

# Endometrial Cancer Survivorship: Improving long-term outcomes

**Gwyneth Capes**

Clinical Nurse Specialist – Cancer Nurse Coordinator, Waitemata District Health Board and Institute of Innovation and Improvement, Auckland, NZ

## Background

Endometrial cancer (EC) is the commonest gynaecological cancer in the developed world and increasing at a significant rate. In New Zealand (NZ) there has been a 39% rise in the incidence of endometrial cancer over the past four decades. This increase has been largely driven by risk factors linked to lifestyle behaviours that are considered modifiable.<sup>1</sup> These risk factors echo those of cardiovascular disease (CVD), and indeed CVD is the leading cause of death in women successfully treated for early stage endometrial cancer.<sup>2</sup>

Previous research has identified marked disparities in the incidence and outcomes of endometrial cancer in Māori and Pacific women.<sup>3</sup> Between 23-27% of deaths from endometrial cancer in NZ are considered avoidable.<sup>4</sup>

## Objective and Study Method

The author elected to undertake Masters research to understand the incidence of EC and patient profile of women residing in Waitemata District Health Board (DHB) catchment.

A retrospective audit was undertaken utilising the clinical records of all women with a confirmed diagnosis of endometrial cancer in a community-based hospital between 2002 and 2014.

## Outcome

The findings highlighted a large number of women possessed modifiable risk factors. A new model of care is proposed for a nurse-led, patient-focused follow-up process that addresses these risk factors in collaboration with primary care and community services.

## Discussion

### New Model of Care (MOC):

International research demonstrates a lack of information and advice given to patients regarding lifestyle behaviours.

A small in-house survey with a representative sample of 17 gynaecology physicians and 7 Pacific patients identified a discrepancy between provider and recipient perception of information given about risk factors. Whilst doctors stated they “occasionally/frequently” discuss modifiable risk factors and “frequently” discuss adopting healthy lifestyle behaviours, patients stated they could not remember such a conversation. An audit of 61 clinical records revealed no documentation of lifestyle conversations.

The new proposed MOC moves away from a traditional physician-led approach that focuses on recurrence to one that is facilitated by the nurse specialist and primary care team, capitalising on the “teachable moment” and works with the patient and their whānau, empowering women to take responsibility for their own health.

### Strengths:

- The audit identified women residing in the Waitemata DHB catchment possessed risk factors that not only increased their risk of endometrial cancer but may also increase their risk of cardiovascular disease in line with international research.
- NZ has a unique population and this study demonstrated that particular ethnicities possess more risk factors than others.

### Weaknesses:

- The number of patients included in the audit are very small and so may not be representative of the whole of New Zealand.
- The limitations of the model are not yet fully known and it awaits full development.

## References

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## Acknowledgements

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## Results

### Context

**262** Patients were included in the audit

### Patient overview

- Māori and Pacific women had a younger mean age at diagnosis compared with NZ European women (57yrs & 54yrs vs. 65yrs)
- Youngest patient was 23yrs and of Pacific ethnicity

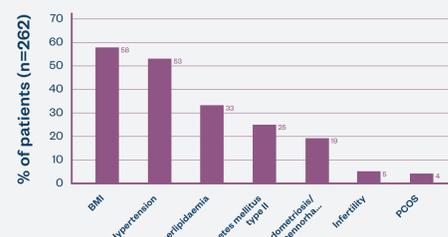
### Histology

- 85% Endometrioid adenocarcinoma
- Of these 45% were Stage 1A, G1 or 2

### Menopausal status & Body Mass Index (BMI)

- The majority of women were post-menopausal (75%)
- 66% of the women were considered obese with 27% categorised as Obesity Class III (BMI ≥40)
- 13% were considered pre-menopausal with 7% being under 40yrs

### Risk factors associated with endometrial cancer (2002-2014)



### Risk Factors Summary

- 34% of all women had 3 or more risk factors
- Of the 27% who were deceased (at end of data collection) — 56% had ≥2 risk factors and 23% had 4-5 risk factors

