



A fact sheet for Health Care Professionals



# Follow-up of survivors of endometrial cancer

This resource provides a guide for general practitioners about women who have had endometrial cancer.

## Key messages

### Survival

- Women diagnosed with endometrial cancer have an 83% chance of surviving at least 5 years.<sup>2</sup>
- Women treated for low risk endometrial cancer have a 90% chance of long term survival.
- Women who have had endometrial cancer may experience physical, emotional, psychosocial and practical effects from endometrial cancer and its treatment.
- Late effects may occur months or years after treatment and are dependent on the type of cancer treatment.<sup>3</sup>
- Obesity is a risk factor for endometrial cancer and is the major cause of morbidity and mortality after treatment.<sup>4</sup>

### Recurrence

- More than 70% of women with recurrence of endometrial cancer present with vaginal bleeding and/or pain.<sup>5</sup>
- Speculum examination will detect 50–80% of all recurrences.<sup>5</sup>
- Most occurrences will occur within the first three years after treatment.<sup>6</sup>
- Recurrence in low-risk groups is 5–10% and mostly occurs in the vaginal vault.
- Distant recurrence (for example: lung, liver, para-aortic lymph nodes) is more likely in high risk groups.<sup>5</sup>

There are two types of endometrial cancer:

Type 1	Type 2
<ul style="list-style-type: none"> <li>• Most common</li> <li>• Frequently associated with metabolic syndrome</li> <li>• Early stage often very good prognosis</li> </ul>	<ul style="list-style-type: none"> <li>• Include serous, clear cell, other</li> <li>• Aggressive treatment may be required</li> <li>• More commonly associated with recommendation for post-operative radiotherapy, chemotherapy or both</li> </ul>

Adapted from [www.obermair.info/medical-conditions/gynaecological-cancer/uterine-cancer/](http://www.obermair.info/medical-conditions/gynaecological-cancer/uterine-cancer/)<sup>1</sup>

Outside of the usual care you provide to women, as a GP you have a vital role in caring for women with endometrial cancer.<sup>7</sup> Once a patient enters the post-treatment phase, her care may be partly or fully transitioned back to you (early low risk endometrial cancer). In some cases, women will require ongoing hospital-based care. The timing and degree of your involvement will vary depending on the patient, her stage of disease and the treatments she had.

## Treatment

Treatment for women diagnosed with endometrial cancer depends on the stage and the histological type.

### Primary treatment

Primary treatment is usually surgery and consists of a hysterectomy, bilateral salpingo-oophorectomy plus examination of the lymph nodes (sentinel lymph node, pelvic and sometimes para-aortic) lymph node sampling or systematic lymphadenectomy. Evidence has shown that if this can be performed laparoscopically, peri-operative outcomes

are better. There is no compromise of survival. Based on final stage and histological type, women are categorised into low, intermediate or high risk groups for recurrence. Risk factors for recurrence determine adjuvant treatment options.

## Recommendations for adjuvant treatment

- Adjuvant therapy is not recommended for women with low risk factors (less than 3% likelihood of recurrence).
- Women with intermediate and with some high risk factors may receive vaginal vault brachytherapy or external beam radiation treatment (radiotherapy).
- Women with high risk factors may be considered for concurrent radiotherapy and chemotherapy treatment.

## Advanced disease

Some women present with advanced disease in which case primary treatment may be hormonal therapy and/or chemotherapy with pelvic radiotherapy for control of local symptoms.



## Follow-up of survivors of endometrial cancer



### Recurrent disease

Treatment of recurrent disease may be with hormones and/or chemotherapy with radiotherapy for control of local symptoms. Surgery may be considered if recurrent disease is isolated.

### Follow-up schedule

Follow-up schedule may change in accordance with patient or clinician preference; the detection of recurrence or the development of other illnesses. The schedule needs to be tailored to individual situations. There is no evidence that follow-up more frequent than the minimal review schedule confers any survival benefit or increase in quality of life.

