Body System: Reproductive-Female		
Session Topic: Endometrial Cancer		
Educational Format		**Faculty Expertise Required**
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	**Learning Objective(s) that will close the gap and meet the need**	**Outcome Being Measured**
• Knowledge gaps with regard to the screening and management of endometrial cancer. • Knowledge and practice gaps with regard to effective strategies to offer and encourage HPV vaccination; performing biopsies; coordination of referral; and diagnostic evaluation (e.g. transvaginal US; EMB) of patients with post-menopausal bleeding • Knowledge gaps regarding resources available to help mitigate the psychosocial effects of cancer including issues such as infertility, chemotherapy complications, cultural competency and stigma related to cancer • Knowledge gaps regarding communication between specialists treating cancer patients and to coordinate	1. Screen for endometrial cancer in accordance with current clinical guidelines. 2. Diagnose endometrial cancer though 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.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

care during follow-up visits. • Knowledge gaps with regard to follow up recommendations regarding post treatment management, surveillance and coordination of care for cancer survivors.		

ACGME Core Competencies Addressed (select all that apply)			
X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
  - Visit http://www.aafp.org/journals for additional resources
  - Visit http://familydoctor.org for patient education and resources
- Provide recommendations for screening for endometrial cancer in accordance with current clinical guidelines, including family history to determine if she might have an increased genetic risk of endometrial cancer.
- Provide recommendations for diagnosing endometrial cancer though physical examination and appropriate laboratory and diagnostic studies, as indicated.
- Provide strategies and resources for developing collaborative treatment plans based on the patient's desire for future fertility and results of the diagnosis; including an overview of new treatment options.
- Provide strategies and resources for developing communication strategies to improve communication with sub-specialists treating cancer patients to improve coordination of care.
- Provide recommendations regarding guidelines for Medicare reimbursement.
- Provide recommendations to maximize office efficiency and guideline adherence to the diagnosis and management of endometrial cancer.
- Provide an overview of newly available treatments, including efficacy, safety, contraindications, and cost/benefit relative to existing treatments.

- Provide instructions regarding the incorporation and use of the PCMH/ACO/Primary Care Core Measure Set into practice.

Needs Assessment

Endometrial (uterine) cancer is the fourth most common cancer in women in the United States and the most commonly diagnosed gynecologic cancer; in 2010 44,717 women in the U.S. were diagnosed with endometrial cancer, and 8,402 women in the U.S. died from endometrial cancer.[1] The American Cancer Society estimates there will be approximately 54,870 new cases of cancer of the body of the uterus in 2014, with about 10,170 deaths from endometrial cancers.[2] As endometrial cancer is the leading cause of gynecologic cancer in the United States, it should be the primary focus of this education.

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment Survey suggests that family physicians have gaps in the medical knowledge necessary to provide optimal patient care for endometrial cancer, as well as providing care for cancer survivors generally; as well as the evaluation of abnormal uterine bleeding.[3] More specifically, CME outcomes data from 2015 AAFP FMX (formerly Assembly) *Uterine Cancer* sessions, as well as from 2015 FP Essentials: *Genital Cancers in Women-Uterine Cancer* monograph, suggest that physicians have knowledge and practice gaps with regard to following evidence-based screening guidelines; effective strategies to offer and encourage HPV vaccination; performing biopsies; coordination of referral; and diagnostic evaluation (e.g. transvaginal US; EMB) of patients with post-menopausal bleeding.[4,5]

With more than eighty percent (81.5%) surviving endometrial cancer for five years, there are an estimated 610,804 survivors of this cancer; thereby making is important for physicians to increase their knowledge and skills to provide optimal cancer survivorship care.[6] Data from a recent AAFP CME Needs Assessment Survey indicates that family physicians have gaps in the medical knowledge and skill necessary to provide optimal cancer survivorship care.[3] Therefore, physicians can improve their care of vulvar cancer survivors by integrating relevant evidence-based practices from the American Society of Clinical Oncology Survivorship Guidelines.[7]

Physicians should be familiar with screening guidelines, especially for those with risk factors for developing endometrial cancer, such as long-term use of high-dose menopausal estrogens, high cumulative doses of tamoxifen, estrogen-producing tumor, obesity, nulliparity, diabetes, hypertension, thyroid or gallbladder disease, older age, history of infertility, late age natural menopause, early age at menarche, menstrual irregularities, white race, long-term use of high doses of combination oral contraceptives, cigarette smoking, family history of endometrial cancer, early-onset colorectal cancer without a MMR gene mutation, postmenopausal bleeding, and polycystic ovary syndrome.[8-12] Obesity is a known risk factor for endometrial carcinoma in white women; and a recent study has also found a strong positive association between obesity and endometrial cancer in black women.[13]

Family physicians should be prepared to diagnose endometrial cancer by physical examination, appropriate laboratory evaluation, and diagnostic studies.[14] Staging of endometrial cancer is

surgically based, and for primary care physicians the preoperative evaluation should also focus on optimizing medical comorbidities that could complicate the course of treatment.[14] Physicians should be familiar with the two systems used for staging endometrial cancer, the FIGO (International Federation of Gynecology and Obstetrics) system and the American Joint Committee on Cancer TNM staging system. Physicians should also be familiar with recent studies indicating that tubal ligation is associated with lower stage and mortality among women with aggressive endometrial carcinomas, suggesting transtubal spread is clinically important.[15]

Physicians may improve their care of patients with endometrial cancer by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[14,16-20]

