patients with apparent uterine-confined disease.<sup>10-23,26</sup> If SLN mapping is considered, the expertise of the surgeon and attention to technical detail is critical. Recent evidence indicates that SLN mapping may also be used in high-risk histologies (ie, serous carcinoma, clear cell carcinoma, carcinosarcoma).<sup>24,25</sup>
- SLN mapping can be considered for the surgical staging of apparent uterine-confined malignancy when there is no metastasis demonstrated by imaging studies or no obvious extrauterine disease at exploration.
- A cervical injection with dye has emerged as a useful and validated technique for identification of lymph nodes that are at high risk for metastases (ie, SLN in patients with early-stage endometrial cancer<sup>10-12</sup>).
- Superficial (1–3 mm) and optional deep (1–2 cm) cervical injection leads to dye delivery to the main layers of lymphatic channel origins in the cervix and corpus, namely the superficial subserosal, intermediate stromal, and deep submucosal lymphatic sites of origin (see Figure 1 on [ENDO-C 4 of 6](#)).<sup>26</sup>
- Injection into the uterine cervix provides excellent dye penetration to the uterine vessels and main uterine lymphatic trunks that condense in the parametria and appear in the broad ligament leading to pelvic and occasionally paraaortic sentinel nodes.
- The uterine body lymphatic trunks commonly cross over the obliterated umbilical artery with the most common location of pelvic SLN being medial to the external iliac, ventral to the hypogastric, or in the superior part of the obturator region (see Figure 2 on [ENDO-C 4 of 6](#)).
- A less common location is usually seen when the lymphatic trunks do not cross over the obliterated umbilical and move cephalad following the mesoureter; in these cases, the SLN is usually seen in the common iliac presacral region (see Figure 3 on [ENDO-C 4 of 6](#)).
- Indocyanine green (ICG) is the preferred imaging dye for SLN mapping.<sup>20,26,27</sup>
- The radiolabeled colloid most commonly injected into the cervix is technetium-99m (99mTc); colored dyes are available in a variety of forms (Isosulfan Blue 1%, Methylene Blue 1%, and Patent Blue 2.5% sodium).
- Low-volume nodal metastasis to SLN detected only by enhanced pathologic ultrastaging is another potential value to staging with SLN.<sup>10,21-23</sup>
- The key point to successful SLN mapping is adherence to the SLN algorithm, which requires the performance of a side-specific nodal dissection in cases of failed mapping and removal of any suspicious or grossly enlarged nodes regardless of mapping (see Figure 4 on [ENDO-C 5 of 6](#)).<sup>10-12,23,25</sup>
- For cases of failed SLN mapping, reinjection of the cervix may be considered. An additional 1 mL in the non-detected side can be infiltrated in the superficial cervical area.
- If there is no mapping on a hemi-pelvis, then a side-specific LND is recommended. However, if expert gynecologic pathology is available, a frozen section to assess myoinvasion can be obtained and LND can be avoided if no myoinvasion or cervical invasion is identified.
- SLN identification should always be done prior to hysterectomy, except in cases where a bulky uterus must be removed to allow access to iliac vessels and lymph nodes.

Note: All recommendations are category 2A unless otherwise indicated.

[Continued](#)

ENDO-C  
2 OF 6



## PRINCIPLES OF EVALUATION AND SURGICAL STAGING WHEN SLN MAPPING IS USED

### Principles of Sentinel Lymph Node(s) Mapping for Endometrial Cancer Staging (continued)<sup>10-26</sup>

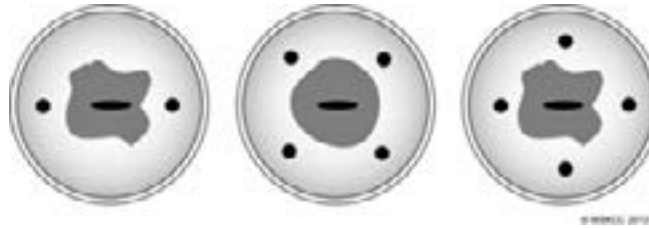
- SLNs are processed using ultrastaging, which typically includes two components: serial sectioning with review of multiple hematoxylin and eosin (H&E)-stained slides with or without cytokeratin IHC staining.
  - ▶ Protocols of serial sectioning and ultrastaging vary among gynecologic pathologists.<sup>28</sup> Comparison of two different ultrastaging protocols in endometrial cancer SLN did not reveal significant advantages when serial H&E sectioning and IHC staining were used.<sup>29</sup>
- Recent data highlight the potential importance of ultrastaging for detection of low-volume metastasis. In general, SLN mapping allows for increased intraoperative surgical precision to identify nodes more likely to harbor metastasis combined with enhanced pathology protocols, which has been shown to increase the detection of nodal metastasis, which may alter stage and adjuvant therapy recommendations.
- Lymph nodes with isolated tumor cells should be clearly reported. In endometrial cancer, when isolated tumor cells are detected in the absence of macrometastasis and micrometastasis, the lymph node stage is designated pN0(i+).<sup>30</sup>

[Continued](#)

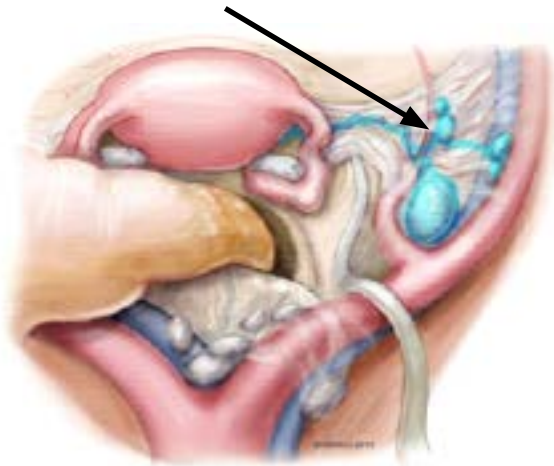
**Note: All recommendations are category 2A unless otherwise indicated.**

**PRINCIPLES OF EVALUATION AND SURGICAL STAGING WHEN SLN MAPPING IS USED**

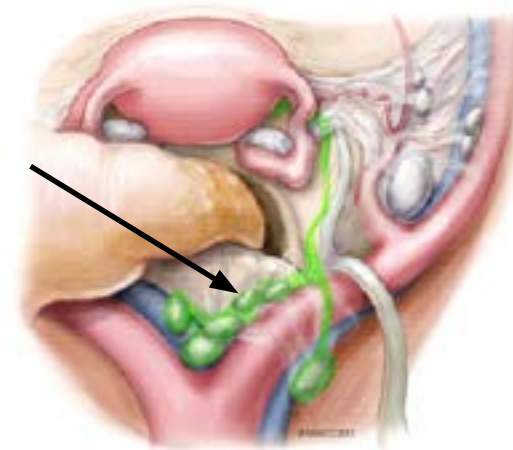
**Figure 1: Common cervical injection sites for mapping uterine cancer<sup>a</sup>**



**Figure 2: Most common location of SLNs (blue, arrow) following a cervical injection<sup>a</sup>**



**Figure 3: Less common location of SLNs (green, arrow) usually seen when lymphatic trunks are not crossing over the umbilical ligament but following the mesoreuter cephalad to common iliac and presacral region<sup>a</sup>**



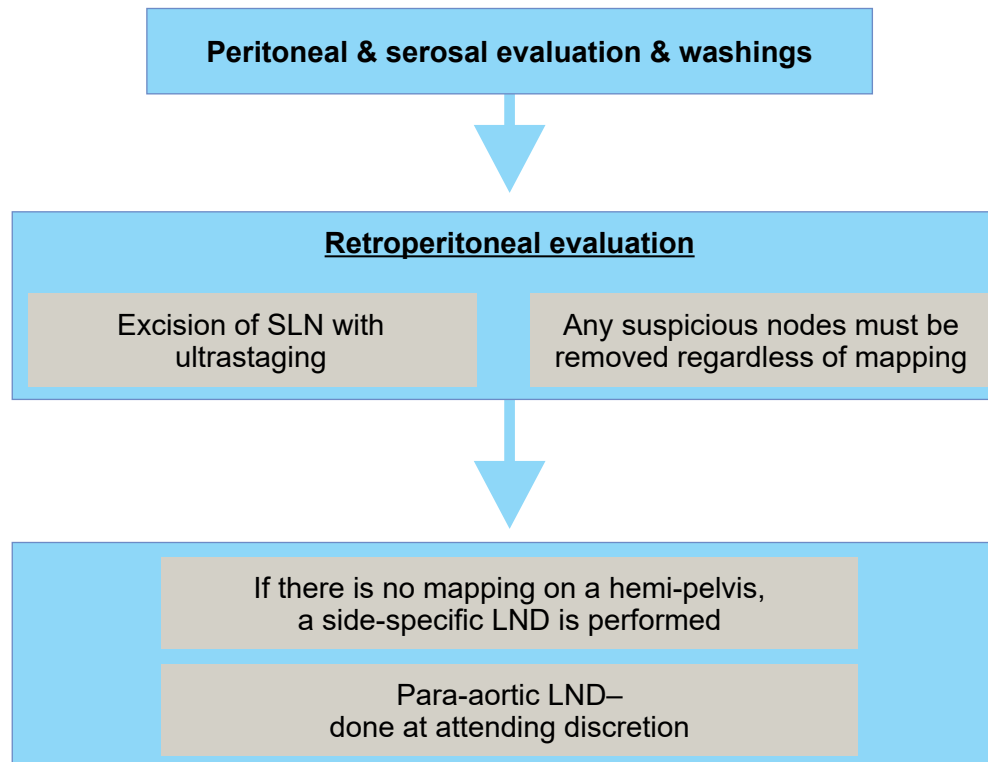
<sup>a</sup> Figures 1, 2, and 3 are reproduced with permission from Memorial Sloan Kettering Cancer Center. © 2013, Memorial Sloan Kettering Cancer Center.

**Note: All recommendations are category 2A unless otherwise indicated.**

[Continued](#)

**PRINCIPLES OF EVALUATION AND SURGICAL STAGING WHEN SLN MAPPING IS USED**

**Figure 4: The SLN algorithm for surgical staging of endometrial cancer<sup>b</sup>**



<sup>b</sup> Reproduced with permission from Barlin JN, Khoury-Collado F, Kim CH, et al. The importance of applying a sentinel lymph node mapping algorithm in endometrial cancer staging: Beyond removal of blue nodes. *Gynecol Oncol* 2012;125:531-535.

**Note: All recommendations are category 2A unless otherwise indicated.**

**Continued**

**ENDO-C**  
**5 OF 6**

### PRINCIPLES OF EVALUATION AND SURGICAL STAGING REFERENCES

- 1 American College of Obstetricians and Gynecologists. ACOG practice bulletin, clinical management guidelines for obstetrician-gynecologists, number 65, August 2005: management of endometrial cancer. *Obstet Gynecol* 2005;106:413-425.
- 2 Bakkum-Gamez JN, Gonzalez-Bosquet J, Laack NN, et al. Current issues in the management of endometrial cancer. *Mayo Clin Proc* 2008;83:97-112.
- 3 Edge SB, Byrd DR, Compton CC. *AJCC Cancer Staging Manual*, 7th edition. New York: Springer; 2010.
- 4 Walker JL, Piedmonte MR, Spirtos NM, et al. Laparoscopy compared with laparotomy for comprehensive surgical staging of uterine cancer: Gynecologic Oncology Group Study LAP2. *J Clin Oncol* 2009;27:5331-5336.
- 5 Kornblith AB, Huang HQ, Walker JL, et al. Quality of life of patients with endometrial cancer undergoing laparoscopic international federation of gynecology and obstetrics staging compared with laparotomy: a Gynecologic Oncology Group study. *J Clin Oncol* 2009;27:5337-5342.
- 6 Galaal K, Bryant A, Fisher AD, et al. Laparoscopy versus laparotomy for the management of early stage endometrial cancer. *Cochrane Database Syst Rev* 2012;9:CD006655.
- 7 Scalici J, Laughlin BB, Finan MA, et al. The trend towards minimally invasive surgery (MIS) for endometrial cancer: an ACS NSQIP evaluation of surgical outcomes. *Gynecol Oncol* 2015;136:512-515.
- 8 Fader AN, Weise RM, Sinno AK, et al. Utilization of minimally invasive surgery in endometrial cancer care: a quality and cost disparity. *Obstet Gynecol* 2016;127:91-100.
- 9 Mannschreck D, Matsuno RK, Moriarty JP, et al. Disparities in surgical care among women with endometrial cancer. *Obstet Gynecol* 2016;128:526-534.
- 10 Abu-Rustum NR, Khoury-Collado F, Pandit-Taskar N, et al. Sentinel lymph node mapping for grade 1 endometrial cancer: is it the answer to the surgical staging dilemma? *Gynecol Oncol* 2009;113:163-169.
- 11 Khoury-Collado F, Glaser GE, Zivanovic O, et al. Improving sentinel lymph node detection rates in endometrial cancer: how many cases are needed? *Gynecol Oncol* 2009;115:453-455.
- 12 Khoury-Collado F, Murray MP, Hensley ML, et al. Sentinel lymph node mapping for endometrial cancer improves the detection of metastatic disease to regional lymph nodes. *Gynecol Oncol* 2011;122:251-254.
- 13 Frimer M, Khoury-Collado F, Murray MP, et al. Micrometastasis of endometrial cancer to sentinel lymph nodes: is it an artifact of uterine manipulation? *Gynecol Oncol* 2010;119:496-499.
- 14 Leitao MM Jr, Khoury-Collado F, Gardner G, et al. Impact of incorporating an algorithm that utilizes sentinel lymph node mapping during minimally invasive procedures on the detection of stage IIIc endometrial cancer. *Gynecol Oncol* 2013;129:38-41.
- 15 Holloway RW, Abu-Rustum NR, Backes FJ, et al. Sentinel lymph node mapping and staging in endometrial cancer: A society of gynecologic oncology literature review with consensus recommendations. *Gynecol Oncol* 2017;146:405-415.
- 16 Kim CH, Soslow RA, Park KJ, et al. Pathologic ultrastaging improves micrometastasis detection in sentinel lymph nodes during endometrial cancer staging. *Int J Gynecol Cancer* 2013;23:964-970.
- 17 Barlin JN, Khoury-Collado F, Kim CH, et al. The importance of applying a sentinel lymph node mapping algorithm in endometrial cancer staging: Beyond removal of blue nodes. *Gynecol Oncol* 2012;125:531-535.
- 18 Vidal F, Leguevaque P, Motton S, et al. Evaluation of the sentinel lymph node algorithm with blue dye labeling for early-stage endometrial cancer in a multicentric setting. *Int J Gynecol Cancer* 2013;23:1327-1243.
- 19 Abu-Rustum NR. The Increasing credibility of sentinel lymph node mapping in endometrial cancer. *Ann Surg Oncol* 2013;20:353-354.
- 20 Sinno AK, Fader AN, Roche KL, et al. A comparison of colorimetric versus fluorometric sentinel lymph node mapping during robotic surgery for endometrial cancer. *Gynecol Oncol* 2014;134:281-286.
- 21 Holloway RW, Gupta S, Stavitski NM, et al. Sentinel lymph node mapping with staging lymphadenectomy for patients with endometrial cancer increases the detection of metastasis. *Gynecol Oncol* 2016;141:206-210.
- 22 Paley P, Veljovich DS, Press JZ, et al. A prospective investigation of fluorescence imaging to detect sentinel lymph nodes at robotic-assisted endometrial cancer staging. *Am J Obstet Gynecol* 2016;215:117.e1-7.
- 23 Sinno AK, Peijnenberg E, Fader AN, et al. Reducing overtreatment: a comparison of lymph node assessment strategies for endometrial cancer. *Gynecol Oncol* 2016;143:281-286.
- 24 Schiavone MB, Zivanovic O, Zhou Q, et al. Survival of patients with uterine carcinosarcoma undergoing sentinel lymph node mapping. *Ann Surg Oncol* 2016;23:196-202.
- 25 Soliman PT, Westin SN, Dioun S, et al. A prospective validation study of sentinel lymph node mapping for high-risk endometrial cancer. *Gynecol Oncol* 2017;146:234-239.
- 26 Rossi EC, Kowalski LD, Scalici J, et al. A comparison of sentinel lymph node biopsy to lymphadenectomy for endometrial cancer staging (FIRES trial): a multicentre, prospective, cohort study. *Lancet Oncol* 2017;18:384-392.
- 27 Frumovitz M, Plante M, Lee PS, et al. Near-infrared fluorescence for detection of sentinel lymph nodes in women with cervical and uterine cancers (FILM): a randomised, phase 3, multicentre, non-inferiority trial. *Lancet Oncol* 2018;19:1394-403.
- 28 Cormier B, Rozenholc AT, Gotlieb W, et al. Sentinel lymph node procedure in endometrial cancer: A systematic review and proposal for standardization of future research. *Gynecol Oncol* 2015;138:478-485.
- 29 Euscher E, Sui D, Soliman P, et al. Ultrastaging of sentinel lymph nodes in endometrial carcinoma according to use of 2 different methods. *Int J Gynecol Pathol* 2018;37:242-251.
- 30 Olawaiye AB, Mutch DG. Lymphnode staging update in the American Joint Committee on Cancer 8th Edition cancer staging manual. *Gynecol Oncol* 2018;150:7-8.

**Note: All recommendations are category 2A unless otherwise indicated.**



### SYSTEMIC THERAPY FOR ENDOMETRIAL CARCINOMA<sup>a</sup>

Primary or Adjuvant Therapy (Stage I–IV)	
Chemoradiation Therapy	Systemic Therapy
<p><b>Preferred Regimen</b></p> <ul style="list-style-type: none"> <li>• Cisplatin plus RT followed by carboplatin/paclitaxel<sup>1,2</sup></li> </ul> <p><b>Other Recommended Regimens (if cisplatin and carboplatin are unavailable)</b></p> <ul style="list-style-type: none"> <li>• Capecitabine/mitomycin<sup>3</sup> (category 2B)</li> <li>• Gemcitabine<sup>4</sup> (category 2B)</li> <li>• Paclitaxel<sup>5,6</sup> (category 2B)</li> </ul>	<p><b>Preferred Regimens</b></p> <ul style="list-style-type: none"> <li>• Carboplatin/paclitaxel/pembrolizumab (for stage III–IV tumors, except for carcinosarcoma) (category 1)<sup>b,c,d,7,8</sup></li> <li>• Carboplatin/paclitaxel/dostarlimab-gxly (for stage III–IV tumors) (category 1)<sup>c,d,e,9</sup></li> <li>• Carboplatin/paclitaxel/durvalumab (for stage III–IV dMMR tumors only) (category 1)<sup>c,d,f,10</sup></li> <li>• Carboplatin/paclitaxel/trastuzumab (for stage III–IV HER2-positive uterine serous carcinoma or carcinosarcoma)<sup>d,g,11</sup></li> <li>• Carboplatin/paclitaxel/bevacizumab (stage III–IV with measurable disease)<sup>d,12,13</sup></li> <li>• Carboplatin/paclitaxel<sup>14</sup></li> </ul>

<sup>a</sup> An FDA-approved biosimilar is an appropriate substitute for any recommended systemic biologic therapy in the NCCN Guidelines.

<sup>b</sup> For stage III or IVA with measurable disease post surgery or stage IVB with or without measurable disease. For patients not meeting the eligibility criteria for NRG-GY018, carboplatin/paclitaxel + pembrolizumab should be considered for stage III–IV dMMR tumors (Van Gorp T, et al. Ann Oncol. Published online August 23, 2024).

<sup>c</sup> [NCCN Guidelines for Management of Immunotherapy-Related Toxicities](#).

<sup>d</sup> Checkpoint inhibitors and/or monoclonal antibodies included in this regimen may be continued as maintenance therapy. Refer to the original study protocol for maintenance therapy dosing schedules.

<sup>e</sup> For adult patients with primary advanced endometrial carcinoma (post surgery): stage IIIA, IIIB, or IIIC1 with measurable disease, stage IIIC1 with carcinosarcoma, clear-cell, serous, or mixed histology regardless of the presence of measurable disease, and stage IIIC2 or stage IV regardless of the presence of measurable disease.

<sup>f</sup> For stage III with measurable disease post surgery and stage IV with or without measurable disease.

<sup>g</sup> For patients who have not received prior trastuzumab therapy.

**Note: All recommendations are category 2A unless otherwise indicated.**

### SYSTEMIC THERAPY FOR ENDOMETRIAL CARCINOMA<sup>a</sup>

#### RECURRENT DISEASE<sup>h,i</sup>

First-Line Therapy for Recurrent Disease <sup>j</sup>	Second-Line or Subsequent Therapy <sup>j</sup>
<p><b>Preferred Regimens</b></p> <ul style="list-style-type: none"> <li>• Carboplatin/paclitaxel/pembrolizumab (except for carcinosarcoma) (category 1)<sup>c,d,k,8</sup></li> <li>• Carboplatin/paclitaxel/dostarlimab-gxly (category 1)<sup>c,d,k,9</sup></li> <li>• Carboplatin/paclitaxel/durvalumab (for dMMR only) (category 1)<sup>c,d,k,10</sup></li> <li>• Carboplatin/paclitaxel/trastuzumab (for HER2-positive uterine serous carcinoma or carcinosarcoma)<sup>d,g,11</sup></li> <li>• Carboplatin/paclitaxel (category 1 for carcinosarcoma)<sup>l,14</sup></li> </ul> <p><b>Other Recommended Regimens</b></p> <ul style="list-style-type: none"> <li>• Carboplatin/docetaxel<sup>m</sup></li> <li>• Carboplatin/paclitaxel/bevacizumab<sup>d,12,13</sup></li> </ul> <p><b>Useful in Certain Circumstances</b> (Biomarker-directed therapy: after prior platinum-based therapy including neoadjuvant and adjuvant)</p> <ul style="list-style-type: none"> <li>• MMR-proficient (pMMR) tumors <ul style="list-style-type: none"> <li>▶ Lenvatinib/pembrolizumab (category 1)<sup>c,15,16</sup></li> </ul> </li> <li>• TMB-high (TMB-H) tumors<sup>n</sup> <ul style="list-style-type: none"> <li>▶ Pembrolizumab<sup>c,17</sup></li> </ul> </li> <li>• MSI-H/dMMR tumors<sup>o</sup> <ul style="list-style-type: none"> <li>▶ Pembrolizumab<sup>c,18</sup></li> <li>▶ Dostarlimab-gxly<sup>c,19</sup></li> </ul> </li> </ul>	<p><b>Other Recommended Regimens</b></p> <ul style="list-style-type: none"> <li>• Cisplatin/doxorubicin<sup>20</sup></li> <li>• Cisplatin/doxorubicin/paclitaxel<sup>p,20</sup></li> <li>• Cisplatin/gemcitabine<sup>21</sup></li> <li>• Cisplatin</li> <li>• Carboplatin</li> <li>• Doxorubicin</li> <li>• Liposomal doxorubicin</li> <li>• Paclitaxel<sup>22</sup></li> <li>• Albumin-bound paclitaxel<sup>q</sup></li> <li>• Topotecan</li> <li>• Bevacizumab<sup>r,23</sup></li> <li>• Temsirolimus<sup>24</sup></li> <li>• Cabozantinib</li> <li>• Lenvatinib<sup>25</sup></li> <li>• Gemcitabine<sup>26</sup></li> <li>• Docetaxel (category 2B)</li> <li>• Ifosfamide (for carcinosarcoma)</li> <li>• Ifosfamide/paclitaxel (for carcinosarcoma)<sup>27</sup></li> <li>• Cisplatin/ifosfamide (for carcinosarcoma)</li> </ul> <p><b>Useful in Certain Circumstances (Biomarker-directed therapy)</b></p> <ul style="list-style-type: none"> <li>• pMMR tumors <ul style="list-style-type: none"> <li>▶ Lenvatinib/pembrolizumab (category 1)<sup>c,15,16</sup></li> </ul> </li> <li>• TMB-H tumors<sup>n</sup> <ul style="list-style-type: none"> <li>▶ Pembrolizumab<sup>c,17</sup></li> </ul> </li> <li>• MSI-H/dMMR tumors<sup>o</sup> <ul style="list-style-type: none"> <li>▶ Pembrolizumab<sup>c,18</sup></li> <li>▶ Dostarlimab-gxly<sup>c,19</sup></li> <li>▶ Avelumab<sup>c</sup></li> <li>▶ Nivolumab<sup>c,28</sup></li> </ul> </li> <li>• HER2-positive tumors (IHC 3+ or 2+) <ul style="list-style-type: none"> <li>▶ Fam-trastuzumab deruxtecan-nxki<sup>29</sup></li> </ul> </li> <li>• <i>NTRK</i> gene fusion-positive tumors <ul style="list-style-type: none"> <li>▶ Larotrectinib</li> <li>▶ Entrectinib</li> <li>▶ Repotrectinib<sup>s,30</sup></li> </ul> </li> </ul>

#### Footnotes on ENDO-D 2A of 5

Note: All recommendations are category 2A unless otherwise indicated.



### SYSTEMIC THERAPY FOR ENDOMETRIAL CARCINOMA FOOTNOTES FOR ENDO-D 2 OF 5

- <sup>a</sup> An FDA-approved biosimilar is an appropriate substitute for any recommended systemic biologic therapy in the NCCN Guidelines.
- <sup>c</sup> [NCCN Guidelines for Management of Immunotherapy-Related Toxicities](#).
- <sup>d</sup> Checkpoint inhibitors and/or monoclonal antibodies included in this regimen may be continued as maintenance therapy. Refer to the original study protocol for maintenance therapy dosing schedules.
- <sup>g</sup> For patients who have not received prior trastuzumab therapy.
- <sup>h</sup> Cisplatin, carboplatin, liposomal doxorubicin, paclitaxel, and docetaxel may cause drug reactions (see [NCCN Guidelines for Ovarian Cancer—Management of Drug Reactions \[OV-D\]](#)).
- <sup>i</sup> Chemotherapy regimens can be used for all carcinoma histologies. Carcinosarcomas are now considered and treated as high-grade carcinomas.
- <sup>j</sup> These agents can be used as second-line or subsequent therapy as clinically appropriate.
- <sup>k</sup> For adult patients with recurrent endometrial carcinoma with or without measurable disease.
- <sup>l</sup> Carboplatin/paclitaxel is preferred only for patients who have not received any prior systemic therapy. Can be considered as an option under the "Other Recommended Regimens" list if or when re-use is appropriate in the first-line setting for recurrent disease.
- <sup>m</sup> Docetaxel may be considered for patients in whom paclitaxel is contraindicated.
- <sup>n</sup> NCCN recommends TMB-H testing if not previously done. Pembrolizumab is indicated for patients with unresectable or metastatic tumors with TMB-H [ $\geq 10$  mutations/megabase (mut/Mb)], whose disease has progressed following prior treatment and who have no satisfactory alternative treatment options.
- <sup>o</sup> For recurrent endometrial cancer, NCCN recommends MSI-H or dMMR testing if not previously done.
- <sup>p</sup> The cisplatin/doxorubicin/paclitaxel regimen is not widely used because of concerns about toxicity.
- <sup>q</sup> Albumin-bound paclitaxel is a reasonable substitute for patients with a hypersensitivity to paclitaxel. If a skin test is done, and is positive, then the patient requires desensitization to paclitaxel. Albumin-bound paclitaxel is not a reasonable substitute for paclitaxel if the patient's skin test is positive.
- <sup>r</sup> Bevacizumab may be considered for use in patients whose disease has progressed on prior cytotoxic chemotherapy.
- <sup>s</sup> *NTRK*-positive tumors that are naïve to prior *NTRK*-targeted therapy or have progressed on prior *NTRK* therapy.

**Note: All recommendations are category 2A unless otherwise indicated.**



### SYSTEMIC THERAPY FOR ENDOMETRIAL CARCINOMA

#### Hormonal Therapy for Recurrent or Metastatic Endometrial Carcinoma<sup>†</sup>

<u>Preferred Regimens</u>	<u>Other Recommended Regimens</u>	<u>Useful in Certain Circumstances</u>
<ul style="list-style-type: none"> <li>• Megestrol acetate/tamoxifen (alternating)</li> <li>• Everolimus/letrozole</li> </ul>	<ul style="list-style-type: none"> <li>• Medroxyprogesterone acetate/tamoxifen (alternating)</li> <li>• Progestational agents               <ul style="list-style-type: none"> <li>‣ Medroxyprogesterone acetate</li> <li>‣ Megestrol acetate</li> </ul> </li> <li>• Aromatase inhibitors               <ul style="list-style-type: none"> <li>‣ Anastrozole</li> <li>‣ Letrozole</li> <li>‣ Exemestane</li> </ul> </li> <li>• Tamoxifen</li> <li>• Fulvestrant</li> </ul>	<ul style="list-style-type: none"> <li>• ER-positive tumors               <ul style="list-style-type: none"> <li>‣ Letrozole/ribociclib</li> <li>‣ Letrozole/abemaciclib</li> </ul> </li> </ul>

#### Hormonal Therapy for Uterine-Limited Disease Not Suitable for Primary Surgery or for Those Desiring Uterine Preservation for Fertility (ENDO-1)<sup>†</sup>

<u>Preferred Regimen</u>	<u>Other Recommended Regimens</u>
<ul style="list-style-type: none"> <li>• Levonorgestrel IUD</li> </ul>	<ul style="list-style-type: none"> <li>• Progestational agents               <ul style="list-style-type: none"> <li>‣ Megestrol acetate</li> <li>‣ Medroxyprogesterone acetate</li> </ul> </li> <li>• Dual progestin agents               <ul style="list-style-type: none"> <li>‣ Megestrol acetate + levonorgestrel IUD</li> <li>‣ Medroxyprogesterone acetate + levonorgestrel IUD</li> </ul> </li> </ul>

<sup>†</sup> Hormonal therapy is typically used for lower-grade endometrioid histologies, preferably in patients with small tumor volume or an indolent growth pace.

**Note: All recommendations are category 2A unless otherwise indicated.**

### SYSTEMIC THERAPY FOR ENDOMETRIAL CARCINOMA – REFERENCES

- <sup>1</sup> de Boer SM, Powell ME, Mileschkin L, et al. Toxicity and quality of life after adjuvant chemoradiotherapy versus radiotherapy alone for women with high-risk endometrial cancer (PORTEC-3): an open-label, multicentre, randomised, phase 3 trial. *Lancet Oncol* 2016;17:1114-1126.
- <sup>2</sup> Greven K, Winter K, Underhill K, et al. Final analysis of RTOG 9708: adjuvant postoperative irradiation combined with cisplatin/paclitaxel chemotherapy following surgery for patients with high-risk endometrial cancer. *Gynecol Oncol* 2006;103:155-159.
- <sup>3</sup> Lorvidhaya V, Chitapanaarux I, Sangruchi S, et al. Concurrent mitomycin C, 5-fluorouracil, and radiotherapy in the treatment of locally advanced carcinoma of the cervix: a randomized trial. *Int J Radiat Oncol Biol Phys* 2003;55:1226-1232.
- <sup>4</sup> Pattaranutaporn P, Thirapakawong C, Chansilpa Y, et al. Phase II study of concurrent gemcitabine and radiotherapy in locally advanced stage IIIB cervical carcinoma. *Gynecol Oncol* 2001;81:404-407.
- <sup>5</sup> Candelaria M, Garcia-Arias A, Cetina L, A Dueñas-Gonzalez. Radiosensitizers in cervical cancer. Cisplatin and beyond. *Radiat Oncol* 2006;1:15.
- <sup>6</sup> Cerrota A, Gardan G, Cavina R et al. Concurrent radiotherapy and weekly paclitaxel for locally advanced or recurrent squamous cell carcinoma of the uterine cervix. A pilot study with intensification of dose. *Eur J Gynaecol Oncol* 2002;23:115-119.
- <sup>7</sup> Eskander RN, Sill MW, Beffa L, et al. Pembrolizumab plus chemotherapy in advanced endometrial cancer. *N Engl J Med* 2023;388:2159-2170.
- <sup>8</sup> Van Gorp T, Cibula D, Lv W, et al. ENGOT-en11/GOG-3053/KEYNOTE-B21: A randomised, double-blind, phase III study of pembrolizumab or placebo plus adjuvant chemotherapy with or without radiotherapy in patients with newly diagnosed, high-risk endometrial cancer. *Ann Oncol* 2024;35:968-980.
- <sup>9</sup> Powell MA, Bjørge L, Willmott L, et al. Overall survival in patients with endometrial cancer treated with dostarlimab plus carboplatin-paclitaxel in the randomized ENGOT-EN6/GOG-3031/RUBY trial. *Ann Oncol* 2024;35:728-738.
- <sup>10</sup> Westin SN, Moore K, Chon HS, et al. Durvalumab plus carboplatin/paclitaxel followed by maintenance durvalumab with or without olaparib as first-line treatment for advanced endometrial cancer: The phase III DUO-E trial. *J Clin Oncol* 2024;42:283-299.
- <sup>11</sup> Fader AN, Roque DM, Siegel E, et al. Randomized phase II trial of carboplatin-paclitaxel compared with carboplatin-paclitaxel-trastuzumab in advanced (stage III-IV) or recurrent uterine serous carcinomas that overexpress Her2/Neu (NCT01367002): Updated overall survival analysis. *Clin Cancer Res* 2020;26:3928-3935.
- <sup>12</sup> Rose PG, Ali S, Moslemi-Kebria M, Simpkins F. Paclitaxel, carboplatin, and bevacizumab in advanced and recurrent endometrial carcinoma. *Int J Gynecol Cancer* 2017;27:452-458.
- <sup>13</sup> Leslie K, Filiaci V, Mallen A, et al. Mutated p53 portends improvement in outcomes when bevacizumab is combined with chemotherapy in advanced/recurrent endometrial cancer: An NRG Oncology study. *Gynecol Oncol* 2021;161:113-121.
- <sup>14</sup> Miller DS, Filiaci VL, Mannel RS, et al. Carboplatin and paclitaxel for advanced endometrial cancer: Final overall survival and adverse event analysis of a phase III trial (NRG Oncology/GOG0209). *J Clin Oncol* 2020;38:3841-3850.
- <sup>15</sup> Makker V, Colombo N, Casado Herráez A, et al. Lenvatinib plus pembrolizumab in previously treated advanced endometrial cancer: updated efficacy and safety from the randomized phase III Study 309/KEYNOTE-775. *J Clin Oncol* 2023;41:2904-2910.
- <sup>16</sup> Marth C, Moore RG, Bidziński M, et al. First-Line Lenvatinib Plus Pembrolizumab Versus Chemotherapy for Advanced Endometrial Cancer: A Randomized, Open-Label, Phase III Trial. *Journal of Clinical Oncology* 2024;0:JCO-24-01326.
- <sup>17</sup> Marabelle A, Fakih M, Lopez J, et al. Association of tumour mutational burden with outcomes in patients with advanced solid tumours treated with pembrolizumab: prospective biomarker analysis of the multicohort, open-label, phase 2 KEYNOTE-158 study. *Lancet Oncol* 2020;21:1353-1365.
- <sup>18</sup> O'Malley DM, Bariani GM, Cassier PA, et al. Pembrolizumab in patients with microsatellite instability-high advanced endometrial cancer: Results from the KEYNOTE-158 study. *J Clin Oncol* 2022;40:752-761.
- <sup>19</sup> Oaknin A, Tinker AV, Gilbert L, et al. Clinical activity and safety of the anti-programmed death 1 monoclonal antibody dostarlimab for patients with recurrent or advanced mismatch repair-deficient endometrial cancer a nonrandomized phase 1 clinical trial. *JAMA Oncol* 2020;6:1766-1772.

**Note: All recommendations are category 2A unless otherwise indicated.**

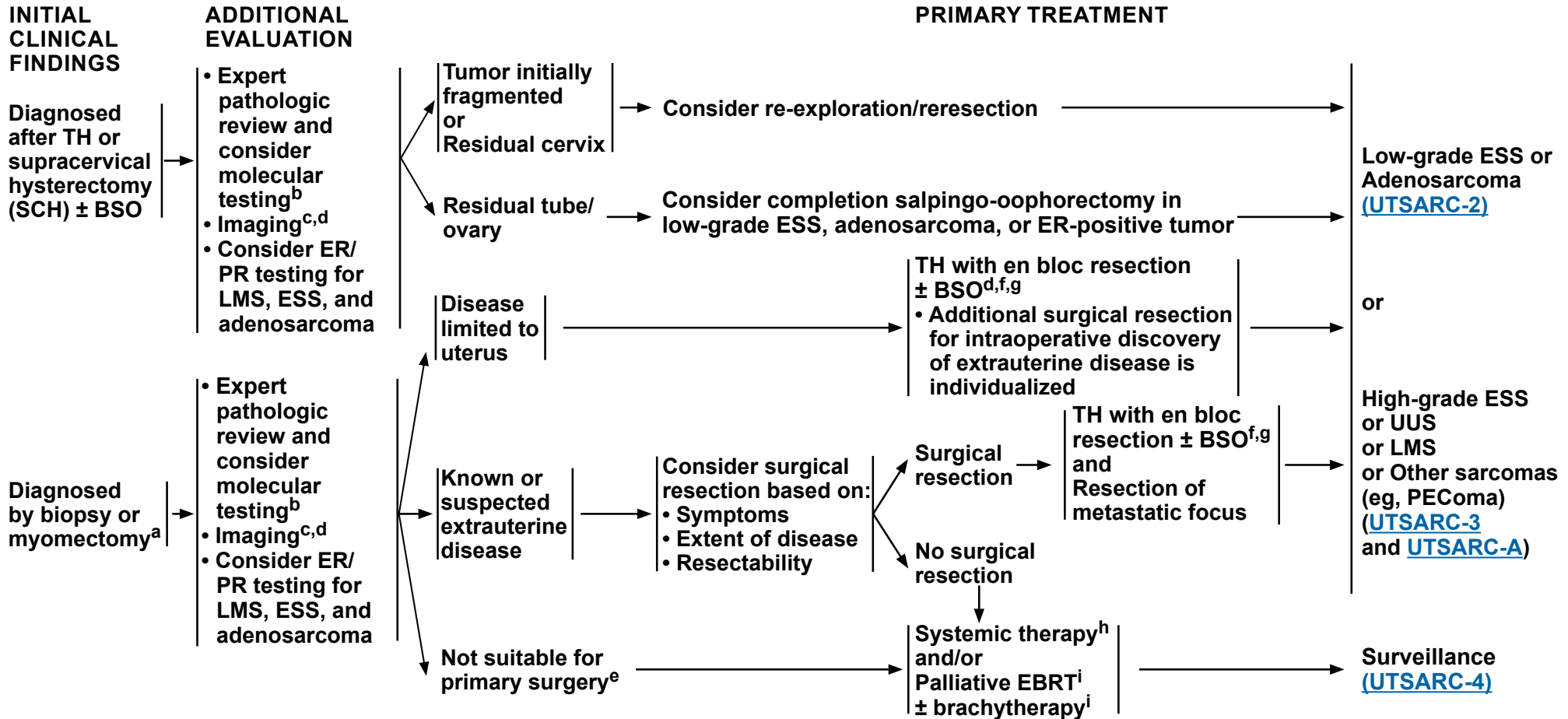
[Continued](#)



## SYSTEMIC THERAPY FOR ENDOMETRIAL CARCINOMA – REFERENCES

- 20 Homesley HD, Filiaci V, Gibbons SK, et al. A randomized phase III trial in advanced endometrial carcinoma of surgery and volume directed radiation followed by cisplatin and doxorubicin with or without paclitaxel: A Gynecologic Oncology Group study. *Gynecol Oncol* 2009;112:543-552.
- 21 Brown J, Smith JA, Ramondetta L, et al. Combination of gemcitabine and cisplatin is highly active in women with endometrial carcinoma: Results of a prospective phase 2 trial. *Cancer* 2010;116:4973-4979.
- 22 Picard M, Pur L, Caiado J, et al. Risk stratification and skin testing to guide re-exposure in taxane-induced hypersensitivity reactions. *J Allergy Clin Immunol* 2016;137:1154-1164.
- 23 Aghajanian C, Sill MW, Darcy KM, et al. Phase II trial of bevacizumab in recurrent or persistent endometrial cancer: a Gynecologic Oncology Group study. *J Clin Oncol* 2011;29:2259-2265.
- 24 Oza AM, Elit L, Tsao MS, et al. Phase II study of temsirolimus in women with recurrent or metastatic endometrial cancer: a trial of the NCIC Clinical Trials Group. *J Clin Oncol* 2011;29:3278-3285.
- 25 Vergote I, Powell MA, Teneriello MG, et al. Second-line lenvatinib in patients with recurrent endometrial cancer. *Gynecol Oncol* 2020;156:575-582.
- 26 Grisham RN, Adaniel C, Hyman DM, et al. Gemcitabine for advanced endometrial cancer: a retrospective study of the Memorial Sloan-Kettering Cancer Center experience. *Int J Gynecol Cancer* 2012;22:807-11.
- 27 Homesley HD, Filiaci V, Markman M, et al. Phase III trial of ifosfamide with or without paclitaxel in advanced uterine carcinosarcoma: a Gynecologic Oncology Group Study. *J Clin Oncol* 2007;25:526-531.
- 28 Azad NS, Gray RJ, Overman MJ, et al. Nivolumab is effective in mismatch repair-deficient noncolorectal cancers: Results from Arm Z1D-A Subprotocol of the NCI-MATCH (EAY131) study. *J Clin Oncol* 2020;38:214-222.
- 29 Meric-Bernstam F, Makker V, Oaknin A, et al. Efficacy and safety of trastuzumab deruxtecan in patients with HER2-expressing solid tumors: DESTINYPanTumor02 phase II trial. *J Clin Oncol* 2024;42:47-58.
- 30 Solomon BJ, Drilon A, Lin JJ, et al. 1372P Repotrectinib in patients (pts) with NTRK fusion-positive (NTRK+) advanced solid tumors, including NSCLC: Update from the phase I/II TRIDENT-1 trial [abstract]. *Ann Oncol* 2023;34:S787-S788.

**Note: All recommendations are category 2A unless otherwise indicated.**



<sup>a</sup> Preoperative imaging and biopsy may help to identify uterine sarcomas, although biopsy sensitivity is less than for endometrial cancer. If there is suspicion of malignant mesenchymal sarcoma, fragmentation/morcellation should be avoided.

<sup>b</sup> [Principles of Pathology and Molecular Analysis \(UTSARC-A\)](#).

<sup>c</sup> [Principles of Imaging \(UTSARC-B\)](#).

<sup>d</sup> For incidental finding of uterine sarcoma after TH/BSO or fragmented specimen: recommend imaging and consider additional surgical resection on an individual basis.

<sup>e</sup> Disease is not amenable to resection, or patient is not suitable for surgery based on comorbidities.

<sup>f</sup> Oophorectomy is individualized for patients of reproductive age. Favor BSO if ER/PR positive.

<sup>g</sup> Morcellation should be avoided.

<sup>h</sup> [Systemic Therapy \(UTSARC-C\)](#).

<sup>i</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

**Note: All recommendations are category 2A unless otherwise indicated.**

**PATHOLOGIC FINDINGS/  
HISTOLOGIC GRADE<sup>j</sup>**

**ADDITIONAL THERAPY**

**Low-grade ESS  
or  
Adenosarcoma  
without  
sarcomatous  
overgrowth (SO)**

**Stage I**

BSO (preferred)  
or  
Observe, if menopausal<sup>k</sup>  
or prior BSO

**Stage II, III, IVA, IVB**

BSO  
± anti-estrogen hormone therapy<sup>h</sup>  
± EBRT<sup>h</sup> (palliative for stage IVB)  
(category 2B for EBRT for stage II, III, IVA)

**Surveillance  
([UTSARC-4](#))**

**Adenosarcoma with SO**

**Stage I**

BSO  
or  
Observe, if menopausal  
or prior BSO

**Stage II, III, IVA, IVB**

BSO  
Consider systemic therapy (recommended  
for residual measurable disease)<sup>h</sup>  
± EBRT<sup>i</sup> (palliative for stage IVB)  
(category 2B for EBRT for stage II, III, IVA)

**Surveillance  
([UTSARC-4](#))**

<sup>h</sup> [Systemic Therapy \(UTSARC-C\)](#).

<sup>i</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>j</sup> [Principles of Pathology and Molecular Analysis \(UTSARC-A 2 of 8\)](#).