### Example follow-up schedule

Stage and risk	Type of follow up	Years 1–2	Years 3–5	After 5 years
Early stage low risk (less than 3% of recurrence)	May not require review unless they develop symptoms	As required	As required	As required
All other patients	Physical and gynaecological examination which includes pelvic examination	Every 3–6 months	Every 6–12 months	As required
	Cervical screening tests	Not routinely recommended for women treated for endometrial cancer		

**Source:** Adapted from Victorian Department of Health and Human Services (2015). Optimal cancer care pathway for women with endometrial cancer. Melbourne. Available at [www.cancervic.org.au/for-health-professionals/optimal-care-pathways](http://www.cancervic.org.au/for-health-professionals/optimal-care-pathways)

### Potential issues for women following treatment for endometrial cancer

All women	Explanatory notes	Considerations
Surveillance for endometrial cancer recurrence	<ul style="list-style-type: none"> <li>Routine screening is not indicated in women who are asymptomatic</li> <li>Most women will receive regular follow up at the treating centre</li> <li>Most cancer recurrences are symptomatic, 70% of women will present with vaginal bleeding or pain</li> </ul>	<ul style="list-style-type: none"> <li>Ask about history of PV bleeding, pain and physical examination</li> <li>Abdomino–pelvic examination, speculum examination of vaginal vault, palpate inguinal nodes</li> <li>Request urgent assessment at treatment centre if possible recurrence</li> </ul>
Screening for other cancers	<ul style="list-style-type: none"> <li>Patients who have undergone pelvic radiation have an increased risk of bladder and colorectal cancer</li> </ul>	<ul style="list-style-type: none"> <li>Investigate or refer if any signs of haematuria</li> <li>Investigate or refer any rectal bleeding, pain or other symptoms of unknown origin</li> <li>Regular mammograms</li> </ul>
Loss of fertility	<ul style="list-style-type: none"> <li>Majority of women diagnosed with endometrial cancer are post-menopausal</li> </ul>	<ul style="list-style-type: none"> <li>Assess emotional impact of treatment induced loss of fertility as required</li> <li>Referral to clinician skilled in this area</li> </ul>
Menopause	<ul style="list-style-type: none"> <li>Surgically induced menopause may result in more severe symptoms</li> <li>Chemotherapy and radiotherapy may both induce menopause. Full dose radiation to the pelvis definitely will</li> <li>Majority of women are post-menopausal at diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>Assess for menopausal symptoms</li> <li>Refer to specialist physician or menopause after cancer clinic</li> <li>Referral to counsellor, psychologist or psychiatrist may be appropriate</li> </ul>
Pain	<ul style="list-style-type: none"> <li>Can be associated with treatment (post-surgery, chemotherapy or radiotherapy) or may be a sign of recurrence</li> </ul>	<ul style="list-style-type: none"> <li>Pain management</li> </ul>
Fatigue	<ul style="list-style-type: none"> <li>Fatigue is very common among people who have completed cancer treatment</li> <li>Moderate intensity physical activity is proven to combat CRF and improve overall energy levels</li> <li>A variety of mind-body treatments are likely to be effective in reducing CRF</li> <li>See ACSC Fact sheet: <i>Follow-up of survivors with cancer-related fatigue</i><sup>8</sup></li> </ul>	<ul style="list-style-type: none"> <li>Screen for cancer related fatigue (CRF) at regular intervals. Using a numerical scale to quantify severity of fatigue (0 being no fatigue and 10 being worst fatigue) can be useful</li> <li>Assess treatable risk factors for CRF (e.g. pain, anaemia, anxiety, depression, other comorbidities, side effects of current medications, alcohol or substance abuse)</li> <li>Refer to allied health professionals experienced in treating CRF</li> </ul>
Distress, anxiety depression, fear of cancer recurrence	<ul style="list-style-type: none"> <li>Fear of cancer recurrence is a commonly reported issue for survivors<sup>9</sup></li> <li>Psychological distress generally declines over time</li> </ul>	<ul style="list-style-type: none"> <li>Assess at appropriate intervals and as clinically indicated</li> <li>Manage distress/depression using counselling, support groups and/or pharmacotherapy and specialist referral as appropriate</li> </ul>



