

Discussion

Adjuvant Treatment for Early Endometrial Cancer

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Lessons Learned from the Presentation

Comprehensive and up to date presentation, covering:
Classical evidence (PORTEC-1/2, GOG-99, ASTEC, PORTEC-3)

Integration of molecular classification (POLEmut, MMRd, p53abn, NSMP)

ESGO/ESTRO/ESP Guidelines 2025 and FIGO 2023

Strong emphasis on personalized adjuvant treatment, particularly:

Therapy de-escalation in POLEmut

Therapy intensification in p53abn

Use of clinically relevant translational data, including molecular analyses from *PORTEC-1/2* and *PORTEC-3*

Clinical Implications

The adjuvant treatment approach in endometrial cancer (EC) is shifting from a stage-based to a biology-driven paradigm.

MDT becoming crucial to:

- Determine therapy de-escalation versus intensification
- Avoid overtreatment, particularly in early-stage EC

Real-world implementation challenges remain significant, especially in resource-limited settings (especially in Asia)

Limitations / Gaps

Most molecular evidence (PORTEC) is derived from retrospective subgroup analyses rather than purely prospective, molecularly stratified clinical trials

Limited generalizability

- Unequal access to POLE, p53, and MMR testing across Asia and LMICs
- Variability in radiotherapy (RT) and sentinel lymph node (SLN) practices between countries

Clinical gray areas that remain unresolved, including:

- Stage III–IV POLE-mut → which is still case by case recommendations
- The role of adjuvant immunotherapy, which is still evolving

In settings where comprehensive molecular testing is not universally available, how should clinicians pragmatically apply the 2025 ESGO/ESTRO/ESP guideline without risking under or overtreatment?

Given that most molecular-driven recommendations (e.g. PORTEC-1, 2 and PORTEC-3 molecular analyses) are based on post-hoc or retrospective subgroup analyses, how confident should we be in omitting or intensifying adjuvant therapy solely based on molecular profile in early-stage endometrial cancer?

Sentinel Node Ultrastaging → Ideal vs Reality:

FIGO 2023 and ESGO 2025 endorse SLN biopsy with ultrastaging, detecting low-volume metastasis. Does this translate into meaningful changes in survival, or does it risk stage migration without therapeutic benefit?

THANK YOU