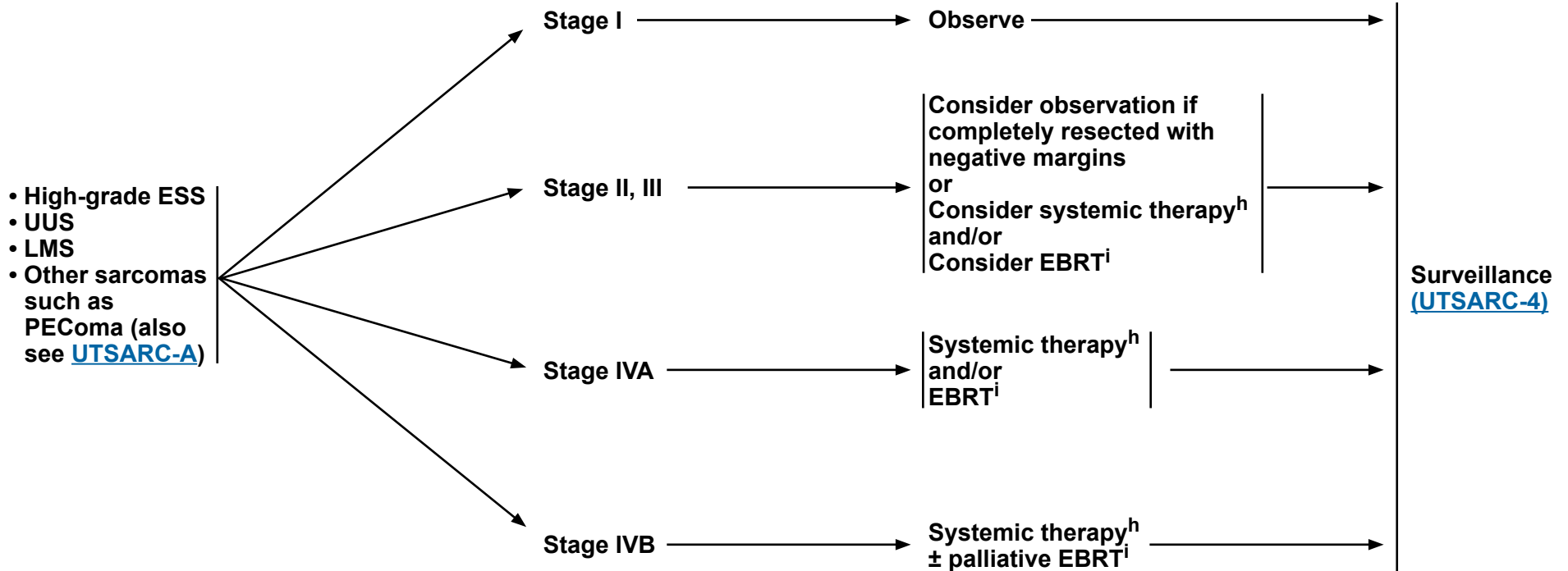
<sup>k</sup> See [Discussion](#). Nasioudis D, et al. Int J Gynecol Cancer 2019;29:126-132.

**Note: All recommendations are category 2A unless otherwise indicated.**



**PATHOLOGIC FINDINGS/  
HISTOLOGIC GRADE<sup>j</sup>**

**ADDITIONAL THERAPY**



<sup>h</sup> [Systemic Therapy \(UTSARC-C\)](#).

<sup>i</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>j</sup> [Principles of Pathology and Molecular Analysis \(UTSARC-A 2 of 8\)](#).

**Note: All recommendations are category 2A unless otherwise indicated.**

### SURVEILLANCE

H&P exam every 3–4 mo (consider every 6 months for low-grade, early-stage sarcomas) for 2–3 y, then every 6–12 mo  
Imaging<sup>c</sup>  
Clinical evaluation and management of potential long-term and late effects of treatment<sup>l</sup> (also see [Principles of Gynecologic Survivorship \(UN-B\)](#), [NCCN Guidelines for Survivorship](#), and [NCCN Guidelines for Smoking Cessation](#))

### RECURRENCE

Local recurrence:  
• Vagina/pelvis  
• Imaging negative for distant metastatic disease<sup>c</sup>

Isolated metastases

Disseminated disease

Resectable

Unresectable

### THERAPY FOR RELAPSE

Therapy for Relapse ([UTSARC-5](#))

- Surgical resection or other local ablative therapy<sup>m</sup>:
  - ▶ Consider preoperative or postoperative systemic therapy<sup>h</sup>
  - ▶ Consider preoperative or postoperative EBRT<sup>i</sup>

Systemic therapy<sup>h</sup> and/or Local therapy (EBRT<sup>i</sup> or local ablative therapy)

If response, consider surgery ± EBRT

Systemic therapy<sup>h</sup> ± palliative EBRT<sup>i</sup> or Best supportive care

<sup>c</sup> [Principles of Imaging \(UTSARC-B\)](#).

<sup>h</sup> [Systemic Therapy \(UTSARC-C\)](#).

<sup>i</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>l</sup> Patient education should include symptoms of potential recurrence, lifestyle, obesity, exercise, sexual health (including vaginal dilator use, lubricants/moisturizers, and local estrogen and hormone therapy for menopause), smoking cessation, and nutrition counseling.

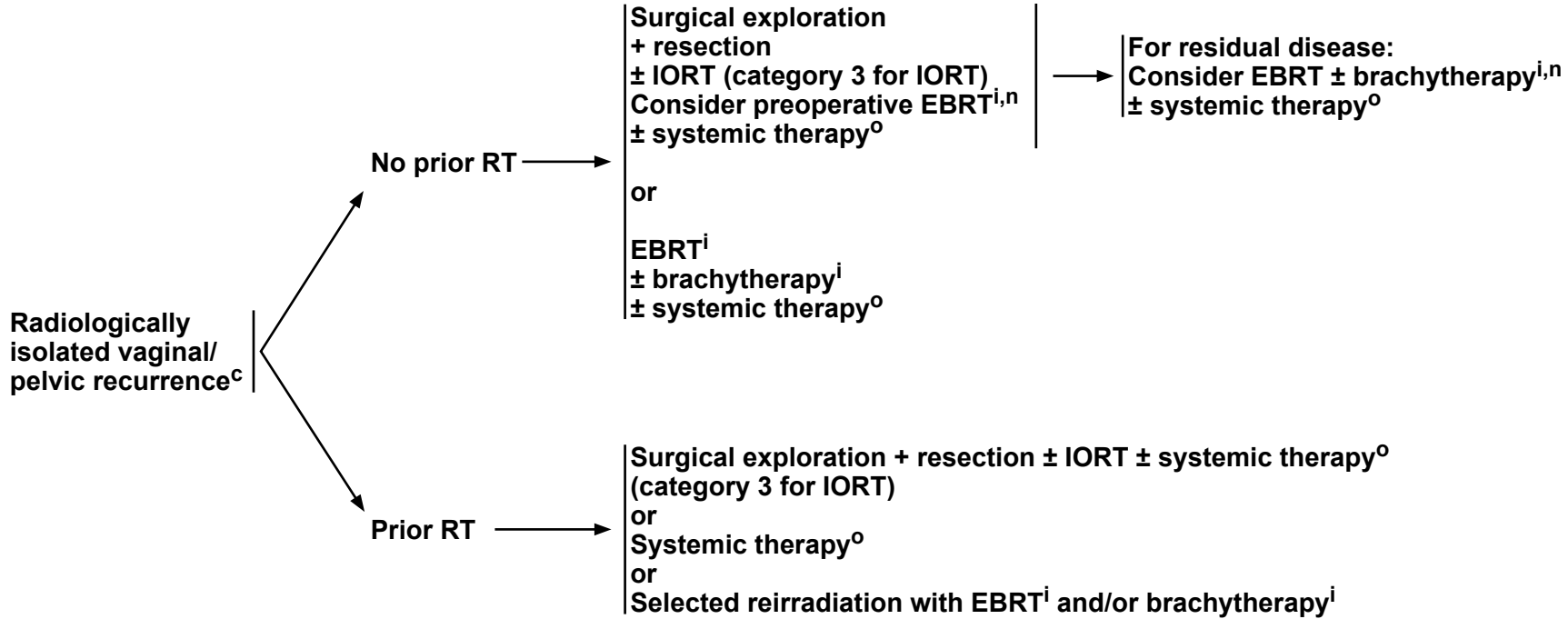
<sup>m</sup> Observation may be an option in select, completely resected cases with no evidence of disease on postoperative imaging.

**Note: All recommendations are category 2A unless otherwise indicated.**



### RECURRENCE

### THERAPY FOR RELAPSE



<sup>c</sup> [Principles of Imaging \(UTSARC-B\)](#).

<sup>i</sup> [Principles of Radiation Therapy for Uterine Neoplasms \(UN-A\)](#).

<sup>n</sup> The use of preoperative EBRT would preclude postoperative EBRT.

<sup>o</sup> For low-grade ESS or adenosarcoma without SO, the first choice of systemic therapy is anti-estrogen hormone therapy. See [Systemic Therapy \(UTSARC-C\)](#).

**Note: All recommendations are category 2A unless otherwise indicated.**



### PRINCIPLES OF PATHOLOGY AND MOLECULAR ANALYSIS<sup>a,1,2</sup>

#### **Procedure:**

- TH ± BSO: Total hysterectomy ± bilateral salpingo-oophorectomy and en bloc resection of tumor

#### **Pathologic Assessment for Sarcoma (including LMS, adenosarcoma, ESS, and UUS):**

- Expert gynecologic pathology review is highly recommended
- Uterus
  - ▶ Hysterectomy type
  - ▶ Specimen integrity (intact, opened, morcellated, other)
  - ▶ Tumor size
  - ▶ Myometrial invasion (for adenosarcoma only)
  - ▶ Histologic type
  - ▶ Histologic grade (for adenosarcoma only)
  - ▶ LVSI
- Other tissue/organ involvement (fallopian tubes, ovaries, vagina, parametrium, peritoneum, omentum, other)
- Peritoneal/ascitic fluid cytology (if collected)
- Lymph nodes (when resected)
  - ▶ Level of nodal involvement<sup>b</sup> (ie, pelvic, common iliac, para-aortic)
  - ▶ Number of lymph nodes with metastasis

#### **Molecular Analysis for Sarcoma:**

- Recommend molecular profiling in gynecologic mesenchymal malignancies for accurate classification<sup>3</sup> ([Table 1 \[UTSARC-A 2 of 8\]](#)).
- Comprehensive genomic profiling in setting of metastatic disease as determined by an FDA-approved assay, or a validated test performed in a CLIA-certified laboratory, is informative for predicting rare pan-tumor targeted therapy opportunities and should include at least *NTRK*, *MSI*, *RET*-fusion, and *TMB*. Preferred on tissue; if tissue is not available, blood-based assays may be considered.

#### **Footnotes**

<sup>a</sup> Also see [Principles of Evaluation and Surgical Staging \(ENDO-C\)](#).

<sup>b</sup> Routine node dissection is not required in the absence of clinical suspicion of nodal involvement.

#### **References**

- <sup>1</sup> American College of Obstetricians and Gynecologists. ACOG practice bulletin, clinical management guidelines for obstetrician-gynecologists, number 65, August 2005: management of endometrial cancer. *Obstet Gynecol* 2005;106:413-425.
- <sup>2</sup> Krishnamurti U and Crothers BA. Protocol for the examination of specimens from patients with primary sarcoma of the uterus. College of American Pathologists 2021. [https://documents.cap.org/protocols/Uterus.Sarc\\_4.2.0.0.REL\\_CAPCP.pdf](https://documents.cap.org/protocols/Uterus.Sarc_4.2.0.0.REL_CAPCP.pdf)
- <sup>3</sup> Parra-Herran C, Howitt BE. Uterine mesenchymal tumors: Update on classification, staging, and molecular features. *Surg Pathol Clin* 2019;12:363-396.

[Continued](#)

**Note: All recommendations are category 2A unless otherwise indicated.**



**PRINCIPLES OF PATHOLOGY AND MOLECULAR ANALYSIS**

**Table 1**

<b>Uterine Sarcoma</b>					
<b>Tumor</b>	<b>Hallmarks for Histologic Diagnosis</b>	<b>Relevant Molecular Finding</b>	<b>Tests Needed to Confirm Diagnosis</b>	<b>Relevant Prognostic Features</b>	<b>Other</b>
Conventional (spindle cell) Leiomyosarcoma (LMS)	Cellular spindle cell proliferation with interlacing long fascicles with $\geq 2$ of the following: moderate to severe atypia, tumor cell necrosis, or mitotic index (MI) $\geq 10/10$ high-power fields (HPFs).	Complex karyotypes are the hallmark of LMS. The most commonly altered genes include <i>TP53</i> , <i>ATRX</i> , <i>RB1</i> , <i>PTEN</i> , <i>DAXX</i> , <i>MDM2</i> , <i>CDKN2A</i> , <i>CDKN2C</i> , <i>PDGFRB</i> , and <i>BRCA2</i> .	Immunoexpression of smooth muscle markers such as desmin, smooth muscle actin (SMA), and/or caldesmon; however, tumors may have variable expression and even lose expression of $\geq 1$ markers. Approximately 1/3 of LMS express ER/PR. Abnormal expression of $\geq 2$ immunohistochemical markers <i>TP53</i> , <i>ATRX</i> , <i>RB1</i> , <i>PTEN</i> , <i>DAXX</i> , <i>MDM2</i> , and <i>MTAP</i> may favor LMS in smooth muscle tumors that do not fulfill traditional histologic criteria for LMS. Genomic risk stratification may predict clinical outcomes.	Prognosis is best predicted by stage. Morphology has not been shown to predict clinical behavior. Limited data suggest PR expression may be a positive prognostic marker in low-stage LMS.	
Epithelioid LMS <sup>1</sup>	Epithelioid histology comprising $\geq 50\%$ of the overall tumor supports classification as an epithelioid smooth muscle tumor. Diagnostic criteria for epithelioid LMS are controversial. By WHO 5th edition, epithelioid LMS is assigned when $\geq 1$ of the following features is present: moderate to severe atypia, tumor cell necrosis, MI of $\geq 4/10$ HPFs. Recent studies suggest assigning epithelioid LMS when $\geq 2$ features are present. <sup>2</sup>	PGR fusions by FISH and/or targeted RNA sequencing in a small subset with uniform nuclear atypia and rhabdoid features.	Immunoexpression of desmin, SMA, and/or caldesmon without MelanA expression is supportive. In some cases of epithelioid LMS, HMB-45 may be expressed.	Unknown	Epithelioid LMS may morphologically and immunohistochemically overlap with malignant PEComa for which there is no gold standard diagnostic test. Detection of pathogenic <i>TSC1/2</i> mutations or <i>TFE3</i> fusion may favor PEComa.

**Note: All recommendations are category 2A unless otherwise indicated.**

[References](#)  
[Continued](#)



### PRINCIPLES OF PATHOLOGY AND MOLECULAR ANALYSIS

**Table 1 (continued)**

Uterine Sarcoma				
Tumor	Hallmarks for Histologic Diagnosis	Relevant Molecular Finding	Tests Needed to Confirm Diagnosis	Relevant Prognostic Features
Myxoid LMS <sup>3,4</sup>	Infiltrative spindle cell proliferation with variable myxoid matrix and tumor necrosis or moderate to severe atypia or MI >1/10 HPFs.	PLAG1 fusion by FISH and/or targeted RNA sequencing in a subset (~25%). NR4A3 fusions are detected in a subset of myxoid LMS.	IHC panel of CD10, ER, PR, desmin, SMA, caldesmon, cyclinD1, and ALK is recommended to exclude morphologic mimics.	Unknown
Low-Grade Endometrial Stromal Sarcoma (ESS) <sup>5-7</sup>	Cytologically bland spindle cell neoplasm resembling proliferative endometrial stroma with distinctive finger-like myoinvasion and/or LVSI.	<i>JAZF1::SUZ12</i> fusion most common (>50%) followed by <i>JAZF1::PHF1</i> , <i>EPC1::PHF1</i> , and <i>MEAF6::PHF1</i> fusions; <i>MBTD1-CXorf67</i> , <i>BRD8::PHF1</i> , <i>EPC2::PHF1</i> , and <i>EPC1::SUZ12</i> . <sup>c</sup>	CD10, ER positivity, PR positivity, and/or demonstration of a low-grade ESS-associated fusion by FISH and/or targeted RNA sequencing is confirmatory.	Stage is the most important prognostic factor.

<sup>c</sup> There are a number of sarcomas reported as low-grade ESS harboring novel fusions and a subset behave more aggressively than typical low-grade ESS; data are evolving in this area for optimal classification.

**Note: All recommendations are category 2A unless otherwise indicated.**

PRINCIPLES OF PATHOLOGY AND MOLECULAR ANALYSIS

Table 1 (continued)

Uterine Sarcoma				
Tumor	Hallmarks for Histologic Diagnosis	Relevant Molecular Finding	Additional Confirmatory Tests	Relevant Prognostic Features
High-Grade Endometrial Stromal Sarcoma (ESS) <sup>5-13</sup>	<i>YWHAE::NUTM2</i> fusion-positive tumors have a high-grade round cell component with delicate branching vasculature. Generally the MI is $\geq 10/10$ HPFs. <i>YWHAE</i> -altered high-grade ESS may be associated with a low-grade fibrous or fibromyxoid spindle cell component with low MI. <i>ZC3H7B::BCOR</i> fusion-positive tumors have high-grade spindle cells embedded in myxoid matrix. <i>BCOR</i> internal tandem duplication (ITD)-positive tumors share morphologic features of <i>ZC3H7B::BCOR</i> fusion-positive tumors. Tongue-like infiltration and LVSI are present in all subtypes.	<i>YWHAE::NUTM2</i> fusion, <i>ZC3H7B::BCOR</i> fusion, or <i>BCOR</i> ITD.	IHC panel of CD10, ER, PR, cyclin D1, $\pm$ <i>BCOR</i> are recommended. Diffuse strong expression of cyclin D1 is present in all subtypes, and/or <i>BCOR</i> is strongly and diffusely expressed in the <i>YWHAE</i> -rearranged sarcomas but positive in only ~50% of the <i>BCOR</i> -altered sarcomas. CD10 is negative in the high-grade round cell component of altered subtype, but may be positive in <i>BCOR</i> -altered mutant subtypes. ER and PR are negative in the high-grade component of <i>YWHAE</i> -altered subtype, and variably positive in <i>BCOR</i> -altered tumors.	Slightly higher rate of lymph node involvement and trend towards worse outcomes when compared to low-grade ESS.
Undifferentiated Uterine Sarcoma (UUS) <sup>13-16</sup>	Infiltrative sheets of pleomorphic epithelioid and/or spindle cells.		This is essentially a diagnosis of exclusion, and thus there are no confirmatory tests. An IHC panel of CD10, cyclin D1, desmin, SMA, caldesmon, pan-CK, EMA, BRG1, INI1, pan-Trk, ALK, HMB45, MelanA, SOX10, S100, CD34, and STAT6 is recommended to consider other tumor types. Absence of ESS-associated fusions by FISH and/or targeted RNA sequencing is recommended.	ER and/or PR expression may correlate with improved survival. MI $\geq 11/\text{mm}^2$ is associated with decreased survival.

Note: All recommendations are category 2A unless otherwise indicated.

References  
Continued

UTSARC-A  
4 OF 8

PRINCIPLES OF PATHOLOGY AND MOLECULAR ANALYSIS

Table 1 (continued)

Uterine Sarcoma				
Tumor	Hallmarks for Histologic Diagnosis	Relevant Molecular Finding	Additional Confirmatory Tests	Relevant Prognostic Features
Perivascular Epithelioid Cell Tumor (PEComa) <sup>17-19</sup>	<p>Mesenchymal neoplasm comprised of perivascular epithelioid and/or spindled cells that coexpress melanocytic and muscle markers. The tumor cells can demonstrate variable cytologic atypia, mitotic activity, and melanin pigment in a background of thin-walled vascular spaces and sclerotic stroma. Proposed algorithms stratify tumors into uncertain malignant potential and malignant as outlined below.</p> <p>Uncertain malignant potential (&lt;3 of the following: ≥5 cm size, high nuclear grade, &gt;1 mitosis/50 mm<sup>2</sup>, necrosis, vascular invasion). Malignant if ≥3 features (&gt;5 cm, infiltrative growth, high nuclear grade, &gt;1 mitosis/50 mm<sup>2</sup>, necrosis, and vascular invasion).</p>	Inactivating mutations of <i>TSC1/TSC2</i> , and fusions of <i>TFE3</i> , <i>RAD51B</i> , or <i>HTR4::ST3GAL1</i> can be seen. In situ hybridization to confirm rearrangement or fusion of <i>TFE3</i> in <i>TFE3</i> -translocation-associated tumors.	Immunoexpression of cathepsin K, variable expression of melanocytic markers (HMB45 is most sensitive and MelanA is most specific), and ≥1 smooth muscle marker (SMA, desmin, and caldesmon). Keratins and hormone receptors can be variably expressed. Translocation-associated tumors show diffuse <i>TFE3</i> expression with weak to negative smooth muscle markers. <i>TSC2</i> mutations may rarely occur in ESS; thus in tumors with ambiguous morphologic/immunophenotypic features, and <i>TSC2</i> mutation identified, consideration for fusion testing is advised to exclude ESS. <sup>20</sup>	Tumor behavior is best predicted using tumor stratification into uncertain malignant potential and malignant subgroups. Treatment with mTOR inhibitors may be considered. <sup>17,21</sup>
Inflammatory Myofibroblastic Tumor (IMT)	Spindle cell neoplasm comprised of spindled cells with admixed inflammatory infiltrate (usually lymphoplasmacytic) in a myxoid stroma. Histologic patterns include myxoid hypocellular areas (resembling fasciitis), storiform or fascicular pattern with compact cellular areas with intersecting fascicles, and hyalinized dense collagenous matrix.	<i>ALK</i> rearrangements by FISH are seen in approximately 75% of patients. Common fusion partners include <i>IGFBP5</i> , <i>THBS1</i> , and <i>TIMP3</i> . <i>RANBP2-ALK</i> and <i>RRBP1::ALK</i> fusions are seen in aggressive IMT with epithelioid morphology. <i>ALK</i> -negative uterine IMTs are rare.	Immunoexpression of <i>ALK</i> (granular cytoplasmic) is sensitive and specific; seen in approximately 95% of patients and can be variable and focal. Immunoexpression of desmin, SMA, and/or caldesmon is common.	Typically benign and confined to the uterus; recurrence and extrauterine spread can occur. Tumors >7 cm with necrosis, lymphovascular invasion, severe cytologic atypia, and high MI behave aggressively as do peritoneal IMTs. <i>ALK</i> -rearranged tumor may respond to <i>ALK</i> inhibitors rather than general tyrosine kinase inhibitors.

Note: All recommendations are category 2A unless otherwise indicated.

References  
Continued

UTSARC-A  
5 OF 8

PRINCIPLES OF PATHOLOGY AND MOLECULAR ANALYSIS

Table 1 (continued)

Uterine Sarcoma					
Tumor	Hallmarks for Histologic Diagnosis	Relevant Molecular Finding	Additional Confirmatory Tests	Relevant Prognostic Features	Other
SMARCA4-Deficient Uterine Sarcoma (SDUS)	SDUS is characterized by sheets of epithelioid/rhabdoid cells associated with hyalinized matrix. LVSI, high MI, and necrosis are common. A small cell component or even spindled morphology may be focally present.	Biallelic SMARCA4 inactivation	Absent CK expression and BRG1 loss (SMARCA4) and/or SMARCA4 mutation detectable by DNA sequencing is helpful to support a diagnosis of SDUS, in the appropriate morphologic context.		Germline SMARCA4 mutation testing should be considered.
New and Emerging Entities					
NTRK-Rearranged Sarcoma	Spindle cell neoplasm with fascicular, herringbone, or patternless growth. Entrapped glands may be present, sometimes with polypoid projections simulating adenocarcinoma; however, there is typically no periglandular stromal condensation.	NTRK1/2/3 fusions	Frequent positivity for CD34 and/or S100 (generally both but with variable extent). IHC for pan-TRK is typically positive, but this marker is not specific for the gene fusion.	Typically present with stage I disease; ~1/3 recur or metastasize. Targeted therapy against NTRK inhibitors has shown clinical benefit.	More commonly occurs in the uterine cervix.

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF PATHOLOGY AND MOLECULAR ANALYSIS

Table 1 (continued)

Uterine Sarcoma				
Tumor	Hallmarks for Histologic Diagnosis	Relevant Molecular Finding	Additional Confirmatory Tests	Relevant Prognostic Features
Uterine Tumor Resembling Ovarian Sex Cord Tumor (UTROSCT) <sup>22-24</sup>	Bland spindle cell proliferation with extensive sex cord-like differentiation and no endometrial stromal component.	<i>ESR1</i> or <i>GREB1</i> fusions in the majority of tumors.	Immunohistochemical expression of sex cord markers (inhibin, calretinin, SF1, FOXL2) and/or detection of <i>GREB1</i> or <i>ESR1</i> fusions by FISH ( <i>NCOA1</i> , <i>NCOA2</i> , <i>NCOA3</i> ) and/or targeted RNA sequencing is confirmatory.	Tumors have uncertain malignant potential with ~25% being malignant. Necrosis and MI $\geq 2/10$ HPFs and/or presence of <i>GREB1</i> fusion may increase likelihood of malignant behavior.
Rhabdomyosarcoma (RMS) <sup>25-27</sup>	Embryonal subtype consists of small primitive cells that may form a cambium layer in botryoid tumors; strap cells and fetal cartilage can be seen. Marked atypia defines the pleomorphic subtype. Alveolar subtype consists of small primitive cells growing in nests or alveoli.	<i>DICER1</i> mutations are present in $\geq 95\%$ of embryonal RMS.  <i>PIK3CA</i> and <i>TP53</i> mutations in pleomorphic tumors. <i>FOXO1</i> fusion in alveolar tumors.	IHC expression of myogenin and/or MyoD1 is confirmatory of RMS differentiation. Extensive sampling must be performed to exclude carcinosarcoma or adenocarcinoma with SO. FISH and/or targeted RNA sequencing for <i>FOXO1</i> fusion is recommended to confirm alveolar subtype.	Embryonal subtype has better prognosis than pleomorphic and alveolar subtypes. Age and stage are prognostic factors.
Müllerian Adenosarcoma (MAS) <sup>28-31</sup>	Biphasic tumor with benign often metaplastic epithelium associated with an atypical usually low-grade spindle cell proliferation exhibiting phyllodes growth and periglandular stromal condensation. SO is defined by sarcoma comprising $\geq 25\%$ of the tumor volume.	BAP1 loss is seen in a subset. <i>ESR1</i> fusions are found in a minority of cases and <i>BCORL1</i> fusions have been reported. <sup>d</sup>	Ancillary testing is usually not required.	High grade, myoinvasion, and SO are poor prognostic factors. High-grade cytologic features may also portend a worse prognosis.

<sup>d</sup> 8q13 amplification and copy number gains of *MYBL1* in a subset; *NCOA2/3* fusions in a subset; rare *FGFR2*, *KMT2C*, *DICER1*, *ATRX*, and *TP53* mutations; *MDM2/CDK4* and *TERT* amplifications.

Note: All recommendations are category 2A unless otherwise indicated.

References

PRINCIPLES OF PATHOLOGY AND MOLECULAR ANALYSIS  
REFERENCES

- 1 Chiang S, Samore W, Zhang L, et al. PGR gene fusions identify a molecular subset of uterine epithelioid leiomyosarcoma with rhabdoid features. *Am J Surg Pathol* 2019;43:810-818.
- 2 Chapel DB, Nucci MR, Quade BJ, Parra-Herran C. Epithelioid leiomyosarcoma of the uterus: Modern outcome-based appraisal of diagnostic criteria in a large institutional series. *Am J Surg Pathol* 2022;46:464-475.
- 3 Arias-Stella JA 3rd, Benayed R, Oliva E, et al. Novel PLAG1 gene rearrangement distinguishes a subset of uterine myxoid leiomyosarcoma from other uterine myxoid mesenchymal tumors. *Am J Surg Pathol* 2019;43:382-388.
- 4 Yoon JY, Mariño-Enriquez A, Stickle N, et al. Myxoid smooth muscle neoplasia of the uterus: comprehensive analysis by next-generation sequencing and nucleic acid hybridization. *Mod Pathol* 2019;32:1688-1697.
- 5 Lee CH, Ali RH, Rouzbahman M, et al. Cyclin D1 as a diagnostic immunomarker for endometrial stromal sarcoma with YWHAE-FAM22 rearrangement. *Am J Surg Pathol* 2012;36:1562-1570.
- 6 Lee CH, Mariño-Enriquez A, Ou W, et al. The clinicopathologic features of YWHAE-FAM22 endometrial stromal sarcomas: a histologically high-grade and clinically aggressive tumor. *Am J Surg Pathol* 2012;36:641-653.
- 7 Lee CH, Ou WB, Mariño-Enriquez A, et al. 14-3-3 fusion oncogenes in high-grade endometrial stromal sarcoma. *Proc Natl Acad Sci U S A* 2012;109:929-934.
- 8 Chiang S, Lee CH, Stewart CJR, et al. BCOR is a robust diagnostic immunohistochemical marker of genetically diverse high-grade endometrial stromal sarcoma, including tumors exhibiting variant morphology. *Mod Pathol* 2017;30:1251-1261.
- 9 Hoang LN, Aneja A, Conlon N, et al. Novel high-grade endometrial stromal sarcoma: a morphologic mimicker of myxoid leiomyosarcoma. *Am J Surg Pathol* 2017;41:12-24.
- 10 Juckett LT, Lin DI, Madison R, et al. A pan-cancer landscape analysis reveals a subset of endometrial stromal and pediatric tumors defined by internal tandem duplications of BCOR. *Oncology* 2019;96:101-109.
- 11 Lewis N, Soslow RA, Delair DF, et al. ZC3H7B-BCOR high-grade endometrial stromal sarcomas: a report of 17 cases of a newly defined entity. *Mod Pathol* 2018;31:674-684.
- 12 Mariño-Enriquez A, Lauria A, Przybyl J, et al. BCOR internal tandem duplication in high-grade uterine sarcomas. *Am J Surg Pathol* 2018;42:335-341.
- 13 Cotzia P, Benayed R, Mullaney K, et al. Undifferentiated uterine sarcomas represent under-recognized high-grade endometrial stromal sarcomas. *Am J Surg Pathol* 2019;43:662-669.
- 14 Binzer-Panchal A, Hardell E, Viklund B, et al. Integrated molecular analysis of undifferentiated uterine sarcomas reveals clinically relevant molecular subtypes. *Clin Cancer Res* 2019;25:2155-2165.
- 15 Kolin DL, Dong F, Baltay M, et al. SMARCA4-deficient undifferentiated uterine sarcoma (malignant rhabdoid tumor of the uterus): a clinicopathologic entity distinct from undifferentiated carcinoma. *Mod Pathol* 2018;31:1442-1456.
- 16 Kolin DL, Quick CM, Dong F, et al. SMARCA4-deficient uterine sarcoma and undifferentiated endometrial carcinoma are distinct clinicopathologic entities. *Am J Surg Pathol* 2020;44:263-270.
- 17 Bennett JA, Braga AC, Pinto A, et al. Uterine PEComas: A morphologic, immunohistochemical, and molecular analysis of 32 tumors. *Am J Surg Pathol* 2018;42:1370-1383.
- 18 Folpe AL, Mentzel T, Lehr H-A, et al. Perivascular epithelioid cell neoplasms of soft tissue and gynecologic origin: a clinicopathologic study of 26 cases and review of the literature. *Am J Surg Pathol* 2005;29:1558-1575.
- 19 Schoolmeester JK, Howitt BE, Hirsch MS, et al. Perivascular epithelioid cell neoplasm (PEComa) of the gynecologic tract: clinicopathologic and immunohistochemical characterization of 16 cases. *Am J Surg Pathol* 2014;38:176-188.
- 20 Chiang S, Vasudevaraja V, Serrano J, et al. TSC2-mutant uterine sarcomas with JAZF1-SUZ12 fusions demonstrate hybrid features of endometrial stromal sarcoma and PEComa and are responsive to mTOR inhibition. *Mod Pathol* 2022;35:117-127.
- 21 WHO Classification of Tumours Editorial Board. Female Genital Tumours. Lyon (France): International Agency for Research on Cancer; 2020. WHO Classification of Tumours, 5th ed.; vol. 4.
- 22 Dickson BC, Childs TJ, Colgan TJ, et al. Uterine tumor resembling ovarian sex cord tumor: A distinct entity characterized by recurrent NCOA2/3 gene fusions. *Am J Surg Pathol* 2019;43:178-186.
- 23 Goebel EA, Hernandez Bonilla S, Dong F, et al. Uterine tumor resembling ovarian sex cord tumor (UTROSCT): A morphologic and molecular study of 26 cases confirms recurrent NCOA1-3 rearrangement. *Am J Surg Pathol* 2020;44:30-42.
- 24 Lee CH, Kao YC, Lee WR, et al. Clinicopathologic characterization of GREB1-rearranged uterine sarcomas with variable sex-cord differentiation. *Am J Surg Pathol* 2019;43:928-942.
- 25 Leiner J, Le Loarer F. The current landscape of rhabdomyosarcomas: an update. *Virchows Arch* 2020;476:97-108.
- 26 Pinto A, Kahn RM, Rosenberg AE, et al. Uterine rhabdomyosarcoma in adults. *Hum Pathol* 2018;74:122-128.
- 27 de Kock L, Yoon JY, Apellaniz-Ruiz M, et al. Significantly greater prevalence of DICER1 alterations in uterine embryonal rhabdomyosarcoma compared to adenocarcinoma. *Mod Pathol* 2020;33:1207-1219.
- 28 Hodgson A, Amemiya Y, Seth A, et al. High-grade Müllerian adenosarcoma: genomic and clinicopathologic characterization of a distinct neoplasm with prevalent TP53 pathway alterations and aggressive behavior. *Am J Surg Pathol* 2017;41:1513-1522.
- 29 Lee JC, Lu TP, Changou CA, et al. Genomewide copy number analysis of Müllerian adenosarcoma identified chromosomal instability in the aggressive subgroup. *Mod Pathol* 2016;29:1070-1082.
- 30 Howitt BE, Sholl LM, Dal Cin P, et al. Targeted genomic analysis of Müllerian adenosarcoma. *J Pathol* 2015;235:37-49.
- 31 Piscuoglio S, Burke KA, Ng CKY, et al. Uterine adenosarcomas are mesenchymal neoplasms. *J Pathol* 2016;238:381-388.

**Note: All recommendations are category 2A unless otherwise indicated.**



### PRINCIPLES OF IMAGING<sup>a,1-9</sup>

#### Initial Workup

- Chest/abdomen/pelvis CT
- For patients who underwent TH with incidental finding of uterine sarcoma or incompletely resected uterus/adnexa (ie, SCH, myomectomy, possible tumor fragmentation, intraperitoneal morcellation) perform chest/abdomen/pelvis CT or abdomen/pelvis MRI and chest CT without contrast to evaluate for metastatic disease.
- Consider pelvis MRI to evaluate local tumor extension or residual abnormality in cases where the uterus or adnexa were not resected or incompletely resected (ie, SCH, myomectomy, possible tumor fragmentation, intraperitoneal morcellation).
- Consider neck/chest/abdomen/pelvis/groin FDG-PET/CT to clarify ambiguous findings.
- Additional imaging should be based on symptomatology and clinical concern for metastatic disease.<sup>b</sup>

#### Follow-up/Surveillance

- Chest/abdomen/pelvis CT every 3–6 months for the first 3 years and then every 6–12 months for the next 2 years. Depending on histology grade and initial stage, consider imaging annually or every other year thereafter up to an additional 5 years.<sup>c</sup>
- Optional abdomen/pelvis MRI and chest CT without contrast every 3–6 months for the first 3 years and then every 6–12 months for the next 2 years. Depending on histology, grade, and initial stage, consider imaging annually or every other year thereafter up to an additional 5 years.<sup>c</sup>
- Consider neck/chest/abdomen/pelvis/groin FDG-PET/CT if metastasis is suspected in select patients.
- Additional imaging should be based on symptomatology and clinical concern for metastatic disease.<sup>d</sup>

<sup>a</sup> MRI is performed with and without contrast and CT is performed with contrast unless contraindicated. Contrast is not required for screening chest CT.

<sup>b</sup> Indications may include abnormal physical exam finding, bulky uterine tumor, vaginal or extrauterine involvement, delay in presentation or treatment, and abdominal or pulmonary symptoms.

<sup>c</sup> Follow-up imaging may be as frequent as every 3 months or change based on histology grade and/or stage of tumor.

<sup>d</sup> Indications may include abnormal physical exam findings such as vaginal involvement; palpable mass or adenopathy; and new pelvic, abdominal, or pulmonary symptoms.

**Note: All recommendations are category 2A unless otherwise indicated.**

[Continued](#)

UTSARC-B  
1 OF 2



### PRINCIPLES OF IMAGING REFERENCES

- <sup>1</sup> Salani R, Khanna N, Frimer M, et al. An update on post-treatment surveillance and diagnosis of recurrence in women with gynecologic malignancies: Society of Gynecologic Oncology (SGO) recommendations. *Gynecol Oncol* 2017;146:3-10.
- <sup>2</sup> Haldorsen IS, Salvesen HB. What is the best preoperative imaging for endometrial cancer? *Curr Oncol Rep* 2016;18:25.
- <sup>3</sup> Elit L, Reade CJ. Recommendations for follow-up care for gynecologic cancer survivors. *Obstet Gynecol* 2015;126:1207-1214.
- <sup>4</sup> Vargas HA, Akin O, Zheng J, et al. The value of MR imaging when the site of uterine cancer origin is uncertain. *Radiology* 2011;258:785-792.
- <sup>5</sup> Sohaib SA, Houghton SL, Meroni R, et al. Recurrent endometrial cancer: patterns of recurrent disease and assessment of prognosis. *Clin Radiol* 2007;62:28-34; discussion 35-36.
- <sup>6</sup> Hensley ML, Barrette BA, Baumann K, et al. Gynecologic Cancer InterGroup (GCIg) consensus review: uterine and ovarian leiomyosarcomas. *Int J Gynecol Cancer* 2014;24(9 Suppl 3):S61-S66.
- <sup>7</sup> Lakhman Y, Katz SS, Goldman DA, et al. Diagnostic performance of computed tomography for preoperative staging of patients with non-endometrioid carcinomas of the uterine corpus. *Ann Surg Oncol* 2016;23:1271-1278.
- <sup>8</sup> Colombo N, Creutzberg C, Amant F, et al; ESMO-ESGO-ESTRO Endometrial Consensus Conference Working Group. ESMO-ESGO-ESTRO Consensus Conference on Endometrial Cancer: diagnosis, treatment and follow-up. *Ann Oncol* 2016;27:16-41.
- <sup>9</sup> Sala E, Rockall AG, Freeman SJ, et al. The added role of MR imaging in treatment stratification of patients with gynecologic malignancies: what the radiologist needs to know. *Radiology* 2013;266:717-740.

**Note: All recommendations are category 2A unless otherwise indicated.**



### SYSTEMIC THERAPY FOR UTERINE SARCOMA<sup>a</sup> (Clinical trials strongly recommended)

#### Advanced, Recurrent/Metastatic or Inoperable Disease

First-Line Therapy <sup>b</sup>	Second-Line or Subsequent Therapy <sup>b</sup>
<p><b>Preferred Regimens</b></p> <ul style="list-style-type: none"> <li>• Doxorubicin</li> <li>• Docetaxel/gemcitabine</li> <li>• Doxorubicin/trabectedin (for LMS)<sup>1</sup></li> <li>• Doxorubicin/ifosfamide</li> <li>• Doxorubicin/dacarbazine (for LMS or ifosfamide ineligible)</li> </ul> <p><b>Useful in Certain Circumstances</b></p> <ul style="list-style-type: none"> <li>• Biomarker-directed therapy           <ul style="list-style-type: none"> <li>▶ <i>NTRK</i> gene fusion-positive tumors               <ul style="list-style-type: none"> <li>◇ Larotrectinib</li> <li>◇ Entrectinib</li> <li>◇ Repotrectinib<sup>c,2</sup></li> </ul> </li> <li>▶ IMT with ALK translocation               <ul style="list-style-type: none"> <li>◇ Crizotinib<sup>3</sup></li> <li>◇ Ceritinib<sup>4</sup></li> <li>◇ Brigatinib<sup>5,6</sup></li> <li>◇ Lorlatinib</li> <li>◇ Alectinib</li> </ul> </li> </ul> </li> <li>• <i>RET</i>-fusion positive tumors           <ul style="list-style-type: none"> <li>▶ Selpercatinib<sup>7</sup></li> <li>▶ PEComa</li> <li>▶ Albumin-bound sirolimus</li> </ul> </li> </ul>	<p><b>Preferred Regimen</b></p> <ul style="list-style-type: none"> <li>• Trabectedin (for LMS)</li> </ul> <p><b>Other Recommended Regimens</b></p> <ul style="list-style-type: none"> <li>• Gemcitabine/dacarbazine</li> <li>• Gemcitabine/vinorelbine</li> <li>• Dacarbazine</li> <li>• Gemcitabine</li> <li>• Epirubicin</li> <li>• Ifosfamide</li> <li>• Liposomal doxorubicin</li> <li>• Pazopanib</li> <li>• Temozolomide</li> <li>• Regorafenib<sup>8</sup></li> <li>• Eribulin (category 2B)</li> </ul> <p><b>Useful in Certain Circumstances</b></p> <ul style="list-style-type: none"> <li>• Biomarker-directed therapy           <ul style="list-style-type: none"> <li>▶ TMB-H tumors<sup>d</sup> <ul style="list-style-type: none"> <li>◇ Pembrolizumab</li> </ul> </li> </ul> </li> <li>• Consider PARP inhibitors for <i>BRCA</i>-altered LMS<sup>e,9-11</sup> <ul style="list-style-type: none"> <li>◇ Olaparib<sup>12</sup></li> <li>◇ Rucaparib</li> <li>◇ Niraparib</li> </ul> </li> <li>• PEComa           <ul style="list-style-type: none"> <li>◇ Sirolimus</li> <li>◇ Everolimus</li> <li>◇ Temsirolimus</li> </ul> </li> </ul>

<sup>a</sup> [NCCN Guidelines for Ovarian Cancer](#)—Management of Drug Reactions (OV-D).

<sup>b</sup> If not used previously, first-line agents can be used as second-line or subsequent therapy as clinically appropriate.

<sup>c</sup> *NTRK*-positive tumors that are naïve to prior *NTRK*-targeted therapy or have progressed on prior *NTRK* therapy.

<sup>d</sup> For the treatment of patients with unresectable or metastatic TMB-H (≥10 mut/Mb) tumors that have progressed following prior treatment and have no satisfactory alternative treatment options.

<sup>e</sup> For oncogenic or likely oncogenic mutations in *BRCA2*, may refer to definitions at [oncokb.org](http://oncokb.org).

**Note: All recommendations are category 2A unless otherwise indicated.**

[Continued](#)



**SYSTEMIC ENDOCRINE THERAPY FOR UTERINE SARCOMA<sup>a</sup>**  
(Clinical trials strongly recommended)

**Anti-Estrogen Hormone Therapy for Low-Grade ESS  
or Adenosarcoma Without SO or Hormone Receptor-Positive (ER/PR) Uterine Sarcomas<sup>f</sup>**

**Preferred Regimens**

- Aromatase inhibitors for low-grade ESS or adenosarcoma without SO<sup>g</sup>
  - ▶ Anastrozole
  - ▶ Letrozole
  - ▶ Exemestane
- Consider gonadotropin-releasing hormone (GnRH) analogs with aromatase inhibitors in patients who are premenopausal and not suitable for surgery (BSO)

**Other Recommended Regimens**

- Aromatase inhibitors<sup>g</sup> (for ER/PR-positive uterine sarcomas)
  - ▶ Anastrozole
  - ▶ Letrozole
  - ▶ Exemestane
- Fulvestrant<sup>g</sup>
- Megestrol acetate (category 2B for ER/PR-positive uterine sarcomas)
- Medroxyprogesterone acetate (category 2B for ER/PR-positive uterine sarcomas)

<sup>a</sup> [NCCN Guidelines for Ovarian Cancer](#)—Management of Drug Reactions (OV-D).

<sup>f</sup> These hormonal therapies may be considered for patients with uterine sarcomas that are ER/PR-positive, preferably with small tumor volume or an indolent growth pace.

<sup>g</sup> Ovarian ablation or suppression is needed in patients who are not postmenopausal. It is unknown if ovarian ablation or suppression is needed in order for fulvestrant to be effective in uterine sarcomas.

**Note: All recommendations are category 2A unless otherwise indicated.**



### SYSTEMIC ENDOCRINE THERAPY FOR UTERINE SARCOMA REFERENCES

- <sup>1</sup> Pautier P, Italiano A, Piperno-Neumann S, et al. Doxorubicin alone versus doxorubicin with trabectedin followed by trabectedin alone as first-line therapy for metastatic or unresectable leiomyosarcoma (LMS-04): a randomized, multicenter, open-label phase 3 trial. *Lancet Oncol* 2022;23:1044-1054.
- <sup>2</sup> Solomon BJ, Drilon A, Lin JJ, et al. 1372P Repotrectinib in patients (pts) with NTRK fusion-positive (NTRK+) advanced solid tumors, including NSCLC: Update from the phase I/II TRIDENT-1 trial [abstract]. *Ann Oncol* 2023;34:S787-S788.
- <sup>3</sup> Butrynski JE, D'Adamo DR, Hornick JL, et al. Crizotinib in ALK-rearranged inflammatory myofibroblastic tumor. *N Engl J Med* 2010;363:1727-1733.
- <sup>4</sup> Shaw AT, Kim DW, Mehra R, et al. Ceritinib in ALK-rearranged non-small-cell lung cancer. *N Engl J Med* 2014;370:1189-1197.
- <sup>5</sup> Camidge DR, Kim HR, Ahn MJ, et al. Brigatinib versus crizotinib in ALK-positive non-small-cell lung cancer. *N Engl J Med* 2018;379:2027-2039.
- <sup>6</sup> Gettinger SN, Bazhenova LA, Langer CJ, et al. Activity and safety of brigatinib in ALK-rearranged non-small –cell lung cancer and other malignancies: a single-arm, open-label, phase 1/2 trial. *Lancet Oncol* 2016;17:1683-1696.
- <sup>7</sup> Subbiah V, Wolf J, Konda B, et al. Tumor-agnostic efficacy and safety of selpercatinib in patients with RET fusion-positive solid tumours other than lung or thyroid tumours (LIBRETTO-001): a phase 1/2, open-label, basket trial. *Lancet Oncol* 2022;23:1261-1273.
- <sup>8</sup> Berry V, Basson L, Bogart E, et al. REGOSARC: Regorafenib versus placebo in doxorubicin-refractory soft-tissue sarcoma-A quality-adjusted time without symptoms of progression or toxicity analysis. *Cancer* 2017;123:2294-2302.
- <sup>9</sup> Hensley ML, Chavan SS, Solit DB, et al. Genomic landscape of uterine sarcomas defined through prospective clinical sequencing. *Clin Cancer Res* 2020;26:3881-3888.
- <sup>10</sup> Shamma N, Yang T, Abidi A, et al. Clinical use of PARP inhibitor in recurrent uterine leiomyosarcoma with presence of a somatic BRCA2 mutation. *Gynecol Oncol Rep* 2022;42:101044.
- <sup>11</sup> Seligson ND, Kautto EA, Passen EN, et al. BRCA1/2 functional loss defines a targetable subset in leiomyosarcoma. *Oncologist* 2019;24:973-979.
- <sup>12</sup> Pan M, Ganjoo K, Karam A. Rapid response of a BRCA2/TP53/PTEN-deleted metastatic uterine leiomyosarcoma to olaparib: A case report. *Perm J* 2021;25:20.251.

