Short Course Adjuvant Vaginal Cuff Brachytherapy in Early Endometrioid Cancer: Adverse Events and Early Patient Reported Outcomes

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Objectives Adjuvant vaginal cuff brachytherapy (VCB) improves vaginal control rates in early stage endometrial cancer. We propose a shorter course of VCB would be non-inferior in safety, efficacy and quality of life metrics compared to standard course VCB.

Methods This multi-institutional trial randomized early stage endometrial patients to adjuvant short course VCB (11 Gy x 2 fractions to the surface delivered a week apart) or the standard of care VCB (either 6 Gy x 5 fractions to the surface, 7 Gy x 3 fractions or 5–5.5 Gy x 4 fractions at 0.5 cm depth). All patients underwent hysterectomy with pathologically confirmed endometrioid adenocarcinoma, serous, clear cell or carcinosarcoma histology. Eligible patients included all FIGO IB or II, FIGO 1A gr 2 -3 or FIGO 1A gr 1 with LVI. Primary endpoint was health related quality of life (HRQOL) using the Global Health Score from the QLQ-C30 at 1 month.

Results There were 108 patients enrolled from 5 institutions. At a median follow-up of 12.85 months, there have been no isolated vaginal recurrences. Table 1 shows the distribution of recurrences. Adverse events are shown in table 2. At the 1 month and 6 month time point, the QLQ-C30 scores in the experimental arm were non-inferior (P = p=0.00002).

Conclusions This prospective randomized trial showed short course VCB is non-inferior to standard course VCB. While longer follow up data is necessary, short course VCB supports a growing literature in providing more options for women with early stage endometrial cancer.

Abstract 0019/#977 Table 1 Distribution of recurrences

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<th>Location</th>
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<th>Control</th>
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<tr>
<td>Pelvic</td>
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<tr>
<td>Distal</td>
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<td>2</td>
<td>5</td>
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<tr>
<td>Distal/pelvic/ vaginal</td>
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Abstract 0019/#977 Table 2 CTCAE adverse events reported during treatment

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<th>G3-4</th>
<th>All Grades</th>
<th>G1/G2</th>
<th>G3-4</th>
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<th>G1/G2</th>
<th>G3-4</th>
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Fragmentation of Care and Survival in High-Grade Endometrial Cancer: A Population-Based Cohort Study

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Objectives Fragmentation of cancer care (FC) occurs when patients receive treatment across several different hospitals. Patients with high-grade endometrial cancer often require adjuvant treatment after surgery, and it is unknown if change of location during treatment impacts patient outcomes.

Methods This population-based retrospective cohort study included patients diagnosed between 2003–2017 with high-grade endometrial cancer who received adjuvant treatment post-operatively. Non-fragmented care (NFC) was defined as receiving surgery and adjuvant treatment at the same institution. The primary outcome was overall survival (OS).

Results We identified 1,795 patients, of whom 583 (32.5%) had FC. Patients with NFC were more likely to have had surgery by a Gynecologic Oncologist (92.4 vs 58.8%, p<0.001), surgical staging (66.6 vs 44.0%, p<0.001), and less travel for surgery (mean 30.8 km vs 93.7 km, p<0.001). They were less likely to receive chemotherapy (26.3 vs 30%, p<0.001) and chemoradiation (38.4 vs 41.3%, p<0.001). Median survival was 9 years. There was no significant difference in OS between patients who received FC and NFC. 92.4 and 93.5% of the patients in the FC and NFC groups were treated at a specialized gynecologic oncology centre for at least part of their treatment (surgery, adjuvant treatment or both).

Conclusions We have previously shown that regionalization of surgery in high-grade endometrial cancer is associated with improved survival. Fragmentation of surgery and adjuvant treatment in this population does not have an adverse effect on survival. After receiving surgical treatment with a Gynecologic Oncologist, these patients may receive adjuvant treatment closer to home to decrease financial and travel burden.