

Year: yr1, yr2, yr3

1a. Please enter the number of patients presenting with newly diagnosed endometrial carcinoma, all stages (surgically and non-surgically treated). \_\_\_\_\_

1b. Please enter the number of patients presenting with relapsed endometrial carcinoma (surgically and non-surgically treated). \_\_\_\_\_

2a. Please enter the number of patients undergoing primary surgery for presumed early stage endometrial carcinoma (FIGO2009 stage I and II). \_\_\_\_\_

2b. Please enter the number of patients undergoing surgery for advanced stage endometrial carcinoma (FIGO2009 stage III and IV). \_\_\_\_\_

3. Please enter the number of patients undergoing primary surgery by minimally invasive approach (laparoscopy or robotic assisted surgery). \_\_\_\_\_

4. Please enter the number of patients with presumed FIGO2009 stage I or II serous, undifferentiated carcinoma or carcinosarcoma who underwent surgery. \_\_\_\_\_

5. Please enter the number of patients with presumed FIGO2009 stage I and II high-intermediate or high-risk disease who underwent surgery. \_\_\_\_\_

6. Please enter the number of patients with presumed FIGO2009 stage I and II undergoing nodal staging. \_\_\_\_\_

7. Please enter the number of patients with primary advanced stage (FIGO2009 stage III and IV) who have undergone cytoreductive surgery (including resection of bulky nodes and also cases after neoadjuvant chemotherapy). \_\_\_\_\_

8. Please enter the number of patients who underwent salvage surgery for locoregional recurrent disease (isolated pelvic or nodal recurrent disease). \_\_\_\_\_

9. Please enter the number of patients who underwent surgery for recurrent disease. \_\_\_\_\_

10. Please enter the number of high-intermediate and high-risk patients with unilaterally or bilaterally failed sentinel lymph node detection. \_\_\_\_\_

11. Please enter the number of patients undergoing surgery (all stages, primary and recurrent disease) by a gynecologic oncologist or trained surgeon dedicated to gynecologic cancer management.<sup>1</sup> \_\_\_\_\_

12a. Please enter the number of patients where decision for any primary treatment has been made by a multi-disciplinary team.<sup>2</sup> \_\_\_\_\_

12b. Please enter the number of patients where decision for any relapse treatment has been made by a multidisciplinary team.<sup>2</sup> \_\_\_\_\_

13. Please enter the number of patients with BMI > 35 kg/m<sup>2</sup> who have undergone surgery for presumed early stage (FIGO2009 stage I-II) endometrial carcinoma. \_\_\_\_\_

14. Please enter the number of patients (all stages, primary setting) with preoperative work-up according to ESGO/ESTRO/ESP guidelines.<sup>3</sup> \_\_\_\_\_

15. Please enter the number of patients with postoperative FIGO2009 stage IVB, including carcinosarcoma, who were presumed FIGO2009 stage I or II preoperatively. \_\_\_\_\_

16. Please enter the number of patients with presumed early stage endometrial carcinoma (FIGO2009 stage I and II) and ruptured uterus after hysterectomy. \_\_\_\_\_

17. Please enter the number of patients with presumed early stage endometrial carcinoma (FIGO2009 I and II) who underwent successful minimally invasive surgery (without intra-peritoneal tumor spillage, tumor rupture or morcellation).<sup>4</sup> \_\_\_\_\_

18. Please enter the number of patients with presumed FIGO2009 stage I or II with BMI > 35 kg/m<sup>2</sup> who underwent successful minimally invasive surgery in the primary setting.<sup>4</sup> \_\_\_\_\_

19. Please enter the number of patients where conversion from MIS to laparotomy was required due to intra-operative findings or complications, in the primary setting. Mini-laparotomy to extract the uterus is not considered a conversion to laparotomy. \_\_\_\_\_

20. Please enter the number of patients with intra-operative injuries, including position complications and urinary, bowel, vascular and neural injuries. All stages in the primary and relapsed setting. \_\_\_\_\_

21. Please enter the number of patients with presumed FIGO2009 stage I or II serous, undifferentiated carcinoma or carcinosarcoma who underwent omentectomy. \_\_\_\_\_