**Note: All recommendations are category 2A unless otherwise indicated.**



### PRINCIPLES OF RADIATION THERAPY FOR UTERINE NEOPLASMS

#### General Principles—Uterine Neoplasms

- RT is directed at sites of known or suspected tumor involvement and may include EBRT and/or brachytherapy. Imaging is required to assess locoregional extent and to rule out distant metastases before administration of RT. In general, EBRT is directed to the pelvis with or without the para-aortic region. Brachytherapy can be delivered: 1) to an intact uterus, either preoperatively or definitively; or 2) more commonly, to the vagina after hysterectomy. For the purposes of these guidelines, whole abdominal radiotherapy is not considered to be tumor-directed RT.
- Chemoradiation can be given concurrently or sequentially.

#### General Treatment Information

##### • Target Volumes

- ▶ Pelvic radiotherapy should target the gross disease (if present), the lower common iliacs, external iliacs, internal iliacs, obturators, parametria, upper vagina/para-vaginal tissue, and presacral lymph nodes (in patients with cervical involvement).
- ▶ Extended-field radiotherapy should include the pelvic volume and also target the entire common iliac chain and para-aortic lymph node region. The upper border of the extended field depends on the clinical situation but should at least be 1–2 cm above the level of the renal vessels.
- ▶ Pelvic tissues at risk, especially in the post-hysterectomy setting, can be highly variable depending on bowel and bladder filling. In this situation, the internal target volume (ITV), which encompasses the range of organ movement and deformation, is considered the clinical target volume (CTV), and should be fully covered in the treatment volume.

Note: All recommendations are category 2A unless otherwise indicated.

[Continued](#)

UN-A  
1 OF 3



### PRINCIPLES OF RADIATION THERAPY FOR UTERINE NEOPLASMS

#### General Treatment Information (continued)

##### • Dosing Prescription Regimen – External Beam

- ▶ External-beam doses for microscopic disease should be 45–50 Gy. CT treatment planning should be utilized, and intensity-modulated RT (IMRT) for normal tissue sparing should be considered, with appropriate attention to quality assurance (QA) and tissue interfraction mobility.
- ▶ Treating with IMRT technique is preferred to minimize toxicities in definitive treatment of the pelvis with or without para-aortic treatment. Regular use of image-guided RT (IGRT) with orthogonal imaging and/or routine volumetric imaging (such as cone beam CT) at the time of treatment delivery is essential to ensure appropriate coverage of targets and sparing of normal tissues.
- ▶ Postoperatively, if there is gross residual disease and the area(s) can be sufficiently localized, a boost can be added to a total dose of 60–70 Gy, respecting normal tissue sensitivity.
- ▶ For gross nodal disease, consider boost to 60–65 Gy while respecting normal tissue constraints.
- ▶ For neoadjuvant radiation, doses of 45–50 Gy are typically used. One could consider adding 1–2 high dose-rate (HDR) insertions to a total dose of 75–80 Gy low dose-rate (LDR) equivalent, to minimize risk of positive or close margins at hysterectomy.
- ▶ For pelvic-confined recurrent endometrial cancer without a prior history of radiation, fields would mirror adjuvant radiation. For reirradiation, fields should be limited to gross disease and target dose prescribed to maximize control while minimizing risk to normal tissues.

##### • Dosing Prescription Regimen – Brachytherapy

- ▶ Initiate brachytherapy as soon as the vaginal cuff is healed, preferably 6–8 weeks after surgery but in general initiation of brachytherapy should not exceed 12 weeks. For vaginal brachytherapy, the dose should be prescribed to the vaginal surface or at a depth of 0.5 cm from the vaginal surface; the dose depends on the use of EBRT. The target for vaginal brachytherapy after hysterectomy should be no more than the upper two-thirds of the vagina; in cases of extensive LVSI or positive margins, a longer segment of the vagina may be treated.
  - ◊ For postoperative HDR vaginal brachytherapy alone, regimens include 6 Gy x 5 fractions prescribed to the vaginal surface, or 7 Gy x 3 fractions or 5.5 Gy x 4 fractions prescribed to 5 mm below the vaginal surface. While 7 Gy x 3 fractions prescribed at a depth of 0.5 cm from the vaginal surface is a regimen used by many, the use of smaller fraction sizes may be considered to potentially further limit toxicity in selected patients.
  - ◊ When HDR brachytherapy is used as a boost to EBRT, doses of 4–6 Gy x 2 to 3 fractions prescribed to the vaginal mucosa are commonly used.
- ▶ For medically inoperable uterine cancer, risk of extrauterine spread determines the combination of EBRT plus brachytherapy or brachytherapy alone. Brachytherapy doses for definitive therapy are individualized based on the clinical situation. When available, image-guided therapy should be used. Based on the best available evidence, an equivalent dose at 2 Gy (EQD2) fractions D90 of ≥48 Gy should be delivered to the uterus, cervix, and upper 1–2 cm of vagina if brachytherapy alone is used, and should be increased to 65 Gy for the combination of EBRT and brachytherapy. If an MRI is used as part of planning, the target dose for the gross tumor volume (GTV) would be an EQD2 of ≥80 Gy.

Note: All recommendations are category 2A unless otherwise indicated.

[Continued](#)

UN-A  
2 OF 3



### PRINCIPLES OF RADIATION THERAPY FOR UTERINE NEOPLASMS

#### General Treatment Information (continued)

##### • Interstitial Brachytherapy

- ▶ Interstitial brachytherapy is an advanced technique where multiple needles/catheters are inserted in the gross disease/target. Interstitial brachytherapy may be preferred to maximize dose to the target and minimize dose to the organs at risk (OARs) for cases where intracavitary brachytherapy is not possible, or anatomy favors interstitial brachytherapy. Three-dimensional treatment planning allows volumetric delineation of targets and OARs on CT and/or MRI with dose-volume histograms. Dose and fractionation depend on prior RT dose, target volume, and OAR doses.

##### Stereotactic Radiosurgery (SRS) and Stereotactic Body RT (SBRT) for Metastatic Disease

- SRS and SBRT are radiation treatment modalities that utilize advanced three-dimensional anatomic targeting accuracy to deliver precise, ablative, high-dose ionizing radiation. The therapy maximizes the cell-killing effect of ionizing radiation while minimizing radiation-induced injury in adjacent sensitive normal tissues. SRS and SBRT demand precise target localization, reproducibility of patient setup, and a sharp radiation dose gradient. SRS is delivered exclusively to intracranial targets while SBRT describes stereotactic therapy to extracranial targets. SRS and SBRT are delivered in 1 to 5 fractions of therapy with the expectation of durable control at the radiated site.

Note: All recommendations are category 2A unless otherwise indicated.



### PRINCIPLES OF GYNECOLOGIC SURVIVORSHIP

#### Physical Effects

- Gynecologic cancer treatment typically involves surgery, chemotherapy, hormone therapy, RT, and/or immunotherapy. These treatments cause acute, short-term, and long-term toxicities.
- Surgical approaches may be extensive and pose risks such as adhesion formation, which may cause pain and may contribute to small bowel obstruction, urinary or gastrointestinal complications (eg, incontinence, diarrhea), pelvic floor dysfunction (manifested by a variety of urinary, bowel, and/or sexual effects), and lymphedema.
- Chemotherapy agents vary, though commonly used regimens may pose a significant risk of neurotoxicity, cardiac toxicity, development of hematologic cancers, and cognitive dysfunction.
- Long-term estrogen deprivation may cause symptoms such as hot flashes, vaginal dryness, and bone loss.
- RT may cause long-term complications (eg, fibrosis, vulvovaginal atrophy) and may predispose patients to secondary cancers of the subcutaneous tissue, and/or underlying organs that are proximal to the radiation field.
- Prior pelvic RT may contribute to bone loss and increase the risk of pelvic fractures. Consider bone density testing and prophylactic use of bisphosphonates, particularly in patients with osteoporosis.
- Immunotherapy use is emerging, and to date, long-term effects of these treatments are unknown.

#### Psychosocial Effects

- Psychosocial effects after cancer may be psychological (eg, depression, anxiety, fear of recurrence, altered body image), financial (eg, return to work, insurance concerns), and/or interpersonal (eg, relationships, sexuality, intimacy) in nature.

#### Clinical Approach

- All gynecologic cancer survivors should receive regular general medical care that focuses on managing chronic disease, monitoring cardiovascular risk factors, providing recommended vaccinations, and encouraging adoption of a healthy lifestyle.
- In order to assess the late and long-term effects of gynecologic cancers, clinicians should comprehensively document the patient's history, conduct a thorough physical examination, and provide any necessary imaging and/or laboratory testing. All patients, whether sexually active or not, should be asked about genitourinary symptoms, including vulvovaginal dryness. Referral to appropriate specialty providers (eg, physical therapy, pelvic floor therapy, sexual therapy, psychotherapy) is recommended. As most treatments for gynecologic cancers will cause sexual dysfunction, early menopause, and infertility, special attention to the resultant medical and psychosocial implications is needed.
- Post-radiation use of vaginal dilators and moisturizers is recommended.
- For treatment-related menopause, hormone therapy should be considered.
- Communication and coordination with all clinicians involved in the care of survivors, including primary care clinicians, is critical. Providing cancer survivors with a summary of their treatment and recommendations for follow-up is recommended.

#### Additional Guidance

- [NCCN Guidelines for Distress Management](#)
- [NCCN Guidelines for Smoking Cessation](#)
- [NCCN Guidelines for Survivorship](#)

Note: All recommendations are category 2A unless otherwise indicated.

**Staging—Uterine Carcinomas and Carcinosarcoma**

**Table 1**

AJCC Tumor-Node-Metastases (TNM) and International Federation of Gynecology and Obstetrics (FIGO) Surgical Staging Systems for Endometrial Cancer

**Definitions for T, N, M**

<b>T</b>	<b>FIGO Stage</b>	<b>Primary Tumor</b>
<b>TX</b>		Primary tumor cannot be assessed
<b>T0</b>		No evidence of primary tumor
<b>T1</b>	<b>I</b>	Tumor confined to the corpus uteri, including endocervical glandular involvement
T1a	<b>IA</b>	Tumor limited to the endometrium or invading less than half the myometrium
T1b	<b>IB</b>	Tumor invading one half or more of the myometrium
<b>T2</b>	<b>II</b>	Tumor invading the stromal connective tissue of the cervix but not extending beyond the uterus. Does NOT include endocervical glandular involvement
<b>T3</b>	<b>III</b>	Tumor involving serosa, adnexa, vagina, or parametrium
T3a	<b>IIIA</b>	Tumor involving the serosa and/or adnexa (direct extension or metastasis)
T3b	<b>IIIB</b>	Vaginal involvement (direct extension or metastasis) or parametrial involvement
<b>T4</b>	<b>IVA</b>	Tumor invading the bladder mucosa and/or bowel mucosa (bullous edema is not sufficient to classify a tumor as T4)

[Continued](#)

Used with permission of the American College of Surgeons, Chicago, Illinois. The original source for this information is the AJCC Cancer Staging Manual, Eighth Edition (2017) published by Springer International Publishing.



**Table 1 - Continued**

<b>N</b>	<b>FIGO Stage</b>	<b>Regional Lymph Nodes</b>
<b>NX</b>		Regional lymph nodes cannot be assessed
<b>N0</b>		No regional lymph node metastasis
<b>N0(i+)</b>		Isolated tumor cells in regional lymph node(s) no greater than 0.2 mm
<b>N1</b>	<b>IIIC1</b>	Regional lymph node metastasis to pelvic lymph nodes
N1mi	<b>IIIC1</b>	Regional lymph node metastasis (greater than 0.2 mm but not greater than 2.0 mm in diameter) to pelvic lymph nodes
N1a	<b>IIIC1</b>	Regional lymph node metastasis (greater than 2.0 mm in diameter) to pelvic lymph nodes
<b>N2</b>	<b>IIIC2</b>	Regional lymph node metastasis to para-aortic lymph nodes, with or without positive pelvic lymph nodes
N2mi	<b>IIIC2</b>	Regional lymph node metastasis (greater than 0.2 mm but not greater than 2.0 mm in diameter) to para-aortic lymph nodes, with or without positive pelvic lymph nodes
N2a	<b>IIIC2</b>	Regional lymph node metastasis (greater than 2.0 mm in diameter) to para-aortic lymph nodes, with or without positive pelvic lymph nodes

Suffix (sn) is added to the N category when metastasis is identified only by sentinel lymph node biopsy.

**M FIGO Stage Distant Metastasis**

<b>M0</b>		No distant metastasis
<b>M1</b>	<b>IVB</b>	Distant metastasis (includes metastasis to inguinal lymph nodes, intraperitoneal disease, lung, liver, or bone). (It excludes metastasis to pelvic or para-aortic lymph nodes, vagina, uterine serosa, or adnexa).

**G Histologic Grade**

<b>GX</b>	Grade cannot be assessed
<b>G1</b>	Well differentiated
<b>G2</b>	Moderately differentiated
<b>G3</b>	Poorly differentiated or undifferentiated

**Table 2. AJCC Prognostic Stage Groups**

	<b>T</b>	<b>N</b>	<b>M</b>
<b>Stage I</b>	T1	N0	M0
<b>Stage IA</b>	T1a	N0	M0
<b>Stage IB</b>	T1b	N0	M0
<b>Stage II</b>	T2	N0	M0
<b>Stage III</b>	T3	N0	M0
<b>Stage IIIA</b>	T3a	N0	M0
<b>Stage IIIB</b>	T3b	N0	M0
<b>Stage IIIC1</b>	T1-T3	N1/N1mi/N1a	M0
<b>Stage IIIC2</b>	T1-T3	N2/N2mi/N2a	M0
<b>Stage IVA</b>	T4	Any N	M0
<b>Stage IVB</b>	Any T	Any N	M1

[Continued](#)

Used with permission of the American College of Surgeons, Chicago, Illinois. The original source for this information is the AJCC Cancer Staging Manual, Eighth Edition (2017) published by Springer International Publishing.

**Staging—Uterine Sarcoma**

**Table 3**

AJCC Tumor-Node-Metastases (TNM) and International Federation of Gynecology and Obstetrics (FIGO) Surgical Staging Systems for Uterine Sarcomas (includes Leiomyosarcoma and Endometrial Stromal Sarcoma)

**Leiomyosarcoma and Endometrial Stromal Sarcoma**

<b>T</b>	<b>FIGO Stage</b>	<b>Primary Tumor</b>
<b>TX</b>		Primary tumor cannot be assessed
<b>T0</b>		No evidence of primary tumor
<b>T1</b>	<b>I</b>	Tumor limited to the uterus
T1a	<b>IA</b>	Tumor 5 cm or less in greatest dimension
T1b	<b>IB</b>	Tumor more than 5 cm
<b>T2</b>	<b>II</b>	Tumor extends beyond the uterus, within the pelvis
T2a	<b>IIA</b>	Tumor involves adnexa
T2b	<b>IIB</b>	Tumor involves other pelvic tissues
<b>T3</b>	<b>III</b>	Tumor infiltrates abdominal tissues
T3a	<b>IIIA</b>	One site
T3b	<b>IIIB</b>	More than one site
<b>T4</b>	<b>IVA</b>	Tumor invades bladder or rectum

<b>N</b>	<b>FIGO Stage</b>	<b>Regional Lymph Nodes</b>
<b>NX</b>		Regional lymph nodes cannot be assessed
<b>N0</b>		No regional lymph node metastasis
<b>N0(i+)</b>		Isolated tumor cells in regional lymph node(s) no greater than 0.2 mm
<b>N1</b>	<b>IIIC</b>	Regional lymph node metastasis

<b>M</b>	<b>FIGO Stage</b>	<b>Distant Metastasis</b>
<b>M0</b>		No distant metastasis
<b>M1</b>	<b>IVB</b>	Distant metastasis (excluding adnexa, pelvic, and abdominal tissues)

**G Histologic Grade**

**GX** Grade cannot be assessed

**G1** Well differentiated

**G2** Moderately differentiated

**G3** Poorly differentiated or undifferentiated

**Table 4. AJCC Prognostic Stage Groups**

	<b>T</b>	<b>N</b>	<b>M</b>
<b>Stage I</b>	T1	N0	M0
<b>Stage IA</b>	T1a	N0	M0
<b>Stage IB</b>	T1b	N0	M0
<b>Stage II</b>	T2	N0	M0
<b>Stage IIIA</b>	T3a	N0	M0
<b>Stage IIIB</b>	T3b	N0	M0
<b>Stage IIIC</b>	T1-3	N1	M0
<b>Stage IVA</b>	T4	Any N	M0
<b>Stage IVB</b>	Any T	Any N	M1

[Continued](#)

Used with permission of the American College of Surgeons, Chicago, Illinois. The original source for this information is the AJCC Cancer Staging Manual, Eighth Edition (2017) published by Springer International Publishing.

**Staging–Uterine Sarcoma**

**Table 4**

AJCC Tumor-Node-Metastases (TNM) and International Federation of Gynecology and Obstetrics (FIGO) Surgical Staging Systems for Uterine Sarcomas (includes Müllerian adenocarcinoma)

<b>T</b>	<b>FIGO Stage</b>	<b>Primary Tumor</b>
<b>TX</b>		Primary tumor cannot be assessed
<b>T0</b>		No evidence of primary tumor
<b>T1</b>	<b>I</b>	Tumor limited to the uterus
T1a	<b>IA</b>	Tumor limited to the endometrium/endocervix
T1b	<b>IB*</b>	Tumor invades less than or equal to half myometrial invasion
T1c	<b>IC*</b>	Tumor invades more than half myometrial invasion
<b>T2</b>	<b>II</b>	Tumor extends beyond the uterus, within the pelvis
T2a	<b>IIA</b>	Tumor involves adnexa
T2b	<b>IIB</b>	Tumor involves other pelvic tissues
<b>T3</b>	<b>III</b>	Tumor infiltrates abdominal tissues
T3a	<b>IIIA</b>	One site
T3b	<b>IIIB</b>	More than one site
<b>T4</b>	<b>IVA</b>	Tumor invades bladder or rectum
<b>N</b>	<b>FIGO Stage</b>	<b>Regional Lymph Nodes</b>
<b>NX</b>		Regional lymph nodes cannot be assessed
<b>N0</b>		No regional lymph node metastasis
<b>N0(i+)</b>		Isolated tumor cells in regional lymph node(s) no greater than 0.2 mm
<b>N1</b>	<b>IIIC</b>	Regional lymph node metastasis

<b>M</b>	<b>FIGO Stage</b>	<b>Distant Metastasis</b>
<b>M0</b>		No distant metastasis
<b>M1</b>	<b>IVB</b>	Distant metastasis (excluding adnexa, pelvic, and abdominal tissues)
<b>G</b>	<b>Histologic Grade</b>	
<b>GX</b>	Grade cannot be assessed	
<b>G1</b>	Well differentiated	
<b>G2</b>	Moderately differentiated	
<b>G3</b>	Poorly differentiated or undifferentiated	

**Table 4. AJCC Prognostic Stage Groups**

	<b>T</b>	<b>N</b>	<b>M</b>
<b>Stage I</b>	T1	N0	M0
<b>Stage IA</b>	T1a	N0	M0
<b>Stage IB</b>	T1b	N0	M0
<b>Stage IC</b>	T1c	N0	M0
<b>Stage II</b>	T2	N0	M0
<b>Stage IIIA</b>	T3a	N0	M0
<b>Stage IIIB</b>	T3b	N0	M0
<b>Stage IIIC</b>	T1-3	N1	M0
<b>Stage IVA</b>	T4	Any N	M0
<b>Stage IVB</b>	Any T	Any N	M1

\*There is a discrepancy between the 2009 FIGO and 2017 AJCC staging documents in the tumor definitions for FIGO stages IB and IC. The NCCN Panel has chosen to use 2009 FIGO language as noted in Corrigendum to “FIGO staging for uterine sarcomas” [International Journal of Gynecology and Obstetrics (2009) 104:179]. Used with permission of the American College of Surgeons, Chicago, Illinois. The original source for this information is the AJCC Cancer Staging Manual, Eighth Edition (2017) published by Springer International Publishing.



### ABBREVIATIONS

<b>99mTC</b>	<b>technetium-99m</b>	<b>ICG</b>	<b>indocyanine green</b>	<b>OAR</b>	<b>organ at risk</b>
<b>BSO</b>	<b>bilateral salpingo-oophorectomy</b>	<b>IGRT</b>	<b>image-guided radiation therapy</b>	<b>PEComa</b>	<b>perivascular epithelioid cell tumor</b>
<b>CBC</b>	<b>complete blood count</b>	<b>IHC</b>	<b>immunohistochemistry</b>	<b>pMMR</b>	<b>mismatch repair proficient</b>
<b>CLIA</b>	<b>Clinical Laboratory Improvement Amendments</b>	<b>IMRT</b>	<b>intensity-modulated radiation therapy</b>	<b>PR</b>	<b>progesterone receptor</b>
<b>CTV</b>	<b>clinical target volume</b>	<b>IMT</b>	<b>inflammatory myofibroblastic tumor</b>	<b>QA</b>	<b>quality assurance</b>
<b>D&amp;C</b>	<b>dilation and curettage</b>	<b>IORT</b>	<b>intraoperative radiation therapy</b>	<b>RH</b>	<b>radical hysterectomy</b>
<b>dMMR</b>	<b>mismatch repair deficient</b>	<b>ITD</b>	<b>internal tandem duplication</b>	<b>RMS</b>	<b>rhabdomyosarcoma</b>
<b>EBRT</b>	<b>external beam radiation therapy</b>	<b>ITV</b>	<b>internal target volume</b>	<b>SBRT</b>	<b>stereotactic body radiation therapy</b>
<b>EQD2</b>	<b>equivalent dose at 2 Gy</b>	<b>IUD</b>	<b>intrauterine device</b>	<b>SCH</b>	<b>supracervical hysterectomy</b>
<b>ER</b>	<b>estrogen receptor</b>	<b>LDR</b>	<b>low dose rate</b>	<b>SDUS</b>	<b>SMARCA4-deficient uterine sarcoma</b>
<b>ESS</b>	<b>endometrial stromal sarcoma</b>	<b>LFT</b>	<b>liver function test</b>	<b>SLN</b>	<b>sentinel lymph node</b>
<b>FDG</b>	<b>fluorodeoxyglucose</b>	<b>LMS</b>	<b>leiomyosarcoma</b>	<b>SMA</b>	<b>smooth muscle actin</b>
<b>FIGO</b>	<b>International Federation of Gynecology and Obstetrics</b>	<b>LND</b>	<b>lymphadenectomy</b>	<b>SO</b>	<b>sarcomatous overgrowth</b>
<b>FISH</b>	<b>fluorescence in situ hybridization</b>	<b>LVSI</b>	<b>lymphovascular space invasion</b>	<b>SRS</b>	<b>stereotactic radiosurgery</b>
<b>GnRH</b>	<b>gonadotropin-releasing hormone</b>	<b>MAS</b>	<b>Müllerian adenosarcoma</b>	<b>TH</b>	<b>total hysterectomy</b>
<b>GTV</b>	<b>gross tumor volume</b>	<b>MI</b>	<b>mitotic index</b>	<b>TMB</b>	<b>tumor mutational burden</b>
<b>H&amp;E</b>	<b>hematoxylin and eosin</b>	<b>MIS</b>	<b>minimally invasive surgery</b>	<b>TMB-H</b>	<b>tumor mutational burden-high</b>
<b>H&amp;P</b>	<b>history and physical</b>	<b>MMR</b>	<b>mismatch repair</b>	<b>UUS</b>	<b>undifferentiated uterine sarcoma</b>
<b>HDR</b>	<b>high dose rate</b>	<b>MSI</b>	<b>microsatellite instability</b>	<b>UTROSCT</b>	<b>uterine tumor resembling ovarian sex cord tumor</b>
<b>HPF</b>	<b>high-power field</b>	<b>MSI-H</b>	<b>microsatellite instability-high</b>		
		<b>mut/Mb</b>	<b>mutations/megabase</b>		
		<b>NGS</b>	<b>next-generation sequencing</b>		
		<b>NSMP</b>	<b>no specific molecular profile</b>		



NCCN Categories of Evidence and Consensus	
<b>Category 1</b>	Based upon high-level evidence (≥1 randomized phase 3 trials or high-quality, robust meta-analyses), there is uniform NCCN consensus (≥85% support of the Panel) that the intervention is appropriate.
<b>Category 2A</b>	Based upon lower-level evidence, there is uniform NCCN consensus (≥85% support of the Panel) that the intervention is appropriate.
<b>Category 2B</b>	Based upon lower-level evidence, there is NCCN consensus (≥50%, but <85% support of the Panel) that the intervention is appropriate.
<b>Category 3</b>	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise indicated.

NCCN Categories of Preference	
<b>Preferred intervention</b>	Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability.
<b>Other recommended intervention</b>	Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes.
<b>Useful in certain circumstances</b>	Other interventions that may be used for selected patient populations (defined with recommendation).

All recommendations are considered appropriate.

**Discussion**

This discussion corresponds to the NCCN Guidelines for Uterine Neoplasms. Last updated: April 28<sup>th</sup>, 2023.

**Table of Contents**

Overview .....	2	Primary Treatment.....	20
Guidelines Update Methodology .....	2	Treatment of Recurrent or Metastatic Disease .....	21
Literature Search Criteria.....	2	Locoregional Recurrence.....	21
Sensitive/Inclusive Language Usage .....	2	Distant Metastases .....	21
Initial Evaluation .....	3	Hormonal Therapy.....	22
Endometrial Cancer.....	3	Systemic Therapy.....	22
Molecular Analysis and Genetic Factors .....	4	Systemic Therapy Options for High-Risk Endometrial Histologies .....	25
Diagnosis and Workup .....	5	Radiotherapy Principles .....	26
Imaging .....	5	Post-Treatment Surveillance .....	26
Disease Staging .....	5	Hormone Therapy for Hypoestrogenism.....	27
Principles of Evaluation and Surgical Staging for Endometrial Carcinoma .....	6	Uterine Sarcomas .....	28
Pathology.....	6	Overview.....	28
Lymphadenectomy.....	7	Pathology and Molecular Analysis.....	28
SLN Ultrastaging.....	9	Low-Grade and High-Grade Endometrial Stromal Sarcoma (ESS).....	29
Minimally Invasive Procedures .....	10	Undifferentiated Uterine Sarcoma (UUS).....	29
Primary Treatment.....	11	Uterine Leiomyosarcoma (uLMS).....	30
Disease Limited to the Uterus .....	12	Uterine Tumor Resembling Ovarian Sex Cord Tumor (UTROSCT).....	30
Suspected or Gross Cervical Involvement.....	13	Rhabdomyosarcoma.....	30
Suspected Extruterine Disease .....	13	Staging and Treatment.....	31
Adjuvant Therapy .....	14	Low-Grade Endometrial Stromal Sarcoma .....	31
Uterine-Confined Disease .....	14	High-Grade Endometrial Stromal Sarcoma, Leiomyosarcoma, Undifferentiated Uterine Sarcoma, and PEComa .....	32
Advanced Stage/Extruterine Disease .....	17	Treatment of Recurrent or Metastatic Disease .....	32
High-Risk Endometrial Carcinoma Histologies .....	20	Systemic Therapy for Advanced, Metastatic/Recurrent or Inoperable Disease .....	33
Overview.....	20	Post-Treatment Surveillance .....	34
		Drug Reactions .....	34
		Gynecologic Survivorship.....	35
		References .....	37

### Overview

Adenocarcinoma of the endometrium (also known as endometrial cancer, or more broadly as uterine cancer or carcinoma of the uterine corpus) is the most common malignancy of the female genital tract in the United States. It is estimated that 65,950 new uterine cancer cases will occur in 2022, with 12,550 deaths resulting from the disease.<sup>1</sup> Stromal or mesenchymal sarcomas are uncommon subtypes accounting for approximately 3% of all uterine cancers.<sup>2,3</sup> The NCCN Guidelines for Uterine Neoplasms describe malignant epithelial tumors and uterine sarcomas; each of these major categories contains specific histologic groups that require different management (see *Initial Clinical Findings* in the NCCN Guidelines for Uterine Neoplasms).

Risk factors for uterine neoplasms include increased levels of estrogen (caused by obesity, diabetes, and high-fat diet), early age at menarche, nulliparity, late age at menopause, Lynch syndrome, ages between 55 and 64 years, and tamoxifen use.<sup>4-7</sup> Thus, the incidence of endometrial cancer is increasing because of increased life expectancy and obesity. The *Summary of the Guidelines Updates* describes the most recent revisions to the algorithms, which have been incorporated into this revised Discussion text (see the NCCN Guidelines for Uterine Neoplasms). The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) cannot incorporate all possible clinical variations and are not intended to replace good clinical judgment or individualization of treatments. “Many exceptions to the rule” were discussed among the members of the panel during the process of developing these guidelines. Recommendations in the NCCN Guidelines® are category 2A unless otherwise noted.

### Guidelines Update Methodology

The complete details of the Development and Update of the NCCN Guidelines are available at [www.NCCN.org](http://www.NCCN.org).

### Literature Search Criteria

Prior to the update of this version of the NCCN Guidelines for Uterine Neoplasms an electronic search of the PubMed database was performed to obtain key literature in uterine neoplasms published since the previous Guidelines update, using the following search terms: endometrial cancer or endometrial carcinoma or uterine sarcoma or endometrial stromal sarcoma or uterine leiomyosarcoma. The PubMed database was chosen as it remains the most widely used resource for medical literature and indexes peer-reviewed biomedical literature.

The search results were narrowed by selecting studies in humans published in English. Results were confined to the following article types: Clinical Trial, Phase II; Clinical Trial, Phase III; Clinical Trial, Phase IV; Guideline; Randomized Controlled Trial; Meta-Analysis; Systematic Reviews; and Validation Studies.

The data from key PubMed articles as well as articles from additional sources deemed as relevant to these guidelines as discussed by the panel during the Guidelines update process have been included in this version of the Discussion section. Recommendations for which high-level evidence is lacking are based on the panel’s review of lower-level evidence and expert opinion.

### Sensitive/Inclusive Language Usage

NCCN Guidelines strive to use language that advances the goals of equity, inclusion, and representation. NCCN Guidelines endeavor to use language that is person-first; not stigmatizing; anti-racist, anti-classist, anti-misogynist, anti-ageist, anti-ableist, and anti-fat-biased; and inclusive of individuals of all sexual orientations and gender identities. NCCN Guidelines incorporate non-gendered language, instead focusing on organ-specific recommendations. This language is both more accurate and more inclusive and can help fully address the needs of individuals of



all sexual orientations and gender identities. NCCN Guidelines will continue to use the terms men, women, female, and male when citing statistics, recommendations, or data from organizations or sources that do not use inclusive terms. Most studies do not report how sex and gender data are collected and use these terms interchangeably or inconsistently. If sources do not differentiate gender from sex assigned at birth or organs present, the information is presumed to predominantly represent cisgender individuals. NCCN encourages researchers to collect more specific data in future studies and organizations to use more inclusive and accurate language in their future analyses.

### Initial Evaluation

For patients with known or suspected uterine neoplasms, the initial preoperative evaluation/workup for known or suspected malignancy includes a history and physical examination, complete blood count (including platelets), expert pathology review with additional endometrial biopsy as indicated, imaging, recommendation of genetic evaluation of tumor and for inherited cancer risk, consideration of liver function tests (LFTs)/renal function tests or chemistry profile, and other studies (see *Initial Evaluation* and *Principles of Imaging* in the NCCN Guidelines for Uterine Neoplasms).<sup>8</sup> Preoperative imaging and biopsy may help to identify uterine sarcomas, although biopsy sensitivity is less than that for endometrial cancer. An expert pathology review will determine whether a patient has a malignant epithelial tumor or a stromal/malignant mesenchymal tumor. Epithelial tumor types include pure endometrioid cancer and carcinomas with high-risk endometrial histology (including uterine serous carcinoma, clear cell carcinoma, carcinosarcoma [also known as malignant mixed Müllerian tumor (MMMT)], and undifferentiated/dedifferentiated carcinoma). Stromal or mesenchymal tumor types (interchangeable terms) include uterine leiomyosarcoma (uLMS), endometrial stromal sarcoma (ESS), undifferentiated uterine sarcoma (UUS, previously called high-grade undifferentiated endometrial

sarcoma), adenosarcoma, and perivascular epithelioid cell neoplasm (PEComa). Given the typical age group at risk for uterine neoplasms (ie,  $\geq 55$  years) and the presence of comorbid illnesses, also see the NCCN Guidelines for Older Adult Oncology available at [https://www.nccn.org/professionals/physician\\_gls/pdf/senior.pdf](https://www.nccn.org/professionals/physician_gls/pdf/senior.pdf).

### Endometrial Cancer

Data show that almost 67% of patients with adenocarcinoma of the endometrium are diagnosed with disease confined to the uterus at diagnosis.<sup>9</sup> Regional and distant disease comprise approximately 21% and 8% of cases, respectively.

Many physicians believe that adenocarcinoma of the endometrium is a more treatable malignancy because the early symptoms of metrorrhagia or post-menopausal vaginal bleeding often trigger patients to seek care when the disease is at an early and treatable stage. However, data show that the mortality rate for uterine cancer has increased more rapidly than the incidence rate.<sup>10</sup> This increased mortality may be related to an increased rate of advanced-stage cancers, high-risk histologies (eg, serous carcinomas), and patients being diagnosed at an age  $\geq 65$  years. Analysis of SEER data suggests that survival is increased in patients who are younger, have early-stage disease, and have lower-grade disease.<sup>11</sup> In addition to grade and depth of myometrial invasion, other risk factors associated with poor prognosis include age, lymph node involvement, tumor size, lymphovascular space invasion (LVSI), and lower uterine segment invasion.<sup>12,13</sup> Depth of myometrial invasion is considered one of the critical criteria for evaluation of surgical-pathologic staging.<sup>14,15</sup> To further improve outcomes for patients with this disease, physicians need to identify patients who are at high-risk and to tailor treatment appropriately to provide the best long-term survival. The panel suggests that gynecologic oncologists be involved in the primary management of all patients with endometrial cancer.

### Molecular Analysis and Genetic Factors

Most endometrial cancer (95%) is caused by sporadic (somatic) mutations. However, genetic mutations cause endometrial cancer in about 5% of patients, which occurs 10 to 20 years before sporadic cancer.<sup>16</sup> Since there is increasing overlap in histopathologic features of these tumors, molecular analysis (eg, identification of characteristic translocations and/or mutations) and subtype classification are useful in selecting appropriate therapies. The Cancer Genome Atlas (TCGA) study performed an integrated genomic, transcriptomic, and proteomic analysis of 373 endometrial carcinomas including low-grade endometrioid, high-grade endometrioid, and serous carcinomas for their molecular classification. The study identified four major clinically significant molecular subtypes with differing clinical prognosis: *POLE* (DNA polymerase epsilon) mutations, microsatellite instability-high (MSI-H), copy number low (wild type *p53*), and copy number high (abnormal *p53*). The *POLE* comprises tumors with *POLE* exonuclease domain mutations. The copy number high group is characterized by an elevated incidence of *TP53* alterations. These genomic classes are also associated with characteristic phenotypes. The endometrial cancers with *POLE* mutations are usually high-grade tumors with deep myometrial invasion and LVSI, and usually have a good prognosis.<sup>17,18</sup> The *p53* mutant is the most aggressive subtype and requires a multimodality treatment, especially chemotherapy. The MSI-H tumors have an intermediate prognosis, but could be associated with other genetic cancer predisposition, and sensitivity to chemotherapy has been under investigation. Further studies have attempted to study the association of TCGA subgroups with histologic features such as tumor grade and histologic type.<sup>19</sup>

The NCCN Guidelines for Uterine Neoplasms include a diagnostic algorithm for integrated genomic-pathologic classification of endometrial carcinomas based on the TCGA study and add that the decision to use molecular testing/classification depends on resource availability and each

center's multidisciplinary team. The panel encourages comprehensive genomic profiling via a validated and/or FDA-approved assay in the initial evaluation of uterine neoplasms to help facilitate cancer diagnoses. The panel also encourages ancillary studies of *POLE* mutations, mismatch repair (MMR)/MSI, and aberrant *p53* expression to complement the morphologic assessment of histologic tumor type. In addition, the panel includes consideration for *NTRK* gene fusion testing for metastatic or recurrent endometrial carcinoma, and for tumor mutational burden (TMB) testing through a validated and/or FDA-approved assay.

Screening of the tumor for defective DNA MMR using immunohistochemistry (IHC) and/or MSI is used to identify which patients should undergo mutation testing for Lynch syndrome (see *Lynch Syndrome* in the NCCN Guidelines for Colorectal Cancer Screening available at [https://www.nccn.org/professionals/physician\\_gls/pdf/colorectal\\_screening.pdf](https://www.nccn.org/professionals/physician_gls/pdf/colorectal_screening.pdf)).<sup>16,20-26</sup> At a minimum, universal testing of endometrial tumors for defects in DNA MMR is recommended (eg, *MLH1*, *MSH2*, *MSH6*). MSI testing is recommended if MMR results are equivocal. Testing may be performed on the initial biopsy or dilation and curettage (D&C) material or the final hysterectomy specimen. *MLH1* loss should be further evaluated for promoter methylation to assess for an epigenetic process rather than a germline mutation.<sup>23</sup> Genetic counseling, molecular analysis, and testing are recommended for patients with all other MMR abnormalities. Patients with a significant family history of endometrial and/or colorectal cancer (even for those without MMR defects, who are MSI-stable, or those without screening) should be referred for genetic counseling and evaluation (See *Lynch Syndrome [Hereditary Non-Polyposis Colorectal Cancer]* in the NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal available at [https://www.nccn.org/professionals/physician\\_gls/pdf/genetics\\_colon.pdf](https://www.nccn.org/professionals/physician_gls/pdf/genetics_colon.pdf)). Screening for genetic mutations should be considered, especially for



patients <50 years of age.<sup>7,16,20,27-30</sup> If these patients have Lynch syndrome, they are at a higher lifetime risk ( $\leq 60\%$ ) for endometrial cancer; thus, close monitoring and discussion of risk-reducing strategies is recommended.<sup>20,31,32, 5,27,33</sup> In addition, their relatives may have Lynch syndrome. For patients and family members with Lynch syndrome but without endometrial cancer, a yearly endometrial biopsy is recommended to assess for cancer.<sup>29,34</sup> This strategy also enables select patients to defer surgery (and surgical menopause) and to preserve fertility. Prophylactic hysterectomy/bilateral salpingo-oophorectomy (BSO) is recommended after childbearing is complete.<sup>35,36</sup> In addition, interventions to decrease the risk from colorectal cancer are recommended (eg, annual colonoscopy).

### Diagnosis and Workup

Currently, there is no validated screening test for endometrial carcinoma.<sup>37,38</sup> About 90% of patients with endometrial carcinoma have metrorrhagia, most commonly in the postmenopausal period. The workup was previously described above (see *Initial Evaluation*). Diagnosis can usually be made by an office endometrial biopsy, with a false-negative rate of about 10%.<sup>39,40</sup> Thus, a negative endometrial biopsy in a symptomatic patient must be followed by a fractional D&C under anesthesia.<sup>39,41</sup> Hysteroscopy may be helpful in evaluating the endometrium for lesions, such as a polyp, if the patient has persistent or recurrent bleeding.<sup>42</sup> Endometrial biopsy may not be accurate for diagnosing malignancies of the uterine wall such as mesenchymal tumors. The histologic information from the endometrial biopsy (with or without endocervical curettage) is sufficient for planning definitive treatment.

### Imaging

For detailed imaging recommendations by stage and planned treatment approach, see *Principles of Imaging* in the NCCN Guidelines for Uterine Neoplasms. Consideration of preoperative chest imaging (chest x-ray) is

recommended. Based on the fertility-sparing or non–fertility-sparing treatment criteria, other imaging tests such as CT, MRI, ultrasound (US), and/or FDG-PET/CT may be used to assess disease extent and to evaluate for metastatic disease as indicated based on clinical symptoms, physical findings, or abnormal laboratory findings.<sup>43-49</sup> In patients with extrauterine disease, a serum CA-125 assay may be helpful in monitoring clinical response.<sup>50,51</sup> However, serum CA-125 levels can be falsely increased in patients who have peritoneal inflammation/infection or radiation injury, may be normal in patients with isolated vaginal metastases, and may not predict recurrence in the absence of other clinical findings.<sup>52-54</sup>

### Disease Staging

The FIGO (International Federation of Gynecology and Obstetrics) system is most commonly used for staging uterine cancer. The original 1970 criteria for staging endometrial cancer only used information gained from the presurgical evaluation (including physical examination and diagnostic fractional D&C). The 1970 staging system is rarely used today (eg, when the patient is not a surgical candidate).

Several studies demonstrated that clinical staging was inaccurate and did not reflect actual disease extent in 15% to 20% of patients.<sup>55-57</sup> This reported understaging and, more importantly, the ability to identify multiple prognostic factors with a full pathologic review made possible with surgical staging motivated a change in the staging classification. Therefore, in 1988, FIGO modified its staging system to emphasize thorough surgical/pathologic assessment of data, such as histologic grade, myometrial invasion, and the extent and location of extrauterine spread (including retroperitoneal lymph node metastases).<sup>58</sup> FIGO updated and refined the surgical/pathologic staging criteria for uterine neoplasms in 2009.<sup>59-62</sup> Separate staging systems for malignant epithelial tumors and uterine sarcomas are now available (see *Staging* section of the algorithm).

In 2017, the AJCC Cancer Staging Manual was further updated (which took effect in January 2018).<sup>63</sup>

The 2009 FIGO staging system streamlined stages I and II of endometrial carcinoma. These revisions were made because the survival rates for some of the previous sub-stages were similar.<sup>61</sup> Currently stage IA describes tumors with less than 50% myometrial invasion, and stage IB describes those with 50% or more myometrial invasion. Stage II describes patients with tumors that invade the cervical stroma. Patients with uterine-confined disease and endocervical glandular involvement (mucosal involvement) without cervical stromal invasion are no longer considered stage II.<sup>61</sup> Stage IIIC is subdivided into IIIC1 (pelvic nodal involvement alone) and IIIC2 (para-aortic involvement +/- pelvic node involvement), reflecting the inferior survival in those patients with positive para-aortic nodes.<sup>61</sup> To maintain consistency, the NCCN Panel has reinterpreted historical studies using the 1988 FIGO staging system to reconcile those studies with the 2009 staging system.

In the 2009 FIGO staging the presence of positive peritoneal cytology no longer increases the disease stage, as its importance as an independent risk factor has been called into question.<sup>62</sup> However, FIGO and AJCC continue to recommend that peritoneal washings be obtained and results be recorded (see *Principles of Evaluation and Surgical Staging* in the NCCN Guidelines for Endometrial Carcinoma).<sup>64</sup>

### **Principles of Evaluation and Surgical Staging for Endometrial Carcinoma**

Staging should be done by a team with expertise in imaging, pathologic evaluation, and surgery. The amount of surgical staging that is necessary to determine disease status depends on preoperative and intraoperative assessment by experienced surgeons. Pathologic nodal assessment for apparent uterine-confined endometrial cancer informs both stage and adjuvant therapy. However, if final pathology shows a noninvasive

endometrioid histology, nodal assessment can be eliminated. The NCCN sentinel lymph node (SLN) algorithm is recommended if sentinel node mapping is utilized.

