Supplementary Table 2: Results of Delphi Round Three (Questionnaire 2)
Level of consensus on steps (mandatory optional, prohibited) to complete a SLND.

Domain	**Level of Consensus/Response**
Indigo-Cyanine Green (ICG) MUST be used for SLN Mapping in Endometrial Cancer. Adding blue dye or radiolabelled technetium is optional	Agree 75.8% Disagree 24.2%
Injection of ICG should be into the ectocervix in two or four positions	Agree 87.9% Disagree 12.1%
ICG Dilution 1.5mg/ml (dilute 25mg of ICG with 20ml sterile water). (In the survey, 59.4% of respondents answered mandatory; 37.5% optional; 3.1% prohibited/unwarranted) Based on those results, please select	Mandatory 57.6% Optional 42.4%
ICG Dilution 0.5mg/ml. (In the first survey, 6.3% of respondents answered mandatory; 40.6% optional; 53.1% prohibited/unwarranted) Based on those results, please select final response	Optional 51.5% Prohibited 48.5%
Injection of ICG into the cervix should be done with a 20 to 25G needle (In the first survey, 20 to 25G needle diameter was within the 10-90th percentile responses)	Agree 97.0% Disagree 3.0%
Total volume of ICG injection should be 2ml total (In the first survey round, 28.1% of respondents answered mandatory, 46.9% answered optional; 25.0% answered prohibited/unwarranted)	Mandatory 18.2% Optional 60.6% Prohibited 21.2%

Total volume of ICG injection should be 4ml total (In the first survey, 50% of respondents answered mandatory, 40.6% optional; 9.4% prohibited/unwarranted)	Mandatory 39.4% Optional 57.6% Prohibited 3.0%
A 1ml syringe be used for ICG injection	Agree 54.5% Disagree 45.5%
A 2ml syringe be used for ICG injection	Agree 54.5% Disagree 45.5%
A 5ml syringe be used for ICG injection	Agree 48.5% Disagree 51.5%
Superficial injection of ICG into the cervix is mandatory. A deep injection is optional	Agree 63.6% Disagree 36.4%
The needle and syringe used to inject ICG should be changed after each injection (In the first survey, 12.5% of respondents answered mandatory; 50.0% optional; 37.5% prohibited/unwarranted)	Mandatory 9.1% Optional 66.7% Prohibited 24.2%
The surgeon should inject ICG slowly (In the first survey, 65.6% of respondents stated slow injection is mandatory; 21.9% optional; 12.5% prohibited/unwarranted) each hemi-pelvis, the sentinel node that you remove is…	Mandatory 66.7% Optional 30.3% Prohibited 3.0%
The pace of injection does not matter (In the first survey, 18.8% of respondents answered mandatory; 21.9% optional; 59.4% prohibited/unwarranted)	Mandatory 9.1% Optional 36.4% Prohibited 54.5%
The surgeon should aim for feeling of resistance (In the first	Mandatory 78.8%

survey, 62.5% of respondents answered mandatory; 28.1% optional; 9.4% prohibited/unwarranted)	Optional 18.2% Prohibited 3.0%
The surgeon should aim to achieve sub-mucosal bleb (In the first survey, 40.6% of respondents answered mandatory; 50.0% optional; 9.4% prohibited/unwarranted)	Mandatory 45.5% Optional 48.5% Prohibited 6.1%
The needle used to inject ICG should be long enough to ensure easy and accurate access to the injection sites on the ectocervix	Agree 100% Disagree 0%
ICG should be injected	BEFORE establishing a pneumoperitoneum 39.4% AFTER establishing a pneumoperitoneum 24.2% EITHER before or after establishing a pneumoperitoneum 36.4%
If using a uterine manipulator, it is mandatory to insert it AFTER ICG injection	Agree 90.6% Disagree 9.4%
It is important to mobilise pelvic adhesions	BEFORE ICG injection 24.2% AFTER ICG injection 33.3% EITHER before or after ICG injection 42.4%
Is it necessary to undertake a staging inspection of abdomino-pelvic surfaces with white light	BEFORE ICG injection 24.2% AFTER ICG injection 27.3%