## Follow-up of survivors of endometrial cancer



All women	Explanatory notes	Considerations
Lymphoedema	<ul style="list-style-type: none"> <li>Key risk factors for development include extent of surgery, lymph node dissection and radiotherapy treatment</li> <li>Other factors include trauma, infection, higher body mass index and immobility</li> <li>Regular physical activity such as walking can reduce the severity and symptoms of lymphoedema. Flexibility exercises can help with maintaining mobility</li> <li>Refer to Cancer Council <i>Understanding Lymphoedema</i> Fact Sheet <a href="http://www.cancervic.org.au/downloads/resources/factsheets/Understanding-Lymphoedema.pdf">www.cancervic.org.au/downloads/resources/factsheets/Understanding-Lymphoedema.pdf</a><sup>10</sup></li> </ul>	<ul style="list-style-type: none"> <li>Assess for signs of lymphoedema</li> <li>Advise woman about care of the limb/body part including skin care to maintain a protective barrier against infection</li> <li>Advise women about exercise such as regular walking and flexibility exercises</li> <li>Refer to lymphoedema clinic or specialist <a href="http://www.lymphoedema.org.au">www.lymphoedema.org.au</a></li> </ul>
Impaired cognitive function (such as altered memory, attention)	<ul style="list-style-type: none"> <li>Well described post chemotherapy</li> <li>Studies indicate that cognitive changes can be present at the time of diagnosis with cancer even before treatment. Generally improves over time after treatment</li> <li>Association with surgery and radiotherapy treatment not well understood</li> </ul>	<ul style="list-style-type: none"> <li>Assess for cognitive changes</li> <li>Assess for concurrent anxiety or depression which may be impacting on cognition if not treated</li> <li>Recommend practical approaches such as note taking, reminders</li> <li>Referral for neurocognitive assessment in severe cases</li> </ul>
Decline in mobility / physical function as a result of treatment	<ul style="list-style-type: none"> <li>Associated with acute, late and long term effects of surgery, radiotherapy and chemotherapy treatments</li> </ul>	<ul style="list-style-type: none"> <li>Referral to physiotherapy or occupational therapy</li> <li>Consider community based cancer rehabilitation services</li> </ul>
Healthy living	<ul style="list-style-type: none"> <li>Excessive fat consumption and being overweight (body mass index of at least 25kg/m<sup>2</sup>) are important risk factors for almost 50% of women who have been diagnosed with endometrial cancer<sup>11</sup></li> <li>General healthy living recommendations apply</li> </ul>	<ul style="list-style-type: none"> <li>Follow Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children in Australia<sup>12</sup></li> <li>Follow Australian Dietary Guidelines<sup>13</sup></li> <li>Follow Australia's Physical Activity and Sedentary Behaviour Guidelines for Adults<sup>14</sup></li> <li>Follow Australian Guidelines to Reduce Health Risks from Drinking Alcohol<sup>15</sup></li> <li>Follow RACGP <i>Support smoking cessation – a guide for health professional</i> <a href="http://www.racgp.org.au/guidelines/smokingcessation">www.racgp.org.au/guidelines/smokingcessation</a></li> <li>Chronic disease management plan/Team Care arrangement as per usual care</li> <li>Issues regarding obesity may require referral dietician, endocrinologist or bariatric service<sup>6</sup></li> </ul>