### **Pathology**

An expert pathologic review determines the specific epithelial histology of the tumor (endometrioid, serous, clear cell, carcinosarcoma, or undifferentiated). Morphologic evaluation of endometrial carcinoma to determine histologic type—especially in high-grade cancers—is challenging and issues exist regarding diagnostic reproducibility. The pathologic assessment of the uterus and the nodes is described in the algorithm. The assessment of the uterus includes the hysterectomy type, specimen integrity, tumor site and size, histologic type and grade if applicable, myometrial invasion (depth of invasion in mm/myometrial thickness in mm), cervical stromal involvement, and LVSI. Pathologists may be asked to quantify LVSI. The current definition of substantial LVSI is 4 or more LVSI-involved vessels in at least one hematoxylin and eosin (H&E) slide (for clinically relevant LVSI in endometrial cancer).<sup>65</sup> The pathologic assessment should also include assessment of involvement by other tissues such as the fallopian tubes, ovaries, vagina, parametrium, peritoneum, and omentum. The assessment of peritoneal/ascitic fluid cytology should also be obtained. If nodal resection was performed, the level of nodal involvement (ie, pelvic, common iliac, para-aortic) should be determined. SLNs should undergo ultrastaging for the detection of low-volume metastases (LVMs). Ultrastaging commonly entails thin serial sectioning of the gross SLN and review of multiple H&E-stained sections with or without cytokeratin IHC for all blocks of SLN. There is no standard protocol for lymph node ultrastaging. See *Principles of Pathology* in the NCCN Guidelines for Endometrial Carcinoma. The *Protocol for the Examination of Specimens From Patients With Carcinoma and Carcinosarcoma of the Endometrium* from the College of American Pathologists (CAP) is a useful guide



(<https://cap.objects.frb.io/protocols/cp-femalereproductive-endometrium-18protocol-4100.pdf>). This CAP protocol was revised to reflect the updated pTNM requirements from the AJCC Cancer Staging Manual (8<sup>th</sup> edition) and 2015 FIGO Cancer Report.<sup>63,66</sup>

Estrogen receptor (ER) testing is recommended in the setting of stage III, IV, or recurrent endometrioid carcinoma. Evaluation of human epidermal growth factor receptor 2 (HER2) overexpression should also be considered. Rottmann et al recently showed that 16% of 80 gynecologic carcinosarcomas (including uterine carcinosarcoma) showed HER2 overexpression and amplification when using the 2013 ASCO/CAP scoring system.<sup>67</sup> Similar results were reported by Jenkins et al, Yoshida et al, and others.<sup>68-72</sup> The panel recommends HER2 IHC testing (with reflex to HER2 fluorescence in situ hybridization [FISH] for equivocal IHC) for possible treatment for advanced-stage or recurrent serous endometrial carcinoma or carcinosarcoma. HER2 IHC testing should also be considered in *TP53*-aberrant endometrial carcinoma regardless of histotyping.

As the grade of the tumor increases, the accuracy of intraoperative evaluation of myometrial invasion decreases (ie, assessment by gross examination of fresh tissue).<sup>73</sup> In one study, the depth of invasion was accurately determined by gross examinations in 87.3% of grade 1 lesions, 64.9% of grade 2 lesions, and 30.8% of grade 3 lesions.<sup>74</sup> Studies show that in 15% to 20% of cases, the preoperative grade (as assessed by endometrial biopsy or curettage) is upgraded on final fixed pathologic evaluation of the hysterectomy specimen.<sup>75</sup>

### **Lymphadenectomy**

Previously, a full standard lymphadenectomy (ie, dissection and assessment of both pelvic and para-aortic nodes) was recommended for all patients; however, to decrease side effects, a more selective and tailored nodal evaluation approach that includes the SLN algorithm is recommended by the NCCN Panel.<sup>76</sup> No randomized trial data support

routine full lymphadenectomy,<sup>77</sup> although some retrospective studies have suggested that it is beneficial.<sup>78-80</sup> Two randomized clinical trials from Europe reported that routine lymph node dissection did not improve the outcome of patients with endometrial cancer, but lymphadenectomy did identify those with nodal disease.<sup>81,82</sup> However, these findings remain a point of contention.<sup>83-85</sup> To avoid over-interpretation of these results, it is important to address the limitations of these randomized studies, including selection of patients, extent of lymph node dissection, and standardization of postoperative therapy.<sup>86</sup> One of the trials did not standardize adjuvant treatment after staging surgery with lymphadenectomy and this has been identified as a weakness of the trial and may have contributed to the lack of difference in recurrence and survival in the two groups.<sup>80</sup> The other concerns include the lack of central pathology review, subspecialty of surgeons, and adequacy of statistical power.

Decisions about whether to perform lymphadenectomy, and, if done, to what extent (eg, pelvic nodes only or both pelvic and para-aortic nodes), can be made based on preoperative and intraoperative findings. Criteria have been suggested as indicative of low risk for nodal metastases: 1) less than 50% myometrial invasion; 2) tumor less than 2 cm; and 3) well or moderately differentiated histology.<sup>87,88</sup> However, this may be difficult to accurately determine before final pathology results are available. If expert gynecologic pathology is available, a frozen section to assess myoinvasion can be obtained and lymphadenectomy avoided if no myoinvasion or cervical invasion is identified.<sup>89</sup>

Nodal evaluation will identify those patients with nodal metastases. Identification of metastatic disease guides appropriate adjuvant treatment that has been shown to improve survival and decrease locoregional recurrence.

The question of whether to add para-aortic lymphadenectomy to pelvic node dissection has been debated. Prior studies have shown conflicting

information regarding the risk of para-aortic nodal metastases in patients without disease in the pelvic nodes.<sup>57,87,90,91</sup> Para-aortic lymphadenectomy up to the renal vessels may be considered for selective patients, including those with pelvic lymphadenectomy or high-risk histologic features. Many surgeons do not do a full lymphadenectomy in patients with grade 1 early-stage endometrial cancer.<sup>76</sup>

In summary, lymph node dissection identifies patients requiring adjuvant treatment with radiation therapy (RT) and/or systemic therapy.<sup>92</sup> A subset of patients may not benefit from lymphadenectomy; however, it may be difficult to preoperatively identify these patients. The NCCN Panel recommends that nodal evaluation be performed in patients with endometrial carcinoma, including para-aortic lymphadenectomy in patients who are at higher-risk (see *Principles of Evaluation and Surgical Staging* in the NCCN Guidelines for Endometrial Carcinoma).<sup>6</sup> SLN mapping is the preferred alternative to full lymphadenectomy in the setting of apparent uterine-confined disease. The SLN surgical algorithm is described below. Lymphadenectomy is not recommended for patients with uterine sarcoma as metastasis to the nodes is unusual.

### *Sentinel Lymph Node Mapping*

The section on surgical staging (see *Principles of Evaluation and Surgical Staging* in the NCCN Guidelines for Endometrial Carcinoma) includes recommendations about SLN mapping. SLN mapping may be considered for patients without suspicion of metastatic disease by preoperative imaging and no obvious extrauterine disease at exploration.<sup>93-97</sup> In SLN mapping, dye is injected into the cervix, which travels to the sentinel nodes. This has emerged as a useful and validated technique for identification of lymph nodes that are at high risk for metastases (ie, SLN in patients with early-stage endometrial cancer).<sup>98</sup> Superficial (1–3 mm) and optional deep (1–2 cm) cervical injection leads to dye delivery to the main layers of lymphatic channel origins in the cervix and corpus, namely

the superficial subserosal, intermediate stromal, and deep submucosal lymphatic sites of origin.<sup>99</sup> Injection into the uterine cervix provides excellent dye penetration to the uterine vessels and main uterine lymphatic trunks that condense in the parametria and appear in the broad ligament leading to pelvic and occasionally paraaortic sentinel nodes. The uterine body lymphatic trunks commonly cross over the obliterated umbilical artery with the most common location of pelvic SLN being medial to the external iliac, ventral to the hypogastric, or in the superior part of the obturator region. A less common location is usually seen when the lymphatic trunks do not cross over the obliterated umbilical and move cephalad following the mesoureter; in these cases, the SLN is usually seen in the common iliac presacral region (see Figures 1–3 in *Principles of Evaluation and Surgical Staging* in the NCCN Guidelines for Endometrial Carcinoma). The radiolabeled colloid most commonly injected into the cervix is technetium-99m (<sup>99m</sup>Tc); colored dyes are available in a variety of forms (Isosulfan Blue 1%, Methylene Blue 1%, and Patent Blue 2.5% sodium). Indocyanine green (ICG) recently emerged as a useful imaging dye that requires a near-infrared camera for localization, provides a very high SLN detection rate, and is commonly used in many practices at the present time.<sup>89,99-105</sup>

A surgical SLN algorithm is proposed to decrease the false-negative rate in patients with apparent uterine-confined disease (see Figure 4 in *Principles of Evaluation and Surgical Staging* in the NCCN Guidelines for Endometrial Carcinoma).<sup>93,106</sup> SLN mapping may be most appropriate for those at low to intermediate risk for metastases and/or for those who may not tolerate a standard lymphadenectomy.<sup>97,99,107-112</sup> SLN identification should always be done prior to hysterectomy, except in cases where a bulky uterus must be removed to allow access to iliac vessels and LNs. For example, suspicious or grossly enlarged nodes should be removed regardless of SLN mapping results. In SLN mapping, the surgeon's expertise and attention to technical detail are critical. Patients may be able

to avoid the morbidity of a standard lymphadenectomy with SLN mapping.<sup>111,113</sup> Because SLNs identify the primary lymphatic pathway, this increases the yield of finding metastatic disease during the mapping process. For cases of failed SLN mapping, reinjection of the cervix may be considered. However, if SLN mapping fails, a reflex side-specific nodal dissection should be performed and any suspicious or grossly enlarged nodes should be removed regardless of mapping.<sup>93,112</sup>

A literature review and consensus recommendations for SLN mapping in endometrial cancer were released by the Society of Gynecologic Oncology (SGO).<sup>97</sup> Close adherence to the NCCN SLN surgical algorithm was found to result in accurate prediction of pelvic lymph node metastasis with a less than 5% false-negative rate.<sup>93</sup> Additionally, results were published from the FIRES trial, which compared SLN mapping to lymphadenectomy for endometrial cancer in the largest multicenter prospective study to date ( $n = 385$ ).<sup>99</sup> Mapping of at least one SLN was successful in 86% of patients; sensitivity was 97.2% (95% CI, 85.0–100), and negative predictive value was 99.6% (95% CI, 97.9–100).

A systematic review of 17 studies with  $n > 30$  patients revealed detection rates of 60% to 100%; detection rates for studies with larger cohorts ( $n > 100$ ) were at least 80%. Retrospective application of a surgical algorithm generated 95% sensitivity, 99% predictive value, and a 5% false-negative rate.<sup>114</sup> Another systematic review and meta-analysis of 55 studies with  $n > 10$  patients ( $n = 4915$ ) generated an overall detection rate of 81% with a 50% bilateral pelvic node detection rate and 17% paraaortic detection rate.<sup>89</sup> In a retrospective analysis of patients with early-stage endometrial cancer ( $n = 780$ ) who underwent SLN mapping with lymphadenectomy versus lymphadenectomy alone, SLN mapping led to the detection of more metastasis (30.3% vs. 14.7%,  $P < .001$ ) and was associated with greater use of adjuvant therapy.<sup>115</sup> Long-term follow-up was reported from a prospective multicenter study in 125 patients with early-stage

endometrial carcinoma who underwent SLN biopsy. Patients with a positive SLN underwent external beam RT (EBRT) and chemotherapy at a higher rate than those with a negative SLN. In patients with a detected SLN, recurrence-free survival (RFS) at 50 months was 84.7%, and no difference was detected between patients with and without a positive SLN ( $P = .5$ ).<sup>116</sup>

SLN mapping should be done in institutions with expertise in this procedure. If patients have apparent distant metastatic disease (based on imaging and/or surgical exploration), removal of nodes for staging purposes is not necessary because it will not change management.<sup>43,49</sup>

Historically, SLN mapping was controversial in patients with high-risk histology (eg, serous carcinoma, clear cell carcinoma, carcinosarcoma).<sup>76,117</sup> However, SLN mapping in patients with high-risk histologies (ie, grade 3, serous, clear cell, carcinosarcoma) has been reported with promising results as a potential alternative to complete lymphadenectomy.<sup>112,118,119</sup> A recent multi-institutional retrospective study concluded that SLN mapping versus SLN mapping with lymphadenectomy in high-risk endometrial cancer did not impact survival outcomes.<sup>120</sup> A recent prospective, multicenter cohort study (SENTOR-trial) examined the diagnostic accuracy of SLN mapping versus lymphadenectomy for intermediate- and high-grade endometrial cancer in 156 patients. Of 27 patients with nodal metastasis, SLN mapping correctly identified 26 of them (96% sensitivity; 95% CI; 81%–100%), thus concluding the acceptable accuracy of SLN mapping in high-grade endometrial cancer.<sup>121</sup> More studies have suggested the value of using SLN mapping for surgical staging in high-grade endometrial cancer.<sup>122</sup>

### **SLN Ultrastaging**

In general, SLN mapping allows for increased intraoperative surgical precision to identify nodes more likely to harbor metastasis combined with enhanced pathology protocols, which has been shown to increase the



detection of nodal metastasis, which may alter stage and adjuvant therapy recommendations. Studies have suggested that SLN ultrastaging leads to upstaging in 5% to 15% of patients.<sup>96,108,110,113,114</sup>

Ultrastaging typically includes two components: serial sectioning with review of multiple H&E-stained slides with or without cytokeratin IHC staining.<sup>123</sup> Recent data highlight the potential significance and impact of SLN ultrastaging to improve the accuracy of detecting micrometastases.<sup>124</sup>

In a cohort of 508 patients who underwent SLN mapping, ultrastaging detected 23 additional cases of micrometastasis that would have been missed by conventional H&E staining.<sup>125</sup> A multicenter study of 304 patients with presumed low- or intermediate-risk disease showed that SLN biopsy and ultrastaging detected metastatic SLNs in a 3-fold greater number of patients than standard lymphadenectomy.<sup>126</sup>

The implications and appropriate management of micrometastases and isolated tumor cells (ITCs), jointly referred to as LVM, detected via SLN ultrastaging are not yet clear.<sup>97,110,113,127-131</sup> Studies have recently begun to investigate the significance of ITCs discovered during SLN mapping in early-stage endometrial cancer. The AJCC 8<sup>th</sup> edition cancer staging manual indicates that the lymph nodes with ITCs should be clearly reported even though they do not affect the overall staging.<sup>132</sup> When ITCs are detected in the absence of macrometastasis and micrometastasis, the lymph node stage is designated as pN0(i+).

A retrospective review examined 844 patients with endometrial cancer that underwent SLN mapping.<sup>133</sup> The majority of patients with ITCs, micrometastasis, and macrometastasis received adjuvant chemotherapy (83%, 81%, and 89%, respectively). RFS at 3 years was 90% for those with negative SLNs, 86% for ITCs, and 86% for micrometastasis. Only patients with SLN macrometastasis had significantly lower RFS (71%,  $P < .001$ ).

A prospective observational study of 519 patients compared outcomes for patients with SLN macrometastasis, micrometastasis, and ITCs, taking into account adjuvant treatment.<sup>134</sup> Patients with SLN ITCs had a significantly better 3-year progression-free survival (PFS) compared with patients with SLN macrometastasis (95.5% vs. 58.5%), and outcomes were similar between patients with negative SLNs, ITCs, and micrometastasis. Recurrence was detected in only 1 of 31 patients with ITCs (stage IB carcinosarcoma) and adjuvant treatment did not appear to influence outcomes. Based on these early data, it is unclear if patients with SLN ITCs would derive significant benefit from adjuvant treatment.<sup>135</sup> Future evaluation of prognosis/outcome may need to prospectively examine the threshold for and impact of adjuvant therapy for patients with scattered ITCs.

### ***Minimally Invasive Procedures***

Over the past decade, practice has trended towards minimally invasive approaches to total abdominal hysterectomy (TH)/BSO and lymph node assessment in patients with early-stage endometrial cancer.<sup>136</sup> Although these procedures may be performed by any surgical route (eg, laparoscopic, robotic, vaginal, abdominal), the standard in those with apparent uterine-confined disease is to perform the procedure via a minimally invasive approach. Randomized trials, a Cochrane Database Systematic Review, and population-based surgical studies support that minimally invasive techniques are preferred in the appropriate candidate due to a lower rate of surgical site infection, transfusion, venous thromboembolism, decreased hospital stay, and lower cost of care, without compromise in oncologic outcome.<sup>136-142</sup> Despite data showing that minimally invasive procedures result in lower perioperative complications and lower cost of care, racial and geographic disparities in access to minimally invasive surgical care have been observed.<sup>138,142</sup>



A randomized phase III trial evaluated laparoscopy for comprehensive surgical staging; patients (n = 2616) with clinical stage I to IIA disease (GOG-LAP2) were assessed.<sup>141,143</sup> Patients were randomly allocated 2:1 to laparoscopy or laparotomy. Results from LAP2 indicate that 26% of patients needed conversion to laparotomy because of poor visibility, metastatic cancer, bleeding, increased age, or increased body mass index. Detection of advanced cancer was not significantly different between the groups. However, significant differences were noted in removal of pelvic and para-aortic nodes (8% not removed with laparoscopy vs. 4% with laparotomy,  $P < .0001$ ).<sup>144,145</sup> Significantly fewer postoperative adverse events and shorter hospitalization occurred with laparoscopy compared with laparotomy. Recurrence rates were 11.4% for laparoscopy versus 10.2% for laparotomy. The 5-year overall survival (OS) rate was 84.8% for both arms of LAP2.<sup>143</sup> Laparoscopic staging was associated with improved postoperative quality of life across several parameters.<sup>140</sup>

The LACE trial compared outcomes of patients with stage I endometrial carcinoma (n = 760) who were randomized to undergo TH or total laparoscopic hysterectomy (TLH), where half of the patients received concomitant lymphadenectomy.<sup>137</sup> At a median follow-up of 4.5 years, disease-free survival (DFS) was 81.3% for laparotomy versus 81.6% for laparoscopy, with no significant differences observed between groups for recurrence and OS. Another randomized trial (n = 283) comparing laparoscopy versus laparotomy reported shorter hospital stay, less pain, and faster resumption of daily activities with laparoscopy.<sup>146</sup> A recent follow-up study of a multicenter randomized trial evaluated outcomes for TLH versus TH in 279 patients with early-stage, low-risk endometrial cancer who did not undergo concomitant lymphadenectomy and reported comparable disease recurrence and 5-year survival rates. The results were also similar to studies with lymphadenectomy.<sup>147</sup> Laparotomy may

still be required for certain clinical situations (eg, patients who are older, those with a very large uterus) or certain metastatic presentations.<sup>141,148,149</sup>

Robotic surgery is a minimally invasive technology that has been increasingly used in the surgical staging of endometrial carcinoma due to its potential advantages over laparotomy, especially for patients who are overweight.<sup>150-154</sup> Prospective cohort and retrospective studies suggest that robotic approaches perform similarly to laparoscopy and result in comparable or improved perioperative outcomes.<sup>154-159</sup> Oncologic outcomes appear to be comparable to other surgical approaches, although longer-term outcomes are still being investigated.<sup>160-162</sup> In certain patients, robotic surgery may result in less frequent conversion to laparotomy when compared with laparoscopic approaches and also appears to be safe and feasible in patients at higher anesthesiologic risk.<sup>154,155,163</sup>

Costs for robotic equipment and maintenance remain high.<sup>164,150,151,160-162,165</sup> The SGO, American Association of Gynecologic Laparoscopists (AAGL), and American Congress of Obstetricians and Gynecologists (ACOG) have published guidelines or position statements about robotic surgery.<sup>166-168</sup> For reviews on the robotic-assisted surgery for gynecologic malignancies and associated cost issues, see Sinno and Fader and Gala et al.<sup>169,170</sup>

### Primary Treatment

These NCCN Guidelines divide pure endometrioid cancer into three categories for delineating treatment: 1) disease limited to the uterus; 2) suspected or gross cervical involvement; and 3) suspected extrauterine disease. Most patients with endometrial cancer have stage I disease at presentation, and surgery (with or without adjuvant therapy) is recommended for patients who are medically operable. As a general principle, endometrial carcinoma should be removed en bloc to optimize outcomes; intraperitoneal morcellation should be avoided.<sup>171-174</sup>

***Disease Limited to the Uterus***

To stage patients who are medically operable with endometrioid histologies clinically confined to the fundal portion of the uterus, the recommended surgical procedure includes removal of the uterus and bilateral tubes and ovaries with lymph node and abdominal assessment (see *Principles of Evaluation and Surgical Staging* in the NCCN Guidelines for Endometrial Carcinoma and in this Discussion and *Lymphadenectomy* and *Sentinel Lymph Node Mapping* in this Discussion).<sup>83</sup> Ovarian preservation may be safe in select patients who are premenopausal with stage I endometrioid cancer.<sup>175-177</sup> Minimally invasive surgery is the preferred approach when technically feasible and is considered a quality measure by the SGO and the American College of Surgeons ([www.sgo.org/quality-outcomes-and-research/quality-indicators](http://www.sgo.org/quality-outcomes-and-research/quality-indicators); <https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/quality-of-care-measures>).

During surgery, the intraperitoneal structures should be carefully evaluated, and suspicious areas should be biopsied. While not specifically affecting staging, FIGO and AJCC recommend that peritoneal cytology should be collected and results should be recorded. Cytology results should not be taken in isolation to guide adjuvant therapy. Enlarged or suspicious lymph nodes should be excised to confirm or rule out metastatic disease. Retroperitoneal node dissection with pathologic evaluation—in the absence of clinically apparent lymphadenopathy—is useful when using the 2009 FIGO staging criteria, but its routine use has been questioned (see *Lymphadenectomy* in this Discussion). For stage II patients, TH/BSO is the standard procedure. Radical hysterectomy should only be performed if needed to obtain negative margins.

Patients with apparent uterine-confined endometrial carcinoma are candidates for sentinel node mapping, which assesses the pelvic nodes bilaterally and may be less morbid than complete lymphadenectomy (see

*Sentinel Lymph Node Mapping* in this Discussion). Adherence to the NCCN SLN algorithm is critical.

***Incomplete Surgical Staging***

For patients with incomplete surgical staging and high-risk intrauterine features, imaging is recommended, especially in patients with higher grade histologies.<sup>178,179</sup> Surgical restaging, including lymph node dissection, can also be done.<sup>87</sup> Based on the imaging and/or surgical restaging results, recommended adjuvant treatment options are provided in the algorithm (see Adjuvant Treatment for *Incompletely Surgically Staged* in the NCCN Guidelines for Endometrial Carcinoma).

***Fertility-Sparing Therapy***

Although the primary treatment of endometrial cancer is usually hysterectomy, continuous progestin-based therapy may be considered for highly selected patients with grade 1, stage IA (noninvasive) disease who wish to preserve fertility.<sup>180-184</sup> Likewise, it may also be selectively used for young patients with endometrial hyperplasia who desire fertility preservation. The guidelines include an algorithm for fertility-sparing therapy in selected patients with biopsy-proven grade 1 (preferably by D&C), stage IA noninvasive endometrioid adenocarcinoma (see *Criteria for Considering Fertility-Sparing Options* in the NCCN Guidelines for Endometrial Carcinoma). The panel recommends consultation with a fertility expert and genetic evaluation of tumor and evaluation for inherited cancer risk. When considering fertility-sparing therapy, all of the criteria must be met as outlined in the algorithm (eg, no metastatic disease) and a negative pregnancy test must be ensured. Patients should also receive counseling that fertility-sparing therapy is not the standard of care for the treatment of endometrial carcinoma. TH/BSO with surgical staging is recommended after childbearing is complete, if therapy is not effective, or if progression occurs. Fertility-sparing therapy is not recommended for high-risk patients (eg, those with high-grade endometrioid

adenocarcinomas, uterine serous carcinoma, clear cell carcinoma, carcinosarcoma, and uLMS).

Continuous progestin-based therapy may include megestrol acetate, medroxyprogesterone, or an intrauterine device (IUD) containing levonorgestrel.<sup>180,181,185</sup> A complete response occurs in about 50% of patients.<sup>180</sup> The use of progestin-based therapy should be carefully considered in the context of other patient-specific factors, including contraindications such as breast cancer, stroke, myocardial infarction, pulmonary embolism, deep vein thrombosis, and smoking. The panel also recommends counseling for weight management and lifestyle modification (see *Healthy Lifestyles* and *Nutrition and Weight Management* in the NCCN Guidelines for Survivorship available at [https://www.nccn.org/professionals/physician\\_gls/pdf/survivorship.pdf](https://www.nccn.org/professionals/physician_gls/pdf/survivorship.pdf)).

In patients receiving progestin-based therapies, the NCCN Panel recommends close monitoring with endometrial sampling (biopsies or D&C) every 3 to 6 months. TH/BSO with staging is recommended: 1) after childbearing is complete; 2) if patients have documented progression on biopsy; or 3) if endometrial cancer is still present after 6 to 12 months of progestin-based therapy.<sup>184,186</sup> Although some young patients who had subsequent negative endometrial biopsies after hormonal therapy were able to become pregnant (35%), the ultimate recurrence rate was high (35%).<sup>180,183,187-189</sup> In patients with persistent endometrial carcinoma after 6 months of failed hormonal therapy, the panel recommends pelvic MRI to exclude myoinvasion and nodal/ovarian metastasis before continuing fertility-sparing therapy.

In a study of patients who are premenopausal and have stage IA to B endometrial cancer, median 16-year follow-up data suggest that ovarian preservation is safe and not associated with an increased risk of cancer-related mortality.<sup>175</sup> Other studies also suggest that ovarian preservation may be safe in select patients.<sup>176,177</sup>

### ***Suspected or Gross Cervical Involvement***

For patients with suspected or gross cervical involvement (endometrioid histologies), cervical biopsy or pelvic MRI should be performed if not done previously (see *Additional Workup* in the NCCN Guidelines for Endometrial Carcinoma).<sup>178,179,190,191</sup> If negative, patients are assumed to have disease that is limited to the uterus and are treated as previously described, although a radical hysterectomy may be performed when necessary to obtain negative margins. It may be difficult to distinguish primary cervical carcinoma from stage II endometrial carcinoma. Thus, for patients suitable for primary surgery, TH or radical hysterectomy is recommended along with BSO, cytology (peritoneal lavage), and evaluation of lymph nodes if indicated (see *Principles of Evaluation and Surgical Staging* in the NCCN Guidelines for Endometrial Carcinoma).<sup>83</sup> In these patients, radical or modified radical hysterectomy may improve local control and survival when compared with TH.<sup>192,193</sup> Alternatively, the patient may undergo EBRT and brachytherapy (category 2B) followed by TH/BSO and surgical staging.

### ***Suspected Extrauterine Disease***

If extrauterine disease (endometrioid histologies) is suspected, imaging studies are recommended along with CA-125 testing (see *Additional Workup* in the NCCN Guidelines for Endometrial Carcinoma). ER testing is recommended in the setting of stage III or IV endometrioid tumors. Patients with no evidence of extrauterine disease are treated using the guidelines for disease limited to the uterus. Patients with abdominal- or pelvic-confined disease require surgical intervention using TH/BSO with surgical staging and surgical debulking with the goal to have no measurable residual disease; several studies support debulking.<sup>83,194-196</sup> Consider preoperative chemotherapy.<sup>197</sup> For distant visceral metastasis (eg, liver involvement), recommended options include systemic therapy with (or without) EBRT with (or without) TH/BSO and with (or without)

stereotactic body RT (SBRT). Ablative radiation can be considered for 1 to 5 metastatic lesions if disease is otherwise controlled (category 2B).<sup>198</sup>

#### *Patients Not Suited for Primary Surgery*

For uterine-confined disease not suitable for primary surgery, EBRT and/or brachytherapy is the preferred treatment approach. Alternatively, progestational agents (such as medroxyprogesterone acetate and megestrol acetate) and levonorgestrel IUD can also be considered for select patients (eg, estrogen and progesterone receptor–positive [ER/PR–positive]). Patients receiving hormonal therapy alone should be closely monitored by endometrial biopsy (eg, consider endometrial biopsies every 3–6 months).<sup>37,199</sup>

For suspected gross cervical involvement in patients who are not suited for primary surgery, EBRT and brachytherapy is an effective treatment that can provide pelvic control and long-term PFS (see *Principles of Radiation Therapy* in the NCCN Guidelines for Uterine Neoplasms).<sup>200-203</sup> EBRT and brachytherapy may be administered with or without platinum-based chemosensitization, depending on the clinical situation and medical fitness of the patient. If rendered operable, local treatment consisting of surgery should follow. Systemic therapy alone is also a primary treatment option (category 2B), but should be followed by EBRT + brachytherapy if the patient remains inoperable.

Patients with unresectable extrauterine pelvic disease (ie, vaginal, bladder, bowel/rectal, nodal, or parametrial involvement) are typically treated with EBRT with (or without) brachytherapy with (or without) systemic therapy, followed by re-evaluation of tailored surgery.<sup>204-207</sup> Systemic therapy alone can also be considered. Based on treatment response, patients should be re-evaluated for surgical resection and/or RT.

## **Adjuvant Therapy**

### ***Uterine-Confined Disease***

Thorough surgical staging provides important information to assist in selection of adjuvant therapy for endometrial tumors (see *Principles of Evaluation and Surgical Staging* in the NCCN Guidelines for Endometrial Carcinoma). Patients with stage I endometrial cancer who have thorough surgical staging are stratified by adverse risk factors (ie, age, positive LVSI, tumor size, and lower uterine segment or surface glandular involvement).<sup>208,209</sup> Recommended adjuvant treatment is outlined in the algorithm (see the NCCN Guidelines for Endometrial Carcinoma). Note that the treatment algorithm was revised in 2010 based on the updated FIGO staging.<sup>61</sup> However, by necessity, much of the discussion in this manuscript has been based on data from patients staged using the older FIGO/AJCC staging system. The implications of *stage migration* should be considered when evaluating historical data.

The basic concept underlying the recommendations in the NCCN Guidelines is the trend toward selection of more aggressive adjuvant therapy for patients as tumor grade and myometrial and/or cervical invasion increase, as risk of systemic metastases increase.<sup>210-212</sup> In surgical stage I and II endometrial cancer, other pathologic factors that may influence the decision regarding adjuvant therapy include LVSI, patient age, tumor volume, depth of invasion, and lower uterine segment or cervical glandular involvement. When administering adjuvant RT, it should be initiated as soon as the vaginal cuff has healed, but no later than 12 weeks after surgery.

Significant controversy centers on how much adjuvant therapy is necessary in patients with surgical stage I endometrial cancer. The practice of surgical staging has led to a decrease in the use of adjuvant therapy for stage I endometrial carcinoma, which is reflected in the option of observation in the NCCN Guidelines for selected patients with low-risk



features (see section on *Adjuvant Treatment* in the NCCN Guidelines for Endometrial Carcinoma).<sup>92,209,210,213-215</sup> The NCCN Panel prefers observation for patients with stage IA, grade 1/2 disease, but strongly suggests treatment with adjuvant vaginal brachytherapy for those  $\geq 60$  years and/or those with LVSI. For patients with stage IA, grade 3 tumors, especially in those who have been surgically staged, vaginal brachytherapy is the preferred option, or observation can be considered if no myometrial invasion is present. If higher risk factors are present, ie, age  $\geq 70$  years or LVSI, EBRT can be considered as a category 2B option. For patients with stage IB, grade 1–2 disease, vaginal brachytherapy is preferred although observation can be considered if no adverse risk factors are present. In these patients, the PORTEC-2 trial, without evaluation of pelvic nodes, found pelvic recurrence to be low with vaginal brachytherapy alone.<sup>216</sup> EBRT can be considered in grade 2 tumors if additional risk factors are present such as age  $\geq 60$  years and/or if LVSI is present. For stage IB, grade 3 disease with adverse risk factors, systemic therapy is added as a category 2B option (in addition to EBRT and/or vaginal brachytherapy).

The recommended postoperative (ie, adjuvant) treatment options for surgical stage II patients (using thorough surgical staging) are shown in the algorithm (see *Adjuvant Treatment* for stage II in the NCCN Guidelines for Endometrial Carcinoma). The NCCN Panel generally agrees on the role of adjuvant therapy for patients with an invasive cervical component if extrafascial hysterectomy is performed. However, for patients with stage II disease who have had a radical hysterectomy with negative surgical margins and no evidence of extrauterine disease, EBRT (preferred) and/or vaginal brachytherapy with (or without) systemic therapy (category 2B) are options. As with stage I disease, the presence of adverse risk factors (including depth of stromal invasion, grade, LVSI, and adverse fundal risk factors) should be considered when selecting adjuvant therapy for stage II disease.<sup>217</sup>

### *Adjuvant RT*

Several phase III trials have assessed adjuvant therapy in patients with uterine-confined disease. In summary, the use of adjuvant RT improves pelvic control in patients with selected risk factors (and may improve PFS), but has not been shown to improve OS. However, many of the earlier trials had limitations as the patients were primarily low risk (ie, they had low-risk intrauterine pathologic risk factors). It is recognized that in patients with uterine-confined disease, there is a spectrum of risk based on intrauterine pathologic findings. Adverse intrauterine pathologic risk factors include high-grade tumors, deep myometrial invasion (and consequently more advanced stage), LVSI (especially extensive), and serous or clear cell carcinoma histologies.

Four trials have evaluated the role of adjuvant external-beam pelvic RT in patients with endometrial carcinoma. In two of these trials, the patients were not formally staged (Postoperative Radiation Therapy in Endometrial Carcinoma [PORTEC-1], Aalders).<sup>218,219</sup> In the third trial (ASTEC/EN.5), only 50% of the patients were thoroughly staged as part of a companion surgical protocol.<sup>81,220</sup> However, formal surgical staging was mandated for all patients in the GOG 99 trial.<sup>221</sup> Note that these trials used the older staging system (ie, before 2009).

The PORTEC-1 and GOG 99 trials suggest that external-beam pelvic RT provides a locoregional control benefit in selected patients with uterine-confined disease.<sup>218,222</sup> Radiation was not shown to increase OS.<sup>223</sup> It is important to note that the PORTEC 1 trial was powered to evaluate OS, although the GOG 99 trial was not. Similarly the Aalders' randomized trial found that RT reduced vaginal (ie, locoregional) recurrences but did not reduce distant metastases or improve survival.<sup>219</sup> A pooled randomized trial (ASTEC/EN.5) suggested that adjuvant pelvic RT alone did not improve either relapse-free survival (ie, PFS) or OS in patients with intermediate-risk or high-risk early-stage endometrial cancer,

but there was an improvement in pelvic control.<sup>220</sup> However, the ASTEC/EN.5 study is very controversial; 51% of the patients in the ASTEC observation group received vaginal brachytherapy. Vaginal brachytherapy has been shown to decrease vaginal recurrence, and in PORTEC 2 vaginal brachytherapy was compared in a prospective randomized trial with EBRT in low-risk patients. Vaginal brachytherapy alone was shown to sufficiently control the pelvis and was less toxic than full pelvic RT. As most pelvic recurrences are vaginal, inclusion of vaginal brachytherapy in the “observation” arm of the ASTEC/EN.5 study weakens any conclusions regarding pelvic radiation.<sup>85,224</sup> The Keys’ trial (GOG 99) showed that adjuvant pelvic RT improved locoregional control and relapse-free interval (ie, PFS), without an OS benefit, although the study was not powered to evaluate OS.<sup>221,225,226</sup> In both trials pelvic radiation was found to be of greater benefit in patients >60 years with higher grade and more deeply invasive disease.

To help select the appropriate patient population that may benefit from adjuvant pelvic RT, the GOG 99 and PORTEC trials defined risk factors for patients at high-intermediate risk (HIR) for recurrence, although the definition differed between these trials.<sup>218,221</sup> Risk factors for recurrence identified in both trials included higher age, deep myometrial invasion (>50%), higher grade (grade 2 or 3, serous or clear cell), and LVSI (especially extensive as defined in the PORTEC trials). Based on risk factors identified in GOG 99, HIR disease was defined as patients <50 years with grade 2 or 3 disease, myometrial invasion greater than 50%, and LVSI.<sup>221</sup> Patients 50 to 70 years of age were considered HIR if they had 2 of the 3 identified high-risk features. Patients ≥70 years were defined as HIR if they also had one risk feature present. Based on data from PORTEC-1, HIR patients were defined as having 2 of 3 risk factors (ie, age >60 years, deep myometrial invasion, grade 3 histology).<sup>218,225</sup> LVSI was not considered in the original PORTEC trials, but a subsequent

retrospective evaluation demonstrated increased recurrence with extensive LVSI, as defined by the protocol.

Due to concerns about potential toxicity of external-beam pelvic RT, the role of vaginal brachytherapy alone in uterine-confined disease has been evaluated. PORTEC-2 randomly assigned patients to external-beam pelvic RT versus vaginal brachytherapy alone in uterine-confined disease. PORTEC-2 showed excellent and equivalent vaginal and pelvic control rates with both adjuvant radiation approaches and no difference in OS.<sup>216</sup> Given that vaginal brachytherapy is associated with significantly less toxicity than pelvic RT, vaginal brachytherapy alone is a reasonable choice for patients with uterine-confined endometrial cancer as defined in the PORTEC 2 trial.<sup>216,225-233</sup> The use of vaginal brachytherapy and/or whole pelvic RT should be carefully tailored to a patient’s pathologic findings. Both PORTEC-1 and PORTEC-2 specifically excluded patients with 1998 FIGO stage 1C and grade 3 endometrial carcinoma (2009 FIGO stage IB, grade 3);<sup>61</sup> thus, the use of adjuvant brachytherapy alone in this higher risk subset remains more controversial. PORTEC studies did not evaluate lymph nodes and, therefore, in the context of complete surgical staging and the lack of a survival benefit, the need for pelvic irradiation remains controversial in uterine-confined disease.

A meta-analysis evaluated results from studies that compared adjuvant postoperative EBRT with or without vaginal brachytherapy and vaginal brachytherapy alone in stage II endometrial cancer. EBRT + vaginal brachytherapy significantly reduced locoregional recurrence versus vaginal brachytherapy alone. OS was comparable in both arms.<sup>234</sup>

The GOG 249 trial examined vaginal cuff brachytherapy and 3 cycles of carboplatin/paclitaxel therapy (3 cycles) versus pelvic EBRT only in patients with high-risk, uterine-confined endometrial carcinoma (n = 601), including serous and clear cell carcinoma. GOG 249 reported significantly increased rates of nodal recurrence (primarily pelvic) in the brachytherapy



plus chemotherapy arm compared with the pelvic EBRT arm. No significant between-group differences in vaginal or distant recurrence rates were observed. However, there were more extravaginal pelvic failures in the brachytherapy plus chemotherapy arm. At a median follow-up of 53 months, 3-year RFS was 82% for both treatment arms; 3-year OS was 88% for the brachytherapy plus chemotherapy cohort and 91% for the pelvic EBRT cohort. Acute toxicity was more common and severe for patients receiving brachytherapy with chemotherapy. No differences in late-onset toxicities were observed.<sup>235</sup> Questions were raised whether 3 cycles of chemotherapy were sufficient to control distant disease.

Analysis of pooled data from PORTEC-1 and PORTEC-2 ranked the predictive power of multiple variables on patient outcomes examined in these trials. Patient age, tumor grade, and LVSI were highly predictive for locoregional relapse (LRR), distant relapse (DR), OS, and DFS, and treatment given (EBRT vs. vaginal brachytherapy) was predictive for LRR and DFS.<sup>208</sup> The benefit of adjuvant EBRT in the highest risk spectrum of uterine-confined disease remains controversial. Most NCCN Panel Members feel that patients with deeply invasive grade 3 tumors should receive adjuvant treatment. Two large retrospective SEER analyses of patients with endometrial cancer found that adjuvant RT improved OS in those with high-risk disease.<sup>236,237</sup> In a meta-analysis of randomized trials, a subset analysis found that adjuvant pelvic RT for stage I disease was associated with a trend towards a survival advantage in the highest-risk spectrum (eg, those with 1988 FIGO stage IC grade 3) but not in lower risk patients; however, other reviews have shown conflicting results.<sup>228,238-242</sup>

The long-term follow-up study (median 20.5 years) of 568 patients with early-stage endometrial carcinoma enrolled in the Aalders trial compared long-term outcomes in patients who received vaginal brachytherapy plus EBRT versus vaginal brachytherapy alone. The findings suggested no statistical difference in OS between the study groups, and in this cohort,

patients <60 years of age who received EBRT had increased incidence of secondary cancers and subsequent higher mortality rates.<sup>228</sup> Evaluation of secondary malignancies in the context of increased genetic susceptibility (eg, MSI-H) and radiation is ongoing.

### *Adjuvant Systemic Therapy*

Patients with deeply invasive, grade 3, uterine-confined disease (2009 FIGO stage IB, grade 3 [formerly 1988 FIGO stage IC, grade 3]) have a relatively poor prognosis. Despite adjuvant therapy with pelvic RT, a significant number of patients continue to have a significant risk of distant metastases, and an optimal adjuvant therapy is still sought.<sup>221,222</sup>

Therefore, some clinicians suggested that adding systemic therapy to adjuvant RT may provide added therapeutic benefit (ie, decrease in distant metastases).<sup>210,243</sup> Studies have evaluated the role of systemic therapy in highest risk uterine-confined disease.<sup>243,244</sup> PFS is improved with adjuvant sequential chemotherapy.<sup>243</sup> However, the NCCN Panel feels that adjuvant systemic therapy is a category 2B recommendation in this setting because an OS advantage has not been shown.<sup>243</sup> The GOG-249 phase 3 trial evaluated the benefit of adjuvant pelvic RT versus vaginal cuff brachytherapy plus 3 cycles of paclitaxel/carboplatin combination in 601 patients with high-intermediate and high-risk early-stage endometrial cancer. The 5-year RFS and OS were similar in both groups and superiority of any of these treatments were not demonstrated. Acute toxicity was greater in the combination therapy.<sup>245</sup>

### *Advanced Stage/Extrauterine Disease*

There is a consensus that patients with documented extrauterine disease are at increased risk for recurrence and need adjuvant therapy; however, the optimal form of adjuvant therapy has yet to be determined.<sup>246-248</sup>

Patients with extrauterine disease confined to the lymph nodes or the adnexa may be treated with pelvic or extended-field RT alone or with chemotherapy (radiation is targeted to sites of nodal disease).<sup>249</sup> However,



systemic therapy is regarded as the foundation of adjuvant therapy for patients with extrauterine disease. The NCCN Guidelines include carboplatin/paclitaxel as the preferred systemic therapy option in the primary/adjuvant setting for advanced-stage disease or high-risk histologies.<sup>250-252</sup> The NCCN Guidelines recently added the pembrolizumab/carboplatin/paclitaxel and dostarlimab carboplatin/paclitaxel triplet regimens as Category 1, preferred, primary therapy options for stage III or IV disease based on the data from phase III NRG-GY018 and RUBY trials, respectively.<sup>253,254</sup> The pembrolizumab/carboplatin/paclitaxel regimen is recommended for stage III or IVA with measurable disease or for stage IVB with or without measurable disease. Since the NRG-GY018 trial did not include patients with carcinosarcoma histology, the NCCN Panel do not recommend the pembrolizumab/carboplatin/paclitaxel treatment option for patients with carcinosarcoma disease. The dostarlimab carboplatin/paclitaxel option is recommended for patients with stage IIIA, IIIB, or IIIC1 with measurable disease, stage IIIC1 with carcinosarcoma, clear-cell, serous, or mixed histology regardless of the presence of measurable disease; and stage IIIC2 or stage IV disease regardless of the presence of measurable disease.

For stages III and IV disease, systemic therapy forms the mainstay of treatment and can be combined with EBRT with (or without) vaginal brachytherapy. The combination of therapies depends on assessment of both locoregional and distant metastatic risk. Combination therapy can be considered for stages IIIB and IIIC disease.

Previously, whole abdominal RT was used for carefully selected patients deemed at risk for peritoneal failure, and RT appeared to have provided therapeutic benefit in retrospective studies. However, it is considered too toxic and has largely been abandoned.<sup>255,256</sup> A randomized phase III GOG (122) trial assessed optimal adjuvant therapy for patients with endometrial

cancer who had extrauterine disease. In this trial, patients with stage III and intra-abdominal stage IV disease who had minimal residual disease were randomly assigned to whole abdominopelvic RT versus 7 cycles of combined doxorubicin (60 mg/m<sup>2</sup>) and cisplatin (50 mg/m<sup>2</sup>) treatment, with an additional cycle of cisplatin (AP). This GOG trial reported that AP chemotherapy improved PFS and OS when compared with whole abdominopelvic RT; however, acute toxicity (eg, peripheral neuropathy) was greater in the AP chemotherapy arm.<sup>205</sup>

The GOG 122 study established the role of adjuvant multiagent systemic chemotherapy for curative intent in patients with extrauterine disease. Thus, in the NCCN Guidelines, systemic therapy forms the established framework of adjuvant therapy for patients with stage III or IV disease. Whole abdominal RT as a single modality (as used in GOG 122) is considered inferior to chemotherapy and is too toxic; therefore, it is no longer recommended. For the purposes of these guidelines, whole abdominal RT is not considered to be tumor-directed RT (see *Principles of Radiation Therapy* in the NCCN Guidelines for Uterine Neoplasms).

