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**American College of Radiology  
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**ADJUVANT MANAGEMENT OF EARLY STAGE ENDOMETRIAL CANCER**

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**Summary of Literature Review**

**Introduction/Background**

Endometrial cancer is the most common gynecologic malignancy diagnosed in the United States and is second to ovarian cancer in annual mortality for gynecologic cancers, with 10,170 deaths [1]. With the decline in hormone replacement therapy utilization, there was a corresponding decline in the incidence of endometrial cancer. However, more recently this trend has reversed as obesity rates have increased [2]. The majority of new endometrial cancers will be International Federation of Gynecology and Obstetrics (FIGO) stage I-II disease, at approximately 85% of new cases [3]. Recurrence rates of early endometrial cancers vary within a specific stage and thus treatment options differ across the early endometrial cancers [4,5]. Endometrial cancer is less likely to lead to death than other medical comorbidities [6-8]. A Surveillance, Epidemiology, and End Results (SEER) study of early-stage, low-grade endometrial carcinoma showed that 7% of patients diagnosed died of malignancy, whereas 42% died of cardiovascular disease [9].

The most common presenting symptom of uterine carcinoma is vaginal bleeding, typically after menopause. Workup of a suspected endometrial cancer includes history and physical examination with an endometrial biopsy. A false-negative result can occur in 10% of cases, so a negative biopsy is typically followed by dilation and curettage [10]. Once a histopathologic diagnosis is established and uterine-confined disease is suspected, blood counts, routine biochemistry, and chest radiographs are recommended to complete workup [11]. Surgery consists of total hysterectomy and bilateral salpingo-oophorectomy with or without lymph node dissection. Visual inspection of the peritoneal, serosal, and diaphragmatic surfaces with biopsy of suspicious lesions is required to evaluate for extrauterine disease. FIGO recommends obtaining peritoneal washings even though a positive finding was removed from the most recent staging system.

**Vaginal Brachytherapy**

The recommendations for adjuvant radiation therapy in early-stage endometrial cancer depend on the presence or absence of several risk factors, such as older age, deep myometrial invasion, high grade, large tumor size, and lymphovascular space invasion (LVSI) [12-14]. Classification into low-risk, intermediate-risk, and high-risk early-stage uterine cancer is based on a combination of these risk factors, but investigators and studies often differ in their definitions. In early-stage endometrial cancer, the most common site of recurrence in the absence of adjuvant radiation therapy is the vaginal cuff. Vaginal brachytherapy reduces the risk of a vaginal recurrence and has a low side-effect profile.

Sorbe et al [15] published a randomized trial comparing adjuvant vaginal brachytherapy to observation in grade 1 or 2, stage IA endometrioid carcinoma in 645 patients. After a median follow-up of 68 months, there was no difference in vaginal recurrence rates (1.2% in the brachytherapy group versus 3.1% in the observation group ( $P=0.114$ )). The impact of adjuvant brachytherapy appears to be limited in low-risk patients. The toxicity of vaginal brachytherapy is mild and limited to urinary (2.8% brachytherapy group versus 0.6% observation group ( $P=0.063$ )), and vaginal side effects (8.8% brachytherapy group versus 1.5% observation group,  $P<0.01$ ) [15].

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Fluoroscopic or computed tomography (CT)–based treatment planning for vaginal brachytherapy is generally used. Confirmation of appropriate placement of the cylinder at the top of the vagina is generally accomplished utilizing fiducials placed at the top of the vagina or review of CT images. The dose fractionation regimens for high-dose-rate (HDR) vaginal brachytherapy have generally been developed to approximate 60 Gy low-dose-rate (LDR) equivalent to the surface of the vagina. Lower-dose HDR regimens may provide an equivalent outcome with lower toxicity rates. A prospective, randomized trial of 2 dose fractionation regimens, 2.5 Gy  $\times$  6 fractions versus 5.0 Gy  $\times$  6 fractions, was carried out in 230 patients. The dose was prescribed to 5 mm in both groups. There was no difference in local control between the 2 doses but vaginal foreshortening was more pronounced in the 5.0 Gy fraction group [16]. Other investigators have reported other dose fractionation regimens with good outcomes, 7.0 Gy  $\times$  3 fractions prescribed to 5 mm [17], 4 Gy  $\times$  6 fractions prescribed to the surface [18], 6 Gy  $\times$  5 fractions prescribed to the surface [16,19] and 5.5 Gy  $\times$  4 fractions prescribed to 0.5 cm [20].