- Women older than 65 years should be informed of the risks and symptoms of endometrial cancer and advised to seek evaluation if symptoms occur.
- Women with abnormal uterine bleeding should be evaluated for endometrial cancer if they are older than 45 years or if they have a history of unopposed estrogen exposure.
- In postmenopausal women, the endometrial thickness on transvaginal ultrasonography should be less than 4 to 5 mm. With thickness above this level, biopsy should be considered to rule out endometrial hyperplasia or cancer.
- The American Cancer Society recommends offering annual screening for endometrial cancer with endometrial biopsy beginning at 35 years of age for women who have or are at risk of developing hereditary nonpolyposis colorectal cancer.
- Endometrial assessment to exclude cancer is indicated in all women older than 35 years with suspected anovulatory uterine bleeding.
- For postmenopausal women with benign endometrial cells on Pap smear, endometrial assessment is recommended regardless of symptoms.
- Women with atypical endometrial cells on Pap smear should be evaluated initially with endocervical and endometrial sampling.
- Women 35 years or older with recurrent anovulation, women younger than 35 years with risk factors for endometrial cancer, and women with excessive bleeding unresponsive to medical therapy should undergo endometrial biopsy.
- Two or more colposcopic-directed cervical biopsies should be performed to increase the sensitivity of colposcopy for identifying high-grade CIN lesions.
- Colposcopic-directed biopsies of acetowhite epithelium should be performed even when the colposcopic impression is squamous metaplasia or low-grade disease.
- Excisional and ablative methods have similar outcomes for eradication of CIN.
- Excisional techniques for treating CIN increase the risk of preterm labor and low birth weight, especially with greater depth of excision.
- Endometrial biopsy can accurately detect carcinoma involving a large portion of the endometrium, but may fail to detect focal lesions and carcinoma involving 50% or less of the endometrial surface area.
- Transvaginal ultrasonography showing endometrial thickness of less than 3 to 4 mm essentially rules out endometrial carcinoma in a postmenopausal woman.
- A focal endometrial lesion found on saline infusion sonohysteroscopy should be evaluated with hysteroscopy.

- Antiestrogen therapy (e.g., tamoxifen) reduces the risk of recurrent cancer in hormone receptor–positive disease, but it causes hot flashes and sexual dysfunction and is associated with an increased risk of endometrial cancer.

Best practices in oncology: recommendations from the Choosing Wisely® campaign:[21]

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

With regard to the care of patients with endometrial cancer, physicians should consider the following evidence-based recommendations:[22]

- Treat chemotherapy-related nausea and vomiting with 5-hydroxytryptamine antagonists.
- Manage chemotherapy-related anemia with epoetin alfa.
- Recommend exercise to mitigate fatigue and improve functional status in patients undergoing chemotherapy and radiation therapy.
- Treat cancer-related fatigue with psychosocial intervention.
- Megestrol (Megace) improves weight gain and appetite in patients with cachexia caused by cancer.
- Massage and aromatherapy massage may enhance psychological well-being, including relief of anxiety, in patients with cancer.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

In general, endometrial cancer can be managed in the office, unless the first steps of management are ineffective or if more specialized investigations are needed; in which case, physicians should have standardized coordination of care protocols in place.[23] Primary care providers are often overburdened by an aging population with multiple chronic conditions and may not be adequately prepared to care for these survivors due to perceived knowledge gaps about the individualized needs, risks, and surveillance plans for cancer survivors.[24-27] Additionally, there is often a lack of inter-professional communication and clarity about responsibilities in the coordination of care between oncology professionals and primary care providers.[25,26,28] In fact, patients are often unaware that a transition back to their primary care provider, from their oncology provider, is an option. Physicians can improve patient satisfaction with the referral process by using readily available strategies and tools such as, improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.[29-31]

The American Academy of Family Physicians Academy has participated in the Core Measures Collaborative (the Collaborative) convened by America's Health Insurance Plans (AHIP) since

August 2014. The Collaborative is a multi-stakeholder effort working to define core measure sets of various specialties promoting alignment and harmonization of measure use and collection across both public and private payers.

Participants in the Collaborative included Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), private payers, provider organizations, employers, and patient and consumer groups. This effort exists to decrease physician burden by reducing variability in measure selection, specifications and implementation– making quality measurement more useful and meaningful for consumers, employers, as well as public and private clinicians.

With significant AAFP input, a PCMH/ACO/Primary Care Core Measure Set has been developed for primary care. The goal of this set is to decrease burden and allow for more congruence between payer reporting programs.[32]

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Diagnosis and Management of Endometrial Cancer[21]
- Endometrial Cancer[14]
- Gynecologic Procedures: Colposcopy, Treatment of Cervical Intraepithelial Neoplasia, and Endometrial Assessment[20]
- Abnormal Uterine Bleeding[9]
- Endometrial cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up[33]
- The role of surgery in endometrial cancer[34]
- ACOG Practice Bulletin number 65: management of endometrial cancer[35]
- Surveillance of the Adult Cancer Survivor[16]
- The role of adjuvant therapy in endometrial cancer[36]
- Epidemiology and investigations for suspected endometrial cancer[37]
- Evaluation and management of abnormal uterine bleeding in premenopausal women[19]
- Simple tools to increase patient satisfaction with the referral process[29]
- Recent Updates to NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)[38]
- Advancing survivorship care through the National Cancer Survivorship Resource Center: developing American Cancer Society guidelines for primary care providers[39]
- Primary care of the patient with cancer[22]
- NCCN Patient and Caregiver Resources[40]
- American Society of Clinical Oncology: Survivorship Guidelines[7]
- Nutrition and physical activity guidelines for cancer survivors[41]
- Models of care for cancer survivorship[42]
- Cancer | After Cancer Treatment (patient education)[43]

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