Endometrial Cancer: Optimal Patient Evaluation

David Weismiller, MD, ScM, FAAFP

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David Weismiller, MD, ScM, FAAFP

Professor, Department of Family and Community Medicine, University of Nevada, Las Vegas School of Medicine

Dr. Weismiller is a graduate of Jefferson Medical College of Thomas Jefferson University in Philadelphia, Pennsylvania, and completed his residency at the University of Virginia Health Sciences Center in Charlottesville. He practices family medicine at the new medical school of the University of Nevada, Las Vegas, where he provides full-scope care that includes inpatient and maternity care. A proponent of "reflection in practice" and "learner-centered instruction," he is recognized nationally for his work in continuing medical education and faculty development. He is a frequent presenter at AAFP Family Medicine Experience (FMX) and teaches American Board of Family Medicine (ABFM) Knowledge Self-Assessments throughout the country. Dr. Weismiller is the author of numerous publications on issues related to women’s and children’s health, and he is an advocate for empowering individuals to make sound health care choices.

Learning Objectives

1. Screen for endometrial cancer in accordance with current clinical guidelines.
2. Diagnose endometrial cancer through physical examination and appropriate laboratory and diagnostic studies, as indicated.
3. Develop collaborative treatment plans based on the patient’s desire for future fertility and results of the diagnosis.
4. Develop communication strategies to improve communication with sub-specialists treating cancer patients to improve coordination of care.

Audience Engagement System

Step 1
Step 2
Step 3
Why discuss this?

- Recognizing that endometrial cancer is not widely known by the general populace, despite its frequency. There is low awareness of the symptoms, which can lead to later diagnosis and worse survival.
- A thorough discussion of the epidemiology, pathophysiology, and diagnostic and management strategies for this type of cancer allows the clinician to identify women at increased risk, contribute toward risk reduction, and facilitate early diagnosis.

AES Question – 1. Which one of the following is the most common cause of postmenopausal bleeding?
A. Continuous hormone therapy
B. Endometrial atrophy
C. Cervical ectropion
D. Endometrial cancer

Endometrial Cancer - Key Facts

- Most common gynecologic malignancy in the USA (adenocarcinoma)
- Abnormal uterine bleeding is the presenting sign in 85% of women with endometrial cancer.
  - Only 10-20% of postmenopausal women who are evaluated for uterine bleeding are diagnosed with endometrial cancer
  - Most common cause of postmenopausal bleeding is endometrial atrophy
  - Assuring that women understand the importance of reporting ANY postmenopausal bleeding. (There is no screening test.)
- Strongest association with reduced risk: Combined hormonal contraception use
  - 50% reduction in risk
  - Protection for 10-15 years after discontinuation

Cancer statistics, 2017

- 2017 – 61,380 cases
  - 10,920 deaths
- Mean age of diagnosis – 63 years
- Premenopausal
  - 15% before age 50
  - 5% before age 40

Histopathology

- Types
  - Type I, Endometroid adenocarcinoma – 70% of cases
    - Associated with unopposed estrogen stimulation
    - Generally low grade tumors
  - Type II, Papillary serous or clear cell; tend to be high grade – 10% of cases
    - Poor prognosis
    - High risk of relapse and metastasis
    - Associated with 40% of related deaths
    - More common in older, non-hormone multiparous women and current smokers
  - Familial tumors – 10% of cases
    - Commonly found in association with Lynch Syndrome (hereditary nonpolyposis colorectal cancer)
  - Hyperplasia
    - Endometrial, 1-3% risk of progression
    - Atypical, 30-40% of patients with concurrent adenocarcinoma
Offending Issue

• Prolonged exposure to unopposed estrogen, whether endogenous or exogenous is associated with MOST cases of type I endometrial cancer

Risk Factors for Type I Uterine Cancer

<table>
<thead>
<tr>
<th>Factors Influencing Risk</th>
<th>Estimated RR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older age</td>
<td>2-3</td>
</tr>
<tr>
<td>Residency in North America or Northern Europe</td>
<td>3-18</td>
</tr>
<tr>
<td>Higher level of education or income</td>
<td>1.5-2</td>
</tr>
<tr>
<td>White race</td>
<td>2</td>
</tr>
<tr>
<td>Nulliparity</td>
<td>3</td>
</tr>
<tr>
<td>History of infertility</td>
<td>2-3</td>
</tr>
<tr>
<td>Menstrual irregularities</td>
<td>1.5</td>
</tr>
<tr>
<td>Late age at natural menopause</td>
<td>2-3</td>
</tr>
</tbody>
</table>

Younger women

• Most common risk factors for development of endometrial cancer in young women:
  – Increasing BMI
  – Nulliparity
  – Irregular menses
  • Chronic anovulation (e.g., PCOS)
• Risk may increased as much as 22X in women younger than 45 whose BMIs are > 35

Unopposed endogenous estrogen

• Adipose tissue
  – Excessive peripheral conversion of androgens to estrone
  – Case-control studies have demonstrated a 200-400% linear increase in risk of endometrial cancer in individual with BMI > 25

So what about weight loss and risk?

• Although obesity is an established endometrial cancer risk factor, information about the influence of weight loss on endometrial cancer risk in postmenopausal women is limited.
• Luo et al. (2018) evaluated associations among weight change by intentionality with endometrial cancer in the Women’s Health Initiative (WHI) observational study

Patients and Methods

• Postmenopausal women (N = 36,794) ages 50 to 79 years at WHI enrollment; body weights measured and BMIs calculated at baseline and at year 3.
• Weight change during that period was categorized as follows: stable (change within ± 5%), loss (change ≥ 5%), and gain (change ≥ 5%).
• Weight loss intentionality was assessed via self-report at year 3; change was characterized as intentional or unintentional.
• During the subsequent 11.4 years (mean) of follow-up, 566 incident endometrial cancer occurrences were confirmed by medical record review.
• Multivariable Cox proportional hazards regression models were used to evaluate relationships (hazard ratios [HRs] and 95% CIs) between weight change and endometrial cancer incidence.
Results

• In multivariable analyses, compared with women who had stable weight (± 5%), women with weight loss had a significantly lower endometrial cancer risk (HR, 0.71; 95% CI, 0.54 to 0.95).
• The association was strongest among obese women with intentional weight loss (HR, 0.44; 95% CI, 0.25 to 0.78).
• Weight gain (≥ 10 pounds) was associated with a higher endometrial cancer risk than was stable weight, especially among women who had never used hormones.

Conclusion

• Intentional weight loss in postmenopausal women is associated with a lower endometrial cancer risk, especially among women with obesity. These findings should motivate programs for weight loss in obese postmenopausal women.


SERMs and Endometrial Cancer

• Although raloxifene has estrogen-like effects on the uterus, it has NOT been shown to increase the risk of endometrial cancer. (SOR A)
• Tamoxifen is a selective estrogen receptor modulator that has estrogen-like effects. While it has a protective effect on breast tissue, its effect on the uterus increases the risk of endometrial cancer. (SOR A)

Tamoxifen

Premenopausal vs Postmenopausal

• Women < 49
  – No statistically significant difference in endometrial cancer rates between women treated with tamoxifen/placebo
• Women ≥ 50
  – Risk ratio 4.01 (95% CI, 1.70-10.90)


What about Ospemifene?

• Ospemifene, which is approved for the treatment of moderate-to-severe dyspareunia, has only limited long-term safety data.
• Among 180 women who were treated with ospemifene for 52 weeks, no cases of endometrial hyperplasia or endometrial carcinoma were identified, although there was a dose-related mean increase in endometrial thickness: 0.68 mm (30 mg/d) and 1.14 mm (60 mg/d)


Link with BRCA mutations?

• Link between BRCA mutations and the risk of uterine cancer has been controversial
  – Some studies have noted an association, others have suggested association is predominantly due to use of tamoxifen citrate
Multicenter Cohort Study
Shu et al. JAMA Oncology June 2016

- 1,083 women who underwent risk-reducing salpingectomy without hysterectomy
- What is long-term risk of uterine cancer
- Result: No statistically significant increased risk of cancer compared with general population

Subset Analysis
Shu et al. JAMA Oncology June 2016

- Stratified by histology
  - No increase risk of endometroid carcinomas
  - Significantly increased risk of uterine serous carcinomas
- Increased risk of serous tumors found for women who harbored BRCA1
  - Observed-to expected ratio 22.2 (95%CI 6.1-56.9)

Bottom Line
- Although study included only a small number of cancers, it suggests that BRCA1 mutation carriers may be at increased risk for serous carcinomas
- BRCA1 mutations carriers undergoing risk-reducing surgery should be informed of the potential risks and benefits of undergoing concomitant hysterectomy

Endometrial Cancer
Protective Factors

- Progesterone
  - Administered continuously, intermittently (at least 10d/month) or through IUS
- Combined Hormonal Contraception
- Cigarette smoking
  - Decreased risk of type I, especially in postmenopausal women
  - Increased risk of type II cancer
- Multiparity
- Breastfeeding
- Physical activity

*All reduce exposure to unopposed estrogens

What about HT?
Exogenous Estrogen

- Use of estrogen along with a 10-14 day progestin course once every 3 months
  - Significantly associated with an elevated risk of developing endometrial carcinoma for exposures of 5 years or more (OR,1.63; 95% CI, 1.12-2.38)
  - Trend toward elevated risk for exposures < 5 years – not statistically significant (OR 1.40; 95% CI, 0.82-2.38)

Bottom Line
- Variable response to HT and the associated risks
  - Recommended that health care providers individualize care and treat women with the lowest effective dose for the shortest duration that is needed to relieve vasomotor symptoms
- Decision to continue HT should be individualized and based on woman’s symptoms and the risk-benefit ration, regardless of age.
Vasomotor Symptoms

Description

• Sudden sensation of extreme heat in the upper body, particularly the face, neck and chest
• Typically last 1-5 minutes
  – Perspiration, flushing, chills, clamminess, anxiety and on occasion, heart palpitations
• May interfere with sleep and cause chronic sleep disruption
• Historically estimated to persist 6 months to 2 years.

...and they last...

• Study of Women’s Health Across the Nation (SWAN)
  – Longitudinal observational study of the menopause transition
• 1449 participants
  – Women who were married or partnered, better educated, less financially stressed, and had greater social support had shorter duration of symptoms.
  – Physical activity and alcohol intake did not affect symptom duration

Avis NE et al. Duration of menopausal vasomotor symptoms over the menopause transition. JAMA Intern Med. 2015 Feb 16; [e-pub].(http://dx.doi.org/10.1001/jamainternmed.2014.8063)

Results

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Duration (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1449 with frequent vasomotor symptoms (VMS) (occurring on &gt;6 of the preceding 14 days)</td>
<td>7.4</td>
</tr>
<tr>
<td>Subset (881) with identifiable final menstrual period (FMP), early onset of symptoms (i.e., during pre- or perimenopause)</td>
<td>11.8</td>
</tr>
<tr>
<td>Post-FMP persistence</td>
<td>9.4</td>
</tr>
<tr>
<td>Post menopausal onset of VMS</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Persistence by race and ethnicity:

- Black: 10.1
- Hispanic: 8.9
- Non-Hispanic white: 6.5
- Chinese: 5.4
- Japanese: 4.8

What can we say?

• Bothersome VMS may persist for more than “a few” years.
• New twist to the guidelines for HT “lowest effective dose, shortest duration”
  – Women may need a range of options for a decade or more
    • Hormonal and nonhormonal therapies
    • Behavioral and lifestyle adaptations
• SWAN results help us individualize counseling as we educate women about the risks and benefits of each treatment strategy

Avis NE et al. Duration of menopausal vasomotor symptoms over the menopause transition. JAMA Intern Med. 2015 Feb 16; [e-pub].(http://dx.doi.org/10.1001/jamainternmed.2014.8063)

Estrogen Alone or Combined with Progestin

• Cochrane meta-analysis, 24 RCTs; 3329 participants
  – 75% reduction in weekly hot flush frequency
  – 87% reduction in symptom severity
• Postmenopausal Estrogen/Progestin Interventions trial; 875 women
  – Significant reduction in self-reported vasomotor symptoms
    • Estrogen alone – 58%
    • Estrogen plus progesterone – 62%

MacLennan AH et al., Cochrane Database of Systematic Reviews 2004, Issue 4. Art. No.: CD0029778

Hormonal Treatment Options

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Dosage/Regimen</th>
<th>Evidence of benefit*</th>
<th>FDA Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estrogen alone or combined with progestin</td>
<td>Conjugated estrogen 0.625 mg/d</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Standard Dose</td>
<td>Micronized estradiol 1 mg/d</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Transdermal estradiol 0.0375-0.05 mg/d</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Low Dose</td>
<td>Estrogen plus daily cyclooxygenase agent</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ultra low Dose</td>
<td>Micronized estradiol 0.025 mg/d</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Transdermal estradiol 0.014 mg/d</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Estrogen combined with estrogen agonist/antagonist</td>
<td>Conjugated estrogen 0.45 mg/d and bazedoxifene 20 mg/d</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Progestin</td>
<td>Oral progesterone ingesting women</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Depot medroxyprogesterone acetate</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Testosterone</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Tibolone (Synthetic steroid)</td>
<td>2.5 mg/d</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Compounded bioidentical hormones</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

* Compared with placebo
Options

- **Hormone Therapy**
  - **Premenopausal**
    - Sequential more effective than continuous
    - Prevents hyperplasia but NO contraception
  - **Postmenopausal**
    - Continuous more effective than sequential

Compounded Bioidentical Hormones?

- Plant derived, chemically similar or structurally identical to those produced by the body
  - FDA Approved
    - Micronized progesterone
    - Estradiol
  - Non-FDA regulated
    - Compounded preparations; purity, potency, and quality are concern
    - Overdosage and underdosage possible because of variable bioactivity and bioavailability

Discontinuation

- HT tapered vs. stopped abruptly – rates of vasomotor symptom recurrence are similar
- Recurrent vasomotor symptoms in approximately 50% of women regardless of age and duration of use.
- Decision to continue HT should be individualized based on each woman’s risk-benefit ratio, regardless of age
  - ACOG recommends AGAINST routine discontinuation of systemic estrogen at age 65 years

Genetic Predisposition

**Lynch Syndrome**

- Increased risk of developing colon cancer, ovarian cancer, and type I endometrial cancer
- Autosomal dominant
- Genetic mutation in one of the mismatch repair genes (MLH1, MSH2, PMS2, or MSH6)

Lynch Syndrome

- Estimated cumulative risk of endometrial cancer by age 70 variable – ranges from 16-61% depending on individual mutation
- Almost 10% of women diagnosed with endometrial cancer < 50 have this syndrome

Summary – Estrogen Therapy for VMS?

- Can be considered after thorough counseling about risks and benefits (SOR A)
- Consider in managing VLS in survivors or early-stage disease (Stages I and II)

Summary - Clinical Presentation

- The most common symptoms of endometrial cancer are abnormal uterine bleeding (including irregular menses and intermenstrual bleeding) and postmenopausal bleeding.
- Patients who have advanced disease may have symptoms similar to those seen with advanced ovarian cancer: abdominal or pelvic pain, abdominal distention, bloating, early satiety, change in bowel or bladder function.
- At present, no available recommended routine screening test to identify endometrial cancer.

AES Question: 2. What is the preferred initial test for a postmenopausal woman presenting with painless vaginal bleeding?

A. Saline infusion sonohysterography  
B. Endometrial sampling  
C. Transvaginal ultrasonography  
D. Hysteroscopy

Diagnostic Studies

- Type of initial study depends on availability of options and their level of invasiveness, and patient and physician preference
  - Transvaginal Ultrasonography  
  - Endometrial Sampling  
  - Saline Infusion Sonohysterography  
  - Hysteroscopy

Premenopausal Women

- The literature is unclear about when evaluation with imaging is indicated in premenopausal women with abnormal uterine bleeding.
- Ultrasound measurement of endometrial thickness in premenopausal women has no diagnostic value and should not be performed.
- The decision to histologically evaluate the endometrium should be based on symptomatology and clinical presentation.

Anovulatory Bleeding Evaluation

- Laboratory  
  - Pregnancy test, TSH, Prolactin
- Endometrial Biopsy
  - Women < 45 with one of the following risk factors:
    - Chronic anovulation
    - DM
    - Family history of colon cancer (Lynch Syndrome)
    - Infertility
    - Nulliparity
    - Obesity
    - Tamoxifen use
  - Women >45 with suspected anovulatory bleeding
- Imaging
  - TVUS or saline infusion sonohysterography if bleeding DOES NOT respond to medical therapy

Evaluation and Treatment Anovulatory Uterine Bleeding

Obtain history and perform PE to rule out systemic disease, medication effects, PCOS, and cervical or vaginal pathology.

Adolescent or <45 years with no risk factors for endometrial cancer
- Obtain history and perform PE to rule out systemic disease, medication effects, PCOS, and cervical or vaginal pathology

Adolescent or <45 years with recurrent anovulation or other risk factors for endometrial cancer
- Obtain history and perform PE to rule out systemic disease, medication effects, PCOS, and cervical or vaginal pathology

>45 years with suspected anovulation
- Obtain history and perform PE to rule out systemic disease, medication effects, PCOS, and cervical or vaginal pathology

Hysteroscopy

Endometrial Biopsy
Evaluation and Treatment of Ovulatory Abnormal Uterine Bleeding

**Ovulatory**

- **Characteristics**
  - Regular intervals (every 24 to 35 days) with excessive bleeding or duration greater than 7 days
  - Less than 1% of women develop cancer or hyperplasia if they have no more than one risk factor for endometrial cancer

**Endometrial Biopsy**

- Normal endometrium
  - Go to § (previous slide)
- Hyperplasia without atypia
  - Treat with medroxyprogesterone acetate, 10mg/d for 14 days/month or daily megestrol (Megace), 40 mg or insert levonorgestrel-releasing intrauterine system (Mirena)
  - Repeat endometrial biopsy in three to six months. Refer to gynecologist if hyperplasia persists
- Hyperplasia with atypia
  - Refer to gynecologist
- Adenocarcinoma
  - Refer to gynecologic oncologist

**Differential Diagnosis**

- Bleeding disorder
  - Factor deficiency
  - Leukemia
  - Platelet disorder
  - Von Willebrand disease
  - Hypothyroidism
  - Liver disease, advanced
  - Structural lesions
    - Fibroids
    - Polyps

**Laboratory**

- Pregnancy test, CBC, TSH
- Tests for bleeding disorder (CBC with platelets, PT/PTT; fibrinogen and thrombin time are optional, bleeding time is neither sensitive nor specific – do not need) in adolescents and in women with one or more of the following risk factors [Iv screen]:
  - Family history of bleeding disorder
  - Menstrual bleeding ≥ 7 days with excessive bleeding or impairment of activities with most periods
  - History of treatment of anemia
  - History of excessive bleeding with tooth extraction, delivery or spontaneous abortion, or surgery
- Imaging (typically only in adults) to rule out structural abnormality:
  - TVUS or saline infusion sonohysterography
  - Endometrial biopsy
    - ≤ 45 with normal laboratory and imaging results and bleeding unresponsive to therapy
    - > 45 with multiple risk factors for cancer

**Imaging**

- TVUS or saline infusion sonohysterography
- If high risk of endometrial cancer, consider EMB in addition to imaging
Postmenopausal Women

- Women with postmenopausal uterine bleeding may be assessed initially with either endometrial biopsy or transvaginal ultrasonography; this initial evaluation does not require performance of both tests.
- Among postmenopausal women who experience uterine bleeding, pelvic ultrasonography and endometrial sampling have shown efficacy.

Diagnostic Evaluation of Abnormal Uterine Bleeding

**Imaging Evaluation**

- Transvaginal ultrasonography (TVUS)
  - Helpful for evaluating the myometrium itself
  - Sensitivity and specificity for evaluating intracavitary pathology are low.
- Saline infusion sonohysterography (SH)
  - Superior (more sensitive and specific) to TVUS in the detection of intracavitary lesions (e.g., polyps, submucosal leiomyomas) [SOR: C]
  - Can distinguish between focal versus uniform thickening of the endometrium and structural abnormalities
- Diagnostic hysteroscopy (DH)
  - Numerous recent studies have demonstrated that DH had a significantly better diagnostic performance than SH and TVUS and was significantly more precise in the diagnosis of intracavitary masses. Hysteroscopy not only has increased accuracy for identifying the etiology of AUB, compared with D&C, but also offers the possibility of in-office use
- MRI - May be useful to guide the treatment of myomas

**Diagnostic Evaluation of Abnormal Uterine Bleeding**

**H&P, Pap ± CBC, STD testing**

**Perform EMB or TVUS**

<table>
<thead>
<tr>
<th>Abnormal results</th>
<th>Normal results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer for treatment</td>
<td></td>
</tr>
</tbody>
</table>

- Bleeding continues? No Yes

**Perform TVUS, SIS, or hysteroscopy**

- ET ≤ 4 mm (˃ 95% sensitivity)
  - Perform SIS, EMB, or hysteroscopy with biopsy
  - Refer for treatment
- ET > 4 mm
  - Atrophic endometrium
  - Perform TVUS, SIS, or hysteroscopy

What Are We Looking for on the Biopsy?

- Cytologic atypia is the SINGLE most important histologic finding.
- Only ATYPICAL hyperplasia has a significant risk of developing into endometrial cancer.
  - 29% progresses to invasion.
  - Need to rule out cancer if atypia is present.
- Endometrial hyperplasia is a BENIGN condition, low incidence of being a cancer precursor.

Triage Guidelines

**Postmenopausal Women**

- No cytologic atypia
  - Progestins for 6 months, then rebiopsy
  - TAH for recurrent EMHP or bleeding
- Cytologic atypia (substantial risk of deeply invasive or poorly differentiated cancer)
  - Hysterectomy

Note -

- Rare cases of endometrial carcinoma (particularly Type II) can present with an endometrial thickness of less than 3mm, persistent or recurrent uterine bleeding should prompt a histologic evaluation of endometrium REGARDLESS of thickness.


Diagnostic Evaluation of Abnormal Uterine Bleeding: An Evidence-Based Workup

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Endometrial biopsy is a gold standard for evaluating endometrial pathology.

- Normal results or no bleeding
- Endometrial hyperplasia or atypia
  - Endometrial carcinoma
- Atrophic endometrium:
  - Endometrial hyperplasia
  - Endometrial carcinoma


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Postmenopausal Bleeding

- Irregular bleeding is common after HT is initiated and improves within 6-12 months for most women.
- Evaluate
  - Cyclic HT, experience unusually prolonged or heavy bleeding that occurs near the end of the progestogen phase of the cycle, or breakthrough bleeding that occurs at any other time.
  - Continuous HT, experience bleeding that persists > 6-12 months or that occurs after amenorrhea has been established.
  - HT < 12 months may be observed for 1 year before diagnosing abnormal uterine bleeding.
  - Postmenopausal on no HT or HT > 12 months with bleeding

Treatment

- Surgery
  - Hysterectomy
  - Debulking
- Adjuvant Radiotherapy
- Systemic adjuvant therapy
  - Chemotherapy
  - Hormone Therapy

Follow-up

- Vaginal cytologic evaluation and annual chest radiograph are not recommended because most vaginal recurrences are detected with clinical examination alone.
- Chest radiography is of low utility in detecting asymptomatic recurrence.

Best Practices in Oncology: Recommendations from the Choosing Wisely Campaign

- Do not perform Papanicolaou tests for surveillance of women with a history of endometrial cancer

Communication

- Survivorship Care Plan (SCP)
  - Patient-Centered communication tool to improve the quality of follow-up care for survivors
  - IOM recommends that, after primary treatment, all patients receive an SCP
    - Treatment summary
    - Individualized follow-up plan that makes clear which physician will be responsible for carrying out the plan

SUMMARY
<table>
<thead>
<tr>
<th>Clinical Recommendation</th>
<th>Evidence Rating</th>
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</thead>
<tbody>
<tr>
<td>Evaluate all women with postmenopausal vaginal bleeding for endometrial cancer</td>
<td>A</td>
</tr>
<tr>
<td>Women with abnormal uterine bleeding should be evaluated for endometrial cancer if they</td>
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<tr>
<td>are older than 45 years or if they have a history of unopposed estrogen exposure.</td>
<td>C</td>
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<tr>
<td>In postmenopausal women, the endometrial thickness on transvaginal ultrasonography</td>
<td>C</td>
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<tr>
<td>should be less than 4 to 5 mm. With thickness above this level, biopsy should be</td>
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<tr>
<td>considered to rule out endometrial hyperplasia or cancer.</td>
<td>A</td>
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<tr>
<td>Estrogen therapy for the management of menopausal symptoms in the survivors of early-</td>
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<tr>
<td>stage endometrial cancer can be considered after thorough counseling about the risks</td>
<td>A</td>
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<tr>
<td>and benefits.</td>
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<tr>
<td>Do not perform Papanicolaou tests for surveillance of women with a history of</td>
<td></td>
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<tr>
<td>endometrial cancer</td>
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</tbody>
</table>

- Use transvaginal ultrasound for the initial study for patients at low risk for         |
  endometrial cancer, and endometrial biopsy for those at higher risk [SOR:B].            |
- Use saline infusion sonography as a second step in the evaluation of postmenopausal   |
  bleeding if the diagnosis remains unclear after a biopsy or the bleeding persists       |
  despite a normal initial workup [SOR:B].                                              |

Questions

Thank you