The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for Uterine Neoplasms published in this issue (page 248) include the latest updates. To assist readers interested in noting how the guidelines were updated, highlights of major changes pertaining to the abbreviated version published in this issue are printed below. To view the complete list of updates and full versions of these guidelines, visit the NCCN Web site at NCCN.org.

Uterine Neoplasms

Updates in Version 1.2014 of the NCCN Guidelines for Uterine Neoplasms from Version 1.2013 include:

- The following tumor classifications were revised:
  - “Papillary serous” changed to “Serous adenocarcinoma.”
  - “Clear cell carcinoma” changed to “Clear cell adenocarcinoma.”
  - “High-grade undifferentiated sarcoma” changed to “High-grade (undifferentiated) endometrial sarcoma.”
  - “Epithelial carcinoma” changed to “Malignant epithelial carcinoma.”
  - “Pure endometrioid” changed to “Pure endometrioid carcinoma.”

- Principles of Radiation; first bullet: the following sentence was added: “Diagnostic imaging is often used to assess locoregional extent and to rule out distant metastases before administration of RT.” (UN-A)

Uterine Neoplasms

UN-1

- Initial Evaluation
  - The recommendation “Current cervical cytology consistent with NCCN Cervical Cancer Screening Guidelines” was removed.
  - Optional; second bullet: modified to “Consider genetic counseling/testing for young patients (< 55 y) and those with...”

- Third column: Stromal/mesenchymal tumors; the decision points of “Disease limited to uterus” and “Known or suspected extrauterine disease” were removed.

- Footnote “a” was revised: “Screening with immunohistochemistry (IHC) should be considered in all patients, but especially in patients younger than 55 years. In relatives with Lynch syndrome, a yearly endometrial biopsy is recommended until a hysterectomy and bilateral salpingo-oophorectomy (BSO) are performed. Recently, immunohistochemistry (IHC) and/or microsatellite instability (MSI) screening of all colorectal and endometrial cancers, regardless of age at diagnosis or family history, has been implemented at some centers to identify individuals at risk for Lynch syndrome (LS). An infrastructure needs to be in place to handle the screening results. IHC and/or MSI screening is usually performed on epithelial tumors and not stromal/mesenchymal endometrial tumors.” Footnote “a” was also added to page ENDO-A.

- Footnote “b” was revised: “By definition, ESS is low-grade histology has low-grade cytologic features. High-grade subtypes of endometrial sarcomas (undifferentiated endometrial sarcomas in WHO classification) are still being defined.” This footnote was also added to the Uterine Sarcoma algorithms (UTSARC-1).
Endometrial Carcinoma

ENDO-1
• Operable pathway; Primary Treatment:
  ▶ The recommendation “Patient desires fertility-sparing options (See ENDO-2)” was added.
  ▶ The recommendation was modified “Total hysterectomy and bilateral salpingo-oophorectomy (TH/BSO) and surgical staging.” The sub-bullets of “Cytology” and “Pelvic and para-aortic lymph node dissection” and corresponding footnotes were removed from this page and placed in the “Principles of Surgical Evaluation and Staging” (ENDO-A). (Also for ENDO-3 and ENDO-4)
  ♦ The next column was modified: “Adjuvant treatment for completely surgically staged...” (Also for ENDO-3, ENDO-4, ENDO-8)
• Footnote “c” is new.
• The following footnotes were removed:
  ▶ Although peritoneal cytology by itself does not affect 2010 FIGO staging, cytology results should still be obtained and recorded.
  ▶ See Discussion for routine lymphadenectomy.
  ▶ Some patients may not be candidates for lymph node dissection.

ENDO-2
• A new section was added that provides recommendations for fertility-sparing treatment options for early-stage disease.

ENDO-5
• Clinical findings: modified to “Completely Surgically staged.” (Also for ENDO-6 and ENDO-7)

ENDO-8
• Third column: modified to “Radiologic imaging.”
• After “Imaging” the finding “Positive” changed to “Suspicious/positive.”
• For Stage IA, G3; stage IB; stage II: The recommendation changed to “Consider surgical restaging (category 3) or pathologic confirmation of metastatic disease in select patients.” After this recommendation, the following 2 decision points were added, “Surgically restaged” and “No surgical restaging.”

ENDO-9
• Surveillance
  ▶ Second bullet changed to “Patient education regarding symptoms, lifestyle, obesity, exercise, and nutrition counseling (see NCCN Guidelines for Survivorship).”
  ▶ Fourth bullet changed to “CT/MR Imaging as clinically indicated.”
  ▶ Fifth bullet changed to “Consider genetic counseling/testing for young patients (< 55 y) and those with a significant family history of endometrial and/or colorectal cancer and/or selected pathologic risk features.”
  ▶ The following recommendations were removed: Vaginal cytology (category 3), Chest x-ray annually (category 2B).
  ▶ “Disseminated metastases” pathway: recommendation modified to “Low grade or Asymptomatic or ER/PR positive.”
  ▶ The following footnote was removed: “Screening with immunohistochemistry (IHC) should be considered in all patients, but especially in patients younger than 55 years.”

Cont. on page xxxiv.
ENDO-11

- The page title was revised to “Serous or Clear Cell Adenocarcinoma or Carcinosarcoma of the Endometrium” for clarity.
- Additional workup: second bullet: changed to “MRI/CT/PET, as clinically indicated.”
- Primary Treatment:
  - Second bullet modified: “TH/BSO and surgical staging—pelvic and para-aortic lymph node dissection, cytology, omentectomy, biopsies of peritoneal surfaces (including underside of diaphragm).”
  - Third bullet modified: “Consider maximal tumor debulking for gross disease.”
- Adjuvant Treatment
  - Stage IA (no myometrial invasion): recommendation changed to, “Chemotherapy ± vaginal brachytherapy.”
  - Stage III, IV: recommendation changed to, “Chemotherapy ± tumor-directed RT or Whole abdominopelvic RT (category 3) ± vaginal brachytherapy (category 3).”
- Footnote “q” was modified: “... or malignant mixed Müllerian tumor. Most Carcinosarcomas are treated the same as poorly differentiated adenocarcinomas.”

ENDO-A

- Page title changed to “Hysterectomy and Pathologic Evaluation.”
- Pathologic assessment
  - Uterus; last bullet: modified to “Consider screening disease with IHC and MSI for inherited mismatch repair gene mutations in young patients < 55 y and those with a significant family history of endometrial and/or colorectal cancer and/or selected pathologic risk features to identify familial cancer syndromes, such as Lynch syndrome/HNPCC.”
  - “Nodes” changed to “Nodes (when resected).”

ENDO-B

- This is a new section that provides recommendations and techniques for surgical staging, sentinel lymph node mapping, and surgical evaluation for endometrial cancer.

ENDO-C

- Hormone Therapy: last bullet was changed to “Megestrol/tamoxifen (alternating).”
- Chemotherapy Regimens
  - Multiagent chemotherapy:
    - Cisplatin/doxorubicin changed from category 1 to category 2A.
    - Cisplatin/doxorubicin/paclitaxel changed from category 1 to category 2A.
  - Single agents
    - Temsirolimus and Topotecan were added as options.
    - Bevacizumab changed from category 2B to category 2A.
- Footnote 6 is new.

Uterine Sarcoma

UTSARC-1

- Primary Treatment: the recommendation “TH/BSO” was changed to “TH ± BSO.”