22. Please enter the number of patients with presumed FIGO2009 stage I and II high-intermediate or high-risk disease undergoing lymph node staging. \_\_\_\_\_

23. Please enter the number of patients with presumed early stage (FIGO2009 I and II) undergoing a sentinel lymph node procedure. \_\_\_\_\_

24. Please enter the number of sentinel lymph node procedures for presumed FIGO2009 stage I and II performed or supervised per surgeon per year at your institution. \_\_\_\_\_

25. Please enter the number of patients with presumed FIGO2009 stage I and II undergoing sentinel lymph node procedure where ICG was used. \_\_\_\_\_

26. Please enter the number of high-intermediate and high-risk patients who underwent side-specific pelvic lymphadenectomy in case of failed sentinel lymph node detection. \_\_\_\_\_

27. Please enter the number of patients where ultra-staging of sentinel lymph nodes was performed. \_\_\_\_\_

28. Please enter the number of all patients with successful bilateral sentinel lymph node mapping. \_\_\_\_\_

29. Please enter the number of patients with advanced stage (FIGO2009 III and IV) who have undergone cytoreductive surgery (including resection of bulky nodes and also cases after neoadjuvant chemotherapy) and in whom complete macroscopic resection was achieved. \_\_\_\_\_

30. Please enter the number of patients who underwent salvage surgery for locoregional recurrent disease (isolated pelvic or nodal recurrent disease) in whom complete macroscopic and clear margins (if applicable) resection is achieved. \_\_\_\_\_

31. Please enter the number of patients undergoing complete molecular classification of their tumor according to the ESGO/ESTRO/ESP guidelines.<sup>2</sup> \_\_\_\_\_

32. Please enter the number of patients with FIGO2009 stage I and II receiving adjuvant treatment according to the ESGO/ESTRO/ESP guidelines.<sup>5</sup> \_\_\_\_\_

33. Please enter the number of patients who have a complete surgical report that contains all required elements according to the ESGO/ESTRO/ESP guidelines (primary and relapsed setting).<sup>6</sup> \_\_\_\_\_

34. Please enter the number of patients in whom all minimum required elements are included in the pathology report, according to the ESGO/ESTRO/ESP guidelines (primary and relapsed setting).<sup>7</sup> \_\_\_\_\_

35. Please enter the number of patients who underwent reoperations for complications after primary minimally

invasive surgery. \_\_\_\_\_

1. A certified gynecologic oncologist, or in countries where certification is not established, by a trained surgeon dedicated to the management of gynecological cancer (accounting for more than 80% of his or her practice) or having completed an ESGO-certified fellowship.
2. The decision for any therapeutic intervention and/or follow-up plan has been made by a multi-disciplinary team including at least a certified gynecologic oncologist (or in countries where certification is not organized, a trained surgeon dedicated to the management of gynecological cancer (accounting for more than 80% of his or her practice) or having completed an ESGO-certified fellowship), a radiologist, a radiation oncologist, a physician certified to deliver chemotherapy (a gynecologic oncologist and/or a physician with special interest to gynecologic oncology (medical or clinical oncologist)), and a pathologist.

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3. The pre-operative mandatory work-up, based on the ESGO/ESTRO/ESP guidelines include: family history; general assessment and inventory of co-morbidities; geriatric assessment, if appropriate; clinical examination, including pelvic examination; expert vaginal or transrectal ultrasound or pelvic MRI. Depending on clinical and pathologic risk, additional imaging modalities (thoracic, abdominal, and pelvic CT scan, MRI, positron emission tomography scan, or ultrasound) should be considered to assess ovarian nodal, peritoneal, and other sites of metastatic disease.
4. Minimally invasive surgery (laparoscopic or robotic) is considered successful if performed without any intra-peritoneal tumor spillage, tumor rupture, or morcellation (including in a bag). If vaginal extraction risks uterine rupture, other measures should be taken (eg, mini-laparotomy, use of endobag). If a mini-laparotomy for such purpose is performed within a minimally invasive procedure, the surgery is still considered a successful minimally invasive surgery.
5. The ESGO/ESTRO/ESP guidelines recommend specific adjuvant treatments based on prognostic risk groups stratification of patients, as follows:

Low risk: no adjuvant treatment is recommended. When molecular classification is known, omission of adjuvant treatment should be considered for patients with endometrial carcinoma stage I-II, low risk based on pathogenic POLE mutation. For the rare patients with endometrial carcinoma stage III-IVA and pathogenic POLE mutation, there are no outcome data with the omission of the adjuvant treatment. Prospective registration is recommended.