### Total of Patients with ≥3 Risk Factors Per Ethnicity



### Social Factors

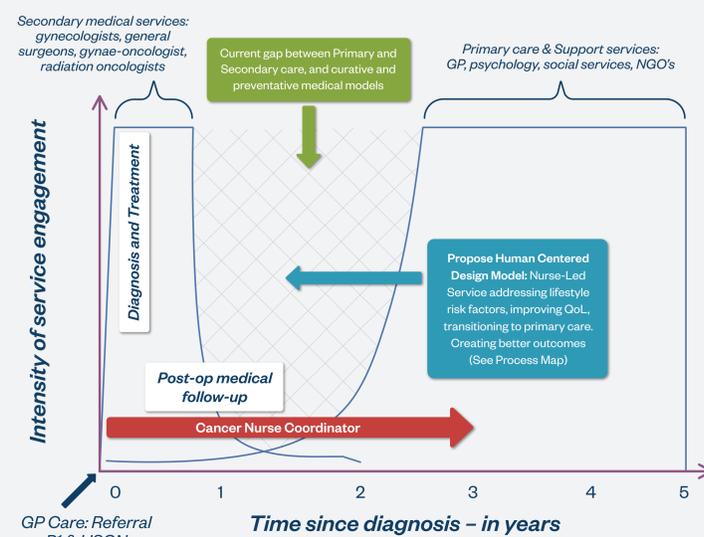
- 40% had a NZ deprivation index score of 7-10 (scale: 1 “least socio-economically deprived” to 10 “most socio-economically deprived”)

### Treatment & Outcome

- 90% underwent surgery as first treatment
- 72% disease-free (at end of data collection)

## Proposed Survivorship Model

Integrating Primary, Secondary and Complimentary Health



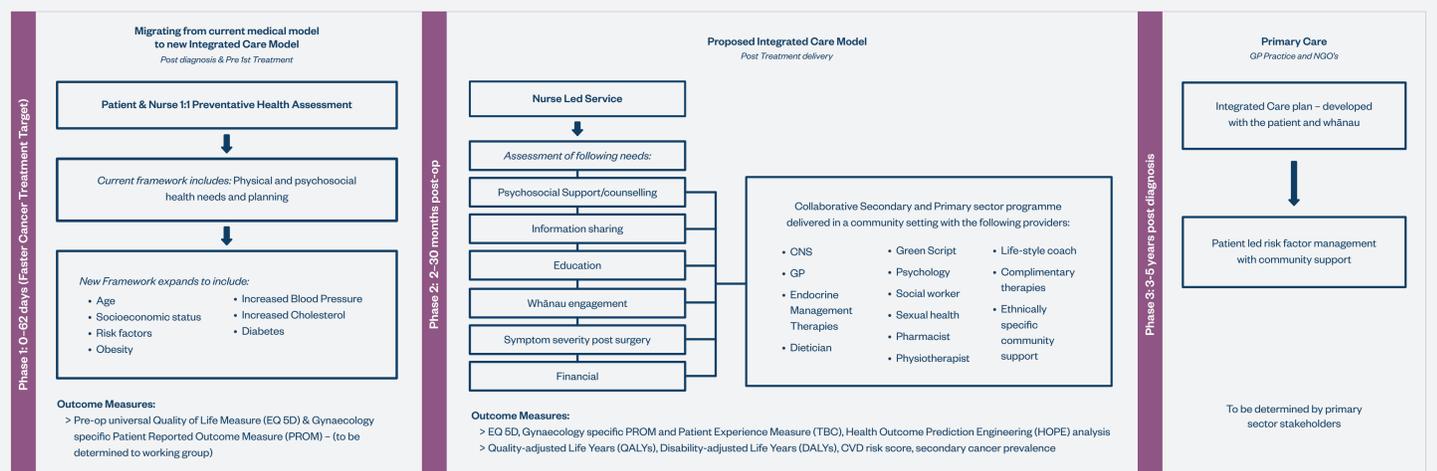
## NZ Gynaecological Cancer Group Follow-up Guidelines for Low-risk EC that have informed the proposed new model of care

### Low Risk — Stage IA, G1, 2

	3 MONTH	6 MONTH	1 YEAR	18 MONTH	2 YEAR	5 YEAR
Gynaecological Surgeon			×		×	
Specialist Nurse*	×				Exit SP	Collect 5 year data outcomes
GP		×		×		

- Consider virtual clinic for well motivated / very rural patients
- Discharge at 2 years if no symptoms / ongoing concerns
- \*3 month and 2 year nurse-led survivorship clinic is recommended

## Process Map for New Model of Care



## Next Steps

Development of the model using a co-design approach.

## Conclusion

The audit highlighted that women with endometrial cancer residing in the Waitemata DHB catchment, possess risk factors that echo those of cardiovascular disease. A link was also demonstrated between ethnicity and increased number of these risk factors. This potentially impacts overall survival. As a result of this research, a revised model of follow-up care is proposed that will be patient-focused and nurse-led, focusing on self-care strategies and survivorship to manage these risk factors, and utilise primary care and community services with the goal of improving outcomes.