

Texas Health Presbyterian Hospital Plano Annual Report 2018*

Oncology Services



**Using 2017 Data*

From the Chair

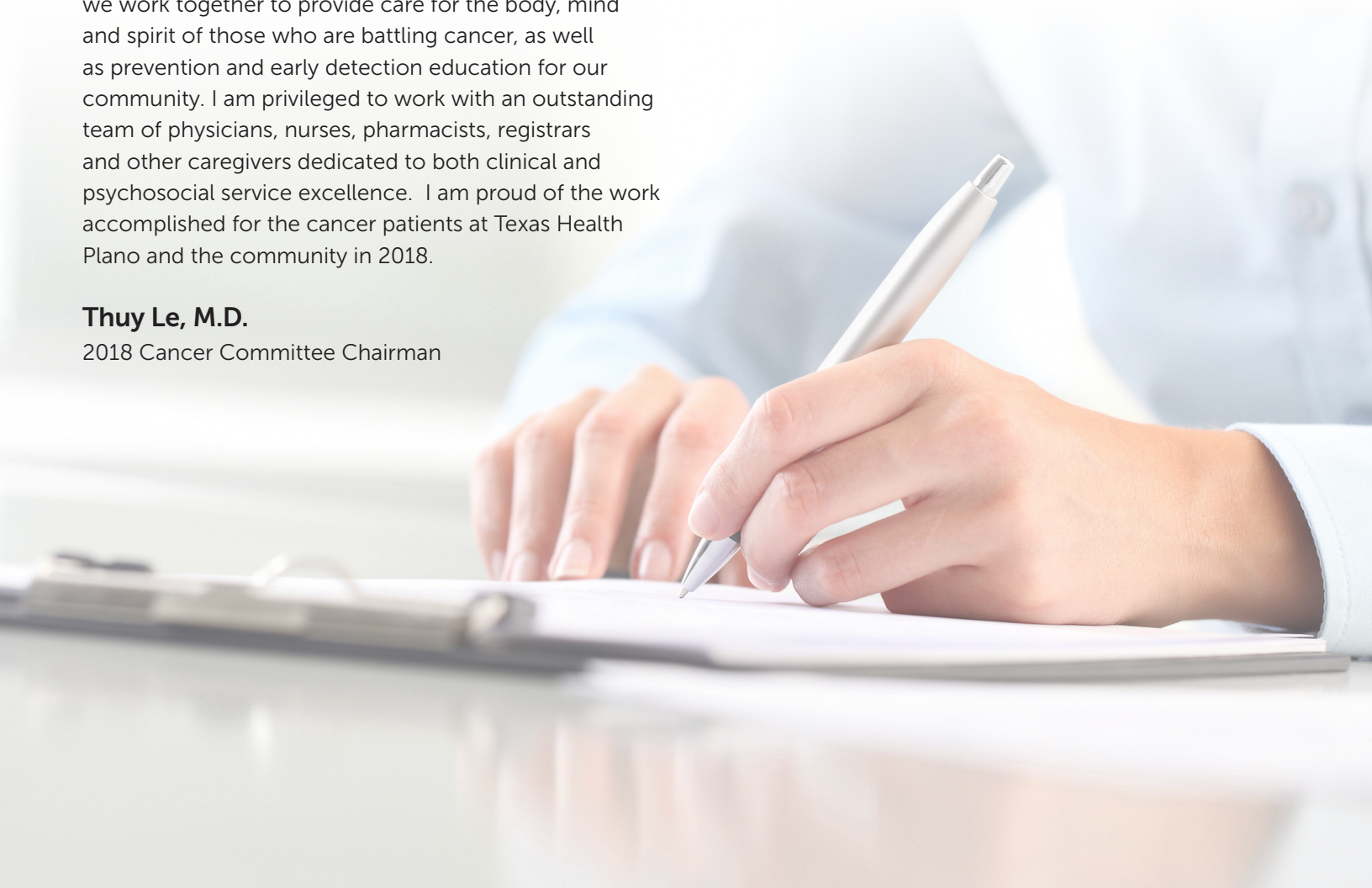
Texas Health Plano is committed to providing quality cancer care from prevention and diagnosis through treatment and survivorship.

This commitment is validated by the fact that the oncology program is a two-time recipient of the American College of Surgeons' Commission on Cancer Outstanding Achievement Award, the highest level of approval from the Commission on Cancer. Texas Health Plano understands that a cancer diagnosis brings with it a plethora of emotional and psychosocial needs. To help assist our patients and their families, we have a close affiliation with Cancer Support Community, which provides comprehensive cancer support at no charge to their members and is located on our campus.

The Oncology Committee will continue to provide strong leadership and guidance in the years to come as we work together to provide care for the body, mind and spirit of those who are battling cancer, as well as prevention and early detection education for our community. I am privileged to work with an outstanding team of physicians, nurses, pharmacists, registrars and other caregivers dedicated to both clinical and psychosocial service excellence. I am proud of the work accomplished for the cancer patients at Texas Health Plano and the community in 2018.

Thuy Le, M.D.

2018 Cancer Committee Chairman



For our 2018 evaluation we reviewed our 2017 Endometrial Cancer data using the NCCN guidelines.

The NCCN Guidelines for Uterine Neoplasms describe malignant epithelial tumors and uterine sarcomas; each of these major categories contains specific histologic groups that require different management. Our review will address only Epithelial tumors.

Adenocarcinoma of the endometrium also known as *endometrial cancer*, or more broadly as *uterine cancer* or *carcinoma of the uterine corpus*, is the most common malignancy of the female genital tract in the United States. It was estimated that 61,380 new uterine cancer cases occurred in 2017, with 10,920 deaths resulting from the disease. Stromal or mesenchymal sarcomas are uncommon subtypes accounting for approximately 3% of all uterine cancers.

Risk factors for epithelial uterine neoplasms include increased levels of estrogen (caused by obesity, diabetes, and high-fat diet), early age at menarche, nulliparity, late age at menopause, Lynch syndrome, older age (≥ 55 years), and tamoxifen use.

The incidence of endometrial cancer is increasing because of increased life expectancy and obesity. Timely diagnosis and staging for appropriate treatment are important to ensure long term survival and cure.

In 2017, 67% of USA patients with adenocarcinoma of the endometrium were diagnosed with disease confined to the uterus at diagnosis.¹ Regional and distant disease comprised 21% and 8% of cases, respectively. Because the early symptoms of irregular vaginal bleeding (in a predominantly postmenopausal patient population) usually will trigger patients to seek care when the disease is at an early and treatable stage, Adenocarcinoma of the endometrium is considered a very treatable malignancy. However, recent data has shown that the mortality rate for uterine cancer has increased more rapidly than the incidence rate.⁸ This increased mortality may be related to an increased rate of advanced-stage cancers, high-risk histologies (eg, serous carcinomas), and patients being diagnosed at an older age.

Analysis of SEER data suggests that survival is increased in patients who are younger, have early-stage disease, and have lower-grade disease. In addition to grade and depth of myometrial invasion, other risk factors associated with poor prognosis include age, lymph node status, tumor size, lymphovascular space invasion (LVSI), and tumor involvement of the lower uterine segment. To further improve outcomes for patients with this disease, physicians need to identify high-risk patients and to tailor treatment appropriately to provide the best long-term survival.

Genetic Factors

Most endometrial cancer is caused by sporadic mutations. However, hereditary genetic mutations cause endometrial cancer in about 5% of patients, which occurs 10 to 20 years before sporadic cancer. Screening of the tumor for defective DNA mismatch

repair (MMR) using immunohistochemistry and/or microsatellite instability (MSI) is used to identify which patients should undergo mutation testing for Lynch syndrome (see "Lynch Syndrome" in the NCCN Guidelines for Colorectal Cancer Screening, available at NCCN.org).¹²⁻¹⁸

Assessment of Evaluation

We reviewed our 2017 Endometrial Cancer data using the NCCN guidelines. Texas Health Presbyterian Hospital of Plano (THP) conducted a retrospective review of monitoring compliance with evidence-based guidelines for patients who were diagnosed with Endometrial cancer in 2017. The objective of the review was to ensure that all THP Endometrial cancer patients received the appropriate histologic diagnosis, had all the tests needed for a clinical staging and were able to rule out Lynch Syndrome.

The analysis included

1. Was the histologic diagnosis obtained through a tissue biopsy?
2. Was the clinical staging established using the appropriate tests (laboratory tests and imaging)?
3. Was the patient's cancer family history documented and testing for MSI defective DNA mismatch repair (MMR) using immunohistochemistry and/or microsatellite instability (MSI) used to identify which patients should undergo mutation testing for Lynch syndrome?

We reviewed records of 16 patients who were diagnosed with Endometrial cancer at THP in 2017.

Endometrium Cancer-2017 | 16 Total Cases

NCCN Clinical Workup	#	%
Family History of Colorectal CA	11/16	69%
Chest X-ray	13/16	81%
Abdominal and Pelvic CT	12/16	75%
C125	13/16	81%
Abnormal CBC Results	16/16	100%
Abnormal Metabolic Panel	15/16	94%
Biopsy	13/16	81%

Findings

Tissue biopsy

Tissue biopsy was obtained in 13/16 patients (81%). Three patients did not have a biopsy for unknown reasons.

Laboratory tests

CBC was documented in 100% and CMP in 94% (15/16). One patient did not have a CMP documented for unknown reasons. Tumor marker Ca125 was documented in 81% (13/16) of the patients. NCCN guidelines states that Ca125 measurement in the management of Endometrial cancer is an optional test.

Imaging studies

Chest Radiography was documented in 81% of (13/16) of the patients. Abdomen/pelvis imaging was documented in 75% (12/16) of the patients. Computed tomography (CT) scan of Abdomen and pelvis were documented in 5 of the patients. 6 patients had an abdominal ultrasound and 1 patient had a MRI of abdomen. Four patients didn't have any abdomen/pelvis imaging study documented in the hospital medical record.

Family History

Family history of cancer, specifically colon cancer, was documented in 69% (11/16) of the patients. Five patients had no documentation of family history in the hospital medical records.

Recommendations/Improvements:

1. This is a potentially curable malignancy and the tissue biopsy is indispensable to establish the diagnosis of Endometrial carcinoma. Lack of biopsy documentation in 3 cases was not satisfactory and the committee will reinforce to the physicians involved in the cases the need to maintain the biopsy results in the patient's hospital medical records.
2. Laboratory tests were about 94% in the hospital records. Which is adequate.
3. 75% of patients had imaging documented (chest radiography and abdomen/pelvis imaging). We feel that there is room for improvement in obtaining and documenting in the patient's hospital medical record the proper staging imaging which such include a Computerized Tomography scan of abdomen and pelvis with contrast and two views radiography of the chest (AP/Lateral) or a CT scan of the chest.
4. To help improving the awareness of the importance of obtaining and documenting family history and appropriate initial staging imaging studies of patients with newly diagnosed endometrial cancer, this committee will promote an education event in the format of a medical lecture delivered by one of our medical staff gynecologist-oncologist, targeting all professional health care providers involved in the initial diagnosis of patients with Endometrial cancer. This Lecture will emphasis the primary risk factors for development of Endometrial cancer, including hereditary predisposition and Lynch Syndrome and all the appropriate initial staging work up tests, including laboratory and imaging.

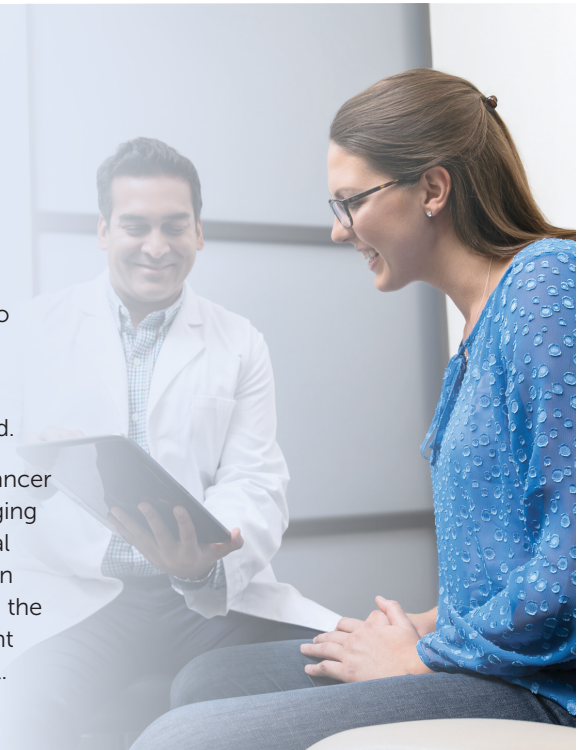
Conclusion

In summary, the tissue diagnosis was appropriately obtained at Texas Health Presbyterian Hospital of Plano for almost all patients newly diagnosed with Endometrial carcinoma, but in 3 patients biopsy information was missing for unknown reasons.

The initial basic clinical staging included laboratory tests in about 97% of the patients and imaging studies in only 75% of patients (25% of the patients had no available imaging study documented in their hospital medical records).

Only 69% of patients had a family history documented. There was a significant shortcoming on documentation of family history in the hospital medical record.

The data suggests that in 2017 most of patients diagnosed with Endometrial cancer at Texas Health Presbyterian Hospital of Plano were likely completing their staging evaluation in the outpatient clinic setting. Most of the patients with Endometrial cancer most likely had their family history obtained by their treating physician in the outpatient clinic setting, and we were not able to obtain this information in the Hospital medical record. Physicians are encouraged to share testing and patient history information done at outside facilities/physician offices with the hospital.



REFERENCE:

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology
Doctors on the medical staffs practice independently and are not employees or agents of Texas Health hospitals or Texas Health Resources.

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