Clearly, multiple dose fractionation regimens exist and future trials, such as Postoperative Radiation Therapy in Endometrial Carcinoma (PORTEC)–4, may help establish care. Ninety-five percent of the vaginal lymphatics lie within 3 mm of the vaginal surface, so ensuring adequate dose to at least this depth may be important [21]. In a recent survey of U.S. radiation oncologists, 61.1% prescribe to 5 mm and 22.5% prescribe to the vaginal surface. The 3 most common doses utilized were 7 Gy  $\times$  3 to 0.5 cm, 6 Gy  $\times$  5 to the vaginal surface (16%) and 5.5 Gy  $\times$  4 to 0.5 cm (9%) [22].

There is also variation in the appropriate length of vagina to treat with vaginal brachytherapy. It is important to establish the length of the vagina on physical exam prior to treatment in order to prescribe the dose to the correct length. The upper one-half of the vagina was treated in PORTEC-2 and the upper two-thirds of the vagina was treated in Sorbe et al [15-17]. The most common prescription length in the United States was either the upper one-half or upper 4 cm of the vagina [22], and the American Brachytherapy Society recommended treatment of the upper 3–5 cm of the vagina [19] (see [Variant 1](#)).

### **Pelvic Radiation Therapy**

Patients with intermediate-risk endometrial cancer have higher risks of recurrence than low-risk patients and are thus more likely to benefit from adjuvant radiation therapy. There are differing definitions of intermediate-risk and high-intermediate–risk disease, which makes comparisons of randomized trials challenging. Typically, intermediate-risk disease consists of early-stage patients with risk factors such as high grade, deep myometrial invasion, LVSI, and/or older age. Numerous retrospective studies of vaginal brachytherapy alone for intermediate-risk endometrial cancer have been published with good outcomes [23-26].

PORTEC-2 was a randomized trial of vaginal brachytherapy versus whole-pelvic radiation therapy (WPRT) in high-intermediate–risk uterine cancer. Inclusion criteria were age  $>60$  years,  $>50\%$  myometrial invasion, and grade 1/2; age  $>60$  years,  $<50\%$  myometrial invasion, and grade 3; or cervical glandular involvement at any age. Staging lymphadenectomy could not be performed. There was no difference in vaginal recurrence rate between vaginal brachytherapy and WPRT (1.8% versus 1.6%,  $P=0.74$ ). WPRT resulted in a lower risk of pelvic recurrence (3.8% compared to 0.5%,  $P<0.02$ ). After randomization, a central pathology review was conducted and the most frequent tumor grade change was from grade 2 to 1, resulting in 79% of the patients having grade 1 disease. Fourteen percent of enrolled patients would have ultimately been ineligible and considered as low-intermediate–risk disease [17].

Two randomized trials of vaginal brachytherapy versus vaginal brachytherapy plus WPRT have been conducted. The most recent study included intermediate-risk patients defined as nuclear grade 1 or 2, stage I endometrioid carcinoma with 1 of the following: deep myometrial invasion, DNA aneuploidy, or FIGO grade 3. Locoregional relapse rates were higher in the vaginal brachytherapy–alone arm (5.0% versus 1.5%, ( $P=0.013$ ) with no corresponding difference in overall survival between arms [27]. An earlier randomized trial from Norway included 537 stage I endometrial cancer patients. Vaginal brachytherapy was compared to vaginal brachytherapy plus WPRT. WPRT resulted in a lower local recurrence rate (2% versus 7%,  $P<0.01$ ) [28]. Although the results of these 2 trials were similar, the lack of well-defined risk groups in the Norwegian trial makes a comparison to modern trials challenging.

