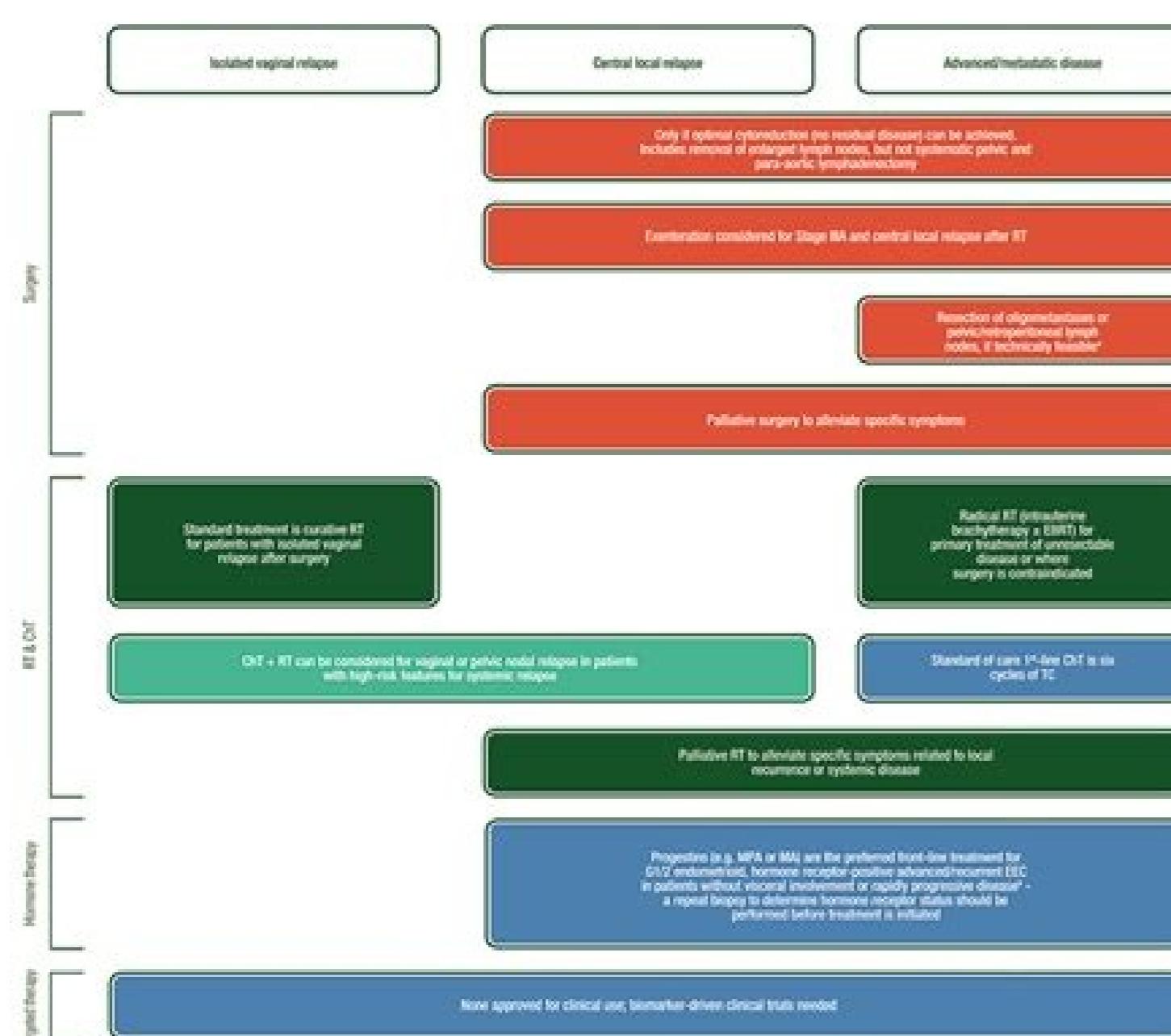


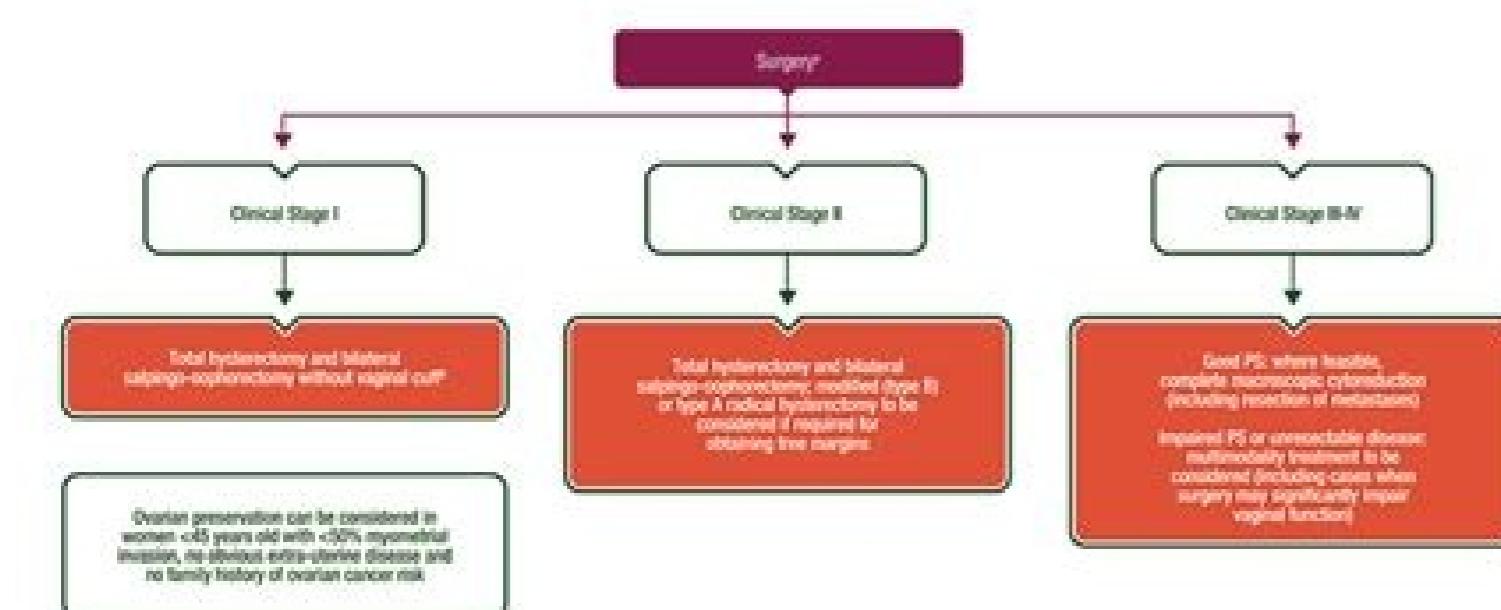
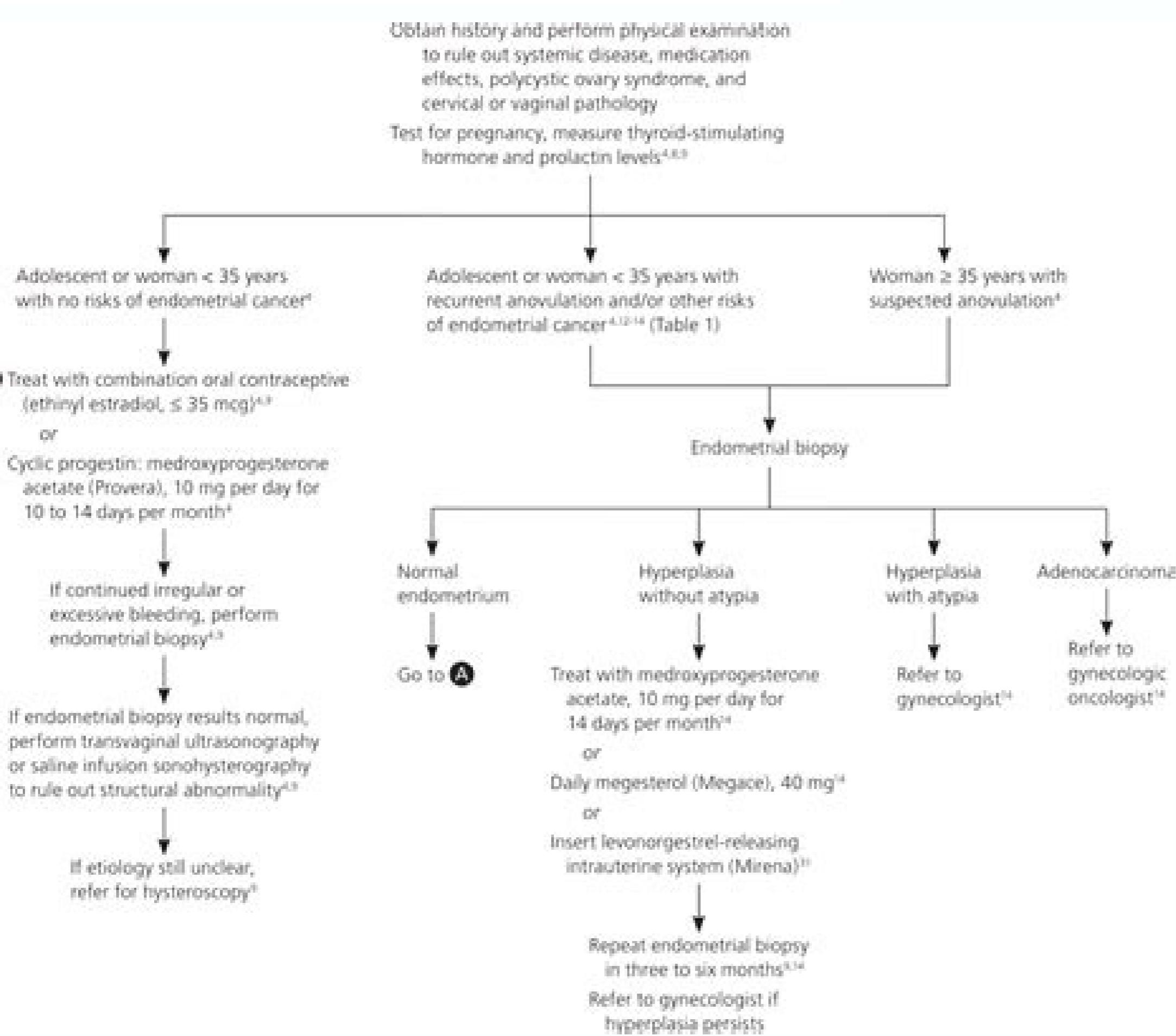
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Endometrial cancer management guidelines