More specific to radiotherapy treatment	Explanatory notes	Considerations
Sexual intimacy changes / dysfunction	<ul style="list-style-type: none"> <li>Can be exacerbated by menopause</li> <li>May be related to aging</li> <li>External beam radiotherapy may result in vaginal dryness, vaginal bleeding, stenosis, dyspareunia, atrophic vaginitis and pain</li> <li>The use of local oestrogen and vaginal applicators is recommended following radiotherapy to reduce the likelihood of vaginal side-effects. Treatment centres can advise</li> <li>Systemic HRT usually avoided in endometrial cancer</li> </ul>	<ul style="list-style-type: none"> <li>Assess sexual function</li> <li>Consider local oestrogen therapy to improve vaginal lubrication</li> <li>Refer to counselling or support services as appropriate</li> <li>Refer to sexual health specialist or psychotherapist to review treatment and counselling options</li> </ul>
Urinary dysfunction	<ul style="list-style-type: none"> <li>External beam radiotherapy and surgery may result in reduction in maximum bladder capacity and increased pressure on the detrusor muscle in the bladder<sup>16</sup></li> <li>Consider age, pre-existing comorbidities of obesity and diabetes as other contributing factors<sup>16</sup></li> </ul>	<ul style="list-style-type: none"> <li>Assess urinary function (frequency, difficulty emptying the bladder) and incontinence</li> <li>Advice about doing pelvic floor exercises</li> <li>Refer for incontinence/pelvic floor rehabilitation and/or surgical treatment options</li> </ul>



## Follow-up of survivors of endometrial cancer



Radiotherapy continued	Explanatory notes	Considerations
Bowel dysfunction and symptoms	<ul style="list-style-type: none"> <li>Bowel may have been included in the radiation field</li> <li>GI symptoms can arise due to the mechanisms of acute and chronic radiation-induced changes</li> <li>40% of patients are affected by chronic GI symptoms<sup>17</sup></li> <li>Some patients may have persistent diarrhoea</li> <li>For rectal bleeding after radiation therapy, colorectal cancer should be ruled out (though other causes are more likely)</li> <li>For more detail refer to: The practical management of gastrointestinal symptoms of pelvic radiation disease<sup>18</sup></li> </ul>	<ul style="list-style-type: none"> <li>Monitor and assess bowel function and symptoms that are outside the norm</li> <li>Prescribe anti-diarrheal medications as appropriate</li> <li>Dietary modifications</li> <li>Investigate for malabsorption (bile salts) – consider bile acid sequestrant</li> <li>Investigate for lactose / fructose intolerance</li> <li>Refer for incontinence/pelvic floor rehabilitation and/or surgical treatment options</li> <li>Discuss with treating radiation oncologist</li> <li>Refer to gastroenterologist as required</li> </ul>
Accelerated loss of bone density, risk of insufficiency fracture	<ul style="list-style-type: none"> <li>Women who have had pelvic radiotherapy and some chemotherapy agents are at risk of accelerated loss of bone density and have increased risk of insufficiency fracture. These are associated with severe back, hip and leg pain<sup>20, 21</sup></li> <li>Other risk factors include menopause, older age and post-menopausal state and history of osteoporosis</li> </ul>	<ul style="list-style-type: none"> <li>Check bone mineral density every two years<sup>19</sup></li> <li>Advise about bone density loss prevention (weight bearing exercise)</li> <li>Consider calcium and vitamin D supplements</li> <li>Consider bisphosphonates for women with osteoporosis, fractures or high rates of bone loss</li> </ul>
More specific to chemotherapy treatment	Explanatory notes	Considerations
Peripheral neuropathy	<ul style="list-style-type: none"> <li>Chemotherapy agents such as taxanes cause peripheral neuropathy</li> <li>Multiple studies and meta-analyses have failed to identify any drug that can prevent chemotherapy-related neuropathy. Duloxetine is the only drug that has demonstrated efficacy for the treatment of chemotherapy-related peripheral neuropathy.<sup>22</sup> Gabapentin and pregabalin are also used to manage symptoms</li> </ul>	<ul style="list-style-type: none"> <li>Self-management advice regarding hand and foot care, regular exercise such as walking, quitting smoking, avoiding excessive alcohol</li> <li>Consider age, pre-existing comorbidities diabetes / inflammatory disorders as other potential contributing factors</li> <li>Consider Duloxetine</li> <li>In severe cases, consider referral to pain specialist or neurologist</li> </ul>
Impaired cognitive function (chemofog) feeling vague during and after chemotherapy	<ul style="list-style-type: none"> <li>Around 20–30% people experience some level during or after chemotherapy<sup>23</sup></li> <li>Impairment can impact memory, word finding, learning, multitasking, taking longer to perform tasks</li> <li>Generally improves over time</li> </ul>	<ul style="list-style-type: none"> <li>Assess for cognitive changes</li> <li>Practical approaches such as note taking, reminders</li> <li>Assess for concurrent anxiety or depression which may be impacting on cognition if not treated</li> <li>Referral for neurocognitive assessment in severe cases</li> </ul>