The Medical Research Council ASTEC trial was a randomized trial of standard surgery of hysterectomy, bilateral salpingo-oophorectomy, washings, and palpation of suspicious lymph nodes with or without lymphadenectomy. In women with intermediate-risk or high-intermediate–risk disease, there was a second randomization of pelvic radiation therapy versus observation. Vaginal brachytherapy could be given in a nonrandomized fashion on study

and 52% of participants in the observation arm received vaginal brachytherapy [29]. Pelvic recurrence rate was 3.2% in the pelvic radiation therapy group versus 6.1% in the observation arm, with no difference in overall survival. There was no difference in effectiveness of pelvic radiation therapy between surgical arms.

Only 2 randomized trials, Gynecologic Oncology Group (GOG)–99 and PORTEC-1, compared adjuvant pelvic radiation therapy to no adjuvant radiation therapy in early-stage, intermediate-risk endometrial carcinoma. GOG-99 defined intermediate-risk as stage I or occult stage II patients, and all patients had pelvic and para-aortic lymphadenectomy. External-beam radiation therapy (EBRT) reduced the recurrence rate (12% in observation group and 3% in radiation therapy group). As a result of lower-than-expected local failure rate, the investigators identified a high-intermediate-risk subgroup on post hoc analysis with the risk factors of grade 2-3, outer one-third invasion, or LVSI. If a patient's age was >70, 1 risk factor was necessary; if age was >50, 2 risk factors were necessary; and if age was <50, 3 risk factors were necessary. The recurrence rate in the high-intermediate-risk group was 27% with observation and 13% with EBRT. At 4 years, the incidence of death was 12% and 26% in the EBRT group and observation group, respectively [4].

In PORTEC-1, patients had grade 1 disease with more than one-half myometrial invasion, grade 2 disease with any invasion, or grade 3 disease with less than one-half myometrial invasion. Surgical staging was not performed. A statistically significant reduction in local failures was noted with the addition of adjuvant pelvic radiation therapy (12% versus 4%,  $P<0.001$ ) [30]. Based on the recurrence rates seen in PORTEC-1 and -2, a nomogram was developed to estimate recurrence rates [31]. No improvement in overall survival was noted with the addition of adjuvant WPRT in either GOG-99 or PORTEC-1. Creutzberg et al [32] reported a 58% overall survival and a 14% locoregional relapse rate in patients with grade 3, outer one-half myometrial invasion, and treated with pelvic radiation therapy. A SEER study of 21,249 patients demonstrated an improved overall survival with the addition of pelvic radiation therapy in patients with invasion of the outer one-half of the myometrium [33] (see [Variant 2](#)).

### **Pelvic Radiation Therapy Technique**

Pelvic radiation therapy is generally associated with more side effects than vaginal brachytherapy. A long-term quality-of-life analysis of PORTEC-2 patients was carried out with a median follow-up of 65 months. The pelvic radiation therapy group reported worse social functioning ( $P=0.005$ ) and higher symptom scores for diarrhea, fecal leakage, and need to stay near a toilet ( $P<0.001$ ) compared to vaginal brachytherapy [34]. In the acute phase of side effects, 50%–80% of pelvic radiation therapy patients experienced grade 2 or greater diarrhea [35].

Two-field or 4-field treatment techniques have traditionally been used to deliver pelvic EBRT using field borders based on bony anatomy. However, using bony landmarks as the sole method of defining treatment fields can lead to a geographic miss, particularly the lateral external iliac lymph node region [36,37]. If CT imaging is obtained, contouring the at-risk nodal groups, vaginal cuff, and organs at risk permits customization of field borders. In cases where a lymphadenectomy was not performed, cross-sectional imaging can be obtained prior to radiation therapy if risk of pelvic lymph node involvement is sufficient. Intensity-modulated radiation therapy (IMRT) has been shown to reduce dose to critical structures in dosimetric studies, and retrospective reviews of IMRT for early-stage endometrial cancer have shown excellent local control rates with low gastrointestinal toxicity rates [38-41]. It is critical to accurately define clinical target volumes using expert consensus guidelines for gynecologic IMRT. Movement of the vaginal cuff is dependent on bladder and rectal filling. Generation of an internal target volume using full and empty bladder scans can account for this movement since nodal volumes move independently with bony landmarks. Image-guidance radiation therapy may account for some degree of independent movement of the vaginal cuff and nodal volumes but is unlikely to help in moderate to extreme cases of bladder or rectal filling where the vaginal clinical target volume is displaced. The ongoing Radiation Therapy Oncology Group® (RTOG) TIME-C trial compares the impact of IMRT to 3D conformal radiation therapy on patient-reported gastrointestinal toxicity.