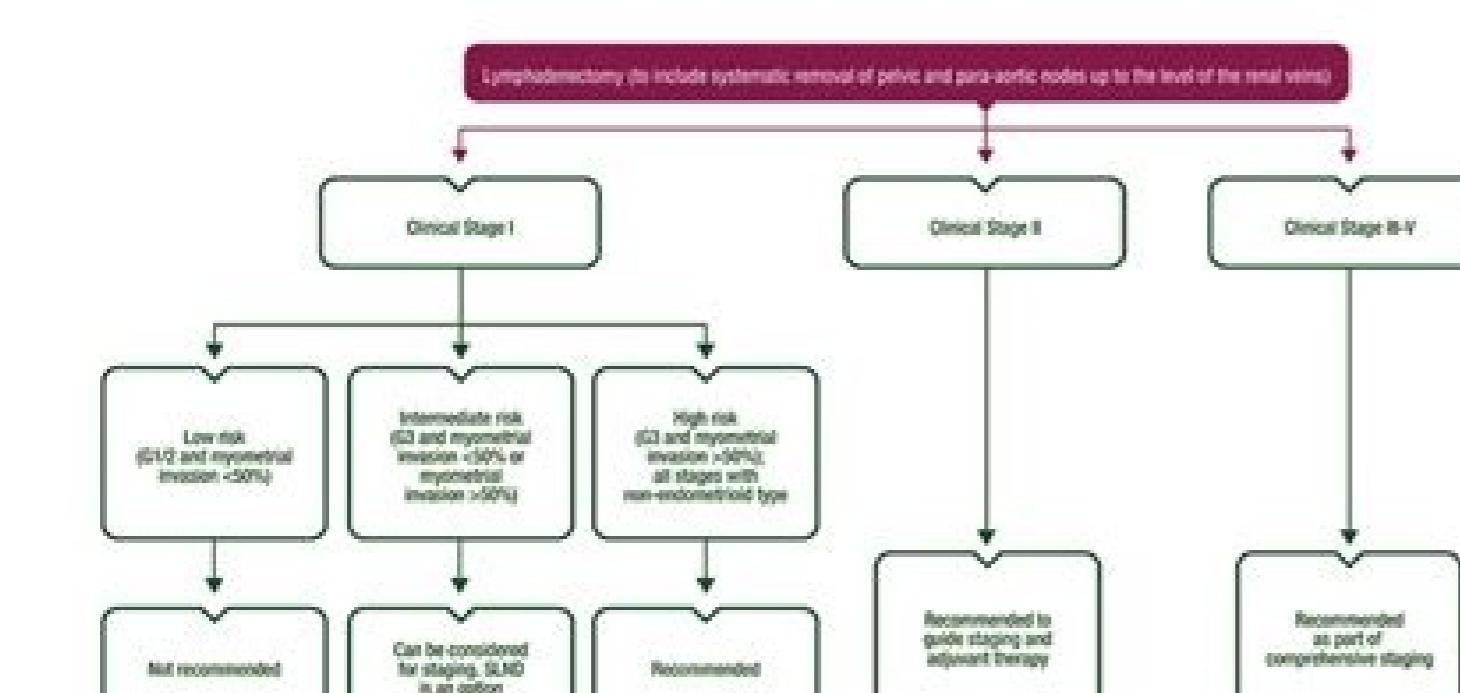
*Evidence for a benefit is limited; other hormonal agents, such as tamoxifen, fulvestrant and aromatase inhibitors, can be considered after progression.

