We reviewed 100% of Uterine Cancer cases in 2013 to ensure that evaluation and first course of treatment provided to patients were compliant with evidence-based national treatment guidelines (in this case, NCCN Guidelines) and were appropriately staged, using the AJCC staging system, including prognostic indicators.

Population: 2013 Analytic Uterine Cancer Cases. 59 cases (100%) were reviewed.

Analysis Method: Chart Review & Review of Cancer Registry Data for the following items:
- Path AJCC Stage
- H&P for Family History of Endometrial and/or Colorectal Cancer
- CBC (including platelets)
- LFT (optional)
- Age at diagnosis
- Genetic Counseling for appropriate patients (under 50 years of age, or with significant family history of Endometrial and/or Colorectal Cancer)
- Endometrial biopsy
- Chest Imaging
- First Course of Treatment

Summary: Path AJCC Stage:
- 1 Stage 0
- 25 Stage IA
- 9 Stage IB
- 3 Stage II
- 1 Stage III
- 2 Stage IIIA
- 6 Stage IIIC1
- 3 Stage IIIC2
- 1 Stage IV
- 1 Stage IVB
- 7 Stage Unknown or Not Applicable

Family History:
- 3 FH Colon cancer
- 9 FH Other and/or unknown types of cancer
- 42 No FH of cancer
- 4 FH Unknown or not applicable (patient referred to hospice)

CBC (including platelets): 56/59 (95%) CBC documented in chart

LFT (Optional): Most patients did not have LFT ordered unless they progressed to chemo and/or radiation

Age at DX:
- 30-39 2
- 40-49 4
- 50-59 20
- 60-69 20
Genetic Counseling (<50 y & w/significant FH of Endometrial and/or Colorectal Cancer (Optional). (BRAF Mutation Analysis is auto reflexed on all Colon and Uterine cancer cases at DeKalb Medical at the time of surgery and a copy is forwarded to our Genetics program coordinator.)

- 31 MMR: No evidence of Lynch Syndrome or HNPCC
- 14 N/A (Either surgery was done elsewhere or no surgery performed.)
- 6 MMS & BRAF not done (3 Test not ordered (2 Surgery at DM & 1 Surgery at Rockdale; 1 No residual disease; 1 Insufficient tumor; 1 Leiomyosarcoma)
- 7 MMR & BRAF: MMR aberrant loss of expression of MLH1 w/secondary loss of PMS2; BRAF Wild-type (No mutation identified). 4/7 (57%) referred for genetic counseling. Two had genetic testing.
- 1 BRAF
  • Wild-type (No mutation identified)

Endometrial BX:
- 52/59 (88%) had an endometrial biopsy

Chest Imaging:
- 32/59 (54%) had chest imaging
- 27 Chest imaging not on chart

First Course of Treatment:

<table>
<thead>
<tr>
<th>Rx Type</th>
<th>Cases</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surg</td>
<td>24</td>
<td>40.68%</td>
</tr>
<tr>
<td>Surg/Rad</td>
<td>12</td>
<td>20.34%</td>
</tr>
<tr>
<td>Surg/Chem/Rad</td>
<td>10</td>
<td>16.95%</td>
</tr>
<tr>
<td>Surg/Chem</td>
<td>7</td>
<td>11.86%</td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>6.78%</td>
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<tr>
<td>Chem</td>
<td>1</td>
<td>1.69%</td>
</tr>
<tr>
<td>Horm</td>
<td>1</td>
<td>1.69%</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>100</td>
</tr>
</tbody>
</table>

All patients were compliant with treatment.
Discussion:
In many cases patients had part of their diagnostic workup in the OB/GYN’s office prior to being referred to the GYN-oncologist and therefore the reports were not found in the chart. “Chest Imaging” is recommended as part of initial evaluation in the NCCN guidelines without further explanation. We will consider recommending chest x-ray, pending further clarification. CXR is often part of the pre-surgical workup and these processes need to be aligned so as not to duplicate or omit studies.

Recommendations:
- Revise gyn-oncologist’s dictation template for initial evaluation to include items recommended in the guidelines, to avoid omissions; in particular, chest x-ray.
- Request records from referring physicians for initial consults.

Reported to Cancer Committee on December 2, 2014

CoC Standard 4.6: Each year, a physician member of the cancer committee performs a study to assess whether patients within the program are evaluated and treated according to evidence-based national treatment guidelines. Study results are presented at cancer committee and documented in the cancer committee minutes.