Recurrences were frequent in both treatment arms of GOG 122, occurring in the pelvis and abdomen. Approximately 52% of patients with advanced endometrial carcinoma had recurrences, indicating the need for further therapeutic improvement in this high-risk patient population.<sup>205</sup> A study found that combined modality adjuvant therapy (using chemotherapy and tumor-directed RT) may provide a therapeutic benefit when compared with single-modality adjuvant therapy.<sup>207,257,258</sup>

A follow-up study evaluated the role of chemotherapy “intensification” for this patient population. The GOG 184 trial compared two chemotherapy regimens (cisplatin and doxorubicin with [or without] paclitaxel) with tumor-directed radiation (involved-field radiation either to the pelvis or to the pelvis plus para-aortic nodes). Results indicate that the 3-drug regimen did not improve survival when compared with the 2-drug regimen after 3 years

of follow-up and that the more intensive chemotherapy resulted in greater toxicity (eg, hematologic toxicity, sensory neuropathy, myalgia).<sup>206</sup>

In a retrospective review of 116 patients with stage IIIC endometrial cancer, adjuvant RT significantly improved OS in patients with endometrioid histology, high-grade tumors, and positive para-aortic lymph nodes. Conversely, patients with low-grade tumors and non-endometrioid histology who received RT had similar OS compared with those who did not.<sup>259</sup> In a multicenter retrospective review of 73 patients with stage IIIA endometrial carcinoma, surgery followed by both chemotherapy and RT provided the highest 5-year OS.<sup>260</sup> A prospective study of 122 patients with fully resected locally advanced disease suggested a potential benefit of adjuvant chemoradiation followed by chemotherapy, with an estimated 5-year PFS and OS of 73% and 84%.<sup>261</sup> Adjuvant therapy options were compared in a multicenter retrospective analysis of 265 patients with optimally resected stage IIIC endometrial carcinoma. Compared with patients receiving adjuvant RT or adjuvant RT plus chemotherapy, patients who received adjuvant chemotherapy alone had a 2.2-fold increased risk of recurrence and a 4.0-fold increased risk of death.<sup>248</sup>

Multimodality therapy is now the basis of randomized trials evaluating therapy. The phase 2, RTOG 9708 trial assessed 46 patients for safety, toxicity, recurrence, and survival when chemotherapy (cisplatin/paclitaxel) was combined with adjuvant radiation in patients with high-risk endometrial cancer. The trial participants included patients with grade 2 or 3 endometrial adenocarcinoma with either >50% myometrial invasion, cervical stromal invasion, or pelvic-confined extrauterine disease. The OS and DFS favored the combined modality treatment.<sup>262</sup>

The phase 3, PORTEC-3 trial investigated the benefit of combined adjuvant chemotherapy and EBRT versus EBRT alone in 686 patients with endometrial cancer (stage I, grade 3 with deep invasion, LVSI, or both; stage II; stage III; or any patient with stage I to III serous or clear cell

endometrial cancer). The 5-year OS was 81.4% (95% CI, 77.2–85.8) with chemoradiotherapy versus 76.1% (95% CI, 71.6–80.9) with radiotherapy alone (HR, 0.70; 95% CI, 0.51–0.97;  $P = .034$ ) and 5-year failure-free survival was 76.5% (95% CI, 71.5–80.7) versus 69.1% (63.8–73.8; HR, 0.70; 95% CI, 0.522–0.94;  $P = .016$ ).<sup>263,264</sup> Patients with serous cancers and with stage III disease were shown to benefit the most from the addition of systemic therapy. The combination treatment was also shown to be associated with more severe adverse events.<sup>265</sup>

The GOG-258 phase 3 trial evaluated 707 patients with stage III or IVA, high-risk endometrial cancer who were randomly assigned 1:1 to receive chemoradiotherapy or chemotherapy only.<sup>266</sup> This trial supported the benefit of using chemotherapy alone by concluding that the combined therapy was not associated with longer relapse-free survival when compared with chemotherapy alone (59% vs. 58%, respectively). OS results are pending.

A follow-up molecular analysis was performed of the PORTEC-3 trial to study the impact of chemoradiotherapy for each molecular subtype using tissue samples from the trial participants. The tumors were classified into *p53* abnormal, *POLE*, MMR-deficient (dMMR), or no specific molecular profile. The 5-year RFS with chemoradiotherapy versus RT alone was *p53* abnormal, 59% versus 36%; *POLE*, 100% versus 97%; dMMR, 68% versus 76%; and 80% versus 68% for no specific molecular profile, suggesting that systemic therapy was beneficial for those patients that were *p53* abnormal.<sup>267</sup> Results are awaited for an ongoing PORTEC-4a trial investigating molecular profile-based directed adjuvant treatment in high-risk endometrial cancer.<sup>268</sup>



### High-Risk Endometrial Carcinoma Histologies

#### Overview

Uterine serous carcinomas, clear cell carcinomas, carcinosarcomas, and undifferentiated/dedifferentiated carcinomas are considered more aggressive histologic variants of malignant epithelial tumors, with a higher incidence of extrauterine disease at presentation.<sup>269-276</sup> Carcinosarcomas are aggressive tumors that are staged as high-grade endometrial cancer.<sup>277,278</sup> Carcinosarcomas (also known as MMMTs) are metaplastic carcinomas and not uterine sarcomas; therefore, carcinosarcomas are included as part of the high-risk malignant epithelial tumors.<sup>273,276,279,280</sup> Even patients with apparent early-stage disease may have distant metastases. Thus, fertility-sparing therapy is not recommended for these aggressive tumors. If done, SLN mapping should proceed with particular caution. Serous carcinomas, clear cell carcinomas, carcinosarcomas, and undifferentiated/dedifferentiated carcinomas are all considered high-risk histologies and high grade by default, although they are staged using the same FIGO/AJCC staging system as endometrial cancers.<sup>63</sup> Patients with uterine serous carcinoma, clear cell carcinoma, carcinosarcoma, or undifferentiated/dedifferentiated carcinomas may present with pelvic masses, abnormal cervical cytology, or ascites in addition to postmenopausal bleeding. Both the NCCN Panel and the SGO recommend that CA-125 and MRI or chest/abdominal/pelvic CT may be useful before surgery to assess if extrauterine disease is present; PET may also be useful.<sup>269</sup> Patterns of failure often mimic those of ovarian cancer.

#### Primary Treatment

##### Suitable for Primary Surgery

Multimodality therapy is typically recommended for these histologically aggressive tumors. Primary treatment includes TH/BSO with surgical staging, peritoneal lavage for cytology, omental and peritoneal biopsies,

and consideration of maximal tumor debulking for gross disease (see *Principles of Evaluation and Surgical Staging* in the NCCN Guidelines for Endometrial Carcinoma).<sup>281</sup> Minimally invasive surgery is the preferred approach when technically feasible.<sup>282-286</sup>

Additional treatment options are highly individualized and are based on the histology and stage of the tumor.<sup>287-294</sup> For patients with clear cell or serous carcinomas with no residual disease in the hysterectomy specimen, observation is the recommended option. For stage IA disease without myometrial invasion with negative peritoneal washings, options include vaginal brachytherapy with (or without) systemic therapy (category 2B for systemic therapy) or observation. If the washings are positive, both systemic therapy and vaginal brachytherapy are recommended.<sup>295,296</sup> For patients with invasive stage IA, IB, or II, options include systemic therapy with (or without) EBRT with (or without) vaginal brachytherapy; or EBRT with (or without) vaginal brachytherapy. For patients with clear cell or serous carcinoma at a more advanced stage (ie, stage III or IV), or with undifferentiated/dedifferentiated histology, systemic therapy with (or without) EBRT with (or without) vaginal brachytherapy is recommended.<sup>271,288,292,297</sup>

For the patients with carcinosarcoma histology at stage IA, systemic therapy and vaginal brachytherapy are recommended with an option for EBRT, if it has high-grade epithelial components and is sarcoma dominant (>50% of sarcoma component in uterine tumor).<sup>298</sup> The panel notes that the initiation of chemotherapy within 3 to 6 weeks postoperatively should be considered and vaginal brachytherapy can be integrated with chemotherapy.

For patients with advanced histologies, whole abdominopelvic RT with (or without) vaginal brachytherapy is no longer recommended as a primary treatment option.<sup>205,297,299</sup> <sup>288</sup> Multimodality therapy including systemic therapy, EBRT, and vaginal brachytherapy appears to be more effective.



Data are conflicting regarding the rate of abdominal recurrence in these patients.<sup>297,300-304</sup> Whole abdominal radiotherapy is not considered to be tumor-directed RT (see *Principles of Radiation Therapy* in the NCCN Guidelines for Uterine Neoplasms). As previously mentioned, *tumor-directed RT* refers to RT directed at sites of known or suspected tumor involvement and may include EBRT with (or without) vaginal brachytherapy. In general, tumor-directed EBRT is directed to the pelvis with (or without) the para-aortic region.

### *Not Suitable for Primary Surgery*

For patients with disease that is not amenable to resection, or is not suitable for surgery due to comorbidities, the primary treatment option is EBRT with (or without) brachytherapy with (or without) systemic therapy and then re-evaluation for surgery. Alternatively, systemic therapy could be given first, and then patients can be re-evaluated for surgery before giving RT based on the tumor response. For patients with carcinosarcoma histology with unresectable tumor that has metastasized, the panel recommends systemic therapy with (or without) EBRT or best supportive care.

## Treatment of Recurrent or Metastatic Disease

### **Locoregional Recurrence**

Patients with local or regional recurrences (negative for distance metastases on radiologic imaging) can be evaluated for further treatment (see *Clinical Presentation* in the NCCN Guidelines for Endometrial Carcinoma). For recurrences confined to the vagina or the pelvis alone, second-line treatment (typically with RT and/or surgery or systemic therapy) can be effective and selection depends on prior therapy. For patients with no prior RT exposure at the recurrence site, the panel recommends EBRT with (or without) brachytherapy and systemic therapy, or surgery with (or without) intraoperative RT (IORT) and systemic therapy. For patients previously treated with brachytherapy only at the

recurrence site, surgery with (or without) IORT is recommended (category 3 for IORT).

For patients previously treated with EBRT at the recurrence site, recommended therapy for isolated relapse includes surgery with (or without) IORT (category 3 for IORT) plus or minus systemic therapy. Use of RT in the context of recurrence depends on the site of recurrence (inside or outside the prior radiation field), and dose of prior therapy. Re-irradiation is used only in the context of limited disease for palliation and lack of other options. In selected patients, radical surgery (ie, pelvic exenteration) has been performed with reported 5-year survival rates approximating 20%.<sup>305-308</sup>

Isolated vaginal recurrences treated with RT have good local control and 5-year survival rates of 50% to 70%.<sup>309-311</sup> Prognosis is worse if there is extravaginal extension or pelvic lymph node involvement.<sup>310</sup> After RT, it is unusual for patients to have recurrences confined to the pelvis. The management of such patients remains controversial.

Additional therapy options for disease confined to vagina or paravaginal soft tissues include EBRT with (or without) brachytherapy with (or without) systemic therapy. EBRT and systemic therapy are also included as options for the additional treatment of pelvic lymph node recurrence, para-aortic or common iliac lymph node invasion, and upper abdominal or peritoneal recurrences as shown in the algorithm (see *Additional Therapy* in the NCCN Guidelines for Endometrial Carcinoma).

### **Distant Metastases**

For gross upper abdominal residual disease, more aggressive treatment for relapse is recommended, as outlined for disseminated metastases in *Therapy for Relapse* in the NCCN Guidelines for Endometrial Carcinoma. For resectable isolated metastases, consider surgical resection and/or EBRT, or ablative therapy. Ablative RT can be considered for 1 to 5

metastatic lesions if the primary cancer has been controlled (category 2B).<sup>198</sup> Providers can also consider systemic therapy (category 2B). Further recurrences or disease not amenable to local therapy are treated as disseminated metastases. Treatment options for disseminated metastases are systemic therapy with (or without) palliative EBRT. For persistent progression of disseminated metastases, best supportive care is recommended (see the NCCN Guidelines for Palliative Care available at [https://www.nccn.org/professionals/physician\\_gls/pdf/palliative.pdf](https://www.nccn.org/professionals/physician_gls/pdf/palliative.pdf) and <http://emedicine.medscape.com/article/270646-overview>).

### **Hormonal Therapy**

The role of hormonal therapy in recurrent or metastatic cancer has been primarily evaluated in patients with endometrioid histologies only. Hormonal therapy is typically used for lower-grade endometrioid histologies, preferably in patients with small tumor volume or an indolent growth pace. Hormonal agents for treating metastatic disease include megestrol acetate with alternating tamoxifen, everolimus/letrozole combination, progestational agents (such as medroxyprogesterone acetate and megestrol acetate), aromatase inhibitors, tamoxifen alone, or fulvestrant.<sup>312-317</sup> No particular drug, dose, or schedule has been found to be superior. The main predictors of response in the treatment of metastatic disease are well-differentiated tumors, expression of ER/PR receptors, a long disease-free interval, and the location and extent of extrapelvic (particularly pulmonary) metastases.

For asymptomatic or low-grade disseminated metastases, hormonal therapy with progestational agents has shown good responses, particularly in patients with ER/PR-positive disease.<sup>318-321</sup> Tamoxifen has a 20% response rate in disease that does not respond to standard progesterone therapy.<sup>322,323</sup> Tamoxifen has also been combined with progestational agents; however, a few patients had grade 4 thromboembolic events with this combination regimen.<sup>314,315,324</sup> In some

patients, aromatase inhibitors (eg, anastrozole, letrozole) may be substituted for progestational agents or tamoxifen.<sup>320,321,325,326</sup>

Everolimus combined with letrozole is recommended for recurrent disease of endometrioid histology. In the phase 2 trial, in patients with progressive or recurrent endometrial cancer who had received up to two prior therapies, the clinical benefit rate and objective response rate among 35 evaluable patients was 40% and 32%, respectively.<sup>327</sup> In a following phase 2 study, patients (with or without prior chemotherapy) were treated either with the everolimus/letrozole combination or medroxyprogesterone acetate/tamoxifen regimen. Twenty-two percent of patients responded to the everolimus/letrozole therapy, while 25% showed a response with the medroxyprogesterone acetate/tamoxifen regimen.<sup>328</sup> Median PFS was 6 months for the everolimus/letrozole arm and 4 months for the hormonal therapy arm. Median OS was 31 months and 17 months for the everolimus/letrozole and medroxyprogesterone acetate/tamoxifen arms, respectively. Higher PFS was observed in both arms for patients who had not received any prior chemotherapy.

Other hormonal modalities have not been well-studied, and adjuvant therapy with hormonal agents has not been compared with cytotoxic agents.<sup>320,329</sup> If disease progression is observed after hormonal therapy, cytotoxic chemotherapy can be considered. However, clinical trials or best supportive care (see the NCCN Guidelines for Palliative Care available at [https://www.nccn.org/professionals/physician\\_gls/pdf/palliative.pdf](https://www.nccn.org/professionals/physician_gls/pdf/palliative.pdf)) are appropriate for patients with disseminated metastatic recurrence who have a poor response to hormonal therapy and chemotherapy.

### **Systemic Therapy**

Based on the current data, multiagent regimens are preferred for advanced disease, if tolerated. The NCCN Guidelines for Endometrial Carcinoma has updated the systemic therapy recommendation by including immunotherapy and chemotherapy-based combination regimens



as preferred, first-line options for recurrent disease. The NRG-GY018, randomized, phase III trial evaluated the benefits of pembrolizumab/carboplatin/paclitaxel regimen over the carboplatin/paclitaxel regimen in 816 patients with stage III or IVA endometrial carcinoma with measurable disease, or stage IVB or recurrent disease of any histologic subtype, except for carcinosarcoma.<sup>254</sup> The patients who had received adjuvant therapy at least 12 months before were included. The patients were stratified based on the dMMR or MMR-proficient (pMMR) status of the tumors. The PFS was 74% versus 38% in the dMMR cohort for the triplet regimen versus the chemotherapy arm, respectively (HR, 0.30; 95% CI, 0.19–0.48;  $P < .001$ ). In pMMR tumors, the median PFS was 13.1 months in pembrolizumab arm versus 8.7 months in the chemotherapy arm (HR, 0.54; 95% CI, 0.41–0.71;  $P < .001$ ). Another phase III, randomized trial (RUBY) showed benefits of adding dostarlimab to the carboplatin/paclitaxel regimen in 494 patients with stage III or IV or recurrent disease, including all histologies.<sup>253</sup> At 24 months, PFS was 36.1% versus 18.1% (HR, 0.64; 95% CI, 0.51–0.80;  $P < .001$ ) and OS was 71.3% versus 56% (HR, 0.64; 95% CI, 0.46–0.87) in the dostarlimab-based arm versus the chemotherapy arm, respectively. Significantly more benefits were observed in patient with dMMR/MSI-H tumors with PFS of 61.4% versus 15.7% (HR, 0.28; 95% CI, 0.16–0.50;  $P < .001$ ) in the triplet versus the doublet therapy arms, respectively.

Based on the results from the NRG-GY018 and RUBY trials, the NCCN Panel has added pembrolizumab/carboplatin/paclitaxel (except for carcinosarcoma histology) and dostarlimab/ carboplatin/paclitaxel as Category 1, preferred, first-line therapy options for recurrent endometrial carcinoma.

Chemotherapy for endometrial cancer has been extensively studied.<sup>330,331</sup> Other multiagent regimens such as carboplatin/paclitaxel,

carboplatin/docetaxel, and carboplatin/paclitaxel/bevacizumab are included as first-line therapy options for the recurrent disease setting.

Carboplatin and paclitaxel is an increasingly used regimen for advanced/metastatic or recurrent endometrial cancer; the response rate is about 40% to 62%, and OS is about 13 to 29 months.<sup>332-335</sup> A phase III trial (GOG 209) compared carboplatin and paclitaxel versus cisplatin, doxorubicin, paclitaxel, and filgrastim (granulocyte colony-stimulating factor).<sup>332</sup> Trial data show that oncologic outcomes are similar, but the toxicity and tolerability profile favor carboplatin/paclitaxel.<sup>336</sup> Thus, the carboplatin/paclitaxel regimen is a preferred, first-line option in the NCCN Guidelines. For patients in whom paclitaxel is contraindicated, docetaxel can be considered in combination with carboplatin.<sup>337,338</sup>

A phase II trial initially examined the addition of bevacizumab to carboplatin and paclitaxel among 15 patients with advanced or recurrent endometrial carcinoma.<sup>339</sup> Although this study was closed early due to the initiation of a national trial, a retrospective analysis was performed to include data from an additional 27 patients who had received carboplatin/paclitaxel/bevacizumab for advanced or recurrent disease.<sup>340</sup> Collective median PFS was 20 months with a median OS of 56 months. An overall response rate (ORR) of 82.8% was noted, with an 87.5% response rate among the subset of 8 patients who received this triplet regimen as second-line therapy after carboplatin/paclitaxel.<sup>340</sup> Another phase 2 randomized study showed that the carboplatin/paclitaxel/bevacizumab combination improved OS from 29.7 months to 40 months compared to the doublet regimen.<sup>341</sup> Another meta-analysis of three studies also concluded similar results where the triplet combination increased the OS and PFS at >12 months with an ORR of 76%.<sup>342</sup>

Other combination therapies such as cisplatin/doxorubicin, cisplatin/doxorubicin/paclitaxel, ifosfamide/paclitaxel (for carcinosarcoma),



and cisplatin/ifosfamide (for carcinosarcoma) are added as subsequent-therapy options. A phase III randomized trial (GOG 177) compared 2 combination chemotherapy regimens in females with advanced/metastatic or recurrent endometrial carcinoma. The 273 participants were randomly assigned to 1) cisplatin/doxorubicin/paclitaxel; or 2) cisplatin/doxorubicin. The 3-drug regimen was associated with improved survival (15 vs. 12 months,  $P < .04$ ) but with significantly increased toxicity (ie, peripheral neuropathy); therefore, it is not widely used.<sup>343-345</sup> These regimens are recommended as subsequent therapy options in the NCCN Guidelines, because most panel members feel that carboplatin/paclitaxel is a less toxic and preferred first-line option. The response rates with other multiagent chemotherapies have ranged from 31% to 81%, but with relatively short durations. The median survival for patients in such trials remains approximately 1 year.<sup>330,331</sup>

If multiagent chemotherapy regimens are contraindicated, then single-agent therapy options for recurrent disease include cisplatin, carboplatin, doxorubicin, liposomal doxorubicin, paclitaxel, albumin-bound paclitaxel, topotecan, temsirolimus, cabozantinib, and docetaxel (category 2B for docetaxel).<sup>320,346-348,321,349</sup> When single agents are used as second-line treatment, responses range from 4% to 27%; paclitaxel is the most active in this setting.<sup>349</sup> Some oncologists have used liposomal doxorubicin, because it is less toxic than doxorubicin; the response rate of liposomal doxorubicin is 9.5%.<sup>350</sup> Docetaxel is recommended for use as a single agent; however, it is a category 2B recommendation because it is less active (7.7% response rate) than other agents.<sup>351,352</sup> Bevacizumab was shown to have a 13.5% response rate and OS rate of 10.5 months in a phase II trial for persistent or recurrent endometrial cancer.<sup>353</sup> Based on these studies, the NCCN Panel considers bevacizumab as appropriate single-agent biologic therapy for patients who have progressed on previous cytotoxic chemotherapy.<sup>353-356</sup>

### *Useful in Certain Circumstances, Biomarker-Directed Therapies*

In the advanced endometrial cancer cohort (n = 24) of the phase Ib KEYNOTE-028 trial, durable antitumor responses were noted in a small subset of patients with programmed death ligand 1 (PD-L1)-positive tumors (3 partial response, 3 stable disease).<sup>357</sup> Studies have also indicated that dMMR tumors are sensitive to programmed death receptor-1 (PD-1) blockade.<sup>358-360</sup> Results were published from a study of patients with dMMR tumors of various disease sites. Among patients with dMMR endometrial carcinoma who received pembrolizumab (n = 15), the objective response rate was 52% and the disease control rate was 73% (3 complete response, 5 partial response, and 3 stable disease).<sup>358</sup> The phase 2 Keynote-158 trial further demonstrated robust antitumor activity of pembrolizumab with encouraging survival outcomes in patients with previously treated MSI-H/dMMR endometrial cancer and manageable adverse events.<sup>361</sup> Pembrolizumab is included as a treatment option for patients with recurrent endometrial cancer with MSI-H/dMMR disease that has progressed on or following prior treatment with a platinum-containing regimen in any setting including neoadjuvant or adjuvant therapy. The panel recommends that recurrent endometrial tumors be tested for MSI-H or dMMR if not done previously. The panel also recommends TMB-H testing if not previously done and has included the pembrolizumab option for patients with TMB-H tumors (>10 mut/Mb), as determined by a validated and/or FDA-approved test, who have progressed following prior treatment and who have no satisfactory alternative treatment options.<sup>362</sup>

Further studies have indicated that pembrolizumab monotherapy is less active in patients with microsatellite-stable or pMMR disease versus MSI-H/dMMR disease. Only 16% to 31% of endometrial cancers are MSI-H/dMMR.<sup>357,363,364</sup> The Keynote-146 phase 1/2 trial showed that the combination of pembrolizumab/lenvatinib had a promising antitumor response in patients with advanced endometrial cancer regardless of their tumor MSI status.<sup>365</sup> The Keynote-775 phase 3 trial randomly assigned

827 patients with pMMR (MSI-stable), previously treated advanced endometrial cancer to receive pembrolizumab/lenvatinib combination or chemotherapy (doxorubicin or paclitaxel).<sup>366</sup> The median PFS for the pembrolizumab/lenvatinib arm was 7.2 months versus 3.8 months for the chemotherapy arm (HR, 0.56; 95% CI, 0.47–0.66;  $P < .001$ ). The median OS was also longer for the pembrolizumab/lenvatinib arm than for the chemotherapy arm (18.3 vs. 11.4 months; HR, 0.62; 95% CI, 0.51–0.75;  $P < .001$ ). Based on these data, the NCCN Guidelines for Endometrial Carcinoma include lenvatinib/pembrolizumab as a category 1 option for pMMR tumors for patients who have received prior platinum-based therapy in any setting, including neoadjuvant and adjuvant therapy.

Other anti-PD-1 inhibitors, such as dostarlimab and nivolumab, have also shown antitumor activity against MSI-H tumors. Dostarlimab is being evaluated in the ongoing GARNET phase 1 trial for patients with advanced endometrial cancer with dMMR/MSI-H disease. The ORR after 16.3 months was 43.5% with a manageable safety profile. The NCCN Panel recommends dostarlimab for the treatment of patients with recurrent dMMR/MSI-H endometrial cancer that has progressed on or following prior treatment with a platinum-containing regimen in any setting including neoadjuvant or adjuvant therapy.

Nivolumab monotherapy has also demonstrated promising activity in endometrial carcinoma with dMMR tumors.<sup>367</sup> The PD-L1 inhibitor, avelumab, has shown an ORR of 26.7% in advanced endometrial cancer with dMMR tumor as monotherapy. Nivolumab and avelumab are included as biomarker-directed subsequent therapy options for recurrent dMMR/MSI-H endometrial tumors. The NCCN Panel also recommends larotrectinib or entrectinib for *NTRK* gene fusion-positive endometrial tumors as a category 2B subsequent therapy option.

### **Systemic Therapy Options for High-Risk Endometrial Histologies**

The NCCN Panel notes that the systemic therapy options recommended in the NCCN Guidelines can be used for all carcinoma histologies. Among these, carboplatin/paclitaxel is included as a category 1, preferred option for patients with carcinosarcoma histology. A randomized phase II study examined the addition of trastuzumab to carboplatin/paclitaxel for patients with advanced or recurrent HER2/neu-positive uterine serous carcinoma.<sup>368</sup> Among patients with stage III/IV disease undergoing primary treatment ( $n = 41$ ), median PFS was 17.9 months versus 9.3 months for the experimental and control arms, respectively ( $P = .013$ ). PFS for patients with recurrent disease ( $n = 17$ ) was 9.2 months versus 6.0 months ( $P = .003$ ). The addition of trastuzumab appeared to improve PFS without increasing overall toxicity. The safety and tolerability of the trastuzumab combination was further evaluated in 61 patients in a recent phase 2 trial with PFS as the primary endpoint.<sup>369</sup> The triplet therapy regimen carboplatin/paclitaxel/trastuzumab is recommended by the NCCN Panel as a preferred option for HER2-positive uterine serous carcinoma or HER2-positive carcinosarcoma as: 1) primary therapy for stage III/IV disease; or 2) a first-line option for recurrent disease. The NCCN Panel has designated the regimen a category 2B option for HER2-positive carcinosarcoma in both disease settings. This triplet regimen is recommended for patients who have not received any prior trastuzumab therapy. In subsequent therapy, the NCCN Panel has included ifosfamide, ifosfamide/paclitaxel, and ifosfamide/cisplatin as options for carcinosarcoma treatment only. For treating carcinosarcoma, ifosfamide was historically considered the most active single agent.<sup>370-372</sup> A phase III trial for advanced carcinosarcoma showed that the combination of ifosfamide and paclitaxel increased survival and was less toxic than the previously used cisplatin/ifosfamide regimen.<sup>370,373</sup> OS was 13.5 months with ifosfamide/paclitaxel versus 8.4 months with ifosfamide alone.<sup>299,370</sup>

### Radiotherapy Principles

RT has been a widely used modality in the treatment of patients with endometrial cancer; it clearly improves locoregional control.

*Tumor-directed RT* refers to RT directed at sites of known or suspected tumor involvement and may include EBRT and/or vaginal brachytherapy.<sup>211</sup> Imaging is required to assess locoregional extent and to rule out distant metastases before administration of RT. In general, EBRT is directed to the pelvis with or without the para-aortic region.

Brachytherapy can be delivered: 1) to an intact uterus, either preoperatively or definitively; or 2) more commonly, to the vagina after hysterectomy. For the purposes of these guidelines, whole abdominal radiotherapy is not considered to be tumor-directed RT. The panel notes that chemoradiation can be given concurrently or sequentially. RT is described in detail in the algorithm, including target areas and doses for pelvic RT and brachytherapy (see *Principles of Radiation Therapy* in the NCCN Guidelines for Uterine Neoplasms). Although adjuvant RT is typically not associated with high rates of severe morbidity,<sup>374</sup> studies have focused on subtle effects on quality of life (eg, diarrhea, bowel symptoms) that deserve further investigation.<sup>229,231,375</sup> In the PORTEC-2 trial, vaginal brachytherapy was associated with better quality of life when compared with EBRT without a significant detriment to outcome.<sup>229</sup> Therefore, many patients who were previously treated with adjuvant EBRT are now appropriately treated with vaginal brachytherapy; this recommendation is reflected in the NCCN Guidelines. Patients treated with RT are prone to vaginal stenosis, which can impair sexual function. Individuals assigned female at birth can use vaginal dilators to prevent or treat vaginal stenosis. Dilator use can start 2 to 4 weeks after RT is completed and can be used indefinitely (<https://www.mskcc.org/cancer-care/patient-education/vaginal-health>).

### Post-Treatment Surveillance

The recommended post-treatment surveillance protocol for endometrial cancer is shown in the algorithm (see *Surveillance* in the NCCN Guidelines for Endometrial Carcinoma).<sup>43,49</sup> These recommendations recognize that the value of intensive surveillance has not been demonstrated in this disease; therefore, ancillary testing is not recommended.<sup>376,377</sup>

Patients with clinical stage I and stage II endometrial cancer have a recurrence rate of approximately 15%;<sup>377-380</sup> 50% to 70% of these patients are symptomatic. For most patients, disease recurs within 3 years of initial treatment. Because most recurrences are symptomatic, all patients should receive verbal and written information regarding the symptoms of potential recurrence.<sup>377</sup> Patients with bleeding (vaginal, bladder, or rectal), decreased appetite, weight loss, pain (in the pelvis, abdomen, hip, or back), cough, shortness of breath, and swelling (in the abdomen or legs) should seek prompt evaluation and not delay until the next scheduled appointment.

History and physical exam is recommended every 3 to 6 months for the first 2 to 3 years, and then every 6 to 12 months thereafter for up to the fifth year, then annually. For non-fertility sparing treatment, imaging should be guided by patient symptoms, risk assessment, and clinical concern for recurrent or metastatic disease. The indications of metastatic disease may include abnormal physical exam finding, bulky uterine tumor, vaginal or extrauterine involvement, delay in presentation or treatment, and abdominal or pulmonary symptoms. For fertility-sparing treatment, the panel recommends repeat pelvic MRI (preferred) for patients with persistent endometrial carcinoma after 6 to 9 months of failed medical therapy, especially if considering further fertility-sparing approaches. Abdominal/pelvic MRI and/or chest CT is recommended based on symptoms or physical exam findings. Whole body FDG-PET/CT and/or

abdomen/pelvis MRI can be considered in select patients as clinically indicated.

In the absence of recurrence, post-treatment surveillance provides psychosocial reassurance and improves quality of life for patients and their families. Health maintenance has been incorporated into the follow-up schedule (eg, blood pressure determination, breast examination, mammography as clinically indicated, stool guaiac test, immunizations). Patients should receive counseling and education regarding lifestyle, obesity, exercise, smoking cessation, sexual health, nutrition, and potential late or long-term effects of treatment (see the NCCN Guidelines for Survivorship (available at [https://www.nccn.org/professionals/physician\\_gls/pdf/survivorship.pdf](https://www.nccn.org/professionals/physician_gls/pdf/survivorship.pdf)), the NCCN Guidelines for Smoking Cessation (available at [https://www.nccn.org/professionals/physician\\_gls/pdf/smoking.pdf](https://www.nccn.org/professionals/physician_gls/pdf/smoking.pdf)), and <http://www.cancer.org/treatment/survivorshipduringandaftertreatment/index>).<sup>375,381-383</sup> Other health problems that often coexist in patients with endometrial cancer can also be evaluated during follow-up.

Given the lack of prospective studies regarding the optimal frequency of post-treatment follow-up, the NCCN Panel believes that the algorithm represents a reasonable surveillance scheme. The use of vaginal cytology is no longer recommended for patients who are asymptomatic consistent with the SGO guidelines.<sup>376,377,380,384</sup> Patients with stage I endometrial cancer have a low risk of asymptomatic vaginal recurrence (2.6%), especially after adjuvant brachytherapy, and vaginal cytology is not independently useful for detecting recurrences in this group of patients.<sup>376,385</sup> A multi-institutional review examined the utility of various surveillance methods in 254 patients with high-grade disease, revealing that symptoms led to the detection of the most recurrences (56%), followed by physical exam (18%), surveillance CT (15%), CA-125 (10%), and vaginal cytology (1%).<sup>386</sup>

### Hormone Therapy for Hypoestrogenism

After BSO, hypoestrogenism is associated with hot flashes, mood lability, vaginal dryness, pelvic soft tissue atrophy, osteoporosis, and an increased risk of cardiovascular disease. In patients who are postmenopausal, estrogen therapy was believed to reduce or reverse some of these signs and symptoms. However, patients who have had BSO for endometrial adenocarcinoma have usually been denied estrogen therapy for fear of inducing a higher relapse rate, because this cancer has historically been considered an estrogen-linked malignancy.<sup>387,388</sup> As such, estrogen therapy for such patients remains controversial.

However, it has never been proven that relapse rates are higher in patients with endometrial cancer who receive estrogen therapy after hysterectomy. Several retrospective trials of estrogen therapy after treatment of early-stage endometrial cancer have shown no increase in tumor recurrence or cancer-related deaths.<sup>389-391</sup> In females with stage I to II endometrial cancer who had hysterectomy, a randomized trial of estrogen therapy versus placebo did not find an increased rate of recurrence or new malignancy; the median follow-up was 35.7 months.<sup>392</sup> However, estrogen trials in postmenopausal females without a history of malignancy have demonstrated a significantly increased risk for breast cancer.<sup>393</sup>

Initially, the Women's Health Initiative (WHI) Estrogen-Alone Trial in females who had hysterectomy (n = 10,739) reported that the risk of breast cancer and cardiovascular disease (eg, stroke) were increased and that estrogen therapy was of concern; thus, the trial was stopped.<sup>394</sup> However, recent long-term follow-up data from this trial suggest that the risk from estrogen-alone replacement therapy (without progesterone) may not be as high in younger patients (<60 years) who have had hysterectomy.<sup>395</sup>

The NCCN Panel agrees that estrogen therapy is a reasonable option for patients who are at low risk for tumor recurrence, but initiating such therapy should be individualized and discussed in detail with the patient.<sup>396,397</sup> If adjuvant treatment is carried out, there should be a 6- to 12-month waiting period before initiation of hormone therapy, and participation in clinical trials is strongly encouraged. Selective estrogen-receptor modulators (SERMs) may prove to be attractive options for hormone therapy.<sup>398,399</sup> Long-term comparisons between conjugated estrogens and SERMs for hormone therapy are needed. Non-hormonal therapy may be considered in patients who are deemed poor candidates for hormone therapy (eg, people who smoke, those with a history of breast cancer, those with a history of multiple strokes).<sup>400,401</sup>

## Uterine Sarcomas

### Overview

Uterine sarcomas are uncommon malignant mesenchymal tumors, accounting for approximately 3% of all uterine cancers, and include high or low-grade ESS, UUS, uLMS, and others such as PEComas (see *Initial Clinical Findings* in the NCCN Guidelines for Uterine Sarcoma).<sup>402</sup> According to a 2012 systematic review of data from 1970 to 2011, uLMS was the most common subtype (63%), followed by ESS (21%) and less common subtypes such as UUS.<sup>403</sup> Even rarer subtypes of malignant mesenchymal tumors that can occur in the uterus include adenosarcoma, rhabdomyosarcoma (RMS), and PEComa.<sup>404</sup> Carcinosarcomas were previously categorized and included in the sarcoma treatment algorithms until the mid-2000s, but are now considered and treated as high-grade epithelial tumors (carcinomas).<sup>273</sup> Screening for Lynch syndrome is not usually done for patients with malignant mesenchymal tumors.

### Pathology and Molecular Analysis

Expert gynecologic pathology review is recommended for the assessment and histologic differentiation of uterine sarcomas including uLMS, UUS,

ESS, and adenosarcoma.<sup>83</sup> The pathologic assessment of the uterus should include hysterectomy type, specimen integrity (intact, opened, morcellated, or other), tumor size, myometrial invasion (for adenosarcoma only), histologic type, grade (for adenosarcoma only), and LVSI. The assessment should also include other tissues/organ involvement (fallopian tubes, ovaries, vagina, parametrium, omentum, or other).

Peritoneal/ascitic fluid cytology should also be done. If the lymph nodes are resected, the level of nodal involvement and the number of lymph nodes with metastasis should be determined. Routine node dissection is not required in the absence of clinical suspicion of nodal involvement.

Recent advances have expanded our understanding of the molecular features of these tumors, leading to the identification of genetic signatures that characterize some of the uterine sarcoma subtypes. Historically, mesenchymal tumors were primarily diagnosed using histopathologic criteria, and the results of molecular studies were not used in routine pathologic evaluation. However, given the overlap in histopathologic features of these tumors, molecular analysis (eg, identification of characteristic translocations) can help classify difficult cases and provide future therapeutic targets. The panel notes that comprehensive genomic profiling in the setting of metastatic disease with a validated and/or FDA-approved assay is informative for predicting rare pan-tumor-targeted therapy opportunities. The panel recommends testing of at least NTRK, MSI, and TMB proteins. Since the molecular profiling is informative in many mesenchymal malignancies for accurate classification,<sup>405</sup> the NCCN Guidelines for Uterine Neoplasms include a table containing information on histologic and molecular findings, specific biomarkers, relevant confirmatory molecular tests, prognostic features, and other clinically useful information to help clinicians differentiate between and classify uterine sarcoma subtypes. This information is intended to complement histopathologic testing to improve differential diagnosis of relatively rare uterine sarcoma subtypes and provide safer, more effective care for

patients with the disease. The panel notes that this information is not exhaustive and intends to update these recommendations as more data becomes available.

#### **Low-Grade and High-Grade Endometrial Stromal Sarcoma (ESS)**

ESSs are the second most common mesenchymal tumors of the uterus. ESSs are composed of cells resembling the endometrial stroma in the proliferative phase.<sup>404,406</sup> LGESSs have distinct fingerlike patterns of myometrial invasion, and LVSI is usually present. ESS displays a heterogenous mix of morphologic and genetic features. A significant proportion of these tumors (ie, up to half) harbor *JAZF1*, *PHF1*, or *EPC1* gene fusions and present as earlier-stage tumors.<sup>407-410</sup> The panel notes that diagnosis of low-grade ESS can be confirmed by identifying any low-grade ESS-associated gene fusion by using FISH and/or targeted RNA sequencing, though the lack of rearrangement or fusion does not exclude the diagnosis. It is worth noting that in rare instances, low-grade ESS can transform into high-grade ESS (either at the time of primary diagnosis or recurrence), which will require histopathologic and molecular (eg, *JAZF1* or *PHF1* translocation) confirmation.

A higher-grade and more aggressively behaving ESS variant with a unique genetic rearrangement *YWHAE::FAM22A/B*, also known as *YWHAE::NUTM2A/B*, has been identified.<sup>411,412</sup> This subtype is known as high-grade ESS. Another subtype of high-grade ESS harboring *BCOR* is either in the form of a *ZC3H7B::BCOR* fusion or an internal tandem duplication. Both *ZC3H7B::BCOR* fusion-positive and *BCOR* internal tandem duplication high-grade ESS have spindle and/or round cells embedded in myxoid matrix, and demonstrate strong and diffuse positivity for cyclin D1 and variable positivity for CD10, ER, and PR.<sup>413</sup> IHC testing for CD10, cyclin D1, and *BCOR* and, in some cases, molecular analysis of *BCOR* alterations, may help differentiate between *BCOR*-altered high-grade ESS and myxoid uterine leiomyosarcoma

(myxoid ULMS) due to overlapping morphologic features. It is currently unclear whether specific types of high-grade ESS (ie, *YWHAE*-altered or *BCOR*-altered) differ in prognosis and/or response to chemotherapy.

These findings provided support for subdividing ESS into distinct low- and high-grade entities based on histopathology, clinical behavior, and patient outcomes. The updated 2014 edition of the WHO *Classification of Tumors of Female Reproductive Organs* recognizes low-grade ESS and high-grade ESS as distinct histopathologic entities.<sup>414</sup> The 5th edition on *Female Genital Tumors* in 2020 also recognizes *BCOR*-altered sarcomas as a distinct subtype of high-grade ESS.<sup>415</sup>

#### **Undifferentiated Uterine Sarcoma (UUS)**

UUSs are a group of high-grade/aggressive sarcomas characterized by infiltrative sheets of epithelioid and/or spindle cells that may be uniform or pleomorphic. As a class, it is a heterogenous group of high-grade mesenchymal neoplasms of the uterus that fail to meet the diagnostic threshold for other characterized uterine mesenchymal neoplasms. As such, UUS is usually reserved as a diagnosis of exclusion, after other defined uterine mesenchymal neoplasms have been excluded using a multiprong approach that often requires a combination of extensive IHC panel and next-generation sequencing (NGS) molecular analysis. For example, high-grade ESS is often misdiagnosed as UUS due to a shared lack of smooth muscle differentiation.<sup>416</sup> The panel notes that molecular testing for *BCOR* alterations, which can occur in high-grade ESS as noted above, is useful to exclude a high-grade ESS diagnosis before rendering a diagnosis of UUS.

A subset of UUSs called *SMARCA4*-deficient uterine sarcomas (SDUSs) have distinctive morphology (eg, phyllodiform architecture) along with biallelic inactivation of *SMARCA4* that results in loss of *SMARCA4/BRG1* expression. These tumors occur in younger patients and may be associated with very aggressive clinical behavior.<sup>417</sup> The panel

recommends analysis of *SMARCA4/BRG1* by IHC and/or *SMARCA4* by DNA sequencing to confirm a diagnosis of SDUS with otherwise appropriate morphologic and immunophenotypic features. However, loss of *SMARCA4/BRG1* alone does not constitute a diagnosis of SDUS, and other aggressive malignancies such as undifferentiated endometrial carcinoma may show loss of expression of this protein.

### **Uterine Leiomyosarcoma (uLMS)**

uLMS are usually of the spindle cell (conventional) type, but less common variants with myxoid or epithelioid morphology also exist. Although morphology differs between subtypes, all express varying degrees of the smooth muscle markers, including desmin, smooth muscle actin (SMA), and caldesmon. The panel recommends an IHC panel including desmin and SMA to support a uLMS diagnosis, particularly if myxoid or epithelioid uLMS is suspected.

Myxoid uLMSs may appear histologically similar to *BCOR*-altered HGESSs or inflammatory myofibroblastic tumor (IMT). The panel recommends cyclin D1 and/or *BCOR* IHC to help exclude an HGESS diagnosis, as the latter is often overexpressed in HGESS. A subset (25%) of myxoid uLMSs also harbor *PLAG1* fusions. Therefore, a myxoid uLMS diagnosis may be supported by positive desmin and SMA IHC along with *PLAG1* rearrangement by FISH assay or RNA sequencing. One differential diagnosis that must be considered for epithelioid uLMS is PEComa, given the observed similarities in morphology and IHC for smooth muscle markers. IHC testing for HMB45 and melanA may be performed if a diagnosis of PEComa is being considered, with HMB45 being fairly sensitive and melanA being specific for PEComa compared with uLMS. However, it is recognized that uterine mesenchymal tumors with myomelanocytic differentiation can still be challenging to classify solely by IHC. A study examining this specific group of diagnostically

challenging tumors supported the use of genomic profiling to aid in their classification.<sup>418</sup>

### **Uterine Tumor Resembling Ovarian Sex Cord Tumor (UTROSCT)**

UTROSCTs are very rare tumors with sex cord-like differentiation, but without a stromal component as observed in ESSs. Most of these tumors harbor either *ESR1* or *GREB1* fusions.<sup>419,420</sup> The panel recommends an IHC panel that includes sex cord markers (eg, inhibin, calretinin, SF1, FOXL2); UTROSCTs are often positive for a broad range of biomarkers. In some cases, FISH or RNA sequencing for *ESR1* or *GREB1* fusions may be helpful to confirm the diagnosis. Approximately 25% of these tumors are malignant; the panel notes that the presence of necrosis, high mitotic index, and *GREB1* fusions may be associated with malignant behavior.

### **Rhabdomyosarcoma**

Uterine RMSs are an aggressive, heterogeneous group of tumors that are extremely rare in adult patients. Subtypes include alveolar, embryonal, and pleomorphic; all express myogenic biomarkers (eg, myogenin and MyoD1).<sup>421</sup> Therefore, the panel notes that diffuse expression of myogenic biomarkers by IHC can help confirm a uterine RMS diagnosis. Prognosis differs between subtypes, with embryonal RMS having the best prognosis of the 3 subtypes. Molecular alterations also differ between subtypes. *FOXO1* fusions are found in alveolar RMS, whereas *PIK3CA* and *TP53* mutations are found in pleomorphic RMS. *DICER1* mutations are present in up to 95% of embryonal RMS. The embryonal subtype also is known to harbor *FGFR4/RAS/AKT* pathway mutations.<sup>422</sup> The panel notes that extensive sampling should be performed to exclude epithelial components and diagnoses of carcinosarcoma and adenosarcoma with heterologous rhabdomyosarcomatous differentiation. The panel recommends FISH and/or RNA sequencing for *FOXO1* to help confirm cases of suspected uterine alveolar RMS.

## Staging and Treatment

When evaluating suspected uterine sarcomas, biopsy may be helpful but is less sensitive than for endometrial cancers. The diagnosis of ESS and uLMS is often made after hysterectomy. The previous FIGO/AJCC staging systems for endometrial cancer were not appropriate for staging ESS and uLMS; patients were often upstaged when using the older AJCC staging system.<sup>423</sup> A new staging system for ESS and uLMS from FIGO/AJCC took effect in 2009 accounting for the differences between uterine sarcomas and endometrial cancers.<sup>63,424</sup>

Confirmation of the type of mesenchymal malignancy by expert pathology review is critical. In addition, initial evaluation should include imaging of the chest/abdomen/pelvis by CT or combination MRI/CT. It is important to determine if the sarcoma is confined to the uterus or if extrauterine disease is present. Pelvic MRI can be used to evaluate local tumor extension or residual abnormality in cases where the uterus or adnexa were not resected or incompletely resected (ie, supracervical hysterectomy, myomectomy, possible tumor fragmentation, intraperitoneal morcellation). Neck/chest/abdomen/pelvis/groin FDG-PET/CT may be used to clarify ambiguous findings. If medically operable, then hysterectomy with (or without) BSO and en bloc resection of tumor is the initial treatment of choice for uterine sarcomas (see *Primary Treatment* in the NCCN Guidelines for Uterine Sarcoma).<sup>425</sup>

The panel recommends ER/PR testing for LMS, ESS, and adenosarcoma to guide decisions regarding management of the ovaries, particularly in young patients who are premenopausal. In general, BSO is favored for low-grade ESS or tumors expressing ER/PR, although management of the ovaries may be individualized in patients of reproductive-age.<sup>426</sup> A systemic review and meta-analysis of 786 patients reported 46.8% of tumor recurrence rate in ovarian preservation group versus 24.2% recurrence in the BSO group.<sup>427</sup> In another multicenter retrospective study,

the PFS for patients who underwent BSO versus ovarian preservation as 38 versus 11 months ( $P = .071$ ).<sup>428</sup>

Uterine sarcoma should be removed en bloc to optimize outcomes; intraperitoneal morcellation is contraindicated.<sup>171,174</sup> For incidental diagnoses of uterine sarcoma after hysterectomy, or in the case of a fragmented specimen, imaging is recommended and re-exploration for surgical resection can be considered. The ovaries may be preserved in selected patients with early-stage uLMS who wish to retain hormonal function.<sup>429</sup> Additional surgical resection should be individualized based on clinical scenarios and intraoperative findings. Lymphadenectomy is controversial.<sup>2,404,429-432</sup> High-grade uterine sarcomas tend to show hematogenous metastases to the lungs; lymph node metastases are uncommon.