CT, chemotherapy; ER/PR, external beam radiotherapy; EEC, endometrial endometrioid cancer; G, grade; MPA, megestrol acetate; RT, radiotherapy; TC, paclitaxel carboplatin.



Patients with ANEC or G1 EEC requesting fertility-preserving therapy must:

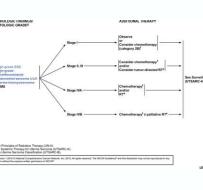
- Be referred to specialized centers
- Undergo pre-treatment evaluation
- Have ANEC or G1 EEC confirmed by a specialist gynecopathologist
- Undergo annual pelvic and breast exam, ovarian function, and breast self-exam
- Be fully informed that fertility-sparing treatment is a trial
- Be willing to accept close follow-up
- For patients undergoing fertility-preserving therapy, MR, MPA, and progesterone-loaded IUD is also an option.
- After completion of chemotherapy, hysterectomy and salpingo-oophorectomy is recommended

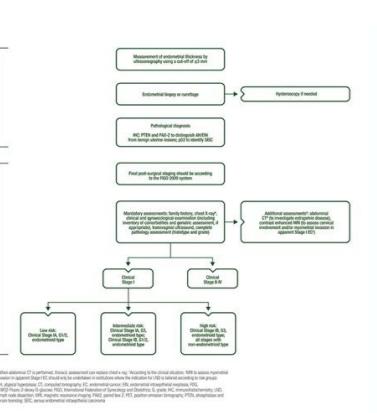


*Patients considered medically unfit for laparoscopy/laparotomy can be managed either by vaginal hysterectomy/bilateral salpingo-oophorectomy (where possible), RT or hormone treatment.

¹Minimally invasive surgery is recommended for low- and intermediate-risk EC and can be considered for high-risk EC.

AN, apical node; G, grade; DR/H, gonadotropin-releasing hormone; IUD, intrauterine device; MPA, megestrol acetate; MPA, medroxyprogesterone acetate; PS, performance status; RT, radiotherapy; SLND, sentinel lymph node dissection.





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