### **Vaginal Cuff Brachytherapy Boost**

Vaginal cuff brachytherapy combined with WPRT is associated with a low risk of vaginal and pelvic recurrences [27,42,43]. Because WPRT alone results in low recurrence rates in early-stage endometrial cancer, the addition of vaginal cuff brachytherapy to WPRT may be of marginal benefit. Two retrospective reviews revealed no improvement in local control with a vaginal cuff brachytherapy boost [44,45]. Common fractionation regimens from RTOG trials are 6 Gy × 3 fractions prescribed to the surface after 45 Gy EBRT or 6 Gy × 2 fractions prescribed to the surface after 50.4 Gy EBRT [46,47]. Although high-level evidence is lacking, vaginal cuff

brachytherapy boost can be administered in grade 3 disease, presence of lymphovascular invasion, or when cervical stromal invasion is present [48,49].

### **Adjuvant Chemotherapy**

Adjuvant chemotherapy is not routinely used in early endometrial cancer as distant recurrence rates are low; however, high-risk endometrioid cancer with grade 3 tumors, deeply invasive tumors, or stage II disease may preferentially benefit. The largest series of patients with cervical stromal invasion who did not receive chemotherapy had a 5-year relapse-free survival rate of 77% and disease-specific survival rate of 91%, which is similar to some stage I patients [50]. Most randomized trials comparing EBRT to sequential EBRT and chemotherapy exclude early-stage disease. The combined analysis of the NSGO/EORTC and MaNGO ILIAD-III trials consisted of FIGO stage I-III endometrial cancer patients who were randomized to EBRT or sequential EBRT and chemotherapy. The addition of chemotherapy resulted in improved cancer-specific survival (hazard ratio [HR], 0.55;  $P=0.01$ ) and a trend to improved overall survival (HR, 0.69;  $P=0.07$ ). Seventy-one percent of patients had endometrioid histology and 79% were FIGO stage I and II [51].

A Japanese trial compared pelvic radiation therapy to cyclophosphamide, doxorubicin, and cisplatin in FIGO I-III endometrial cancer patients with deep myometrial invasion. Nearly 78% of patients were stage I or II. There was no difference in recurrence patterns, disease-free survival, or overall survival [52]. A similar study from Milan comparing adjuvant pelvic or extended-field radiation therapy to chemotherapy demonstrated no difference in progression-free or overall survival [53].

GOG-249 randomized 601 patients with high-intermediate-risk stage I (see GOG-99, except greater than one-half invasion was used), stage II, or stage I-II uterine papillary serous carcinoma or clear cell carcinoma. Patients received either WPRT or vaginal cuff brachytherapy with 3 cycles of carboplatin/paclitaxel. At 2 years, overall survival and relapse-free survival was 93% and 82% in the pelvic radiation therapy arm and 92% and 84% in the vaginal brachytherapy/chemotherapy arm. Acute toxicity was more common in the vaginal brachytherapy/chemotherapy group [54] (see [Variant 3](#)).

### **Salvage Radiation Therapy**

When determining whether adjuvant radiation therapy may be of benefit, one must identify who is at appropriate level risk of recurrence, determine if the adjuvant radiation therapy will reduce the risk of recurrence, and estimate associated toxicity of radiation therapy. It is also critical to determine the probability of a successful salvage treatment in case of a recurrence and determine the toxicity associated with salvage treatment. Pelvic recurrences with or without prior radiation therapy have a low rate of salvage, with a 3-year survival rate of 8% in the PORTEC-1 series [55]. There are emerging data on the use of dose-escalated IMRT for isolated nonvaginal pelvic or para-aortic nodal recurrences in patients who have not previously received radiation therapy. Two-year survival rates were 71%, with a late grade 3-4 gastrointestinal toxicity rate of 8% [56]. Isolated vaginal recurrences in absence of previous radiation therapy can be successfully salvaged with EBRT plus brachytherapy or surgery with or without further radiation therapy. Isolated vaginal cuff recurrences treated with EBRT plus brachytherapy have local control rates of 50%–80% and survival rates of 40%–65% [55,57-59]. The grade 4 toxicity rate of this approach is 9% [57].

