Body System: Reproductive-Female			
Session Topic: Uterine 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**
• Family physicians report knowledge gaps with regard to the screening and management of endometrial cancer. • Family physicians may need to increase their knowledge of resources available to help mitigate the psychosocial effects of cancer including issues such as infertility, chemotherapy complications, cultural competency and stigma related to cancer • Family physicians require additional education to improve communication between specialists treating cancer patients and to coordinate care during follow-up visits. • Knowledge gaps with regard to follow up recommendations regarding post treatment management, surveillance		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. Establish protocols to improve coordination of care with sub-specialists treating cancer patients to improve communication and patient outcomes.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

and coordination of care for cancer survivors.		

ACGME Core Competencies Addressed (select all that apply)			
	Medical Knowledge		Patient Care
	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.
- 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.

Needs Assessment

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 uterine cancer, and 8,402 women in the U.S. died from uterine cancer.[1] The American Cancer Society estimates there will be approximately 52,630 new cases of cancer of the body of the uterus in 2014, with about 8,590 deaths from uterine 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 uterine cancer, as well as providing care for cancer survivors generally.[3] 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.[4]

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.[5-9] Family physicians should be prepared to diagnose endometrial cancer by physical examination, appropriate laboratory evaluation, and diagnostic studies.[10] 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.[10]

Physicians may improve their care of patients with uterine 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:[10-15]

- 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 uterine 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.[16] 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.[17-20] 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.[18,19,21] 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.[22-24]

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

- Endometrial Cancer[10]
- Gynecologic Procedures: Colposcopy, Treatment of Cervical Intraepithelial Neoplasia, and Endometrial Assessment[15]
- Abnormal Uterine Bleeding[6]
- Endometrial cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up[25]
- The role of surgery in endometrial cancer[26]
- ACOG Practice Bulletin number 65: management of endometrial cancer[27]
- Surveillance of the Adult Cancer Survivor[11]
- The role of adjuvant therapy in endometrial cancer[28]
- Epidemiology and investigations for suspected endometrial cancer[29]
- Evaluation and management of abnormal uterine bleeding in premenopausal women[14]
- Simple tools to increase patient satisfaction with the referral process[22]

- Recent Updates to NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)[30]
- Advancing survivorship care through the National Cancer Survivorship Resource Center: developing American Cancer Society guidelines for primary care providers[31]
- NCCN Patient and Caregiver Resources[32]
- American Society of Clinical Oncology: Survivorship Guidelines[33]
- Nutrition and physical activity guidelines for cancer survivors[34]
- Models of care for cancer survivorship[35]
- Cancer | After Cancer Treatment (patient education)[36]

References

1. Centers for Disease Control and Prevention. Gynecologic Cancers: Uterine Cancer Statistics. 2013; http://www.cdc.gov/cancer/uterine/statistics/index.htm. Accessed June, 2014.

2. American Cancer Society. What are the key statistics about endometrial cancer?; What are the key statistics about uterine sarcoma?,. 2013; http://www.cancer.org/cancer/uterinesarcoma/detailedguide/uterine-sarcoma-key-statistics, http://www.cancer.org/cancer/endometrialcancer/detailedguide/endometrial-uterine-cancer-key-statistics. Accessed August, 2014.

3. AAFP. 2012 CME Needs Assessment: Clinical Topics. American Academy of Family Physicians; 2012.

4. National Cancer Institute. SEER Stat Fact Sheets: Endometrial Cancer. 2011; http://seer.cancer.gov/statfacts/html/corp.html. Accessed August, 2014.

5. Batte BA, Bruegl AS, Daniels MS, et al. Consequences of universal MSI/IHC in screening ENDOMETRIAL cancer patients for lynch syndrome. *Gynecologic oncology.* Aug 2014;134(2):319-325.

6. Albers JR, Hull SK, Wesley RM. Abnormal uterine bleeding. *American family physician.* Apr 15 2004;69(8):1915-1926.

7. Dokras A, Witchel SF. Are young adult women with polycystic ovary syndrome slipping through the healthcare cracks? *The Journal of clinical endocrinology and metabolism.* May 2014;99(5):1583-1585.

8. Bharati R, Jenkins MA, Lindor NM, et al. Does risk of endometrial cancer for women without a germline mutation in a DNA mismatch repair gene depend on family history of endometrial cancer or colorectal cancer? *Gynecologic oncology.* May 2014;133(2):287-292.

9. Walker S, Hyde C, Hamilton W. Risk of uterine cancer in symptomatic women in primary care: case-control study using electronic records. *The British journal of general practice : the journal of the Royal College of General Practitioners.* Sep 2013;63(614):e643-648.

10. Buchanan EM, Weinstein LC, Hillson C. Endometrial cancer. *American family physician.* Nov 15 2009;80(10):1075-1080.

11. Wilbur J. Surveillance of the adult cancer survivor. *American family physician.* Jan 1 2015;91(1):29-36.

12. Smith RA, Manassaram-Baptiste D, Brooks D, et al. Cancer screening in the United States, 2014: A review of current American Cancer Society guidelines and current issues in cancer screening. *CA: a cancer journal for clinicians.* 2014;64(1):30-51.