For medically inoperable sarcomas, options include: systemic therapy and/or palliative EBRT with (or without) brachytherapy.

### **Low-Grade Endometrial Stromal Sarcoma**

Recommended adjuvant therapy options for stage I ESS include BSO or observation (if menopausal or prior BSO). BSO with (or without) anti-estrogen hormone therapy is recommended for stages II to IV ESS. Adjuvant EBRT may be added for stage II, III, or IVA (category 2B). Palliative EBRT may be added for patients with stage IVB disease.<sup>404,433,434</sup> Anti-estrogen hormone therapy is also recommended for ESSs that have recurred or are unresectable (see *Therapy for Relapse* in the NCCN Guidelines for Uterine Sarcoma).<sup>435</sup> Given the histologic similarities between low-grade ESS and uterine adenosarcoma, the panel recommends similar adjuvant therapy options for adenosarcoma as provided for low-grade ESS. For patients with uterine adenosarcoma with sarcomatous overgrowth (SO) in advanced stages, the panel recommends BSO with a consideration of systemic therapy and EBRT. EBRT is palliative for stage IVB disease.



Case series of patients with ESS suggest long disease-free intervals in the absence of specific therapy and raise questions about the use of adjuvant RT.<sup>436</sup> Adjuvant radiotherapy in ESS has been demonstrated to reduce local recurrence rates but again with limited effect on survival.<sup>437,438</sup>

Because of concerns about radiation exposure, frequent routine surveillance imaging is no longer recommended for patients who are young and asymptomatic after primary therapy for ESS.<sup>439</sup>

Although anti-estrogen hormone therapy is recommended for low-grade ESS, studies have not yet determined the optimal therapeutic approach for high-grade ESS. However, due to the more aggressive nature of these tumors (eg, those with YWHAE-FAM22 rearrangements), the NCCN Panel has recommended that high-grade ESS be treated according to the algorithms in place for uLMS and UUS.

Typical hormone therapy for low-grade ESS or adenosarcoma without SO or ER/PR-positive uterine sarcoma includes aromatase inhibitors<sup>440</sup> (preferred for low-grade ESS or adenosarcoma without SO), fulvestrant, megestrol acetate (category 2B for ER/PR-positive uterine sarcoma), or medroxyprogesterone acetate (category 2B for ER/PR-positive uterine sarcoma). Gonadotropin-releasing hormone [GnRH] analogs are also included as a category 2B option.<sup>404,429,435</sup> For ER/PR-positive uterine sarcomas, the anti-estrogen hormone therapy should preferably be considered for patients with small tumor volume or an indolent growth pace.

### **High-Grade Endometrial Stromal Sarcoma, Leiomyosarcoma, Undifferentiated Uterine Sarcoma, and PEComa**

The role of adjuvant radiotherapy in nonmetastatic disease is controversial. Most available data are retrospective except for a phase III randomized trial.<sup>441</sup> Most retrospective studies of adjuvant RT suggest an improvement in local pelvic control but no appreciable or consistent improvement in OS, given the propensity of metastatic extrapelvic disease

as a site of first or eventual recurrence.<sup>442-445</sup> In many series, the patients treated with adjuvant radiation presumably had higher-risk factors (eg, larger tumors, deeper myometrial invasion), thus biasing the data against radiotherapy. However, a phase III randomized trial in stage I and II uterine sarcomas reported that postoperative pelvic radiotherapy did not improve OS for uLMS when compared with observation.<sup>441</sup> Therefore, routine postoperative RT is not recommended for stage I patients with uLMS and UUS.<sup>433</sup> If used in more advanced stages, adjuvant RT needs to be individualized and based on careful analysis of surgical pathologic findings.

The role of adjuvant systemic therapy is also poorly defined; however, adjuvant systemic therapy has been used because of the high risk of systemic relapse. Given the uncertainties regarding any adjuvant treatment for stage I high-grade ESS, uLMS, USS, and other sarcomas (such as PEComa) after complete resection, observation is the only option. A systemic review and meta-analysis concluded that adjuvant chemotherapy in early-stage uLMS was not beneficial in reducing locoregional and distant recurrences over observation.<sup>446</sup> Because of the increased risk profile in patients with completely resected stage II and III tumors, the panel believes that it is appropriate to consider adjuvant systemic therapy and/or EBRT. Observation can be considered for patients with completely resected tumors with negative margins. (see *Additional Therapy* in the NCCN Guidelines for Uterine Sarcoma).<sup>447</sup> In patients with stage IV incompletely resected or metastatic disease, systemic therapy and/or EBRT is generally recommended. For stage IVB disease, systemic therapy with an option of palliative EBRT is recommended.

### **Treatment of Recurrent or Metastatic Disease**

The recurrence rate is high in uLMS (50%–70%).<sup>2</sup> The guidelines provide recommendations based on tumor resectability and patients' prior RT

exposure (see *Therapy for Relapse* in the NCCN Guidelines for Uterine Sarcoma). Treatment recommendations are made according to the site and nature of the recurrence.

Local recurrences are classified as recurrence in the vagina/pelvis with imaging that is negative for distant metastatic disease. Surgical and RT treatment pathways are provided. The surgical pathway for treating local recurrence in patients without prior RT exposure includes the option of IORT (category 3 for IORT). Preoperative EBRT with (or without) systemic therapy are also options to consider. For residual disease following surgery in patients without preoperative RT, EBRT with (or without) brachytherapy with (or without) systemic therapy can be considered. Primary RT offers an alternative pathway for treating localized recurrence in patients without prior exposure. EBRT should be given along with the option of brachytherapy and systemic therapy. For both the surgical and RT treatment pathways, further adjuvant systemic therapy should be considered after initial treatment.

Patients with local recurrence who have had prior RT exposure can be treated with: 1) surgery with the option of IORT with (or without) systemic therapy (category 3 for IORT); 2) systemic therapy; or 3) selected reirradiation with EBRT and/or brachytherapy. A retrospective analysis of patients with ESS suggested that cytoreductive resection improved OS in patients with recurrent lesions.<sup>448</sup>

Systemic therapy with (or without) palliative EBRT or best supportive care is recommended for metastatic disease.<sup>449</sup> For patients with isolated metastases that is resectable, surgical resection or other ablative therapy (eg, radiofrequency ablation, SBRT) may be appropriate. Patients with uLMS who experience longer time to recurrence may have improved survival outcomes following metastasectomy.<sup>450</sup> Pre- or postoperative EBRT and/or systemic therapy can be considered. Observation may be an option in select, completely resected cases with no evidence of disease on

postoperative imaging. Systemic therapy and/or local therapy (tumor-directed EBRT or local ablative therapy) are reasonable options for patients with unresectable isolated metastases (see *Therapy for Relapse* in the NCCN Guidelines for Uterine Sarcoma).<sup>451-454</sup> For recurrent low-grade ESS, the first choice of systemic therapy is anti-estrogen hormone therapy.

### **Systemic Therapy for Advanced, Metastatic/Recurrent or Inoperable Disease**

If systemic therapy is used for treating high-grade uterine sarcoma, preferred first-line therapy options include single-agent doxorubicin, gemcitabine/docetaxel,<sup>455-460</sup> doxorubicin/ifosfamide, and doxorubicin/dacarbazine (see *Systemic Therapy* in the NCCN Guidelines for Uterine Sarcoma).<sup>404,406,449</sup> Doxorubicin is an active single agent for uLMS and is less toxic than combination regimens.<sup>404,449</sup>

The LMS-04 phase 3 randomized trial with 150 patients (67 with uLMS and 83 with soft-tissue LMS) tested the benefits of doxorubicin/trabectedin versus doxorubicin alone as first-line therapy. Median PFS for the combination arm was longer than for the doxorubicin arm (12.2 months vs. 6.2 months, respectively; HR, 0.41; 95% CI, 0.29–0.58;  $P < .0001$ ). Based on these findings, the panel recommends doxorubicin/trabectedin for patients with LMS.

For second-line or subsequent therapy, trabectedin is included as a preferred option for unresectable or metastatic uLMS that has been treated with a prior anthracycline-containing regimen. Data indicate that trabectedin may be useful in patients who have exhausted standard chemotherapy.<sup>461-464</sup> The phase III data revealed a 2.7-month PFS benefit versus dacarbazine in metastatic liposarcoma or leiomyosarcoma that progressed after anthracycline-based therapy.<sup>465</sup> Follow-up subgroup analysis of patients with uLMS (n = 232) revealed PFS of 4.0 months for trabectedin versus 1.5 months for dacarbazine (HR, 0.57; 95% CI, 0.41–



0.81;  $P = .0012$ ).<sup>466</sup> However, OS did not differ significantly between the treatment arms (13.4 months for trabectedin vs. 12.9 months for dacarbazine; HR, 0.89; 95% CI, 0.65–1.24;  $P = .51$ ). Other recommended regimens include gemcitabine/dacarbazine, gemcitabine/vinorelbine, dacarbazine, gemcitabine, epirubicin, ifosfamide, liposomal doxorubicin, pazopanib, temozolomide, and eribulin (category 2B).<sup>372,452,455,456,467-483</sup>

Eribulin is included based on results from a phase III trial comparing the survival benefit of eribulin and dacarbazine in 452 patients with advanced leiomyosarcoma or adipocytic sarcoma.<sup>484</sup> Median OS was 13.5 and 11.5 months for eribulin and dacarbazine, respectively (HR, 0.77; 95% CI, 0.62–0.95;  $P = .017$ ). Eribulin was designated as category 2B upon panel review of the mature trial data.

For first-line biomarker-directed therapies, the panel recently added crizotinib, ceritinib, brigatinib, lorlatinib, and alectinib for anaplastic lymphoma kinase (ALK) fusion-positive IMTs for uterine sarcomas based on the literature evidence derived from non-small cell lung cancer.<sup>485-488</sup>

The panel also recommends larotrectinib or entrectinib for *NTRK* gene fusion-positive tumors. For PEComa, albumin-bound sirolimus is recommended as a first-line therapy option and sirolimus, everolimus, temsirolimus are recommended as second-line or subsequent therapy options. Pembrolizumab has been added for the treatment of patients with unresectable or metastatic TMB-H tumors that have progressed following prior treatment and have no satisfactory alternative treatment options. Olaparib, rucaparib, and niraparib are included as second-line/subsequent therapy options for *BRCA2*-altered uLMS.<sup>489</sup>

### Post-Treatment Surveillance

The recommended post-treatment surveillance protocol for uterine sarcoma is depicted in the algorithm (see *Surveillance* in the NCCN Guidelines for Uterine Sarcoma). History and physical exam is

recommended every 3 to 4 months for the first 2 to 3 years, and then every 6 to 12 months thereafter. Imaging surveillance should include chest/abdominal/pelvic CT every 3 to 6 months for the first 3 years and then every 6 to 12 months for the next 2 years. Depending on histology, grade, and initial stage, annual to biannual imaging can be considered for an additional 5 years. Follow-up imaging may be as frequent as every 3 months or change based on histology grade and/or stage of tumor. Abdominal/pelvic MRI and chest CT without contrast is optional. Neck/chest/abdomen/pelvis/groin FDG-PET/CT can be considered if metastasis is suspected in select patients. Additional imaging should be based on symptomatology and clinical concern for metastatic disease.

Patients should receive education regarding the symptoms of recurrent disease. Patients with bleeding (vaginal, bladder, or rectal), decreased appetite, weight loss, pain (in the pelvis, abdomen, hip, or back), cough, shortness of breath, and swelling (in the abdomen or legs) should seek prompt evaluation and not delay until the next scheduled appointment. Imaging may be helpful in the detection of recurrence. Patients should be educated regarding healthy lifestyle choices, obesity, exercise, smoking cessation, nutrition, and potential long-term and late effects of treatment. See *Principles of Gynecologic Survivorship* within the NCCN Guidelines for Uterine Neoplasms (also see the NCCN Guidelines for Survivorship, NCCN Guidelines for Smoking Cessation, and <http://www.cancer.org/treatment/survivorshipduringandaftertreatment/index>).<sup>381-383</sup> The panel also recommends patient education regarding sexual health, vaginal dilator use, and vaginal lubricants or moisturizers.

### Drug Reactions

Virtually all drugs have the potential to cause adverse hypersensitivity reactions, either during or after the infusion.<sup>490</sup> In gynecologic oncology treatment, drugs that more commonly cause adverse reactions include carboplatin, cisplatin, docetaxel, liposomal doxorubicin, and paclitaxel.

Most of these drug reactions are mild infusion reactions (ie, skin reactions, cardiovascular reactions, respiratory or throat tightness), but more severe allergic reactions (ie, life-threatening anaphylaxis) can occur.<sup>491-493</sup> In addition, patients can have mild allergic reactions or severe infusion reactions. Infusion reactions are more common with paclitaxel.<sup>494</sup> Allergic reactions (ie, true drug allergies) are more common with platinum agents (ie, carboplatin, cisplatin).<sup>494,495</sup>

Management of drug reactions is discussed in the NCCN Guidelines for Ovarian Cancer.<sup>494</sup> It is important to note that patients who have had severe life-threatening reactions should not receive the implicated agent again unless under the care of an allergist or expert in managing drug reactions. If a mild allergic reaction has previously occurred and it is appropriate to administer the drug again, a desensitization regimen should be used even if the symptoms have resolved; various desensitization regimens have been published and should be followed.<sup>496-498</sup> Patients must be desensitized with each infusion if they previously had a reaction. Almost all patients can be desensitized (about 90%).<sup>490</sup> To maximize safety, it is prudent to desensitize patients in the intensive care unit.<sup>490</sup>

### Gynecologic Survivorship

Treatment for gynecologic cancer typically involves surgery, chemotherapy, hormone therapy, RT, and/or immunotherapy, which may cause acute, short-term, and long-term toxicities. Surgical approaches may be extensive and cause adhesions to form, which in turn may cause pain and contribute to the development of small bowel obstruction, urinary or gastrointestinal complications (eg, incontinence, diarrhea), pelvic floor dysfunction (manifested by a variety of urinary, bowel, and/or sexual effects), and lymphedema. Chemotherapy agents vary, though commonly used regimens may pose a significant risk of neurotoxicity, cardiac toxicity, cognitive dysfunction, and the development of hematologic cancers. Long-term estrogen deprivation may cause symptoms such as hot flashes,

vaginal dryness, and bone loss. RT may cause long-term complications (eg, fibrosis, stenosis, vulvovaginal atrophy) and may predispose patients to subsequent cancers of the skin, subcutaneous tissue, and/or underlying organs that are proximal to the radiation field. Use of immunotherapy agents in gynecologic cancers is emerging, and to date, long-term effects of these treatments are unknown.

Following completion of treatment, all gynecologic cancer survivors should receive regular general medical care that focuses on managing chronic diseases (eg, depression, diabetes, hypertension), monitoring cardiovascular risk factors, receiving recommended vaccinations, and encouraging adoption of a healthy lifestyle (eg, promoting exercise, smoking cessation). In order to assess the late and long-term effects of gynecologic cancers, clinicians should comprehensively document the patient's history, including prior treatment history, and conduct a thorough physical examination followed by necessary imaging and/or laboratory testing. As most treatments for gynecologic cancers will cause sexual dysfunction, early menopause, and infertility, special attention to the resultant medical and psychosocial implications is needed. All patients, whether sexually active or not, should be asked about genitourinary symptoms, including vulvovaginal dryness. Post-radiation use of vaginal dilators and moisturizers is recommended. Psychosocial effects may include psychological (eg, depression, anxiety, fear of recurrence, altered body image), financial (eg, return to work, insurance concerns), and interpersonal (eg, relationships, sexuality, intimacy). Patients should be referred to appropriate specialty providers (eg, physical therapy, pelvic floor therapy, sexual therapy, psychotherapy) as needed, based on prior treatment history and assessed risk of developing late effects and/or existing concerns. Communication and coordination with all clinicians involved in the care of survivors, including primary care clinicians, is critical. Providing survivors with a summary of their treatment and recommendations for follow-up is also recommended. To this end, the

SGO has developed templates for gynecologic cancer-specific Survivorship Care Plans to aid survivors and their clinicians in summarizing cancer history, treatments received, possible side effects, and recommended follow-up.





### References

1. Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer statistics, 2022. *CA Cancer J Clin* 2022;72:7-33. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/35020204>.
2. D'Angelo E, Prat J. Uterine sarcomas: a review. *Gynecol Oncol* 2010;116:131-139. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19853898>.
3. Siegel RL, Miller KD, Jemal A. Cancer statistics, 2016. *CA Cancer J Clin* 2016;66:7-30. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26742998>.
4. Van den Bosch T, Coosemans A, Morina M, et al. Screening for uterine tumours. *Best Pract Res Clin Obstet Gynaecol* 2012;26:257-266. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22078749>.
5. Kitchener HC, Trimble EL, Endometrial Cancer Working Group of the Gynecologic Cancer I. Endometrial cancer state of the science meeting. *Int J Gynecol Cancer* 2009;19:134-140. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19258955>.
6. Dinkelspiel HE, Wright JD, Lewin SN, Herzog TJ. Contemporary clinical management of endometrial cancer. *Obstet Gynecol Int* 2013;2013:583891. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23864861>.
7. Obermair A, Youlden DR, Young JP, et al. Risk of endometrial cancer for women diagnosed with HNPCC-related colorectal carcinoma. *Int J Cancer* 2010;127:2678-2684. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20533284>.
8. Katz VL. Diagnostic procedures. Imaging, endometrial sampling, endoscopy: indications and contraindications, complications. In: Katz VL, Lentz GM, Lobo RA, Gershenson DM, eds. *Comprehensive Gynecology*. 5th ed. Philadelphia, Pa: Mosby; 2007:chap 11.
9. Siegel RL, Miller KD, Jemal A. Cancer Statistics, 2017. *CA Cancer J Clin* 2017;67:7-30. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28055103>.
10. Ueda SM, Kapp DS, Cheung MK, et al. Trends in demographic and clinical characteristics in women diagnosed with corpus cancer and their potential impact on the increasing number of deaths. *Am J Obstet Gynecol* 2008;198:218 e211-216. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18226630>.
11. Chan JK, Sherman AE, Kapp DS, et al. Influence of gynecologic oncologists on the survival of patients with endometrial cancer. *J Clin Oncol* 2011;29:832-838. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21263082>.
12. Benedetti Panici P, Basile S, Salerno MG, et al. Secondary analyses from a randomized clinical trial: age as the key prognostic factor in endometrial carcinoma. *Am J Obstet Gynecol* 2014;210:363 e361-363 e310. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24361787>.
13. Doll KM, Tseng J, Denslow SA, et al. High-grade endometrial cancer: revisiting the impact of tumor size and location on outcomes. *Gynecol Oncol* 2014;132:44-49. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24183734>.
14. Wang J, Xu P, Yang X, et al. Association of Myometrial Invasion With Lymphovascular Space Invasion, Lymph Node Metastasis, Recurrence, and Overall Survival in Endometrial Cancer: A Meta-Analysis of 79 Studies With 68,870 Patients. *Front Oncol* 2021;11:762329. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/34746002>.
15. Raffone A, Travaglino A, Raimondo D, et al. Prognostic value of myometrial invasion and TCGA groups of endometrial carcinoma. *Gynecol Oncol* 2021;162:401-406. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/34088515>.
16. Resnick KE, Hampel H, Fishel R, Cohn DE. Current and emerging trends in Lynch syndrome identification in women with endometrial cancer.



Gynecol Oncol 2009;114:128-134. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/19375789>.

17. McAlpine JN, Chiu DS, Nout RA, et al. Evaluation of treatment effects in patients with endometrial cancer and POLE mutations: An individual patient data meta-analysis. *Cancer* 2021;127:2409-2422. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/33793971>.

18. Jumaah AS, Salim MM, Al-Haddad HS, et al. The frequency of POLE-mutation in endometrial carcinoma and prognostic implications: a systemic review and meta-analysis. *J Pathol Transl Med* 2020;54:471-479. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/32867011>.

19. Travaglino A, Raffone A, Stradella C, et al. Impact of endometrial carcinoma histotype on the prognostic value of the TCGA molecular subgroups. *Arch Gynecol Obstet* 2020;301:1355-1363. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/32296930>.

20. Kwon JS, Scott JL, Gilks CB, et al. Testing women with endometrial cancer to detect Lynch syndrome. *J Clin Oncol* 2011;29:2247-2252. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/21537049>.

21. Buchanan DD, Tan YY, Walsh MD, et al. Tumor mismatch repair immunohistochemistry and DNA MLH1 methylation testing of patients with endometrial cancer diagnosed at age younger than 60 years optimizes triage for population-level germline mismatch repair gene mutation testing. *J Clin Oncol* 2014;32:90-100. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/24323032>.

22. Ferguson SE, Aronson M, Pollett A, et al. Performance characteristics of screening strategies for Lynch syndrome in unselected women with newly diagnosed endometrial cancer who have undergone universal germline mutation testing. *Cancer* 2014;120:3932-3939. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/25081409>.

23. Goodfellow PJ, Billingsley CC, Lankes HA, et al. Combined Microsatellite Instability, MLH1 Methylation Analysis, and Immunohistochemistry for Lynch Syndrome Screening in Endometrial Cancers From GOG210: An NRG Oncology and Gynecologic Oncology

Group Study. *J Clin Oncol* 2015;33:4301-4308. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/26552419>.

24. Watkins JC, Yang EJ, Muto MG, et al. Universal Screening for Mismatch-Repair Deficiency in Endometrial Cancers to Identify Patients With Lynch Syndrome and Lynch-like Syndrome. *Int J Gynecol Pathol* 2017;36:115-127. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/27556954>.

25. Mills AM, Liou S, Ford JM, et al. Lynch syndrome screening should be considered for all patients with newly diagnosed endometrial cancer. *Am J Surg Pathol* 2014;38:1501-1509. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/25229768>.

26. Raffone A, Travaglino A, Cerbone M, et al. Diagnostic Accuracy of Immunohistochemistry for Mismatch Repair Proteins as Surrogate of Microsatellite Instability Molecular Testing in Endometrial Cancer. *Pathol Oncol Res* 2020;26:1417-1427. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/32377987>.

27. Win AK, Lindor NM, Winship I, et al. Risks of colorectal and other cancers after endometrial cancer for women with Lynch syndrome. *J Natl Cancer Inst* 2013;105:274-279. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/23385444>.

28. Lancaster JM, Powell CB, Kauff ND, et al. Society of Gynecologic Oncologists Education Committee statement on risk assessment for inherited gynecologic cancer predispositions. *Gynecol Oncol* 2007;107:159-162. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/17950381>.

29. Meyer LA, Broaddus RR, Lu KH. Endometrial cancer and Lynch syndrome: clinical and pathologic considerations. *Cancer Control* 2009;16:14-22. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/19078925>.

30. Bonnet D, Selves J, Toulas C, et al. Simplified identification of Lynch syndrome: a prospective, multicenter study. *Dig Liver Dis* 2012;44:515-522. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/22480969>.



31. Smith RA, Cokkinides V, Brawley OW. Cancer screening in the United States, 2012: A review of current American Cancer Society guidelines and current issues in cancer screening. *CA Cancer J Clin* 2012;62:129-142. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22261986>.
32. Crispens MA. Endometrial and ovarian cancer in lynch syndrome. *Clin Colon Rectal Surg* 2012;25:97-102. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23730224>.
33. Walsh CS, Blum A, Walts A, et al. Lynch syndrome among gynecologic oncology patients meeting Bethesda guidelines for screening. *Gynecol Oncol* 2010;116:516-521. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20034658>.
34. Manchanda R, Saridogan E, Abdelraheim A, et al. Annual outpatient hysteroscopy and endometrial sampling (OHES) in HNPCC/Lynch syndrome (LS). *Arch Gynecol Obstet* 2012;286:1555-1562. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22865035>.
35. Jarvinen HJ, Renkonen-Sinisalo L, Aktan-Collan K, et al. Ten years after mutation testing for Lynch syndrome: cancer incidence and outcome in mutation-positive and mutation-negative family members. *J Clin Oncol* 2009;27:4793-4797. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19720893>.
36. Schmeler KM, Lynch HT, Chen LM, et al. Prophylactic surgery to reduce the risk of gynecologic cancers in the Lynch syndrome. *N Engl J Med* 2006;354:261-269. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16421367>.
37. Leslie KK, Thiel KW, Goodheart MJ, et al. Endometrial cancer. *Obstet Gynecol Clin North Am* 2012;39:255-268. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22640714>.
38. Smith RA, Brooks D, Cokkinides V, et al. Cancer screening in the United States, 2013: a review of current American Cancer Society guidelines, current issues in cancer screening, and new guidance on cervical cancer screening and lung cancer screening. *CA Cancer J Clin* 2013;63:88-105. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23378235>.
39. McCluggage WG. My approach to the interpretation of endometrial biopsies and curettings. *J Clin Pathol* 2006;59:801-812. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16873562>.
40. McKeeney JK, Longacre TA. Low-grade endometrial adenocarcinoma: a diagnostic algorithm for distinguishing atypical endometrial hyperplasia and other benign (and malignant) mimics. *Adv Anat Pathol* 2009;16:1-22. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19098463>.
41. Leitao MM, Jr., Kehoe S, Barakat RR, et al. Comparison of D&C and office endometrial biopsy accuracy in patients with FIGO grade 1 endometrial adenocarcinoma. *Gynecol Oncol* 2009;113:105-108. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19167049>.
42. Gimpelson RJ, Rappold HO. A comparative study between panoramic hysteroscopy with directed biopsies and dilatation and curettage. A review of 276 cases. *Am J Obstet Gynecol* 1988;158:489-492. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/3348309>.
43. Lee JH, Dubinsky T, Andreotti RF, et al. ACR appropriateness Criteria(R) pretreatment evaluation and follow-up of endometrial cancer of the uterus. *Ultrasound Q* 2011;27:139-145. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21606818>.
44. Ortashi O, Jain S, Emmanuel O, et al. Evaluation of the sensitivity, specificity, positive and negative predictive values of preoperative magnetic resonance imaging for staging endometrial cancer. A prospective study of 100 cases at the Dorset Cancer Centre. *Eur J Obstet Gynecol Reprod Biol* 2008;137:232-235. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17537566>.
45. Crivellaro C, Signorelli M, Guerra L, et al. Tailoring systematic lymphadenectomy in high-risk clinical early stage endometrial cancer: the role of 18F-FDG PET/CT. *Gynecol Oncol* 2013;130:306-311. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23707673>.



46. Kitajima K, Suzuki K, Senda M, et al. Preoperative nodal staging of uterine cancer: is contrast-enhanced PET/CT more accurate than non-enhanced PET/CT or enhanced CT alone? *Ann Nucl Med* 2011;25:511-519. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21670955>.
47. Antonsen SL, Jensen LN, Loft A, et al. MRI, PET/CT and ultrasound in the preoperative staging of endometrial cancer - a multicenter prospective comparative study. *Gynecol Oncol* 2013;128:300-308. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23200916>.
48. Bollineni VR, Ytre-Hauge S, Bollineni-Balabay O, et al. High Diagnostic Value of 18F-FDG PET/CT in Endometrial Cancer: Systematic Review and Meta-Analysis of the Literature. *J Nucl Med* 2016;57:879-885. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26823564>.
49. Expert Panel on GYN, Imaging OB, Reinhold C, et al. ACR Appropriateness Criteria(R) Pretreatment Evaluation and Follow-Up of Endometrial Cancer. *J Am Coll Radiol* 2020;17:S472-S486. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33153558>.
50. Duk JM, Aalders JG, Fleuren GJ, de Bruijn HW. CA 125: a useful marker in endometrial carcinoma. *Am J Obstet Gynecol* 1986;155:1097-1102. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/3465243>.
51. Duk JM, Aalders JG, Fleuren GJ, et al. Tumor markers CA 125, squamous cell carcinoma antigen, and carcinoembryonic antigen in patients with adenocarcinoma of the uterine cervix. *Obstet Gynecol* 1989;73:661-668. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/2648225>.
52. Patsner B, Orr JW, Jr., Mann WJ, Jr. Use of serum CA 125 measurement in posttreatment surveillance of early-stage endometrial carcinoma. *Am J Obstet Gynecol* 1990;162:427-429. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/2309825>.
53. Rose PG, Sommers RM, Reale FR, et al. Serial serum CA 125 measurements for evaluation of recurrence in patients with endometrial carcinoma. *Obstet Gynecol* 1994;84:12-16. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/8008305>.
54. Price FV, Chambers SK, Carcangiu ML, et al. CA 125 may not reflect disease status in patients with uterine serous carcinoma. *Cancer* 1998;82:1720-1725. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/9576294>.
55. Boronow RC, Morrow CP, Creasman WT, et al. Surgical staging in endometrial cancer: clinical-pathologic findings of a prospective study. *Obstet Gynecol* 1984;63:825-832. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/6728365>.
56. Cowles TA, Magrina JF, Masterson BJ, Capen CV. Comparison of clinical and surgical-staging in patients with endometrial carcinoma. *Obstet Gynecol* 1985;66:413-416. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/4022500>.
57. Creasman WT, Morrow CP, Bundy BN, et al. Surgical pathologic spread patterns of endometrial cancer. A Gynecologic Oncology Group Study. *Cancer* 1987;60:2035-2041. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/3652025>.
58. Benedet JL, Bender H, Jones H, 3rd, et al. FIGO staging classifications and clinical practice guidelines in the management of gynecologic cancers. FIGO Committee on Gynecologic Oncology. *Int J Gynaecol Obstet* 2000;70:209-262. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/11041682>.
59. Wright JD, Barrena Medel NI, Sehouli J, et al. Contemporary management of endometrial cancer. *Lancet* 2012;379:1352-1360. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22444602>.
60. Pecorelli S. Revised FIGO staging for carcinoma of the vulva, cervix, and endometrium. *Int J Gynaecol Obstet* 2009;105:103-104. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19367689>.
61. Creasman W. Revised FIGO staging for carcinoma of the endometrium. *Int J Gynaecol Obstet* 2009;105:109. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19345353>.



62. Mariani A, Dowdy SC, Podratz KC. New surgical staging of endometrial cancer: 20 years later. *Int J Gynaecol Obstet* 2009;105:110-111. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19285672>.
63. Amin MB, Edge SB, Greene FL, et al. *AJCC cancer staging manual*, 8th edition. New York: Springer; 2017.
64. Matsuo K, Yabuno A, Hom MS, et al. Significance of abnormal peritoneal cytology on survival of women with stage I-II endometrioid endometrial cancer. *Gynecol Oncol* 2018;149:301-309. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29605499>.
65. Peters EEM, Leon-Castillo A, Smit V, et al. Defining Substantial Lymphovascular Space Invasion in Endometrial Cancer. *Int J Gynecol Pathol* 2022;41:220-226. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/34261899>.
66. Brierley JD, Gospodarowicz MK, Wittekind C. *TNM classification of malignant tumours*: John Wiley & Sons; 2017.
67. Rottmann D, Snir OL, Wu X, et al. HER2 testing of gynecologic carcinosarcomas: tumor stratification for potential targeted therapy. *Mod Pathol* 2020;33:118-127. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/31477811>.
68. Cimbaluk D, Rotmensch J, Scudiere J, et al. Uterine carcinosarcoma: immunohistochemical studies on tissue microarrays with focus on potential therapeutic targets. *Gynecol Oncol* 2007;105:138-144. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17175012>.
69. Crane E, Naumann W, Tait D, et al. Molecular variations in uterine carcinosarcomas identify therapeutic opportunities. *Int J Gynecol Cancer* 2020;30:480-484. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32114514>.
70. Livasy CA, Reading FC, Moore DT, et al. EGFR expression and HER2/neu overexpression/amplification in endometrial carcinosarcoma. *Gynecol Oncol* 2006;100:101-106. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16157366>.
71. Yoshida H, Nishikawa T, Matsumoto K, et al. Histopathological features of HER2 overexpression in uterine carcinosarcoma: proposal for requirements in HER2 testing for targeted therapy. *Virchows Arch* 2021;478:1161-1171. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33423127>.
72. Jenkins TM, Cantrell LA, Stoler MH, Mills AM. HER2 Overexpression and Amplification in Uterine Carcinosarcomas With Serous Morphology. *Am J Surg Pathol* 2022;46:435-442. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/35125452>.
73. Ali A, Black D, Soslow RA. Difficulties in assessing the depth of myometrial invasion in endometrial carcinoma. *Int J Gynecol Pathol* 2007;26:115-123. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17413976>.
74. Goff BA, Rice LW. Assessment of depth of myometrial invasion in endometrial adenocarcinoma. *Gynecol Oncol* 1990;38:46-48. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/2354826>.
75. Daniel AG, Peters WA, 3rd. Accuracy of office and operating room curettage in the grading of endometrial carcinoma. *Obstet Gynecol* 1988;71:612-614. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/3353053>.
76. Soliman PT, Frumovitz M, Spannuth W, et al. Lymphadenectomy during endometrial cancer staging: practice patterns among gynecologic oncologists. *Gynecol Oncol* 2010;119:291-294. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20708226>.
77. Kumar S, Mariani A, Bakkum-Gamez JN, et al. Risk factors that mitigate the role of paraaortic lymphadenectomy in uterine endometrioid cancer. *Gynecol Oncol* 2013;130:441-445. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23747331>.
78. Kilgore LC, Partridge EE, Alvarez RD, et al. Adenocarcinoma of the endometrium: survival comparisons of patients with and without pelvic node sampling. *Gynecol Oncol* 1995;56:29-33. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/7821843>.



79. Havrilesky LJ, Cragun JM, Calingaert B, et al. Resection of lymph node metastases influences survival in stage IIIC endometrial cancer. *Gynecol Oncol* 2005;99:689-695. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16126261>.
80. Todo Y, Kato H, Kaneuchi M, et al. Survival effect of para-aortic lymphadenectomy in endometrial cancer (SEPAL study): a retrospective cohort analysis. *Lancet* 2010;375:1165-1172. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20188410>.
81. group As, Kitchener H, Swart AM, et al. Efficacy of systematic pelvic lymphadenectomy in endometrial cancer (MRC ASTEC trial): a randomised study. *Lancet* 2009;373:125-136. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19070889>.
82. Benedetti Panici P, Basile S, Maneschi F, et al. Systematic pelvic lymphadenectomy vs. no lymphadenectomy in early-stage endometrial carcinoma: randomized clinical trial. *J Natl Cancer Inst* 2008;100:1707-1716. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19033573>.
83. American College of O, Gynecologists. ACOG practice bulletin, clinical management guidelines for obstetrician-gynecologists, number 65, August 2005: management of endometrial cancer. *Obstet Gynecol* 2005;106:413-425. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16055605>.
84. Seamon LG, Fowler JM, Cohn DE. Lymphadenectomy for endometrial cancer: the controversy. *Gynecol Oncol* 2010;117:6-8. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20110120>.
85. Creasman WT, Mutch DE, Herzog TJ. ASTEC lymphadenectomy and radiation therapy studies: are conclusions valid? *Gynecol Oncol* 2010;116:293-294. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19897230>.
86. Uccella S, Podratz KC, Aletti GD, Mariani A. Lymphadenectomy in endometrial cancer. *Lancet* 2009;373:1170; author reply 1170-1171. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19345823>.
87. Milam MR, Java J, Walker JL, et al. Nodal metastasis risk in endometrioid endometrial cancer. *Obstet Gynecol* 2012;119:286-292. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22270280>.
88. Neubauer NL, Lurain JR. The role of lymphadenectomy in surgical staging of endometrial cancer. *Int J Surg Oncol* 2011;2011:814649. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22312525>.
89. Bodurtha Smith AJ, Fader AN, Tanner EJ. Sentinel lymph node assessment in endometrial cancer: a systematic review and meta-analysis. *Am J Obstet Gynecol* 2017;216:459-476 e410. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27871836>.
90. Mariani A, Dowdy SC, Cliby WA, et al. Prospective assessment of lymphatic dissemination in endometrial cancer: a paradigm shift in surgical staging. *Gynecol Oncol* 2008;109:11-18. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18304622>.
91. Hirahatake K, Hareyama H, Sakuragi N, et al. A clinical and pathologic study on para-aortic lymph node metastasis in endometrial carcinoma. *J Surg Oncol* 1997;65:82-87. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/9209518>.
92. Frederick PJ, Straughn JM, Jr. The role of comprehensive surgical staging in patients with endometrial cancer. *Cancer Control* 2009;16:23-29. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19078926>.
93. Barlin JN, Khoury-Collado F, Kim CH, et al. The importance of applying a sentinel lymph node mapping algorithm in endometrial cancer staging: beyond removal of blue nodes. *Gynecol Oncol* 2012;125:531-535. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22366409>.
94. Ballester M, Koskas M, Coutant C, et al. Does the use of the 2009 FIGO classification of endometrial cancer impact on indications of the sentinel node biopsy? *BMC Cancer* 2010;10:465. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20804553>.
95. How J, Lau S, Press J, et al. Accuracy of sentinel lymph node detection following intra-operative cervical injection for endometrial cancer:



a prospective study. *Gynecol Oncol* 2012;127:332-337. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22910695>.

96. Khoury-Collado F, Murray MP, Hensley ML, et al. Sentinel lymph node mapping for endometrial cancer improves the detection of metastatic disease to regional lymph nodes. *Gynecol Oncol* 2011;122:251-254. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21570109>.

97. Holloway RW, Abu-Rustum NR, Backes FJ, et al. Sentinel lymph node mapping and staging in endometrial cancer: A Society of Gynecologic Oncology literature review with consensus recommendations. *Gynecol Oncol* 2017;146:405-415. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28566221>.

98. Khoury-Collado F, St Clair C, Abu-Rustum NR. Sentinel Lymph Node Mapping in Endometrial Cancer: An Update. *Oncologist* 2016;21:461-466. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26961924>.

99. Rossi EC, Kowalski LD, Scalici J, et al. A comparison of sentinel lymph node biopsy to lymphadenectomy for endometrial cancer staging (FIRES trial): a multicentre, prospective, cohort study. *Lancet Oncol* 2017;18:384-392. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28159465>.

100. Paley PJ, Veljovich DS, Press JZ, et al. A prospective investigation of fluorescence imaging to detect sentinel lymph nodes at robotic-assisted endometrial cancer staging. *Am J Obstet Gynecol* 2016;215:117 e111-117. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26743505>.

101. Sinno AK, Fader AN, Roche KL, et al. A comparison of colorimetric versus fluorometric sentinel lymph node mapping during robotic surgery for endometrial cancer. *Gynecol Oncol* 2014;134:281-286. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24882555>.

102. Ruscito I, Gasparri ML, Braicu EI, et al. Sentinel Node Mapping in Cervical and Endometrial Cancer: Indocyanine Green Versus Other Conventional Dyes-A Meta-Analysis. *Ann Surg Oncol* 2016;23:3749-3756. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27160526>.

103. Frumovitz M, Plante M, Lee PS, et al. Near-infrared fluorescence for detection of sentinel lymph nodes in women with cervical and uterine cancers (FILM): a randomised, phase 3, multicentre, non-inferiority trial. *Lancet Oncol* 2018;19:1394-1403. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/30143441>.

104. Ruiz R, Gorostidi M, Jaunarena I, et al. Maximizing sentinel node detection in endometrial cancer with dual cervical and transcervical fundal indocyanine green injection: 5-year single-center prospective study. *Eur J Obstet Gynecol Reprod Biol* 2021;261:59-64. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33892210>.

105. Backes FJ, Cohen D, Salani R, et al. Prospective clinical trial of robotic sentinel lymph node assessment with isosulfane blue (ISB) and indocyanine green (ICG) in endometrial cancer and the impact of ultrastaging (NCT01818739). *Gynecol Oncol* 2019;153:496-499. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/31230614>.

106. Vidal F, Leguevaque P, Motton S, et al. Evaluation of the sentinel lymph node algorithm with blue dye labeling for early-stage endometrial cancer in a multicentric setting. *Int J Gynecol Cancer* 2013;23:1237-1243. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23839245>.

107. Abu-Rustum NR, Khoury-Collado F, Pandit-Taskar N, et al. Sentinel lymph node mapping for grade 1 endometrial cancer: is it the answer to the surgical staging dilemma? *Gynecol Oncol* 2009;113:163-169. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19232699>.

108. Ballester M, Dubernard G, Lecuru F, et al. Detection rate and diagnostic accuracy of sentinel-node biopsy in early stage endometrial cancer: a prospective multicentre study (SENTI-ENDO). *Lancet Oncol* 2011;12:469-476. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21489874>.

109. Press JZ, Gotlieb WH. Controversies in the treatment of early stage endometrial carcinoma. *Obstet Gynecol Int* 2012;2012:578490. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22685466>.



110. Touhami O, Trinh XB, Gregoire J, et al. Predictors of non-sentinel lymph node (non-SLN) metastasis in patients with sentinel lymph node (SLN) metastasis in endometrial cancer. *Gynecol Oncol* 2015;138:41-45. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25891803>.

111. Group SGOPECW, Burke WM, Orr J, et al. Endometrial cancer: a review and current management strategies: part I. *Gynecol Oncol* 2014;134:385-392. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24905773>.

112. Soliman PT, Westin SN, Dioun S, et al. A prospective validation study of sentinel lymph node mapping for high-risk endometrial cancer. *Gynecol Oncol* 2017;146:234-239. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28528918>.

113. Kim CH, Khoury-Collado F, Barber EL, et al. Sentinel lymph node mapping with pathologic ultrastaging: a valuable tool for assessing nodal metastasis in low-grade endometrial cancer with superficial myoinvasion. *Gynecol Oncol* 2013;131:714-719. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24099838>.

114. Cormier B, Rozenholc AT, Gotlieb W, et al. Sentinel lymph node procedure in endometrial cancer: A systematic review and proposal for standardization of future research. *Gynecol Oncol* 2015;138:478-485. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26047592>.

115. Holloway RW, Gupta S, Stavitzki NM, et al. Sentinel lymph node mapping with staging lymphadenectomy for patients with endometrial cancer increases the detection of metastasis. *Gynecol Oncol* 2016;141:206-210. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26905211>.

116. Darai E, Dubernard G, Bats AS, et al. Sentinel node biopsy for the management of early stage endometrial cancer: long-term results of the SENTI-ENDO study. *Gynecol Oncol* 2015;136:54-59. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25450151>.

117. Naoura I, Canlorbe G, Bendifallah S, et al. Relevance of sentinel lymph node procedure for patients with high-risk endometrial cancer.

*Gynecol Oncol* 2015;136:60-64. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25449312>.

118. Schiavone MB, Zivanovic O, Zhou Q, et al. Survival of Patients with Uterine Carcinosarcoma Undergoing Sentinel Lymph Node Mapping. *Ann Surg Oncol* 2016;23:196-202. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25994210>.

119. Lecointre L, Lodi M, Faller E, et al. Diagnostic Accuracy and Clinical Impact of Sentinel Lymph Node Sampling in Endometrial Cancer at High Risk of Recurrence: A Meta-Analysis. *J Clin Med* 2020;9. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33260511>.

120. Bogani G, Papadia A, Buda A, et al. Sentinel node mapping vs. sentinel node mapping plus back-up lymphadenectomy in high-risk endometrial cancer patients: Results from a multi-institutional study. *Gynecol Oncol* 2021;161:122-129. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33485641>.

121. Cusimano MC, Vicus D, Pulman K, et al. Assessment of Sentinel Lymph Node Biopsy vs Lymphadenectomy for Intermediate- and High-Grade Endometrial Cancer Staging. *JAMA Surg* 2021;156:157-164. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33175109>.

122. Marchocki Z, Cusimano MC, Clarfield L, et al. Sentinel lymph node biopsy in high-grade endometrial cancer: a systematic review and meta-analysis of performance characteristics. *Am J Obstet Gynecol* 2021;225:367 e361-367 e339. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/34058168>.

123. Euscher E, Sui D, Soliman P, et al. Ultrastaging of Sentinel Lymph Nodes in Endometrial Carcinoma According to Use of 2 Different Methods. *Int J Gynecol Pathol* 2018;37:242-251. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28700425>.

124. Burg LC, Hengeveld EM, In 't Hout J, et al. Ultrastaging methods of sentinel lymph nodes in endometrial cancer - a systematic review. *Int J Gynecol Cancer* 2021;31:744-753. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33187974>.



125. Kim CH, Soslow RA, Park KJ, et al. Pathologic ultrastaging improves micrometastasis detection in sentinel lymph nodes during endometrial cancer staging. *Int J Gynecol Cancer* 2013;23:964-970. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23694985>.
126. Raimond E, Ballester M, Hudry D, et al. Impact of sentinel lymph node biopsy on the therapeutic management of early-stage endometrial cancer: Results of a retrospective multicenter study. *Gynecol Oncol* 2014;133:506-511. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24642092>.
127. Touboul C, Bentivegna E, Uzan C, et al. Sentinel lymph node in endometrial cancer: a review. *Curr Oncol Rep* 2013;15:559-565. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24190831>.
128. Amezcua CA, MacDonald HR, Lum CA, et al. Endometrial cancer patients have a significant risk of harboring isolated tumor cells in histologically negative lymph nodes. *Int J Gynecol Cancer* 2006;16:1336-1341. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16803526>.
129. Todo Y, Kato H, Okamoto K, et al. Isolated tumor cells and micrometastases in regional lymph nodes in stage I to II endometrial cancer. *J Gynecol Oncol* 2016;27:e1. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25925293>.
130. Frimer M, Houry-Collado F, Murray MP, et al. Micrometastasis of endometrial cancer to sentinel lymph nodes: is it an artifact of uterine manipulation? *Gynecol Oncol* 2010;119:496-499. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20888626>.
131. Smerage JB, Barlow WE, Hortobagyi GN, et al. Circulating tumor cells and response to chemotherapy in metastatic breast cancer: SWOG S0500. *J Clin Oncol* 2014;32:3483-3489. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24888818>.
132. Olawaiye AB, Mutch DG. Lymphnode staging update in the American Joint Committee on Cancer 8th Edition cancer staging manual. *Gynecol Oncol* 2018;150:7-8. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29540290>.
133. St Clair CM, Eriksson AG, Ducie JA, et al. Low-Volume Lymph Node Metastasis Discovered During Sentinel Lymph Node Mapping for Endometrial Carcinoma. *Ann Surg Oncol* 2016;23:1653-1659. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26714954>.
134. Plante M, Stanleigh J, Renaud MC, et al. Isolated tumor cells identified by sentinel lymph node mapping in endometrial cancer: Does adjuvant treatment matter? *Gynecol Oncol* 2017;146:240-246. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28577885>.
135. Gomez-Hidalgo NR, Ramirez PT, Ngo B, et al. Oncologic impact of micrometastases or isolated tumor cells in sentinel lymph nodes of patients with endometrial cancer: a meta-analysis. *Clin Transl Oncol* 2020;22:1272-1279. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/31863354>.
136. Scalici J, Laughlin BB, Finan MA, et al. The trend towards minimally invasive surgery (MIS) for endometrial cancer: an ACS-NSQIP evaluation of surgical outcomes. *Gynecol Oncol* 2015;136:512-515. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25462206>.
137. Janda M, GebSKI V, Davies LC, et al. Effect of Total Laparoscopic Hysterectomy vs Total Abdominal Hysterectomy on Disease-Free Survival Among Women With Stage I Endometrial Cancer: A Randomized Clinical Trial. *JAMA* 2017;317:1224-1233. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28350928>.
138. Fader AN, Weise RM, Sinno AK, et al. Utilization of Minimally Invasive Surgery in Endometrial Cancer Care: A Quality and Cost Disparity. *Obstet Gynecol* 2016;127:91-100. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26646127>.
139. Galaal K, Bryant A, Fisher AD, et al. Laparoscopy versus laparotomy for the management of early stage endometrial cancer. *Cochrane Database Syst Rev* 2012:CD006655. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22972096>.
140. Kornblith AB, Huang HQ, Walker JL, et al. Quality of life of patients with endometrial cancer undergoing laparoscopic international federation



of gynecology and obstetrics staging compared with laparotomy: a Gynecologic Oncology Group study. *J Clin Oncol* 2009;27:5337-5342. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19805678>.

141. Walker JL, Piedmonte MR, Spirtos NM, et al. Laparoscopy compared with laparotomy for comprehensive surgical staging of uterine cancer: Gynecologic Oncology Group Study LAP2. *J Clin Oncol* 2009;27:5331-5336. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19805679>.

142. Mannschreck D, Matsuno RK, Moriarty JP, et al. Disparities in Surgical Care Among Women With Endometrial Cancer. *Obstet Gynecol* 2016;128:526-534. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27500330>.

143. Walker JL, Piedmonte MR, Spirtos NM, et al. Recurrence and survival after random assignment to laparoscopy versus laparotomy for comprehensive surgical staging of uterine cancer: Gynecologic Oncology Group LAP2 Study. *J Clin Oncol* 2012;30:695-700. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22291074>.

144. King LP, Miller DS. Recent progress: gynecologic oncology group trials in uterine corpus tumors. *Rev Recent Clin Trials* 2009;4:70-74. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19463102>.

145. Vergote I, Amant F, Neven P. Is it safe to treat endometrial carcinoma endoscopically? *J Clin Oncol* 2009;27:5305-5307. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19805666>.

146. Mourits MJ, Bijen CB, Arts HJ, et al. Safety of laparoscopy versus laparotomy in early-stage endometrial cancer: a randomised trial. *Lancet Oncol* 2010;11:763-771. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20638901>.

147. Reijntjes B, van Suijlichem M, Woolderink JM, et al. Recurrence and survival after laparoscopy versus laparotomy without lymphadenectomy in early-stage endometrial cancer: Long-term outcomes of a randomised trial. *Gynecologic Oncology* 2022;164:265-270. Available at:

148. He H, Zeng D, Ou H, et al. Laparoscopic treatment of endometrial cancer: systematic review. *J Minim Invasive Gynecol* 2013;20:413-423. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23506718>.

149. Wang HL, Ren YF, Yang J, et al. Total laparoscopic hysterectomy versus total abdominal hysterectomy for endometrial cancer: a meta-analysis. *Asian Pac J Cancer Prev* 2013;14:2515-2519. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23725166>.

150. Mori KM, Neubauer NL. Minimally invasive surgery in gynecologic oncology. *ISRN Obstet Gynecol* 2013;2013:312982. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23997959>.

151. Krill LS, Bristow RE. Robotic surgery: gynecologic oncology. *Cancer J* 2013;19:167-176. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23528726>.

152. ElSahwi KS, Hooper C, De Leon MC, et al. Comparison between 155 cases of robotic vs. 150 cases of open surgical staging for endometrial cancer. *Gynecol Oncol* 2012;124:260-264. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22036203>.

153. Chan JK, Gardner AB, Taylor K, et al. Robotic versus laparoscopic versus open surgery in morbidly obese endometrial cancer patients - a comparative analysis of total charges and complication rates. *Gynecol Oncol* 2015;139:300-305. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26363212>.

154. Coronado PJ, Herraiz MA, Magrina JF, et al. Comparison of perioperative outcomes and cost of robotic-assisted laparoscopy, laparoscopy and laparotomy for endometrial cancer. *Eur J Obstet Gynecol Reprod Biol* 2012;165:289-294. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22819573>.

155. Seamon LG, Cohn DE, Henretta MS, et al. Minimally invasive comprehensive surgical staging for endometrial cancer: Robotics or laparoscopy? *Gynecol Oncol* 2009;113:36-41. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19168206>.



156. Bell MC, Torgerson J, Seshadri-Kreaden U, et al. Comparison of outcomes and cost for endometrial cancer staging via traditional laparotomy, standard laparoscopy and robotic techniques. *Gynecol Oncol* 2008;111:407-411. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18829091>.

157. Cardenas-Goicoechea J, Adams S, Bhat SB, Randall TC. Surgical outcomes of robotic-assisted surgical staging for endometrial cancer are equivalent to traditional laparoscopic staging at a minimally invasive surgical center. *Gynecol Oncol* 2010;117:224-228. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20144471>.

158. Abel MK, Chan JK, Chow S, et al. Trends and survival outcomes of robotic, laparoscopic, and open surgery for stage II uterine cancer. *Int J Gynecol Cancer* 2020;30:1347-1355. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32753561>.

159. Capozzi VA, Riemma G, Rosati A, et al. Surgical complications occurring during minimally invasive sentinel lymph node detection in endometrial cancer patients. A systematic review of the literature and metanalysis. *Eur J Surg Oncol* 2021;47:2142-2149. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33820674>.

160. Brudie LA, Backes FJ, Ahmad S, et al. Analysis of disease recurrence and survival for women with uterine malignancies undergoing robotic surgery. *Gynecol Oncol* 2013;128:309-315. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23153590>.

161. Backes FJ, Brudie LA, Farrell MR, et al. Short- and long-term morbidity and outcomes after robotic surgery for comprehensive endometrial cancer staging. *Gynecol Oncol* 2012;125:546-551. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22387522>.

162. Fleming ND, Ramirez PT. Robotic surgery in gynecologic oncology. *Curr Opin Oncol* 2012;24:547-553. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22581356>.

163. Siesto G, Ornaghi S, Ieda N, Vitobello D. Robotic surgical staging for endometrial and cervical cancers in medically ill patients. *Gynecol Oncol*

2013;129:593-597. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23454499>.

164. van Dam P, Hauspy J, Verkinderen L, et al. Are costs of robot-assisted surgery warranted for gynecological procedures? *Obstet Gynecol Int* 2011;2011:973830. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21941556>.

165. Weinberg L, Rao S, Escobar PF. Robotic surgery in gynecology: an updated systematic review. *Obstet Gynecol Int* 2011;2011:852061. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22190948>.

166. Ramirez PT, Adams S, Boggess JF, et al. Robotic-assisted surgery in gynecologic oncology: a Society of Gynecologic Oncology consensus statement. Developed by the Society of Gynecologic Oncology's Clinical Practice Robotics Task Force. *Gynecol Oncol* 2012;124:180-184. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22079679>.

167. Worldwide AAMIG. Guidelines for privileging for robotic-assisted gynecologic laparoscopy. *J Minim Invasive Gynecol* 2014;21:157-167. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24509290>.

168. American Congress of Obstetricians and Gynecologists. Statement on Robotic Surgery by ACOG President James T. Breedon. 2013. Available at: <http://www.acog.org/About-ACOG/News-Room/News-Releases/2013/Statement-on-Robotic-Surgery>. Accessed

169. Sinno AK, Fader AN. Robotic-assisted surgery in gynecologic oncology. *Fertil Steril* 2014;102:922-932. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25274485>.

170. Gala RB, Margulies R, Steinberg A, et al. Systematic review of robotic surgery in gynecology: robotic techniques compared with laparoscopy and laparotomy. *J Minim Invasive Gynecol* 2014;21:353-361. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24295923>.

171. SGO position statement: morcellation. Society of Gynecologic Oncology; 2013. Available at: <https://www.sgo.org/newsroom/position-statements-2/morcellation/>. Accessed September 30, 2014.



172. Power morcellation and occult malignancy in gynecologic surgery. The American College of Obstetrics and Gynecologists; 2014. Available at: <http://www.acog.org/Resources-And-Publications/Task-Force-and-Work-Group-Reports/Power-Morcellation-and-Occult-Malignancy-in-Gynecologic-Surgery>. Accessed September 30, 2014.

173. U.S. Department of Health and Human Services. FDA discourages use of laparoscopic power morcellation for removal of uterus or uterine fibroids Food and Drug Administration; 2014. Available at: <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm393689.htm>. Accessed September 30, 2014.

174. Bogani G, Cliby WA, Aletti GD. Impact of morcellation on survival outcomes of patients with unexpected uterine leiomyosarcoma: a systematic review and meta-analysis. *Gynecol Oncol* 2015;137:167-172. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25462199>.

175. Wright JD, Buck AM, Shah M, et al. Safety of ovarian preservation in premenopausal women with endometrial cancer. *J Clin Oncol* 2009;27:1214-1219. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19171707>.

176. Koskas M, Bendifallah S, Luton D, et al. Safety of uterine and/or ovarian preservation in young women with grade 1 intramucous endometrial adenocarcinoma: a comparison of survival according to the extent of surgery. *Fertil Steril* 2012;98:1229-1235. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22959452>.

177. Lee TS, Lee JY, Kim JW, et al. Outcomes of ovarian preservation in a cohort of premenopausal women with early-stage endometrial cancer: a Korean Gynecologic Oncology Group study. *Gynecol Oncol* 2013;131:289-293. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23994534>.

178. Manfredi R, Mirk P, Maresca G, et al. Local-regional staging of endometrial carcinoma: role of MR imaging in surgical planning. *Radiology* 2004;231:372-378. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/15031434>.

179. Akin O, Mironov S, Pandit-Taskar N, Hann LE. Imaging of uterine cancer. *Radiol Clin North Am* 2007;45:167-182. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17157628>.

180. Gunderson CC, Fader AN, Carson KA, Bristow RE. Oncologic and reproductive outcomes with progestin therapy in women with endometrial hyperplasia and grade 1 adenocarcinoma: a systematic review. *Gynecol Oncol* 2012;125:477-482. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22245711>.

181. Baker J, Obermair A, Gebiski V, Janda M. Efficacy of oral or intrauterine device-delivered progestin in patients with complex endometrial hyperplasia with atypia or early endometrial adenocarcinoma: a meta-analysis and systematic review of the literature. *Gynecol Oncol* 2012;125:263-270. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22196499>.

182. Gracia CR, Jeruss JS. Lives in the balance: women with cancer and the right to fertility care. *J Clin Oncol* 2013;31:668-669. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23341520>.

183. Ushijima K, Yahata H, Yoshikawa H, et al. Multicenter phase II study of fertility-sparing treatment with medroxyprogesterone acetate for endometrial carcinoma and atypical hyperplasia in young women. *J Clin Oncol* 2007;25:2798-2803. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17602085>.

184. Hubbs JL, Saig RM, Abaid LN, et al. Systemic and local hormone therapy for endometrial hyperplasia and early adenocarcinoma. *Obstet Gynecol* 2013;121:1172-1180. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23812449>.

185. Trimble CL, Method M, Leitao M, et al. Management of endometrial precancers. *Obstet Gynecol* 2012;120:1160-1175. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23090535>.

186. Mehaseb MK, Latimer JA. Controversies in the management of endometrial carcinoma: an update. *Obstet Gynecol Int* 2012;2012:676032. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22518164>.



187. Hahn HS, Yoon SG, Hong JS, et al. Conservative treatment with progestin and pregnancy outcomes in endometrial cancer. *Int J Gynecol Cancer* 2009;19:1068-1073. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19820370>.

188. Park JY, Kim DY, Kim JH, et al. Long-term oncologic outcomes after fertility-sparing management using oral progestin for young women with endometrial cancer (KGOG 2002). *Eur J Cancer* 2013;49:868-874. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23072814>.

189. Park JY, Seong SJ, Kim TJ, et al. Pregnancy outcomes after fertility-sparing management in young women with early endometrial cancer. *Obstet Gynecol* 2013;121:136-142. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23262938>.

190. Bi Q, Bi G, Wang J, et al. Diagnostic Accuracy of MRI for Detecting Cervical Invasion in Patients with Endometrial Carcinoma: A Meta-Analysis. *J Cancer* 2021;12:754-764. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33403033>.

191. Bi Q, Chen Y, Wu K, et al. The Diagnostic Value of MRI for Preoperative Staging in Patients with Endometrial Cancer: A Meta-Analysis. *Acad Radiol* 2020;27:960-968. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/31636004>.

192. Boente MP, Yordan EL, Jr., McIntosh DG, et al. Prognostic factors and long-term survival in endometrial adenocarcinoma with cervical involvement. *Gynecol Oncol* 1993;51:316-322. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/8112639>.

193. Sartori E, Gadducci A, Landoni F, et al. Clinical behavior of 203 stage II endometrial cancer cases: the impact of primary surgical approach and of adjuvant radiation therapy. *Int J Gynecol Cancer* 2001;11:430-437. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/11906545>.

194. Barlin JN, Puri I, Bristow RE. Cytoreductive surgery for advanced or recurrent endometrial cancer: a meta-analysis. *Gynecol Oncol* 2010;118:14-18. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20434198>.

195. Landrum LM, Moore KN, Myers TK, et al. Stage IVB endometrial cancer: does applying an ovarian cancer treatment paradigm result in similar outcomes? A case-control analysis. *Gynecol Oncol* 2009;112:337-341. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19041126>.

196. Lambrou NC, Gomez-Marin O, Mirhashemi R, et al. Optimal surgical cytoreduction in patients with Stage III and Stage IV endometrial carcinoma: a study of morbidity and survival. *Gynecol Oncol* 2004;93:653-658. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/15196860>.

197. Albright BB, Monuszko KA, Kaplan SJ, et al. Primary cytoreductive surgery for advanced stage endometrial cancer: a systematic review and meta-analysis. *Am J Obstet Gynecol* 2021;225:237 e231-237 e224. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33957111>.

198. Palma DA, Olson R, Harrow S, et al. Stereotactic ablative radiotherapy versus standard of care palliative treatment in patients with oligometastatic cancers (SABR-COMET): a randomised, phase 2, open-label trial. *Lancet* 2019;393:2051-2058. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/30982687>.

199. Gadducci A, Cosio S, Genazzani AR. Old and new perspectives in the pharmacological treatment of advanced or recurrent endometrial cancer: Hormonal therapy, chemotherapy and molecularly targeted therapies. *Crit Rev Oncol Hematol* 2006;58:242-256. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16436330>.

200. Fishman DA, Roberts KB, Chambers JT, et al. Radiation therapy as exclusive treatment for medically inoperable patients with stage I and II endometrioid carcinoma with endometrium. *Gynecol Oncol* 1996;61:189-196. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/8626131>.

201. Coon D, Beriwal S, Heron DE, et al. High-dose-rate Rotte "Y" applicator brachytherapy for definitive treatment of medically inoperable endometrial cancer: 10-year results. *Int J Radiat Oncol Biol Phys* 2008;71:779-783. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18258388>.



202. Niazi TM, Souhami L, Portelance L, et al. Long-term results of high-dose-rate brachytherapy in the primary treatment of medically inoperable stage I-II endometrial carcinoma. *Int J Radiat Oncol Biol Phys* 2005;63:1108-1113. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16099598>.

203. van der Steen-Banasik E, Christiaens M, Shash E, et al. Systemic review: Radiation therapy alone in medical non-operable endometrial carcinoma. *Eur J Cancer* 2016;65:172-181. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27501506>.

204. Smith SC, Koh WJ. Palliative radiation therapy for gynaecological malignancies. *Best Pract Res Clin Obstet Gynaecol* 2001;15:265-278. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/11358401>.

205. Randall ME, Filiaci VL, Muss H, et al. Randomized phase III trial of whole-abdominal irradiation versus doxorubicin and cisplatin chemotherapy in advanced endometrial carcinoma: a Gynecologic Oncology Group Study. *J Clin Oncol* 2006;24:36-44. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16330675>.

206. Homesley HD, Filiaci V, Gibbons SK, et al. A randomized phase III trial in advanced endometrial carcinoma of surgery and volume directed radiation followed by cisplatin and doxorubicin with or without paclitaxel: A Gynecologic Oncology Group study. *Gynecol Oncol* 2009;112:543-552. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19108877>.

207. Secord AA, Havrilesky LJ, O'Malley DM, et al. A multicenter evaluation of sequential multimodality therapy and clinical outcome for the treatment of advanced endometrial cancer. *Gynecol Oncol* 2009;114:442-447. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19560193>.

208. Creutzberg CL, van Stiphout RG, Nout RA, et al. Nomograms for prediction of outcome with or without adjuvant radiation therapy for patients with endometrial cancer: a pooled analysis of PORTEC-1 and PORTEC-2 trials. *Int J Radiat Oncol Biol Phys* 2015;91:530-539. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25680597>.

209. Group SGOCECW, Burke WM, Orr J, et al. Endometrial cancer: a review and current management strategies: part II. *Gynecol Oncol* 2014;134:393-402. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24929052>.

210. Creutzberg CL, Nout RA. The role of radiotherapy in endometrial cancer: current evidence and trends. *Curr Oncol Rep* 2011;13:472-478. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21845420>.

211. Klopp A, Smith BD, Alektiar K, et al. The role of postoperative radiation therapy for endometrial cancer: Executive summary of an American Society for Radiation Oncology evidence-based guideline. *Pract Radiat Oncol* 2014;4:137-144. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24766678>.

212. Meyer LA, Bohlke K, Powell MA, et al. Postoperative Radiation Therapy for Endometrial Cancer: American Society of Clinical Oncology Clinical Practice Guideline Endorsement of the American Society for Radiation Oncology Evidence-Based Guideline. *J Clin Oncol* 2015;33:2908-2913. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26150442>.

213. Neubauer NL, Havrilesky LJ, Calingaert B, et al. The role of lymphadenectomy in the management of preoperative grade 1 endometrial carcinoma. *Gynecol Oncol* 2009;112:511-516. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19144394>.

214. Gretz HFr, Economos K, Husain A, et al. The practice of surgical staging and its impact on adjuvant treatment recommendations in patients with stage I endometrial carcinoma. *Gynecol Oncol* 1996;61:409-415. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/8641624>.

215. Ben-Shachar I, Pavelka J, Cohn DE, et al. Surgical staging for patients presenting with grade 1 endometrial carcinoma. *Obstet Gynecol* 2005;105:487-493. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/15738013>.

216. Nout RA, Smit VT, Putter H, et al. Vaginal brachytherapy versus pelvic external beam radiotherapy for patients with endometrial cancer of

high-intermediate risk (PORTEC-2): an open-label, non-inferiority, randomised trial. *Lancet* 2010;375:816-823. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/20206777>.

217. Elshaikh MA, Al-Wahab Z, Mahdi H, et al. Recurrence patterns and survival endpoints in women with stage II uterine endometrioid carcinoma: a multi-institution study. *Gynecol Oncol* 2015;136:235-239. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/25511158>.

218. Creutzberg CL, van Putten WL, Koper PC, et al. Surgery and postoperative radiotherapy versus surgery alone for patients with stage-1 endometrial carcinoma: multicentre randomised trial. PORTEC Study Group. *Post Operative Radiation Therapy in Endometrial Carcinoma*. *Lancet* 2000;355:1404-1411. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/10791524>.

219. Aalders J, Abeler V, Kolstad P, Onsrud M. Postoperative external irradiation and prognostic parameters in stage I endometrial carcinoma: clinical and histopathologic study of 540 patients. *Obstet Gynecol* 1980;56:419-427. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/6999399>.

220. Group AES, Blake P, Swart AM, et al. Adjuvant external beam radiotherapy in the treatment of endometrial cancer (MRC ASTEC and NCIC CTG EN.5 randomised trials): pooled trial results, systematic review, and meta-analysis. *Lancet* 2009;373:137-146. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/19070891>.

221. Keys HM, Roberts JA, Brunetto VL, et al. A phase III trial of surgery with or without adjunctive external pelvic radiation therapy in intermediate risk endometrial adenocarcinoma: a Gynecologic Oncology Group study. *Gynecol Oncol* 2004;92:744-751. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/14984936>.

222. Creutzberg CL, van Putten WL, Warlam-Rodenhuis CC, et al. Outcome of high-risk stage IC, grade 3, compared with stage I endometrial carcinoma patients: the Postoperative Radiation Therapy in Endometrial Carcinoma Trial. *J Clin Oncol* 2004;22:1234-1241. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/15051771>.

223. Scholten AN, van Putten WL, Beerman H, et al. Postoperative radiotherapy for Stage 1 endometrial carcinoma: long-term outcome of the randomized PORTEC trial with central pathology review. *Int J Radiat Oncol Biol Phys* 2005;63:834-838. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/15927414>.

224. Hockel M, Dornhofer N. Treatment of early endometrial carcinoma: is less more? *Lancet* 2009;373:97-99. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/19070890>.

225. Creutzberg CL, Nout RA, Lybeert ML, et al. Fifteen-year radiotherapy outcomes of the randomized PORTEC-1 trial for endometrial carcinoma. *Int J Radiat Oncol Biol Phys* 2011;81:e631-638. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/21640520>.

226. Alektiar KM, Venkatraman E, Chi DS, Barakat RR. Intravaginal brachytherapy alone for intermediate-risk endometrial cancer. *Int J Radiat Oncol Biol Phys* 2005;62:111-117. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/15850910>.

227. Small W, Jr., Beriwal S, Demanes DJ, et al. American Brachytherapy Society consensus guidelines for adjuvant vaginal cuff brachytherapy after hysterectomy. *Brachytherapy* 2012;11:58-67. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/22265439>.

228. Onsrud M, Cvancarova M, Hellebust TP, et al. Long-term outcomes after pelvic radiation for early-stage endometrial cancer. *J Clin Oncol* 2013;31:3951-3956. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/24019546>.

229. Nout RA, Putter H, Jurgenliemk-Schulz IM, et al. Five-year quality of life of endometrial cancer patients treated in the randomised Post Operative Radiation Therapy in Endometrial Cancer (PORTEC-2) trial and comparison with norm data. *Eur J Cancer* 2012;48:1638-1648. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/22176868>.

230. Roper B, Astner ST, Heydemann-Obradovic A, et al. Ten-year data on 138 patients with endometrial carcinoma and postoperative vaginal brachytherapy alone: no need for external-beam radiotherapy in low and



intermediate risk patients. *Gynecol Oncol* 2007;107:541-548. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17884152>.

231. Nout RA, Putter H, Jurgenliemk-Schulz IM, et al. Quality of life after pelvic radiotherapy or vaginal brachytherapy for endometrial cancer: first results of the randomized PORTEC-2 trial. *J Clin Oncol* 2009;27:3547-3556. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19546404>.

232. McCloskey SA, Tchabo NE, Malhotra HK, et al. Adjuvant vaginal brachytherapy alone for high risk localized endometrial cancer as defined by the three major randomized trials of adjuvant pelvic radiation. *Gynecol Oncol* 2010;116:404-407. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19944453>.

233. Dunn EF, Geye H, Platta CS, et al. Predictive factors of recurrence following adjuvant vaginal cuff brachytherapy alone for stage I endometrial cancer. *Gynecol Oncol* 2014;133:494-498. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24657301>.

234. Narasimhulu DM, Cope A, Riaz IB, et al. External beam radiotherapy versus vaginal brachytherapy in patients with stage II endometrial cancer: a systematic review and meta-analysis. *Int J Gynecol Cancer* 2020;30:797-805. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32221021>.

235. Randall ME, Filiaci V, McMeekin DS, et al. A Phase 3 trial of pelvic radiation therapy versus vaginal cuff brachytherapy followed by paclitaxel/carboplatin chemotherapy in patients with high-risk, early-stage endometrial cancer: A gynecology oncology group study [abstract]. *Int J Radiat Oncol Biol Phys* 2017. Available at: [https://www.astro.org/uploadedFiles/MAIN\\_SITE/Meetings\\_and\\_Education/ASTRO\\_Meetings/2017/Annual\\_Meeting/Content\\_Pieces/Late-breakingAbstracts.pdf](https://www.astro.org/uploadedFiles/MAIN_SITE/Meetings_and_Education/ASTRO_Meetings/2017/Annual_Meeting/Content_Pieces/Late-breakingAbstracts.pdf).

236. Chino JP, Jones E, Berchuck A, et al. The influence of radiation modality and lymph node dissection on survival in early-stage endometrial cancer. *Int J Radiat Oncol Biol Phys* 2012;82:1872-1879. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21640502>.

237. Lee CM, Szabo A, Shrieve DC, et al. Frequency and effect of adjuvant radiation therapy among women with stage I endometrial adenocarcinoma. *JAMA* 2006;295:389-397. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16434629>.

238. Johnson N, Cornes P. Survival and recurrent disease after postoperative radiotherapy for early endometrial cancer: systematic review and meta-analysis. *BJOG* 2007;114:1313-1320. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17803718>.

239. Kong A, Johnson N, Cornes P, et al. Adjuvant radiotherapy for stage I endometrial cancer. *Cochrane Database Syst Rev* 2007. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17443533>.

240. Kong A, Johnson N, Kitchener HC, Lawrie TA. Adjuvant radiotherapy for stage I endometrial cancer: an updated Cochrane systematic review and meta-analysis. *J Natl Cancer Inst* 2012;104:1625-1634. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22962693>.

241. Eifel PJ. The role of adjuvant radiation therapy for stage I endometrial cancer: does meta-analysis reveal the answer? *J Natl Cancer Inst* 2012;104:1615-1616. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23104209>.

242. Park HJ, Nam EJ, Kim S, et al. The benefit of adjuvant chemotherapy combined with postoperative radiotherapy for endometrial cancer: a meta-analysis. *Eur J Obstet Gynecol Reprod Biol* 2013;170:39-44. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23810000>.

243. Hogberg T, Signorelli M, de Oliveira CF, et al. Sequential adjuvant chemotherapy and radiotherapy in endometrial cancer--results from two randomised studies. *Eur J Cancer* 2010;46:2422-2431. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20619634>.

244. Johnson N, Bryant A, Miles T, et al. Adjuvant chemotherapy for endometrial cancer after hysterectomy. *Cochrane Database Syst Rev* 2011;2011:CD003175. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21975736>.



245. Randall ME, Filiaci V, McMeekin DS, et al. Phase III Trial: Adjuvant Pelvic Radiation Therapy Versus Vaginal Brachytherapy Plus Paclitaxel/Carboplatin in High-Intermediate and High-Risk Early Stage Endometrial Cancer. *J Clin Oncol* 2019;37:1810-1818. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/30995174>.

246. Hogberg T. Adjuvant chemotherapy in endometrial carcinoma: overview of randomised trials. *Clin Oncol (R Coll Radiol)* 2008;20:463-469. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18467080>.

247. Koh WJ, Tran AB, Douglas JG, Stelzer KJ. Radiation therapy in endometrial cancer. *Best Pract Res Clin Obstet Gynaecol* 2001;15:417-432. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/11476563>.

248. Secord AA, Geller MA, Broadwater G, et al. A multicenter evaluation of adjuvant therapy in women with optimally resected stage IIIC endometrial cancer. *Gynecol Oncol* 2013;128:65-70. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23085460>.

249. Greven KM, Lanciano RM, Corn B, et al. Pathologic stage III endometrial carcinoma. Prognostic factors and patterns of recurrence. *Cancer* 1993;71:3697-3702. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/8490920>.

250. Mustea A, Koensgen D, Belau A, et al. Adjuvant sequential chemoradiation therapy in high-risk endometrial cancer: results of a prospective, multicenter phase-II study of the NOGGO (North-Eastern German Society of Gynaecological Oncology). *Cancer Chemother Pharmacol* 2013;72:975-983. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23995698>.

251. Jutzi L, Hoskins P, Lim P, et al. The importance of adjuvant chemotherapy and pelvic radiotherapy in high-risk early stage endometrial carcinoma. *Gynecol Oncol* 2013;131:581-585. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24055614>.

252. de Boer SM, Powell ME, Mileskin L, et al. Toxicity and quality of life after adjuvant chemoradiotherapy versus radiotherapy alone for women with high-risk endometrial cancer (PORTEC-3): an open-label, multicentre,

randomised, phase 3 trial. *Lancet Oncol* 2016;17:1114-1126. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27397040>.

253. Mirza MR, Chase DM, Slomovitz BM, et al. Dostarlimab for Primary Advanced or Recurrent Endometrial Cancer. *N Engl J Med* 2023. Available at:

254. Eskander RN, Sill MW, Beffa L, et al. Pembrolizumab plus Chemotherapy in Advanced Endometrial Cancer. *N Engl J Med* 2023. Available at:

255. Gibbons S, Martinez A, Schray M, et al. Adjuvant whole abdominopelvic irradiation for high risk endometrial carcinoma. *Int J Radiat Oncol Biol Phys* 1991;21:1019-1025. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/1917597>.

256. Greer BE, Hamberger AD. Treatment of intraperitoneal metastatic adenocarcinoma of the endometrium by the whole-abdomen moving-strip technique and pelvic boost irradiation. *Gynecol Oncol* 1983;16:365-373. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/6654180>.

257. Abaid LN, Rettenmaier MA, Brown JV, 3rd, et al. Sequential chemotherapy and radiotherapy as sandwich therapy for the treatment of high risk endometrial cancer. *J Gynecol Oncol* 2012;23:22-27. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22355463>.

258. Geller MA, Ivy JJ, Ghebre R, et al. A phase II trial of carboplatin and docetaxel followed by radiotherapy given in a "Sandwich" method for stage III, IV, and recurrent endometrial cancer. *Gynecol Oncol* 2011;121:112-117. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21239048>.

259. Brown AP, Gaffney DK, Dodson MK, et al. Survival analysis of endometrial cancer patients with positive lymph nodes. *Int J Gynecol Cancer* 2013;23:861-868. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23598890>.

260. Lum MM, Belnap TW, Frandsen J, et al. Survival Analysis of Cancer Patients With FIGO Stage IIIA Endometrial Cancer. *Am J Clin Oncol*



2015;38:283-288. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/23774072>.

261. Ren Y, Huang X, Shan B, et al. Adjuvant concurrent chemoradiation followed by chemotherapy for high-risk endometrial cancer. *Gynecol Oncol* 2016;140:58-63. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/26607778>.

262. Greven K, Winter K, Underhill K, et al. Final analysis of RTOG 9708: adjuvant postoperative irradiation combined with cisplatin/paclitaxel chemotherapy following surgery for patients with high-risk endometrial cancer. *Gynecol Oncol* 2006;103:155-159. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/16545437>.

263. de Boer SM, Powell ME, Mileskin L, et al. Adjuvant chemoradiotherapy versus radiotherapy alone for women with high-risk endometrial cancer (PORTEC-3): final results of an international, open-label, multicentre, randomised, phase 3 trial. *Lancet Oncol* 2018;19:295-309. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29449189>.

264. de Boer SM, Powell ME, Mileskin L, et al. Adjuvant chemoradiotherapy versus radiotherapy alone in women with high-risk endometrial cancer (PORTEC-3): patterns of recurrence and post-hoc survival analysis of a randomised phase 3 trial. *Lancet Oncol* 2019;20:1273-1285. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/31345626>.

265. Post CCB, de Boer SM, Powell ME, et al. Long-Term Toxicity and Health-Related Quality of Life After Adjuvant Chemoradiation Therapy or Radiation Therapy Alone for High-Risk Endometrial Cancer in the Randomized PORTEC-3 Trial. *Int J Radiat Oncol Biol Phys* 2021;109:975-986. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33129910>.

266. Matei D, Filiaci V, Randall ME, et al. Adjuvant Chemotherapy plus Radiation for Locally Advanced Endometrial Cancer. *N Engl J Med* 2019;380:2317-2326. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/31189035>.

267. Leon-Castillo A, de Boer SM, Powell ME, et al. Molecular Classification of the PORTEC-3 Trial for High-Risk Endometrial Cancer: Impact on Prognosis and Benefit From Adjuvant Therapy. *J Clin Oncol* 2020;38:3388-3397. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/32749941>.

268. Wortman BG, Bosse T, Nout RA, et al. Molecular-integrated risk profile to determine adjuvant radiotherapy in endometrial cancer: Evaluation of the pilot phase of the PORTEC-4a trial. *Gynecol Oncol* 2018;151:69-75. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/30078506>.

269. Boruta DM, 2nd, Gehrig PA, Fader AN, Olawaiye AB. Management of women with uterine papillary serous cancer: a Society of Gynecologic Oncology (SGO) review. *Gynecol Oncol* 2009;115:142-153. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/19592079>.

270. Olawaiye AB, Boruta DM, 2nd. Management of women with clear cell endometrial cancer: a Society of Gynecologic Oncology (SGO) review. *Gynecol Oncol* 2009;113:277-283. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/19251307>.

271. Mendivil A, Schuler KM, Gehrig PA. Non-endometrioid adenocarcinoma of the uterine corpus: a review of selected histological subtypes. *Cancer Control* 2009;16:46-52. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/19078929>.

272. Varughese J, Hui P, Lu L, et al. Clear cell cancer of the uterine corpus: the association of clinicopathologic parameters and treatment on disease progression. *J Oncol* 2011;2011:628084. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/22187554>.

273. Kernochan LE, Garcia RL. Carcinosarcomas (malignant mixed Mullerian tumor) of the uterus: advances in elucidation of biologic and clinical characteristics. *J Natl Compr Canc Netw* 2009;7:550-556; quiz 557. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19460280>.

274. Cirisano FD, Jr., Robboy SJ, Dodge RK, et al. The outcome of stage I-II clinically and surgically staged papillary serous and clear cell

endometrial cancers when compared with endometrioid carcinoma. *Gynecol Oncol* 2000;77:55-65. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/10739691>.

275. Hendrickson MR, Longacre TA, Kempson RL. Uterine papillary serous carcinoma revisited. *Gynecol Oncol* 1994;54:261-263. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/8088601>.

276. McCluggage WG. Uterine carcinosarcomas (malignant mixed Mullerian tumors) are metaplastic carcinomas. *Int J Gynecol Cancer* 2002;12:687-690. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12445244>.

277. Cantrell LA, Havrilesky L, Moore DT, et al. A multi-institutional cohort study of adjuvant therapy in stage I-II uterine carcinosarcoma. *Gynecol Oncol* 2012;127:22-26. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22727985>.

278. Kanthan R, Senger JL. Uterine carcinosarcomas (malignant mixed mullerian tumours): a review with special emphasis on the controversies in management. *Obstet Gynecol Int* 2011;2011:470795. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22007228>.

279. D'Angelo E, Prat J. Pathology of mixed Mullerian tumours. *Best Pract Res Clin Obstet Gynaecol* 2011;25:705-718. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21742560>.

280. de Jong RA, Nijman HW, Wijbrandi TF, et al. Molecular markers and clinical behavior of uterine carcinosarcomas: focus on the epithelial tumor component. *Mod Pathol* 2011;24:1368-1379. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21572397>.

281. Vorgias G, Fotiou S. The role of lymphadenectomy in uterine carcinosarcomas (malignant mixed mullerian tumours): a critical literature review. *Arch Gynecol Obstet* 2010;282:659-664. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20721670>.

282. Vogel TJ, Knickerbocker A, Shah CA, et al. An analysis of current treatment practice in uterine papillary serous and clear cell carcinoma at

two high volume cancer centers. *J Gynecol Oncol* 2015;26:25-31. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25376917>.

283. Monterossi G, Ghezzi F, Vizza E, et al. Minimally Invasive Approach in Type II Endometrial Cancer: Is It Wise and Safe? *J Minim Invasive Gynecol* 2017;24:438-445. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28065812>.

284. Fader AN, Seamon LG, Escobar PF, et al. Minimally invasive surgery versus laparotomy in women with high grade endometrial cancer: a multi-site study performed at high volume cancer centers. *Gynecol Oncol* 2012;126:180-185. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22555102>.

285. Koskas M, Jozwiak M, Fournier M, et al. Long-term oncological safety of minimally invasive surgery in high-risk endometrial cancer. *Eur J Cancer* 2016;65:185-191. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27505629>.

286. Salehi S, Avall-Lundqvist E, Legerstam B, et al. Robot-assisted laparoscopy versus laparotomy for infrarenal paraaortic lymphadenectomy in women with high-risk endometrial cancer: A randomised controlled trial. *Eur J Cancer* 2017;79:81-89. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28463759>.

287. Fader AN, Drake RD, O'Malley DM, et al. Platinum/taxane-based chemotherapy with or without radiation therapy favorably impacts survival outcomes in stage I uterine papillary serous carcinoma. *Cancer* 2009;115:2119-2127. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19306417>.

288. Fader AN, Nagel C, Axtell AE, et al. Stage II uterine papillary serous carcinoma: Carboplatin/paclitaxel chemotherapy improves recurrence and survival outcomes. *Gynecol Oncol* 2009;112:558-562. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19118888>.

289. Vandenput I, Trovik J, Vergote I, et al. The role of adjuvant chemotherapy in surgical stages I-II serous and clear cell carcinomas and carcinosarcoma of the endometrium: a collaborative study. *Int J Gynecol*



Cancer 2011;21:332-336. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/21270614>.

290. Kelly MG, O'Malley D M, Hui P, et al. Improved survival in surgical stage I patients with uterine papillary serous carcinoma (UPSC) treated with adjuvant platinum-based chemotherapy. *Gynecol Oncol* 2005;98:353-359. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16005947>.

291. Thomas MB, Mariani A, Cliby WA, et al. Role of systematic lymphadenectomy and adjuvant therapy in stage I uterine papillary serous carcinoma. *Gynecol Oncol* 2007;107:186-189. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17688926>.

292. Goldberg H, Miller RC, Abdah-Bortnyak R, et al. Outcome after combined modality treatment for uterine papillary serous carcinoma: a study by the Rare Cancer Network (RCN). *Gynecol Oncol* 2008;108:298-305. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18096209>.

293. Hamilton CA, Cheung MK, Osann K, et al. The effect of adjuvant chemotherapy versus whole abdominopelvic radiation on the survival of patients with advanced stage uterine papillary serous carcinoma. *Gynecol Oncol* 2006;103:679-683. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16793126>.

294. Grice J, Ek M, Greer B, et al. Uterine papillary serous carcinoma: evaluation of long-term survival in surgically staged patients. *Gynecol Oncol* 1998;69:69-73. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/9571001>.

295. Havrilesky LJ, Secord AA, Bae-Jump V, et al. Outcomes in surgical stage I uterine papillary serous carcinoma. *Gynecol Oncol* 2007;105:677-682. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17355889>.

296. Velker V, D'Souza D, Prefontaine M, et al. Role of Adjuvant Therapy for Stage IA Serous and Clear Cell Uterine Cancer: Is Observation a Valid Strategy? *Int J Gynecol Cancer* 2016;26:491-496. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26825823>.

297. Sutton G, Axelrod JH, Bundy BN, et al. Adjuvant whole abdominal irradiation in clinical stages I and II papillary serous or clear cell carcinoma of the endometrium: a phase II study of the Gynecologic Oncology Group. *Gynecol Oncol* 2006;100:349-354. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16213007>.

298. Matsuo K, Takazawa Y, Ross MS, et al. Characterizing sarcoma dominance pattern in uterine carcinosarcoma: Homologous versus heterologous element. *Surg Oncol* 2018;27:433-440. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/30217299>.

299. Galaal K, van der Heijden E, Godfrey K, et al. Adjuvant radiotherapy and/or chemotherapy after surgery for uterine carcinosarcoma. *Cochrane Database Syst Rev* 2013;2013:CD006812. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23450572>.

300. Wang W, Do V, Hogg R, et al. Uterine papillary serous carcinoma: patterns of failure and survival. *Aust N Z J Obstet Gynaecol* 2009;49:419-425. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19694700>.

301. Mehta N, Yamada SD, Rotmensch J, Mundt AJ. Outcome and pattern of failure in pathologic stage I-II papillary serous carcinoma of the endometrium: implications for adjuvant radiation therapy. *Int J Radiat Oncol Biol Phys* 2003;57:1004-1009. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/14575831>.

302. Murphy KT, Rotmensch J, Yamada SD, Mundt AJ. Outcome and patterns of failure in pathologic stages I-IV clear-cell carcinoma of the endometrium: implications for adjuvant radiation therapy. *Int J Radiat Oncol Biol Phys* 2003;55:1272-1276. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12654437>.

303. Sood BM, Jones J, Gupta S, et al. Patterns of failure after the multimodality treatment of uterine papillary serous carcinoma. *Int J Radiat Oncol Biol Phys* 2003;57:208-216. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12909235>.

304. Wolfson AH, Brady MF, Rocereto T, et al. A gynecologic oncology group randomized phase III trial of whole abdominal irradiation (WAI) vs.



cisplatin-ifosfamide and mesna (CIM) as post-surgical therapy in stage I-IV carcinosarcoma (CS) of the uterus. *Gynecol Oncol* 2007;107:177-185.

Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17822748>.

305. Barakat RR, Goldman NA, Patel DA, et al. Pelvic exenteration for recurrent endometrial cancer. *Gynecol Oncol* 1999;75:99-102. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/10502433>.

at: <https://www.ncbi.nlm.nih.gov/pubmed/10502433>.

306. Fleisch MC, Pantke P, Beckmann MW, et al. Predictors for long-term survival after interdisciplinary salvage surgery for advanced or recurrent gynecologic cancers. *J Surg Oncol* 2007;95:476-484. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17192947>.

<https://www.ncbi.nlm.nih.gov/pubmed/17192947>.

307. Dowdy SC, Mariani A, Cliby WA, et al. Radical pelvic resection and intraoperative radiation therapy for recurrent endometrial cancer: technique and analysis of outcomes. *Gynecol Oncol* 2006;101:280-286.

Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16321431>.

308. Tran PT, Su Z, Hara W, et al. Long-term survivors using intraoperative radiotherapy for recurrent gynecologic malignancies. *Int J Radiat Oncol Biol Phys* 2007;69:504-511. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17560736>.

<https://www.ncbi.nlm.nih.gov/pubmed/17560736>.

309. Jhingran A, Burke TW, Eifel PJ. Definitive radiotherapy for patients with isolated vaginal recurrence of endometrial carcinoma after hysterectomy. *Int J Radiat Oncol Biol Phys* 2003;56:1366-1372. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12873682>.

at: <https://www.ncbi.nlm.nih.gov/pubmed/12873682>.

310. Creutzberg CL, van Putten WL, Koper PC, et al. Survival after relapse in patients with endometrial cancer: results from a randomized trial. *Gynecol Oncol* 2003;89:201-209. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12713981>.

<https://www.ncbi.nlm.nih.gov/pubmed/12713981>.

311. Lin LL, Grigsby PW, Powell MA, Mutch DG. Definitive radiotherapy in the management of isolated vaginal recurrences of endometrial cancer. *Int J Radiat Oncol Biol Phys* 2005;63:500-504. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16168841>.

<https://www.ncbi.nlm.nih.gov/pubmed/16168841>.

312. Altman AD, Thompson J, Nelson G, et al. Use of aromatase inhibitors as first- and second-line medical therapy in patients with endometrial adenocarcinoma: a retrospective study. *J Obstet Gynaecol Can* 2012;34:664-672. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22742486>.

<https://www.ncbi.nlm.nih.gov/pubmed/22742486>.

313. Barker LC, Brand IR, Crawford SM. Sustained effect of the aromatase inhibitors anastrozole and letrozole on endometrial thickness in patients with endometrial hyperplasia and endometrial carcinoma. *Curr Med Res Opin* 2009;25:1105-1109. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19301987>.