EBRT doses range from 45–50 Gy, followed by a brachytherapy boost to at least 70- to 80 Gy LDR equivalent [19,57]. Using the linear quadratic model, HDR brachytherapy doses can be converted to LDR doses for tumor and normal tissues [60]. After EBRT, the use of interstitial or intracavitary brachytherapy is dependent on the size and location of the tumor. If the thickness of the residual tumor is  $\geq 5$  mm or tumor involves the lower vagina, interstitial brachytherapy under laparoscopic, CT, or MR guidance is recommended. 3D planning is commonly used with CT or MRI. In the unusual situation where a patient is not medically able to undergo interstitial brachytherapy, an external-beam boost can be considered. The ongoing GOG-238 trial is randomizing patients with an isolated vaginal cuff recurrence to definitive radiation therapy with or without weekly cisplatin. In this protocol, the EBRT dose is 45 Gy. If the residual tumor is  $< 5$  mm, then intracavitary HDR brachytherapy is recommended using 7 Gy  $\times$  3 fractions prescribed to 5 mm.

### **Summary of Recommendations**

- Early-stage endometrial cancer patients are a heterogeneous group of patients with different recurrence rates and treatment approaches.



- Consider observation in patients with low-grade, early-stage endometrial adenocarcinoma without risk factors.
- Vaginal brachytherapy or WPRT can be considered in early-stage patients with risk factors such as high grade, deep myometrial invasion, or LVSI.
- 3D conformal radiation therapy and IMRT are reasonable treatment techniques for adjuvant radiation therapy.

### Summary of Evidence

Of the 60 references cited in the *ACR Appropriateness Criteria® Adjuvant Management of Early Stage Endometrial Cancer* document, 57 are categorized as therapeutic references including 14 well designed studies, 28 good quality studies, and 6 quality studies that may have design limitations. Additionally, 3 references are categorized as diagnostic references including 3 quality studies that may have design limitations. There are 9 references that may not be useful as primary evidence.

The 60 references cited in the *ACR Appropriateness Criteria® Adjuvant Management of Early Stage Endometrial Cancer* document were published from 1965-2016.

While there are references that report on studies with design limitations, 42 well designed or good quality studies provide good evidence.

### Supporting Documents

For additional information on the Appropriateness Criteria methodology and other supporting documents go to [www.acr.org/ac](http://www.acr.org/ac).

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The ACR Committee on Appropriateness Criteria and its expert panels have developed criteria for determining appropriate imaging examinations for diagnosis and treatment of specified medical condition(s). These criteria are intended to guide radiologists, radiation oncologists and referring physicians in making decisions regarding radiologic imaging and treatment. Generally, the complexity and severity of a patient's clinical condition should dictate the selection of appropriate imaging procedures or treatments. Only those examinations generally used for evaluation of the patient's condition are ranked. Other imaging studies necessary to evaluate other co-existent diseases or other medical consequences of this condition are not considered in this document. The availability of equipment or personnel may influence the selection of appropriate imaging procedures or treatments. Imaging techniques classified as investigational by the FDA have not been considered in developing these criteria; however, study of new equipment and applications should be encouraged. The ultimate decision regarding the appropriateness of any specific radiologic examination or treatment must be made by the referring physician and radiologist in light of all the circumstances presented in an individual examination.

**Clinical Condition:** Adjuvant Management of Early Stage Endometrial Cancer

**Variant 1:** 56-year-old woman undergoes a total abdominal hysterectomy, bilateral salpingo-oophorectomy, and para-aortic/pelvic lymph node dissection for a grade 2 endometrial adenocarcinoma, endometrioid type, invading 12 mm of a 22-mm myometrial wall. No LVSI present. Tumor size was 4.0 cm. Para-aortic and pelvic lymph nodes were negative.