13. Smith RA, Cokkinides V, Brawley OW. Cancer screening in the United States, 2012. *CA: a cancer journal for clinicians.* 2012;62(2):129-142.

14. Sweet MG, Schmidt-Dalton TA, Weiss PM, Madsen KP. Evaluation and management of abnormal uterine bleeding in premenopausal women. *American family physician.* Jan 1 2012;85(1):35-43.

15. Apgar BS, Kaufman A, Bettcher C, Parker-Featherstone E. Gynecologic Procedures: Colposcopy, Treatment of Cervical Intraepithelial Neoplasia, and Endometrial Assessment. *American family physician.* 2013;87(12):836-843.

16. Telner DE, Jakubovicz D. Approach to diagnosis and management of abnormal uterine bleeding. *Canadian family physician Medecin de famille canadien.* Jan 2007;53(1):58-64.

17. Hudson SV, Miller Sm Fau - Hemler J, Hemler J Fau - Ferrante JM, et al. Adult cancer survivors discuss follow-up in primary care: 'not what i want, but maybe what i need'. *Ann Fam Med.* Vol 102012:418-427. doi: 410.1370/afm.1379.

18. Kantsiper M, McDonald EL, Geller G, Shockney L, Snyder C, Wolff AC. Transitioning to breast cancer survivorship: perspectives of patients, cancer specialists, and primary care providers. *Journal of general internal medicine.* Nov 2009;24 Suppl 2:S459-466.

19. Ganz PA. Survivorship: adult cancer survivors. *Primary care.* Dec 2009;36(4):721-741.

20. Seehusen DA, Baird D, Bode D. Primary care of adult survivors of childhood cancer. *American family physician.* May 15 2010;81(10):1250-1255.

21. Blanch-Hartigan D, Forsythe LP, Alfano CM, et al. Provision and discussion of survivorship care plans among cancer survivors: results of a nationally representative survey of oncologists and primary care physicians. *Journal of clinical oncology : official journal of the American Society of Clinical Oncology.* May 20 2014;32(15):1578-1585.

22. Jarve RK, Dool DW. Simple tools to increase patient satisfaction with the referral process. *Family practice management.* Nov-Dec 2011;18(6):9-14.

23. American Academy of Family Physicians (AAFP). FPM Toolbox: Referral Management. 2013; http://www.aafp.org/fpm/toolBox/viewToolType.htm?toolTypeId=26. Accessed July, 2014.

24. Ezendam NP, Nicolaije KA, Kruitwagen RF, et al. Survivorship Care Plans to inform the primary care physician: results from the ROGY care pragmatic cluster randomized controlled trial. *Journal of cancer survivorship : research and practice.* May 28 2014.

25. Colombo N, Preti E, Landoni F, et al. Endometrial cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Annals of oncology : official journal of the European Society for Medical Oncology / ESMO.* Sep 2011;22 Suppl 6:vi35-39.

26. Giede C, Le T, Power P, et al. The role of surgery in endometrial cancer. *Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC.* Apr 2013;35(4):370-374.

27. Hernandez E, American College of O, Gynecologists. ACOG Practice Bulletin number 65: management of endometrial cancer. *Obstet Gynecol.* Apr 2006;107(4):952; author reply 952-953.

28. Kupets R, Le T, Le T, et al. The role of adjuvant therapy in endometrial cancer. *Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC.* Apr 2013;35(4):375-379.

29. Renaud MC, Le T, Le T, et al. Epidemiology and investigations for suspected endometrial cancer. *Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC.* Apr 2013;35(4):380-383.

30. National Comprehensive Cancer Network. Recent Updates to NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). 2014; http://www.nccn.org/professionals/physician_gls/recently_updated.asp. Accessed July, 2014.

31. Cowens-Alvarado R, Sharpe K, Pratt-Chapman M, et al. Advancing survivorship care through the National Cancer Survivorship Resource Center: developing American Cancer Society guidelines for primary care providers. *CA: a cancer journal for clinicians.* May 2013;63(3):147-150.

32. National Comprehensive Cancer Network. Patient and Caregiver Resources. 2014; http://www.nccn.org/patients/resources/default.aspx. Accessed July, 2014.

33. American Society of Clinical Oncology. Survivorship Guidelines. 2014; http://www.asco.org/guidelines/survivorship. Accessed June, 2014.

34. Rock CL, Doyle C, Demark-Wahnefried W, et al. Nutrition and physical activity guidelines for cancer survivors. *CA: a cancer journal for clinicians.* Jul-Aug 2012;62(4):243-274.

35. National Guideline Clearinghouse. Models of care for cancer survivorship. 2012; http://www.guideline.gov/content.aspx?id=39428&search=cancer+survivorship. Accessed 7/25/2014.

36. FamilyDoctor.org. Cancer | After Cancer Treatment. 2002; http://familydoctor.org/familydoctor/en/diseases-conditions/cancer/treatment/after-cancer-treatment.html. Accessed July, 2014.