<https://www.ncbi.nlm.nih.gov/pubmed/19301987>.

314. Fiorica JV, Brunetto VL, Hanjani P, et al. Phase II trial of alternating courses of megestrol acetate and tamoxifen in advanced endometrial carcinoma: a Gynecologic Oncology Group study. *Gynecol Oncol* 2004;92:10-14. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/14751131>.

<https://www.ncbi.nlm.nih.gov/pubmed/14751131>.

315. Whitney CW, Brunetto VL, Zaino RJ, et al. Phase II study of medroxyprogesterone acetate plus tamoxifen in advanced endometrial carcinoma: a Gynecologic Oncology Group study. *Gynecol Oncol* 2004;92:4-9. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/14751130>.

<https://www.ncbi.nlm.nih.gov/pubmed/14751130>.

316. Herzog TJ. What is the clinical value of adding tamoxifen to progestins in the treatment [correction for treatment] of advanced or recurrent endometrial cancer? *Gynecol Oncol* 2004;92:1-3. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/14751129>.

<https://www.ncbi.nlm.nih.gov/pubmed/14751129>.

317. Singh M, Zaino RJ, Filiaci VJ, Leslie KK. Relationship of estrogen and progesterone receptors to clinical outcome in metastatic endometrial carcinoma: a Gynecologic Oncology Group Study. *Gynecol Oncol* 2007;106:325-333. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17532033>.

<https://www.ncbi.nlm.nih.gov/pubmed/17532033>.

318. Kauppila A. Oestrogen and progestin receptors as prognostic indicators in endometrial cancer. A review of the literature. *Acta Oncol* 1989;28:561-566. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/2675940>.

<https://www.ncbi.nlm.nih.gov/pubmed/2675940>.



319. Thigpen JT, Brady MF, Alvarez RD, et al. Oral medroxyprogesterone acetate in the treatment of advanced or recurrent endometrial carcinoma: a dose-response study by the Gynecologic Oncology Group. *J Clin Oncol* 1999;17:1736-1744. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/10561210>.

320. Decruze SB, Green JA. Hormone therapy in advanced and recurrent endometrial cancer: a systematic review. *Int J Gynecol Cancer* 2007;17:964-978. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17442022>.

321. Dellinger TH, Monk BJ. Systemic therapy for recurrent endometrial cancer: a review of North American trials. *Expert Rev Anticancer Ther* 2009;9:905-916. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19589030>.

322. Quinn MA, Campbell JJ. Tamoxifen therapy in advanced/recurrent endometrial carcinoma. *Gynecol Oncol* 1989;32:1-3. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/2909443>.

323. Thigpen T, Brady MF, Homesley HD, et al. Tamoxifen in the treatment of advanced or recurrent endometrial carcinoma: a Gynecologic Oncology Group study. *J Clin Oncol* 2001;19:364-367. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/11208827>.

324. Pandya KJ, Yeap BY, Weiner LM, et al. Megestrol and tamoxifen in patients with advanced endometrial cancer: an Eastern Cooperative Oncology Group Study (E4882). *Am J Clin Oncol* 2001;24:43-46. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/11232948>.

325. Rose PG, Brunetto VL, VanLe L, et al. A phase II trial of anastrozole in advanced recurrent or persistent endometrial carcinoma: a Gynecologic Oncology Group study. *Gynecol Oncol* 2000;78:212-216. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/10926805>.

326. McMeekin DS, Gordon A, Fowler J, et al. A phase II trial of arzoxifene, a selective estrogen response modulator, in patients with recurrent or advanced endometrial cancer. *Gynecol Oncol* 2003;90:64-69. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12821343>.

327. Slomovitz BM, Jiang Y, Yates MS, et al. Phase II study of everolimus and letrozole in patients with recurrent endometrial carcinoma. *J Clin Oncol* 2015;33:930-936. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25624430>.

328. Slomovitz BM, Filiaci VL, Walker JL, et al. A randomized phase II trial of everolimus and letrozole or hormonal therapy in women with advanced, persistent or recurrent endometrial carcinoma: A GOG Foundation study. *Gynecol Oncol* 2022;164:481-491. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/35063278>.

329. Quinn MA. Hormonal treatment of endometrial cancer. *Hematol Oncol Clin North Am* 1999;13:163-187, ix. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/10080075>.

330. Ray M, Fleming G. Management of advanced-stage and recurrent endometrial cancer. *Semin Oncol* 2009;36:145-154. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19332249>.

331. Humber CE, Tierney JF, Symonds RP, et al. Chemotherapy for advanced, recurrent or metastatic endometrial cancer: a systematic review of Cochrane collaboration. *Ann Oncol* 2007;18:409-420. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17150999>.

332. Miller D, Filiaci V, Fleming G, et al. Randomized phase III noninferiority trial of first line chemotherapy for metastatic or recurrent endometrial carcinoma: A Gynecologic Oncology Group study [abstract]. *Gynecologic Oncology* 2012;125:771. Available at: [http://www.gynecologiconcology-online.net/article/S0090-8258\(12\)00228-4/abstract](http://www.gynecologiconcology-online.net/article/S0090-8258(12)00228-4/abstract).

333. Sovak MA, Dupont J, Hensley ML, et al. Paclitaxel and carboplatin in the treatment of advanced or recurrent endometrial cancer: a large retrospective study. *Int J Gynecol Cancer* 2007;17:197-203. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17291253>.

334. Pectasides D, Xiros N, Papaxoinis G, et al. Carboplatin and paclitaxel in advanced or metastatic endometrial cancer. *Gynecol Oncol*



2008;109:250-254. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/18299146>.

335. Sorbe B, Andersson H, Boman K, et al. Treatment of primary advanced and recurrent endometrial carcinoma with a combination of carboplatin and paclitaxel-long-term follow-up. *Int J Gynecol Cancer* 2008;18:803-808. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/17944917>.

336. Miller DS, Filiaci VL, Mannel RS, et al. Carboplatin and Paclitaxel for Advanced Endometrial Cancer: Final Overall Survival and Adverse Event Analysis of a Phase III Trial (NRG Oncology/GOG0209). *J Clin Oncol* 2020;38:3841-3850. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/33078978>.

337. Nomura H, Aoki D, Takahashi F, et al. Randomized phase II study comparing docetaxel plus cisplatin, docetaxel plus carboplatin, and paclitaxel plus carboplatin in patients with advanced or recurrent endometrial carcinoma: a Japanese Gynecologic Oncology Group study (JGOG2041). *Ann Oncol* 2011;22:636-642. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/20696677>.

338. Hori K, Nishio S, Ushijima K, et al. A phase II, open-labeled, single-arm study of dose-dense paclitaxel plus carboplatin in advanced or recurrent uterine endometrial cancer treatment: a KCOG-G1303, DOENCA trial. *J Gynecol Oncol* 2021;32:e64. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/34085798>.

339. Simpkins F, Drake R, Escobar PF, et al. A phase II trial of paclitaxel, carboplatin, and bevacizumab in advanced and recurrent endometrial carcinoma (EMCA). *Gynecol Oncol* 2015;136:240-245. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/25485782>.

340. Rose PG, Ali S, Moslemi-Kebria M, Simpkins F. Paclitaxel, Carboplatin, and Bevacizumab in Advanced and Recurrent Endometrial Carcinoma. *Int J Gynecol Cancer* 2017;27:452-458. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/28187088>.

341. Lorusso D, Ferrandina G, Colombo N, et al. Carboplatin-paclitaxel compared to carboplatin-paclitaxel-bevacizumab in advanced or recurrent endometrial cancer: MITO end-2-a randomized phase II trial. *Gynecologic oncology* 2019;155:406-412. Available at:

342. Chen H, Liang M, Min J. Efficacy and Safety of Bevacizumab-Combined Chemotherapy for Advanced and Recurrent Endometrial Cancer: A Systematic Review and Meta-analysis. *Balkan Med J* 2021;38:7-12. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/33593716>.

343. Cella D, Huang H, Homesley HD, et al. Patient-reported peripheral neuropathy of doxorubicin and cisplatin with and without paclitaxel in the treatment of advanced endometrial cancer: Results from GOG 184. *Gynecol Oncol* 2010;119:538-542. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/20863554>.

344. Fleming GF, Brunetto VL, Cella D, et al. Phase III trial of doxorubicin plus cisplatin with or without paclitaxel plus filgrastim in advanced endometrial carcinoma: a Gynecologic Oncology Group Study. *J Clin Oncol* 2004;22:2159-2166. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/15169803>.

345. Spirtos NM, Enserro D, Homesley HD, et al. The addition of paclitaxel to doxorubicin and cisplatin and volume-directed radiation does not improve overall survival (OS) or long-term recurrence-free survival (RFS) in advanced endometrial cancer (EC): A randomized phase III NRG/Gynecologic Oncology Group (GOG) study. *Gynecol Oncol* 2019;154:13-21. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/31053405>.

346. Wadler S, Levy DE, Lincoln ST, et al. Topotecan is an active agent in the first-line treatment of metastatic or recurrent endometrial carcinoma: Eastern Cooperative Oncology Group Study E3E93. *J Clin Oncol* 2003;21:2110-2114. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/12775736>.

347. Traina TA, Sabbatini P, Aghajanian C, Dupont J. Weekly topotecan for recurrent endometrial cancer: a case series and review of the literature.



Gynecol Oncol 2004;95:235-241. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/15385138>.

348. Miller DS, Blessing JA, Lentz SS, Waggoner SE. A phase II trial of topotecan in patients with advanced, persistent, or recurrent endometrial carcinoma: a gynecologic oncology group study. Gynecol Oncol 2002;87:247-251. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/12468321>.

349. Moxley KM, McMeekin DS. Endometrial carcinoma: a review of chemotherapy, drug resistance, and the search for new agents. Oncologist 2010;15:1026-1033. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/20930101>.

350. Muggia FM, Blessing JA, Sorosky J, Reid GC. Phase II trial of the pegylated liposomal doxorubicin in previously treated metastatic endometrial cancer: a Gynecologic Oncology Group study. J Clin Oncol 2002;20:2360-2364. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/11981008>.

351. Garcia AA, Blessing JA, Nolte S, et al. A phase II evaluation of weekly docetaxel in the treatment of recurrent or persistent endometrial carcinoma: a study by the Gynecologic Oncology Group. Gynecol Oncol 2008;111:22-26. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/18675446>.

352. Mountzios G, Pectasides D, Bournakis E, et al. Developments in the systemic treatment of endometrial cancer. Crit Rev Oncol Hematol 2011;79:278-292. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/20833559>.

353. Aghajanian C, Sill MW, Darcy KM, et al. Phase II trial of bevacizumab in recurrent or persistent endometrial cancer: a Gynecologic Oncology Group study. J Clin Oncol 2011;29:2259-2265. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/21537039>.

354. Alvarez EA, Brady WE, Walker JL, et al. Phase II trial of combination bevacizumab and temsirolimus in the treatment of recurrent or persistent endometrial carcinoma: a Gynecologic Oncology Group study. Gynecol

Oncol 2013;129:22-27. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/23262204>.

355. Fleming GF, Filiaci VL, Marzullo B, et al. Temsirolimus with or without megestrol acetate and tamoxifen for endometrial cancer: a gynecologic oncology group study. Gynecol Oncol 2014;132:585-592. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/24456823>.

356. Oza AM, Elit L, Tsao MS, et al. Phase II study of temsirolimus in women with recurrent or metastatic endometrial cancer: a trial of the NCIC Clinical Trials Group. J Clin Oncol 2011;29:3278-3285. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/21788564>.

357. Ott PA, Bang YJ, Berton-Rigaud D, et al. Safety and Antitumor Activity of Pembrolizumab in Advanced Programmed Death Ligand 1-Positive Endometrial Cancer: Results From the KEYNOTE-028 Study. J Clin Oncol 2017;35:2535-2541. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/28489510>.

358. Le DT, Durham JN, Smith KN, et al. Mismatch repair deficiency predicts response of solid tumors to PD-1 blockade. Science 2017;357:409-413. Available at:  
<https://www.ncbi.nlm.nih.gov/pubmed/28596308>.

359. Le DT, Uram JN, Wang H, et al. PD-1 Blockade in Tumors with Mismatch-Repair Deficiency. N Engl J Med 2015;372:2509-2520. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26028255>.

360. Prescribing information: Pembrolizumab 2017. Available at: <http://bit.ly/2cTmltE>. Accessed Jul 25, 2017.

361. O'Malley DM, Bariani GM, Cassier PA, et al. Pembrolizumab in Patients With Microsatellite Instability-High Advanced Endometrial Cancer: Results From the KEYNOTE-158 Study. J Clin Oncol 2022;40:752-761. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/34990208>.

362. Subbiah V, Solit DB, Chan TA, Kurzrock R. The FDA approval of pembrolizumab for adult and pediatric patients with tumor mutational burden (TMB)  $\geq 10$ : a decision centered on empowering patients and



their physicians. *Ann Oncol* 2020;31:1115-1118. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32771306>.

363. Bonneville R, Krook MA, Kautto EA, et al. Landscape of Microsatellite Instability Across 39 Cancer Types. *JCO Precis Oncol* 2017;2017:1-15. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29850653>.

364. Prendergast EN, Holman LL, Liu AY, et al. Comprehensive genomic profiling of recurrent endometrial cancer: Implications for selection of systemic therapy. *Gynecol Oncol* 2019;154:461-466. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/31257009>.

365. Makker V, Taylor MH, Aghajanian C, et al. Lenvatinib Plus Pembrolizumab in Patients With Advanced Endometrial Cancer. *J Clin Oncol* 2020;38:2981-2992. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32167863>.

366. Makker V, Colombo N, Casado Herraes A, et al. Lenvatinib plus Pembrolizumab for Advanced Endometrial Cancer. *N Engl J Med* 2022;386:437-448. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/35045221>.

367. Azad NS, Gray RJ, Overman MJ, et al. Nivolumab Is Effective in Mismatch Repair-Deficient Noncolorectal Cancers: Results From Arm Z1D-A Subprotocol of the NCI-MATCH (EAY131) Study. *J Clin Oncol* 2020;38:214-222. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/31765263>.

368. Fader AN, Roque DM, Siegel E, et al. Randomized Phase II Trial of Carboplatin-Paclitaxel Versus Carboplatin-Paclitaxel-Trastuzumab in Uterine Serous Carcinomas That Overexpress Human Epidermal Growth Factor Receptor 2/neu. *J Clin Oncol* 2018;36:2044-2051. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29584549>.

369. Tymon-Rosario J, Siegel ER, Bellone S, et al. Trastuzumab tolerability in the treatment of advanced (stage III-IV) or recurrent uterine serous carcinomas that overexpress HER2/neu. *Gynecologic oncology* 2021;163:93-99. Available at:

370. Homesley HD, Filiaci V, Markman M, et al. Phase III trial of ifosfamide with or without paclitaxel in advanced uterine carcinosarcoma: a Gynecologic Oncology Group Study. *J Clin Oncol* 2007;25:526-531. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17290061>.

371. Sutton G, Brunetto VL, Kilgore L, et al. A phase III trial of ifosfamide with or without cisplatin in carcinosarcoma of the uterus: A Gynecologic Oncology Group Study. *Gynecol Oncol* 2000;79:147-153. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/11063636>.

372. Hensley ML. Role of chemotherapy and biomolecular therapy in the treatment of uterine sarcomas. *Best Pract Res Clin Obstet Gynaecol* 2011;25:773-782. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21752717>.

373. Sutton G, Kauderer J, Carson LF, et al. Adjuvant ifosfamide and cisplatin in patients with completely resected stage I or II carcinosarcomas (mixed mesodermal tumors) of the uterus: a Gynecologic Oncology Group study. *Gynecol Oncol* 2005;96:630-634. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/15721404>.

374. Le T, Menard C, Samant R, et al. Longitudinal assessments of quality of life in endometrial cancer patients: effect of surgical approach and adjuvant radiotherapy. *Int J Radiat Oncol Biol Phys* 2009;75:795-802. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19250764>.

375. de Boer SM, Nout RA, Jurgenliemk-Schulz IM, et al. Long-Term Impact of Endometrial Cancer Diagnosis and Treatment on Health-Related Quality of Life and Cancer Survivorship: Results From the Randomized PORTEC-2 Trial. *Int J Radiat Oncol Biol Phys* 2015;93:797-809. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26530748>.

376. Salani R, Khanna N, Frimer M, et al. An update on post-treatment surveillance and diagnosis of recurrence in women with gynecologic malignancies: Society of Gynecologic Oncology (SGO) recommendations. *Gynecol Oncol* 2017;146:3-10. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28372871>.



377. Fung-Kee-Fung M, Dodge J, Elit L, et al. Follow-up after primary therapy for endometrial cancer: a systematic review. *Gynecol Oncol* 2006;101:520-529. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16556457>.

378. Lajer H, Elnegaard S, Christensen RD, et al. Survival after stage IA endometrial cancer; can follow-up be altered? A prospective nationwide Danish survey. *Acta Obstet Gynecol Scand* 2012;91:976-982. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22548255>.

379. Greer BE, Goff BA, Koh WJ. Endometrial carcinoma. In: Johnson FE, Virgo KS, eds. *Cancer Patient Follow-up*. St. Louis: Mosby; 1997:357-377.

380. Bristow RE, Purinton SC, Santillan A, et al. Cost-effectiveness of routine vaginal cytology for endometrial cancer surveillance. *Gynecol Oncol* 2006;103:709-713. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16797686>.

381. Cowens-Alvarado R, Sharpe K, Pratt-Chapman M, et al. Advancing survivorship care through the National Cancer Survivorship Resource Center: developing American Cancer Society guidelines for primary care providers. *CA Cancer J Clin* 2013;63:147-150. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23512728>.

382. McCabe MS, Bhatia S, Oeffinger KC, et al. American Society of Clinical Oncology statement: achieving high-quality cancer survivorship care. *J Clin Oncol* 2013;31:631-640. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23295805>.

383. Smith WA, Nolan VG, Robison LL, et al. Physical activity among cancer survivors and those with no history of cancer- a report from the National Health and Nutrition Examination Survey 2003-2006. *Am J Transl Res* 2011;3:342-350. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21904654>.

384. Cooper AL, Dornfeld-Finke JM, Banks HW, et al. Is cytologic screening an effective surveillance method for detection of vaginal recurrence of uterine cancer? *Obstet Gynecol* 2006;107:71-76. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16394042>.

385. Salani R, Nagel CI, Drennen E, Bristow RE. Recurrence patterns and surveillance for patients with early stage endometrial cancer. *Gynecol Oncol* 2011;123:205-207. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21820709>.

386. Hunn J, Tenney ME, Tergas AI, et al. Patterns and utility of routine surveillance in high grade endometrial cancer. *Gynecol Oncol* 2015;137:485-489. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25838164>.

387. Smith DC, Prentice R, Thompson DJ, Herrmann WL. Association of exogenous estrogen and endometrial carcinoma. *N Engl J Med* 1975;293:1164-1167. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/1186789>.

388. Ziel HK, Finkle WD. Increased risk of endometrial carcinoma among users of conjugated estrogens. *N Engl J Med* 1975;293:1167-1170. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/171569>.

389. Creasman WT, Henderson D, Hinshaw W, Clarke-Pearson DL. Estrogen replacement therapy in the patient treated for endometrial cancer. *Obstet Gynecol* 1986;67:326-330. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/3003636>.

390. Lee RB, Burke TW, Park RC. Estrogen replacement therapy following treatment for stage I endometrial carcinoma. *Gynecol Oncol* 1990;36:189-191. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/2298408>.

391. Chapman JA, DiSaia PJ, Osann K, et al. Estrogen replacement in surgical stage I and II endometrial cancer survivors. *Am J Obstet Gynecol* 1996;175:1195-1200. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/8942487>.

392. Barakat RR, Bundy BN, Spirtos NM, et al. Randomized double-blind trial of estrogen replacement therapy versus placebo in stage I or II endometrial cancer: a Gynecologic Oncology Group Study. *J Clin Oncol* 2006;24:587-592. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16446331>.



393. Chlebowski RT, Hendrix SL, Langer RD, et al. Influence of estrogen plus progestin on breast cancer and mammography in healthy postmenopausal women: the Women's Health Initiative Randomized Trial. *JAMA* 2002;289:3243-3253. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12824205>.

394. Anderson GL, Limacher M, Assaf AR, et al. Effects of conjugated equine estrogen in postmenopausal women with hysterectomy: the Women's Health Initiative randomized controlled trial. *JAMA* 2004;291:1701-1712. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/15082697>.

395. LaCroix AZ, Chlebowski RT, Manson JE, et al. Health outcomes after stopping conjugated equine estrogens among postmenopausal women with prior hysterectomy: a randomized controlled trial. *JAMA* 2011;305:1305-1314. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21467283>.

396. Pachman DR, Jones JM, Loprinzi CL. Management of menopause-associated vasomotor symptoms: Current treatment options, challenges and future directions. *Int J Womens Health* 2010;2:123-135. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21072305>.

397. Morrow PK, Mattair DN, Hortobagyi GN. Hot flashes: a review of pathophysiology and treatment modalities. *Oncologist* 2011;16:1658-1664. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22042786>.

398. Levine JP. Treating menopausal symptoms with a tissue-selective estrogen complex. *Gend Med* 2011;8:57-68. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21536225>.

399. Pinkerton JV, Utian WH, Constantine GD, et al. Relief of vasomotor symptoms with the tissue-selective estrogen complex containing bazedoxifene/conjugated estrogens: a randomized, controlled trial. *Menopause* 2009;16:1116-1124. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19546826>.

400. Loprinzi CL, Barton DL, Qin R. Nonestrogenic management of hot flashes. *J Clin Oncol* 2011;29:3842-3846. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21911722>.

401. Sideras K, Loprinzi CL. Nonhormonal management of hot flashes for women on risk reduction therapy. *J Natl Compr Canc Netw* 2010;8:1171-1179. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20971841>.

402. Cancer Facts and Figures 2017. Atlanta, GA: American Cancer Society. Available at: <https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-facts-figures-2017.html>.

403. Trope CG, Abeler VM, Kristensen GB. Diagnosis and treatment of sarcoma of the uterus. A review. *Acta Oncol* 2012;51:694-705. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22793037>.

404. Amant F, Coosemans A, Debiec-Rychter M, et al. Clinical management of uterine sarcomas. *Lancet Oncol* 2009;10:1188-1198. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19959075>.

405. Parra-Herran C, Howitt BE. Uterine Mesenchymal Tumors: Update on Classification, Staging, and Molecular Features. *Surg Pathol Clin* 2019;12:363-396. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/31097109>.

406. Novetsky AP, Powell MA. Management of sarcomas of the uterus. *Curr Opin Oncol* 2013;25:546-552. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23942299>.

407. Lax SF. Molecular genetic changes in epithelial, stromal and mixed neoplasms of the endometrium. *Pathology* 2007;39:46-54. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17365822>.

408. Huang HY, Ladanyi M, Soslow RA. Molecular detection of JAZF1-JJAZ1 gene fusion in endometrial stromal neoplasms with classic and variant histology: evidence for genetic heterogeneity. *Am J Surg Pathol* 2004;28:224-232. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/15043312>.



409. Leath CA, 3rd, Huh WK, Hyde J, Jr., et al. A multi-institutional review of outcomes of endometrial stromal sarcoma. *Gynecol Oncol* 2007;105:630-634. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17320937>.
410. Koontz JI, Soreng AL, Nucci M, et al. Frequent fusion of the JAZF1 and JJAZ1 genes in endometrial stromal tumors. *Proc Natl Acad Sci U S A* 2001;98:6348-6353. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/11371647>.
411. Lee CH, Marino-Enriquez A, Ou W, et al. The clinicopathologic features of YWHAE-FAM22 endometrial stromal sarcomas: a histologically high-grade and clinically aggressive tumor. *Am J Surg Pathol* 2012;36:641-653. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22456610>.
412. Sciallis AP, Bedroske PP, Schoolmeester JK, et al. High-grade endometrial stromal sarcomas: a clinicopathologic study of a group of tumors with heterogenous morphologic and genetic features. *Am J Surg Pathol* 2014;38:1161-1172. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25133706>.
413. Lewis N, Soslow RA, Delair DF, et al. ZC3H7B-BCOR high-grade endometrial stromal sarcomas: a report of 17 cases of a newly defined entity. *Mod Pathol* 2018;31:674-684. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29192652>.
414. Kurman RJ, Carcangiu ML, Herrington CS, Young RH. WHO Classification of Tumours of Female Reproductive Organs. Fourth Edition. Vol. 6: World Health Organization; 2014.
415. Hohn AK, Brambs CE, Hiller GGR, et al. 2020 WHO Classification of Female Genital Tumors. *Geburtshilfe Frauenheilkd* 2021;81:1145-1153. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/34629493>.
416. Binzer-Panchal A, Hardell E, Viklund B, et al. Integrated Molecular Analysis of Undifferentiated Uterine Sarcomas Reveals Clinically Relevant Molecular Subtypes. *Clin Cancer Res* 2019;25:2155-2165. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/30617134>.
417. Kolin DL, Quick CM, Dong F, et al. SMARCA4-deficient Uterine Sarcoma and Undifferentiated Endometrial Carcinoma Are Distinct Clinicopathologic Entities. *Am J Surg Pathol* 2020;44:263-270. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/31567195>.
418. Selenica P, Conlon N, Gonzalez C, et al. Genomic Profiling Aids Classification of Diagnostically Challenging Uterine Mesenchymal Tumors With Myomelanocytic Differentiation. *Am J Surg Pathol* 2021;45:77-92. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32889887>.
419. Goebel EA, Hernandez Bonilla S, Dong F, et al. Uterine Tumor Resembling Ovarian Sex Cord Tumor (UTROSCT): A Morphologic and Molecular Study of 26 Cases Confirms Recurrent NCOA1-3 Rearrangement. *Am J Surg Pathol* 2020;44:30-42. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/31464709>.
420. Lee CH, Kao YC, Lee WR, et al. Clinicopathologic Characterization of GREB1-rearranged Uterine Sarcomas With Variable Sex-Cord Differentiation. *Am J Surg Pathol* 2019;43:928-942. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/31094921>.
421. Leiner J, Le Loarer F. The current landscape of rhabdomyosarcomas: an update. *Virchows Arch* 2020;476:97-108. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/31696361>.
422. Bennett JA, Ordulu Z, Young RH, et al. Embryonal rhabdomyosarcoma of the uterine corpus: a clinicopathological and molecular analysis of 21 cases highlighting a frequent association with DICER1 mutations. *Mod Pathol* 2021;34:1750-1762. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/34017064>.
423. Zivanovic O, Leitao MM, Iasonos A, et al. Stage-specific outcomes of patients with uterine leiomyosarcoma: a comparison of the international Federation of gynecology and obstetrics and american joint committee on cancer staging systems. *J Clin Oncol* 2009;27:2066-2072. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19255317>.



424. Prat J. FIGO staging for uterine sarcomas. *Int J Gynaecol Obstet* 2009;104:177-178. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19135669>.

425. Rauh-Hain JA, del Carmen MG. Endometrial stromal sarcoma: a systematic review. *Obstet Gynecol* 2013;122:676-683. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23921879>.

426. Dondi G, Porcu E, De Palma A, et al. Uterine Preservation Treatments in Sarcomas: Oncological Problems and Reproductive Results: A Systematic Review. *Cancers (Basel)* 2021;13. Available at:

427. Nasioudis D, Ko EM, Kolovos G, et al. Ovarian preservation for low-grade endometrial stromal sarcoma: a systematic review of the literature and meta-analysis. *Int J Gynecol Cancer* 2019;29:126-132. Available at:

428. Stewart LE, Beck TL, Giannakopoulos NV, et al. Impact of oophorectomy and hormone suppression in low grade endometrial stromal sarcoma: A multicenter review. *Gynecol Oncol* 2018;149:297-300. Available at:

429. Group EESNW. Soft tissue and visceral sarcomas: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol* 2012;23 Suppl 7:vii92-99. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22997462>.

430. Barney B, Tward JD, Skidmore T, Gaffney DK. Does radiotherapy or lymphadenectomy improve survival in endometrial stromal sarcoma? *Int J Gynecol Cancer* 2009;19:1232-1238. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19823060>.

431. Shah JP, Bryant CS, Kumar S, et al. Lymphadenectomy and ovarian preservation in low-grade endometrial stromal sarcoma. *Obstet Gynecol* 2008;112:1102-1108. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18978112>.

432. Signorelli M, Fruscio R, Dell'Anna T, et al. Lymphadenectomy in uterine low-grade endometrial stromal sarcoma: an analysis of 19 cases

and a literature review. *Int J Gynecol Cancer* 2010;20:1363-1366. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21051978>.

433. Reichardt P. The treatment of uterine sarcomas. *Ann Oncol* 2012;23 Suppl 10:x151-157. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22987952>.

434. Thanopoulou E, Judson I. Hormonal therapy in gynecological sarcomas. *Expert Rev Anticancer Ther* 2012;12:885-894. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22845404>.

435. Pink D, Lindner T, Mrozek A, et al. Harm or benefit of hormonal treatment in metastatic low-grade endometrial stromal sarcoma: single center experience with 10 cases and review of the literature. *Gynecol Oncol* 2006;101:464-469. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16368128>.

436. Mansi JL, Ramachandra S, Wiltshaw E, Fisher C. Endometrial stromal sarcomas. *Gynecol Oncol* 1990;36:113-118. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/2295442>.

437. Berchuck A, Rubin SC, Hoskins WJ, et al. Treatment of endometrial stromal tumors. *Gynecol Oncol* 1990;36:60-65. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/2295453>.

438. Weitmann HD, Knocke TH, Kucera H, Potter R. Radiation therapy in the treatment of endometrial stromal sarcoma. *Int J Radiat Oncol Biol Phys* 2001;49:739-748. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/11172957>.

439. Brenner DJ, Hall EJ. Computed tomography--an increasing source of radiation exposure. *N Engl J Med* 2007;357:2277-2284. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18046031>.

440. Edmondson RJ, O'Connell RL, Banerjee S, et al. Phase 2 study of anastrozole in rare cohorts of patients with estrogen receptor/progesterone receptor positive leiomyosarcomas and carcinosarcomas of the uterine corpus: The PARAGON trial (ANZGOG 0903). *Gynecol Oncol* 2021;163:524-530. Available at:



441. Reed NS, Mangioni C, Malmstrom H, et al. Phase III randomised study to evaluate the role of adjuvant pelvic radiotherapy in the treatment of uterine sarcomas stages I and II: an European Organisation for Research and Treatment of Cancer Gynaecological Cancer Group Study (protocol 55874). *Eur J Cancer* 2008;44:808-818. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18378136>.

442. Sampath S, Schultheiss TE, Ryu JK, Wong JY. The role of adjuvant radiation in uterine sarcomas. *Int J Radiat Oncol Biol Phys* 2010;76:728-734. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19700247>.

443. Mahdavi A, Monk BJ, Ragazzo J, et al. Pelvic radiation improves local control after hysterectomy for uterine leiomyosarcoma: a 20-year experience. *Int J Gynecol Cancer* 2009;19:1080-1084. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19820372>.

444. Giuntoli RL, 2nd, Metzinger DS, DiMarco CS, et al. Retrospective review of 208 patients with leiomyosarcoma of the uterus: prognostic indicators, surgical management, and adjuvant therapy. *Gynecol Oncol* 2003;89:460-469. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12798712>.

445. Dusenbery KE, Potish RA, Judson P. Limitations of adjuvant radiotherapy for uterine sarcomas spread beyond the uterus. *Gynecol Oncol* 2004;94:191-196. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/15262141>.

446. Rizzo A, Nannini M, Astolfi A, et al. Impact of Chemotherapy in the Adjuvant Setting of Early Stage Uterine Leiomyosarcoma: A Systematic Review and Updated Meta-Analysis. *Cancers (Basel)* 2020;12. Available at:

447. Ricci S, Giuntoli RL, 2nd, Eisenhauer E, et al. Does adjuvant chemotherapy improve survival for women with early-stage uterine leiomyosarcoma? *Gynecol Oncol* 2013;131:629-633. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24016408>.

448. Yoon A, Park JY, Park JY, et al. Prognostic factors and outcomes in endometrial stromal sarcoma with the 2009 FIGO staging system: a

multicenter review of 114 cases. *Gynecol Oncol* 2014;132:70-75. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24184602>.

449. Karavasili V, Seddon BM, Ashley S, et al. Significant clinical benefit of first-line palliative chemotherapy in advanced soft-tissue sarcoma: retrospective analysis and identification of prognostic factors in 488 patients. *Cancer* 2008;112:1585-1591. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18278813>.

450. Leitao MM, Brennan MF, Hensley M, et al. Surgical resection of pulmonary and extrapulmonary recurrences of uterine leiomyosarcoma. *Gynecol Oncol* 2002;87:287-294. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12468327>.

451. Sharma S, Takyar S, Manson SC, et al. Efficacy and safety of pharmacological interventions in second- or later-line treatment of patients with advanced soft tissue sarcoma: a systematic review. *BMC Cancer* 2013;13:385. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23937858>.

452. Bernstein-Molho R, Grisaro D, Soyfer V, et al. Metastatic uterine leiomyosarcomas: a single-institution experience. *Int J Gynecol Cancer* 2010;20:255-260. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20134269>.

453. Dhakal S, Corbin KS, Milano MT, et al. Stereotactic body radiotherapy for pulmonary metastases from soft-tissue sarcomas: excellent local lesion control and improved patient survival. *Int J Radiat Oncol Biol Phys* 2012;82:940-945. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21277105>.

454. Mehta N, Selch M, Wang PC, et al. Safety and efficacy of stereotactic body radiation therapy in the treatment of pulmonary metastases from high grade sarcoma. *Sarcoma* 2013;2013:360214. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24198717>.

455. Maki RG, Wathen JK, Patel SR, et al. Randomized phase II study of gemcitabine and docetaxel compared with gemcitabine alone in patients with metastatic soft tissue sarcomas: results of sarcoma alliance for



research through collaboration study 002 [corrected]. J Clin Oncol 2007;25:2755-2763. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17602081>.

456. Davis EJ, Chugh R, Zhao L, et al. A randomised, open-label, phase II study of neo/adjuvant doxorubicin and ifosfamide versus gemcitabine and docetaxel in patients with localised, high-risk, soft tissue sarcoma. Eur J Cancer 2015;51:1794-1802. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26066736>.

457. Hensley ML, Ishill N, Soslow R, et al. Adjuvant gemcitabine plus docetaxel for completely resected stages I-IV high grade uterine leiomyosarcoma: Results of a prospective study. Gynecol Oncol 2009;112:563-567. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19135708>.

458. Hensley ML, Wathen JK, Maki RG, et al. Adjuvant therapy for high-grade, uterus-limited leiomyosarcoma: results of a phase 2 trial (SARC 005). Cancer 2013;119:1555-1561. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23335221>.

459. Hensley ML, Miller A, O'Malley DM, et al. Randomized phase III trial of gemcitabine plus docetaxel plus bevacizumab or placebo as first-line treatment for metastatic uterine leiomyosarcoma: an NRG Oncology/Gynecologic Oncology Group study. J Clin Oncol 2015;33:1180-1185. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25713428>.

460. Hensley ML, Maki R, Venkatraman E, et al. Gemcitabine and docetaxel in patients with unresectable leiomyosarcoma: results of a phase II trial. J Clin Oncol 2002;20:2824-2831. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12065559>.

461. Gajdos C, Elias A. Trabectedin: safety and efficacy in the treatment of advanced sarcoma. Clin Med Insights Oncol 2011;5:35-43. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21499557>.

462. Demetri GD, Chawla SP, von Mehren M, et al. Efficacy and safety of trabectedin in patients with advanced or metastatic liposarcoma or leiomyosarcoma after failure of prior anthracyclines and ifosfamide: results

of a randomized phase II study of two different schedules. J Clin Oncol 2009;27:4188-4196. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19652065>.

463. Fayette J, Boyle H, Chabaud S, et al. Efficacy of trabectedin for advanced sarcomas in clinical trials versus compassionate use programs: analysis of 92 patients treated in a single institution. Anticancer Drugs 2010;21:113-119. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19887935>.

464. Pautier P, Floquet A, Chevreau C, et al. Trabectedin in combination with doxorubicin for first-line treatment of advanced uterine or soft-tissue leiomyosarcoma (LMS-02): a non-randomised, multicentre, phase 2 trial. Lancet Oncol 2015;16:457-464. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25795402>.

465. Demetri GD, von Mehren M, Jones RL, et al. Efficacy and Safety of Trabectedin or Dacarbazine for Metastatic Liposarcoma or Leiomyosarcoma After Failure of Conventional Chemotherapy: Results of a Phase III Randomized Multicenter Clinical Trial. J Clin Oncol 2016;34:786-793. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26371143>.

466. Hensley ML, Patel SR, von Mehren M, et al. Efficacy and safety of trabectedin or dacarbazine in patients with advanced uterine leiomyosarcoma after failure of anthracycline-based chemotherapy: Subgroup analysis of a phase 3, randomized clinical trial. Gynecol Oncol 2017;146:531-537. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28651804>.

467. Garcia-Del-Muro X, Lopez-Pousa A, Maurel J, et al. Randomized phase II study comparing gemcitabine plus dacarbazine versus dacarbazine alone in patients with previously treated soft tissue sarcoma: a Spanish Group for Research on Sarcomas study. J Clin Oncol 2011;29:2528-2533. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21606430>.

468. Sleijfer S, Ray-Coquard I, Papai Z, et al. Pazopanib, a multikinase angiogenesis inhibitor, in patients with relapsed or refractory advanced



soft tissue sarcoma: a phase II study from the European organisation for research and treatment of cancer-soft tissue and bone sarcoma group (EORTC study 62043). *J Clin Oncol* 2009;27:3126-3132. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19451427>.

469. Rajendra R, Jones RL, Pollack SM. Targeted treatment for advanced soft tissue sarcoma: profile of pazopanib. *Onco Targets Ther* 2013;6:217-222. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23524973>.

470. Pautier P, Floquet A, Penel N, et al. Randomized multicenter and stratified phase II study of gemcitabine alone versus gemcitabine and docetaxel in patients with metastatic or relapsed leiomyosarcomas: a Federation Nationale des Centres de Lutte Contre le Cancer (FNCLCC) French Sarcoma Group Study (TAXOGEM study). *Oncologist* 2012;17:1213-1220. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22907974>.

471. van Hoesel QG, Verweij J, Catimel G, et al. Phase II study with docetaxel (Taxotere) in advanced soft tissue sarcomas of the adult. EORTC Soft Tissue and Bone Sarcoma Group. *Ann Oncol* 1994;5:539-542. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/7918126>.

472. Edmonson JH, Ebbert LP, Nascimento AG, et al. Phase II study of docetaxel in advanced soft tissue sarcomas. *Am J Clin Oncol* 1996;19:574-576. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/8931674>.

473. van der Graaf WT, Blay JY, Chawla SP, et al. Pazopanib for metastatic soft-tissue sarcoma (PALETTE): a randomised, double-blind, placebo-controlled phase 3 trial. *Lancet* 2012;379:1879-1886. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22595799>.

474. Ridolfi C, Pasini G, Drudi F, et al. Long lasting clinical response to chemotherapy for advanced uterine leiomyosarcoma: a case report. *J Med Case Rep* 2013;7:29. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23347560>.

475. Ferriss JS, Atkins KA, Lachance JA, et al. Temozolomide in advanced and recurrent uterine leiomyosarcoma and correlation with o6-

methylguanine DNA methyltransferase expression: a case series. *Int J Gynecol Cancer* 2010;20:120-125. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20130512>.

476. Anderson S, Aghajanian C. Temozolomide in uterine leiomyosarcomas. *Gynecol Oncol* 2005;98:99-103. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/15916799>.

477. Talbot SM, Keohan ML, Hesdorffer M, et al. A phase II trial of temozolomide in patients with unresectable or metastatic soft tissue sarcoma. *Cancer* 2003;98:1942-1946. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/14584078>.

478. Oosten AW, Seynaeve C, Schmitz PI, et al. Outcomes of first-line chemotherapy in patients with advanced or metastatic leiomyosarcoma of uterine and non-uterine origin. *Sarcoma* 2009;2009:348910. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20066161>.

479. Look KY, Sandler A, Blessing JA, et al. Phase II trial of gemcitabine as second-line chemotherapy of uterine leiomyosarcoma: a Gynecologic Oncology Group (GOG) Study. *Gynecol Oncol* 2004;92:644-647. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/14766260>.

480. Judson I, Radford JA, Harris M, et al. Randomised phase II trial of pegylated liposomal doxorubicin (DOXIL/CAELYX) versus doxorubicin in the treatment of advanced or metastatic soft tissue sarcoma: a study by the EORTC Soft Tissue and Bone Sarcoma Group. *Eur J Cancer* 2001;37:870-877. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/11313175>.

481. Sutton G, Blessing J, Hanjani P, et al. Phase II evaluation of liposomal doxorubicin (Doxil) in recurrent or advanced leiomyosarcoma of the uterus: a Gynecologic Oncology Group study. *Gynecol Oncol* 2005;96:749-752. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/15721421>.

482. Gallup DG, Blessing JA, Andersen W, et al. Evaluation of paclitaxel in previously treated leiomyosarcoma of the uterus: a gynecologic oncology



group study. *Gynecol Oncol* 2003;89:48-51. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12694653>.

483. Mancari R, Signorelli M, Gadducci A, et al. Adjuvant chemotherapy in stage I-II uterine leiomyosarcoma: a multicentric retrospective study of 140 patients. *Gynecol Oncol* 2014;133:531-536. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24631454>.

484. Schoffski P, Maki RG, Italiano A, et al. Randomized, open-label, multicenter, phase III study of eribulin versus dacarbazine in patients (pts) with leiomyosarcoma (LMS) and adipocytic sarcoma (ADI) [abstract]. *ASCO Meeting Abstracts* 2015;33:LBA10502. Available at: [http://meeting.ascopubs.org/cgi/content/abstract/33/18\\_suppl/LBA10502](http://meeting.ascopubs.org/cgi/content/abstract/33/18_suppl/LBA10502).

485. Butrynski JE, D'Adamo DR, Hornick JL, et al. Crizotinib in ALK-rearranged inflammatory myofibroblastic tumor. *N Engl J Med* 2010;363:1727-1733. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20979472>.

486. Shaw AT, Engelman JA. Ceritinib in ALK-rearranged non-small-cell lung cancer. *N Engl J Med* 2014;370:2537-2539. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24963575>.

487. Camidge DR, Kim HR, Ahn MJ, et al. Brigatinib Versus Crizotinib in Advanced ALK Inhibitor-Naive ALK-Positive Non-Small Cell Lung Cancer: Second Interim Analysis of the Phase III ALTA-1L Trial. *J Clin Oncol* 2020;38:3592-3603. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32780660>.

488. Gettinger SN, Bazhenova LA, Langer CJ, et al. Activity and safety of brigatinib in ALK-rearranged non-small-cell lung cancer and other malignancies: a single-arm, open-label, phase 1/2 trial. *Lancet Oncol* 2016;17:1683-1696. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27836716>.

489. Hensley ML, Chavan SS, Solit DB, et al. Genomic Landscape of Uterine Sarcomas Defined Through Prospective Clinical Sequencing. *Clin Cancer Res* 2020;26:3881-3888. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32299819>.

490. Castells MC, Tennant NM, Sloane DE, et al. Hypersensitivity reactions to chemotherapy: outcomes and safety of rapid desensitization in 413 cases. *J Allergy Clin Immunol* 2008;122:574-580. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18502492>.

491. Dizon DS, Sabbatini PJ, Aghajanian C, et al. Analysis of patients with epithelial ovarian cancer or fallopian tube carcinoma retreated with cisplatin after the development of a carboplatin allergy. *Gynecol Oncol* 2002;84:378-382. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/11855873>.

492. Sampson HA, Munoz-Furlong A, Campbell RL, et al. Second symposium on the definition and management of anaphylaxis: summary report—second National Institute of Allergy and Infectious Disease/Food Allergy and Anaphylaxis Network symposium. *Ann Emerg Med* 2006;47:373-380. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16546624>.

493. Manivannan V, Decker WW, Stead LG, et al. Visual representation of National Institute of Allergy and Infectious Disease and Food Allergy and Anaphylaxis Network criteria for anaphylaxis. *Int J Emerg Med* 2009;2:3-5. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19390910>.

494. Lenz HJ. Management and preparedness for infusion and hypersensitivity reactions. *Oncologist* 2007;12:601-609. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17522249>.

495. Markman M, Zanotti K, Peterson G, et al. Expanded experience with an intradermal skin test to predict for the presence or absence of carboplatin hypersensitivity. *J Clin Oncol* 2003;21:4611-4614. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/14673050>.

496. Lee CW, Matulonis UA, Castells MC. Rapid inpatient/outpatient desensitization for chemotherapy hypersensitivity: standard protocol effective in 57 patients for 255 courses. *Gynecol Oncol* 2005;99:393-399. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16054201>.

497. Lee CW, Matulonis UA, Castells MC. Carboplatin hypersensitivity: a 6-h 12-step protocol effective in 35 desensitizations in patients with



gynecological malignancies and mast cell/IgE-mediated reactions.

Gynecol Oncol 2004;95:370-376. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/15491759>.

498. Markman M, Hsieh F, Zanotti K, et al. Initial experience with a novel desensitization strategy for carboplatin-associated hypersensitivity reactions: carboplatin-hypersensitivity reactions. J Cancer Res Clin Oncol 2004;130:25-28. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/14564516>.

A large, light gray circular watermark is centered on the page. It contains the text "Discussion update in progress" in a bold, sans-serif font, arranged in three lines: "Discussion", "update in", and "progress".

Discussion  
update in  
progress