Intermediate risk: adjuvant brachytherapy can be recommended to decrease vaginal recurrence. Omission of adjuvant brachytherapy can be considered, especially for patients aged < 60 years. When molecular classification is known, POLE mutation and p53 abnormal with myometrial invasion have specific recommendations.

High-intermediate risk (pN0 after lymph node staging): adjuvant brachytherapy can be recommended to decrease vaginal recurrence. External beam radiation therapy can be considered for substantial lymphovascular space involvement and for stage II. Adjuvant chemotherapy can be considered, especially for high-grade and/or substantial lymphovascular space involvement. Omission of any adjuvant treatment is an option. When molecular classification is known, POLE mutation and p53 abnormal have specific recommendations.

High-intermediate risk cN0/pNx (lymph node staging not performed): adjuvant external beam radiation therapy is recommended, especially for substantial lymphovascular space involvement and/or for stage II. Additional adjuvant chemotherapy can be considered, especially for high-grade and/or substantial lymphovascular space involvement. Adjuvant brachytherapy alone can be considered for high-grade lymphovascular space involvement negative and for stage II grade 1 endometrioid carcinomas. When molecular classification is known, POLE mutation and p53 abnormal have specific recommendations. High risk: external beam radiation therapy with concurrent and adjuvant chemotherapy or, alternatively, sequential chemotherapy and radiotherapy is recommended.

Chemotherapy alone is an alternative option. Carcinosarcomas should be treated as high-risk carcinomas (not as sarcomas). When the molecular classification is known, p53 abnormal carcinomas without myometrial invasion and POLE mutation have specific recommendations

6. According to the ESGO/ESTRO/ESP guidelines, the surgical report requires inclusion of at least the following elements:

Abdominal findings status at start and at end of surgery  
Description of tumor spread (if any)  
Lymph node evaluation  
Complications  
Total blood loss  
Tracer used for the sentinel lymph node procedure  
Number of sentinel lymph nodes removed (if any)  
Location of sentinel lymph nodes (if any)  
Residual post-operative disease; location of residual disease (if any)  
Kind of procedure (sentinel lymph node procedure, debulking, etc)  
Adhesiolysis (yes vs no)  
Aim of surgery (palliative vs curative)  
Stage of the disease  
Rupture of uterus

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7. According to the ESGO/ESTRO/ESP guidelines, the minimum required elements in pathology reports include at least the following elements:

Description of the specimen(s) submitted for histologic evaluation  
Attached anatomic structures  
Accompanying

specimens Tumor type (WHO Classification of Tumors (fifth edition)) Tumor grade (FIGO and WHO Classification of Tumors (fifth edition)) Absence or presence and depth of myometrial invasion Lymphovascular space involvement should be unequivocal and reported as focal and extensive/  
substantial (five vessels or more) Presence of cervical stromal invasion should be described Presence or absence of vaginal involvement Presence or absence of uterine serosal involvement Presence or absence of parametrial involvement Presence or absence of adnexal involvement Presence or absence of omental involvement Presence or absence of peritoneal involvement Lymph node status, including sentinel lymph node status, reports the total number of nodes found and the number of positive lymph nodes, and the presence of extranodal extension (list for all separate sites). Micrometastasis (>0.2 mm and up to 2 mm) are reported as pN1(mi). Isolated tumor cells no greater than 0.2 mm in regional nodes should be reported as pN0 (i+). Presence or absence of pathologically proven distant metastases Required ancillary techniques Tumor site Tumor size Percentages of different components of mixed carcinoma and in carcinosarcoma Presence or absence of myometrial invasion. Depth of myometrial invasion (none or less than half, or half or more) Measurement should be performed from the adjacent endometrial-myometrial interface. Microcystic, elongated, fragmented pattern of invasion Peritoneal cytology (if available)