

Radiance 2: Reducing delays in endometrial cancer Care Gynecologic Oncology Care



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Introduction

- Endometrial Cancer is the most common gynecologic malignancy in the United States, and is rising
- Risk factors that increase the likelihood of developing the disease include age, race, unopposed estrogen exposure, metabolic syndrome, and genetic predisposition
- Most common presenting symptom is abnormal uterine bleeding, often postmenopausal bleeding and abnormal discharge.
- Early diagnoses and treatment leads to improved outcomes

Objective

- We aimed to identify actionable delays in care that for women with endometrial cancer (EC) from the time of gynecologic oncology referral through adjuvant therapy.

Methodology

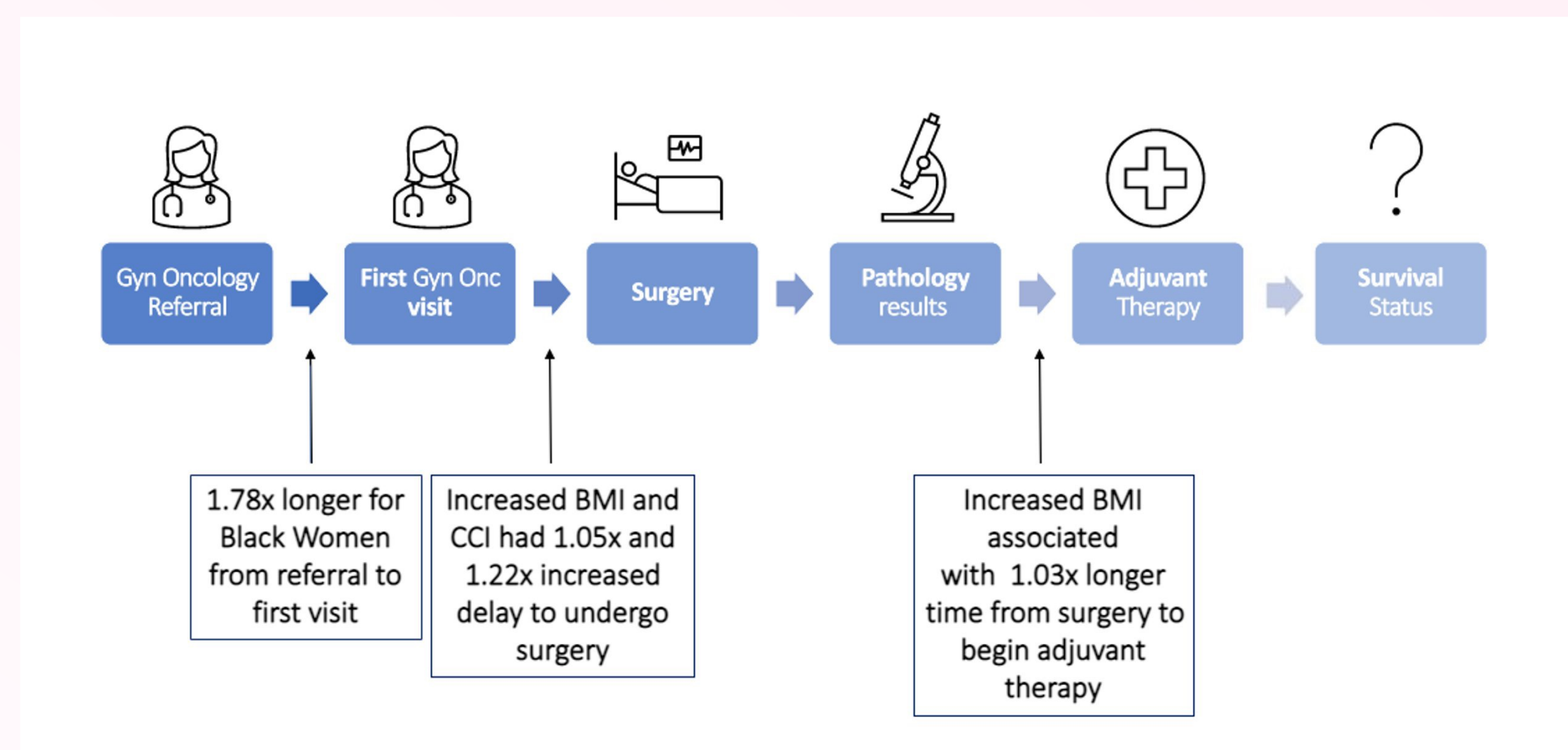
- A multicenter, IRB-approved retrospective chart review was performed. Women diagnosed with Stage I-IV endometrial cancer from 2013 to 2022 were included. Demographic, pathologic, treatment, and survival data were collected. Symptom duration and key appointment, procedure, or result dates were recorded. Time frames between key events were calculated. Timed events were censored if there was insufficient data to make a calculation.
- Categorical covariates were summarized with counts and percentages; continuous variables were summarized via means and standard deviations. Categorical covariates were compared across groups using a fisher exact test, while continuous variables were compared using t tests. Multivariable quasi-Poisson regression was performed to predict each treatment time difference for patients to determine if any disparities existed.
- Time periods were evaluated for difference with regards to race, insurance status, cancer stage, BMI, CCI and distance from the clinic site.

Results

- Of the 449 women included, 184 (43.7%) were Black-not Hispanic. Most (76.2%) had stage I-II EC, with 23.8% presenting with advanced stage disease. The mean BMI was 37.22 (SD= 10.35) and Charleston Comorbidity Index (CCI) was 4.77 (SD= 2.41).
- Days from GON referral to visit was 1.78 times longer for Black patients than non-black patients (95%CI 1.07-2.99, p= 0.029). Time from first GON visit to surgery was longer with increasing BMI (1.05, 95%CI= 1.02-1.08, p= 0.003) and CCI (1.22, 95%CI= 1.04-1.42, p= 0.014).
- No differences were noted for time from surgical therapy to pathologic read. Women with a higher BMI experienced a longer time from surgery to initiation of adjuvant therapy (1.03, 95%CI 1.01-1.05, p=0.002).

Conclusion

- Black patients experienced longer delays from GON referral to first GON visit. This data likely reflects systemic processes as well as patient factors that contribute to delays in initiation of GON care.
- Increased BMI and CCI were associated with 1.05 and 1.22 times increase in time delays from date of first GON visit to surgery; this is expected given that these patients may require additional preoperative optimization.
- Obesity is also more strongly associated with type I endometrioid cancers rather than more aggressive type II histologies; this may mean that physicians are more willing to tolerate delays to adjuvant therapy in these patients.



References

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