Treatment	Rating	Comments
<b>Adjuvant Management</b>		
Observation	6	
Vaginal cuff brachytherapy	7	
WPRT	3	
<b>Vaginal Brachytherapy Dose</b>		
7 Gy × 3 prescribed to 5 mm	8	
5.5 Gy × 4 prescribed to 5 mm	7	
6 Gy × 5 to surface	7	
4 Gy × 3 prescribed to 5 mm	3	
4 Gy × 6 to surface	6	
<b>Vaginal Length Treated if Using Vaginal Brachytherapy</b>		
Upper 1/3	8	
Upper 1/2	7	
Upper 2/3	3	
Upper 3 cm	8	
Upper 4 cm	7	
Upper 5 cm	5	
Entire vagina	2	
<b>Brachytherapy Planning</b>		
2D planning with fiducial placement	7	Practice varies by institution, but treatment plans are rarely changed based on CT imaging. CT can provide more information regarding implant quality.
3D planning with CT simulation prior to each insertion	7	
3D planning with CT simulation before first insertion	7	
<b>Rating Scale:</b> 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate		

**Clinical Condition:** Adjuvant Management of Early Stage Endometrial Cancer

**Variant 2:** 70-year-old woman undergoes a total abdominal hysterectomy and bilateral salpingo-oophorectomy without a pelvic lymph node dissection for a grade 2 endometrial adenocarcinoma, endometrioid type, invading 8 mm of a 15-mm myometrial wall. LVSI was present. Patient is healthy otherwise.

Treatment	Rating	Comments
<b>Nodal Evaluation Prior to Radiotherapy</b>		
No lymphadenectomy	5	
No lymphadenectomy after CT or PET/CT obtained	7	
Pelvic node dissection	5	
Pelvic and para-aortic node dissection	5	
<b>Adjuvant Management</b>		
Observation	3	
Vaginal cuff brachytherapy	6	
WPRT	7	
WPRT with vaginal cuff brachytherapy boost	5	
<b>Upper Field Border if Using WPRT</b>		
Bony landmark L5-S1	7	
Bony landmark L4-L5	7	
Aortic bifurcation	7	
Common iliac bifurcation	6	
<b>WPRT Technique if Using WPRT</b>		
2D radiotherapy	3	
3D conformal radiotherapy	7	
IMRT	7	
Daily image guidance if using IMRT	7	
<b><u>Rating Scale:</u> 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate</b>		

**Clinical Condition:** Adjuvant Management of Early Stage Endometrial Cancer

**Variant 3:** 66-year-old woman undergoes a total abdominal hysterectomy and bilateral salpingo-oophorectomy with a para-aortic and pelvic lymph node dissection for a grade 3 endometrial adenocarcinoma, endometrioid type, with deep myometrial invasion (19/21 mm). No LVSI was present. Deeply invasive cervical stromal invasion was present. Margins were negative. Five left pelvic, 6 right pelvic, and 4 para-aortic lymph nodes were negative.

Treatment	Rating	Comments
<b>Adjuvant Management</b>		
Observation	2	
Vaginal cuff brachytherapy	4	
WPRT alone	6	
WPRT with vaginal cuff brachytherapy boost	7	
Vaginal cuff brachytherapy with paclitaxel and carboplatin for 3 cycles	4	
<b>Upper Field Border if Using WPRT</b>		
Bony landmark L5-S1 or common iliac bifurcation	7	
Bony landmark L4-L5 or aortic bifurcation	7	
<b>Vaginal Length Treated if Using Vaginal Brachytherapy</b>		
Upper 1/3	7	
Upper 1/2	7	
Upper 2/3	4	
Entire vagina	3	
<b>Brachytherapy Dose if Using Vaginal Cuff Boost after 50.4 Gy WPRT</b>		
6 Gy × 2 fractions to surface	7	
6 Gy × 3 fractions to surface	6	
5.5 Gy × 2 fractions to 5 mm	5	
5.9 Gy × 3 fractions to 5 mm	3	
<b>Simulation for WPRT</b>		
Empty bladder	4	
Full bladder	7	
Full bladder and empty bladder fusion for ITV generation	8	
<b>Adjuvant Chemotherapy</b>		
Yes	5	
No	7	
<b>Rating Scale:</b> 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate		