

ASGO Webinar #67

Adjuvant Therapy for Early Endometrial Cancer

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Key principles of adjuvant treatment for early-stage endometrial cancer

- Adjuvant treatment in early-stage endometrial cancer must be individualized according to integrated risk assessment, including:
 - FIGO 2023 stage
 - Histology and LVSI
 - Molecular classification (POLEmut, MMRd, NSMP, p53abn)
- This approach allows safe de-escalation in clinically favorable disease (*POLEmut*) and treatment intensification in high-risk molecular subtypes, particularly p53-abnormal tumors, even at early stage.
 - *POLEmut* -> observation
 - **MMRd and MMRp (low Gr. and ER+) -> observation, VBT, EBRT**
 - P53abn and MMRp (high Gr. and ER-) -> Chemotherapy + RT

Question 1

- For patients with **high–intermediate risk MMRp** endometrial cancer, guidelines allow either no adjuvant therapy or radiotherapy. In your clinical practice, which clinicopathologic factors most strongly influence your decision to recommend adjuvant treatment, and what guides your choice between EBRT and vaginal brachytherapy?

Question 2

- FIGO 2023 staging and the ESGO–ESTRO–ESP 2025 guideline do NOT incorporate peritoneal washing cytology into staging or risk stratification. In your clinical practice, does a positive peritoneal washing cytology influence your decision-making regarding adjuvant treatment, and if so, how do you integrate this finding with other molecular and clinicopathologic factors?

Question 3

- In **KEYNOTE-B21**, although adjuvant pembrolizumab did not improve DFS in the overall high-risk population, a prespecified subgroup analysis suggested an improvement in DFS among patients with **MMRd** tumors when pembrolizumab was added to chemotherapy.
- Based on these findings, and while we are awaiting the results of NRG-GY020 and the RAINBO MMRd-GREEN trial, do you consider the addition of ICIs to adjuvant treatment or ICI monotherapy a reasonable approach for patients with early-stage high-risk MMRd endometrial cancer?