### Resources for health care professionals

This information sheet is part of a series designed for health professionals. Review the rest of the series on our website:

[www.petermac.org/services/support-services/australian-cancer-survivorship-centre/health-professionals/resources](http://www.petermac.org/services/support-services/australian-cancer-survivorship-centre/health-professionals/resources)

A detailed reference list supporting this document is available upon request: [contactacsc@petermac.org](mailto:contactacsc@petermac.org)

If you have a passion for cancer survivorship, contact us to join our online collaborative workspace: [contactacsc@petermac.org](mailto:contactacsc@petermac.org)

### Further resources for cancer survivors

- Australian Cancer Survivorship Centre (ACSC), support services for survivors  
[www.petermac.org/services/support-services/australian-cancer-survivorship-centre/cancer-survivors](http://www.petermac.org/services/support-services/australian-cancer-survivorship-centre/cancer-survivors)

- ACSC Follow-up of survivors with cancer-related fatigue (2016)  
[www.petermac.org/services/support-services/australian-cancer-survivorship-centre/health-professionals/resources](http://www.petermac.org/services/support-services/australian-cancer-survivorship-centre/health-professionals/resources)
- Cancer Council, Endometrial cancer: what to expect  
[www.cancerpathways.org.au/optimal-care-pathways/endometrial-cancer](http://www.cancerpathways.org.au/optimal-care-pathways/endometrial-cancer)
- Cancer Council Information and Support Service telephone 13 11 20
- Cancer Council Understanding Lymphoedema Fact Sheet (2017)  
[www.cancerciv.org.au/downloads/resources/factsheets/Understanding-Lymphoedema.pdf](http://www.cancerciv.org.au/downloads/resources/factsheets/Understanding-Lymphoedema.pdf)
- Counterpart is a service of Women's Health Victoria. It connects, supports and informs women with breast or a gynaecological cancer to live well. Phone 1300 781 500  
[www.counterpart.org.au](http://www.counterpart.org.au)

### Acknowledgement

Thank you to the health professionals who reviewed this resource.

Last reviewed: March 2018





## Follow-up of survivors of endometrial cancer – a fact sheet for health care providers: Reference list



### Further information

This overview was prepared with reference to latest evidence and guidelines:

- Obermair, A. Gynaecological Cancer. (2015). Available: <http://www.obermair.info/medical-conditions/gynaecological-cancer/uterine-cancer/>
- Cancer Council Australia. (2014) Clinical practice guidelines for the treatment and management of endometrial cancer. Available: [http://wiki.cancer.org.au/australia/Guidelines:Endometrial\\_cancer/Treatment/Early\\_stage](http://wiki.cancer.org.au/australia/Guidelines:Endometrial_cancer/Treatment/Early_stage)
- Obermair, A. (2012). How to treat: endometrial cancer. *Australian Doctor*, 6 April 29–36
- Colombo, N., Preti, E., Landoni, F., Carinelli, S., Colombo, A., Marini, C., ... & ESMO Guidelines Working Group. (2013). Endometrial cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Annals of oncology*, 24(suppl\_6), vi33–vi38.
- Australian Institute of Health and Welfare. (2016). Uterine cancer. Available: <http://www.aihw.gov.au/cancer/uterine/>
- Victorian Department of Health and Human Services. (2015) Optimal cancer care pathway for women with endometrial cancer. Melbourne. Available: <https://www.cancerciv.org.au/for-health-professionals/optimal-care-pathways>
- Rubin, G., Berendsen, A., Crawford, S. M., Dommett, R., Earle, C., Emery, J., ... & Hamilton, W. (2015). The expanding role of primary care in cancer control. *The Lancet Oncology*, 16(12), 1231–1272.
- Australian Cancer Survivorship Centre. (2016). Follow-up of survivors with cancer-related fatigue Available: [www.petermac.org/services/support-services/australian-cancer-survivorship-centre/health-professionals/resources](http://www.petermac.org/services/support-services/australian-cancer-survivorship-centre/health-professionals/resources)
- Simard, S., Thewes, B., Humphris, G., Dixon, M., Hayden, C., Mireskandari, S., & Ozakinci, G. (2013). Fear of cancer recurrence in adult cancer survivors: a systematic review of quantitative studies. *Journal of Cancer Survivorship*, 7(3), 300–322.
- Cancer Council Australia. (2017). Understanding Lymphoedema A guide for people affected by cancer Practical and support information fact sheet. Available: <https://canceraustralia.gov.au/publications-and-resources/cancer-australia-publications/management-secondary-lymphoedema-guide-health-professionals>
- Amant, F., Moerman, P., Neven, P., Timmerman, D., Van Limbergen, E., & Vergote, I. (2005). Endometrial cancer. *The Lancet*, 366(9484), 491–505.
- National Health and Medical Research Council.(2013). Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children in Australia. Available: <https://www.nhmrc.gov.au/guidelines-publications/n57>
- National Health and Medical Research Council.(2013). Australian Dietary Guidelines. <https://www.nhmrc.gov.au/guidelines-publications/n55>
- Australian Government Department of Health.(2014). Australia's Physical Activity and Sedentary Behaviour Guidelines for Adults. Available: <http://www.health.gov.au/internet/main/publishing.nsf/content/health-pubhlth-strateg-phys-act-guidelines>
- National Health and Medical Research Council. (2009). Australian Guidelines to Reduce Health Risks from Drinking Alcohol. Available: [https://www.nhmrc.gov.au/files\\_nhmrc/publications/attachments/ds10-alcohol.pdf](https://www.nhmrc.gov.au/files_nhmrc/publications/attachments/ds10-alcohol.pdf)
- Fernandes, A., Bhua, N. J., & Taylor, A. (2015). Management of toxicities following pelvic irradiation for gynaecological cancers. *Current opinion in oncology*, 27(5), 405–411.
- Andreyev, H. J. N., Davidson, S. E., Gillespie, C., Allum, W. H., & Swarbrick, E. (2011). Practice guidance on the management of acute and chronic gastrointestinal problems arising as a result of treatment for cancer. *Gut*, gutjnl-2011.
- Andreyev, H. J. N., Muls, A. C., Norton, C., Ralph, C., Watson, L., Shaw, C., & Lindsay, J. O. (2015). Guidance: The practical management of the gastrointestinal symptoms of pelvic radiation disease. *Frontline gastroenterology*, 6(1), 53–72.
- Osteoporosis Australia. (2014). Bone density testing in general practice pdf. Available: <https://www.osteoporosis.org.au/sites/default/files/files/Bone%20Density%20Testing%20in%20General%20Practice.pdf>
- Viswanathan, A. N., Lee, L. J., Eswara, J. R., Horowitz, N. S., Konstantinopoulos, P. A., Mirabeau Beale, K. L., ... & Wo, J. Y. (2014). Complications of pelvic radiation in patients treated for gynecologic malignancies. *Cancer*, 120(24), 3870–3883.
- Mehmood, Q., Beardwood, M., Swindell, R., Greenhalgh, S., Wareham, T., Barraclough, L., ... & Davidson, S. E. (2014). Insufficiency fractures in patients treated with pelvic radiotherapy and chemotherapy for uterine and cervical cancer. *European journal of cancer care*, 23(1), 43–50.
- Hershman, D. L., Lacchetti, C., Dworkin, R. H., Lavoie Smith, E. M., Bleeker, J., Cavaletti, G., ... & Paice, J. (2014). Prevention and management of chemotherapy-induced peripheral neuropathy in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline. *Journal of Clinical Oncology*, 32(18), 1941–1967.
- Tannock, I. F., Ahles, T. A., Ganz, P. A., & Van Dam, F. S. (2004). Cognitive impairment associated with chemotherapy for cancer: report of a workshop. *Journal of Clinical Oncology*, 22(11), 2233–2239.