	EITHER before or after ICG injection 48.5%
Identifying lymphatic channels and nodes: It is OPTIONAL to undertake near-infrared transperitoneal inspection of the common iliac, pre-sacral and para-aortic areas prior to commencing the dissection	Agree 63.6% Disagree 36.4%
Preserving or dividing of the round ligament for SLN mapping is OPTIONAL	Agree 93.9% Disagree 6.1%
Preserving or dividing of the IP ligament for SLN mapping is OPTIONAL	Agree 90.9% Disagree 9.1%
The pararectal space should be opened (In the first survey, 68.8% of respondents answered mandatory; 28.1% optional; 3.1% prohibited/unwarranted)	Mandatory 66.7% Optional 33.3% Prohibited 0%
The superior vesical artery should be identified (mandatory/optional) or should not be identified (prohibited/unwarranted) during sentinel lymph node detection (In the first survey, 28.1% of respondents answered mandatory; 62.5% optional; 9.4% prohibited/unwarranted)	Mandatory 39.4% Optional 60.6% Prohibited 0%
The uterine artery (medial to the ureter) should be identified (mandatory/optional) or should not be identified (prohibited/unwarranted) during sentinel lymph node detection (In the first survey, 34.4% of respondents	Mandatory 18.2% Optional 78.8% Prohibited 3.0%

answered mandatory; 65.6% optional; 0% prohibited/unwarranted)	
The uterine artery (lateral to the ureter) should be identified (mandatory/optional) or should not be identified (prohibited/unwarranted) during sentinel lymph node detection (In the first survey, 37.5% of respondents answered mandatory; 56.3% optional; 6.2% prohibited/unwarranted)	Mandatory 39.4% Optional 60.6% Prohibited 0%
The obturator nerve should be identified (mandatory/optional) or should not be identified (prohibited/unwarranted) during sentinel lymph node detection (In the first survey, 65.6% of respondents answered mandatory; 31.3% optional; 3.1% prohibited/unwarranted)	Mandatory 66.7% Optional 30.3% Prohibited 3.0%
Start SLN mapping at the level of the uterine artery and continue medially TOWARDS uterus (In the first survey round, 9.4% of respondents answered mandatory; 62.5% optional; 28.1% prohibited/unwarranted)	Mandatory 0% Optional 72.7% Prohibited 27.3%
Start SLN mapping at the level of the uterine artery and continue laterally AWAY from the uterus (In the first survey round, 65.6% of respondents answered mandatory; 21.9% optional; 12.5% prohibited/unwarranted)	Mandatory 66.7% Optional 33.3% Prohibited 0%

Start SLN mapping at the level of the uterine artery and continue towards the presacral areas (In the first survey round, 21.9% of respondents answered mandatory; 56.3% optional; 21.9% prohibited/unwarranted)	Mandatory 12.1% Optional 78.8% Prohibited 9.1%
Start SLN mapping at the most highlighted node and dissect proximally (TOWARDS cervix) (In the first survey round, 15.6% of respondents answered mandatory; 59.4% optional; 25.0% prohibited/unwarranted)	Mandatory 6.1% Optional 72.7% Prohibited 21.2%
Start SLN mapping at the most highlighted node and dissect cephalad (AWAY from the cervix) (In the first survey round, 28.1% of respondents answered mandatory; 40.6% optional; 31.3% prohibited/unwarranted)	Mandatory 0% Optional 75.8% Prohibited 24.2%
Retroperitoneal dissection CAN involve blunt or electrosurgical dissection techniques, gentle traction and/or clips	Agree 97.0% Disagree 3.0%
The most proximal node, irrespective of the nodal station in which the node is found (e.g. obturator, external iliac, para-aortic)	Agree 90.9% Disagree 9.1%
A sentinel node(s) should be defined as....	Single mapped node 65.6% The most proximal node plus the next station (station 2) echelon nodes 9.4%

	All mapped (green) nodes 25.0%
Sentinel lymph node dissection/excision should be completed in one hemi-pelvis before proceeding to the contralateral side (In the first survey, 53.1% of respondents answered mandatory; 37.5% optional; 9.4% prohibited/unwarranted)	Agree 87.5% Disagree 12.5%
Troubleshooting when 'no nodes are mapped' In the event that no nodes are mapped, activating any combination of the following troubleshooting strategies is OPTIONAL: - Wait. Undertake dissection on the contralateral side before returning to original side - Extend retroperitoneal dissection to encompass common, pre-sacral and/or paraaortic areas - Re-inject ICG - Undertake a side-specific lymphadenectomy	Agree 97.0% Disagree 3.0%
Specimen extraction It is MANDATORY to extract sentinel nodes using any of the following containment techniques: endo-catch bag finger of sterile glove, laparoscopic 'cup forceps' contained extraction via port, contained extraction via colpotomy	Agree 97.0% Disagree 3.0%
Specimen labelling It is MANDATORY to label sentinel nodal tissue according to laterality (right/left) and nodal station	Agree 100% Disagree 0%

(obturator/external iliac/internal iliac/presacral/common iliac/aortic/caval)	