# Shared follow-up and survivorship care model for women with low-risk endometrial cancer

## Guidance toolkit

Australian Government
Cancer Australia

Endometrial cancer is cancer affecting the lining of the uterus (called the endometrium). It is the most common type of cancer of the uterus and the most common gynaecological cancer diagnosed amongst Australian women.

Follow-up and survivorship care is recommended for women who have completed their active treatment for **low-risk endometrial cancer.**[1] Follow-up and survivorship care allows for:

- early detection of recurrence
- identification, monitoring and management of side-effects and co-morbidities
- screening and management of supportive care needs
- support for living well.

Within Australia, shared follow-up care has been successfully and safely implemented across a range of health settings and conditions including diabetes, paediatric oncology and obstetric care. It involves active participation from both the Primary care practitioner/s and specialist teams to help plan and manage patient care.[2]

This guidance toolkit is relevant for anyone involved in shared follow-up and survivorship care for women with low-risk endometrial cancer. In particular, it can be used by healthcare professionals as a general guide to appropriate practice when managing shared follow-up and survivorship care for women with low-risk endometrial cancer.

**The definition of 'low-risk endometrial cancer' may vary from one specialist gynaecological cancer service to another. Suitability of a woman with endometrial cancer to participate in shared follow-up care should be determined by the treating multidisciplinary team.**

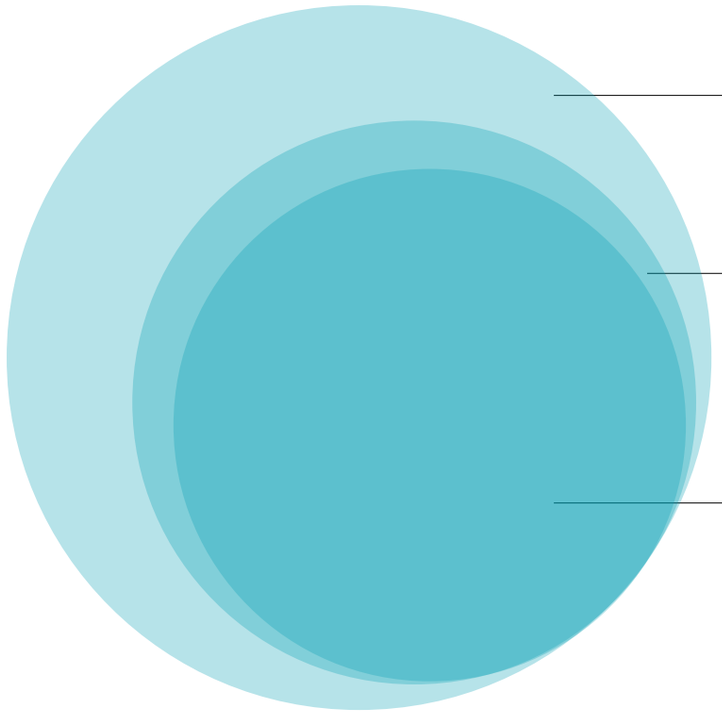
**The International Federation of Gynaecology and Obstetrics (FIGO) endometrial cancer stage according to 2009 definitions can be found here: https://meteor.aihw.gov.au/content/index.phtml/itemId/424206.**

References: 1. Cancer Australia. Follow-up care for women with low-risk endometrial cancer: A guide for General Practitioners. Surry Hills, NSW: Cancer Australia; 2020.
2. Smith SM, Allwright S, T. OD. Effectiveness of shared care across the interface between primary and specialty care in chronic disease management. Cochrane Database Syst Rev. 2007;18(3).

# Snapshot

Endometrial cancer is cancer that arises from the lining of the uterus (called the endometrium).[1] Endometrial cancer is the most common type of uterine cancer, which is the most common gynaecological cancer diagnosed in Australian women.[2,3]

## Incidence rates of gynaecological cancers in 2020.[3-5]



### Gynaecological cancer

include cancers of the uterus (endometrium), ovary, cervix, vulva, fallopian tubes, placenta and vagina

### Uterine cancer

(49.6% of gynaecological cancers)[3]

include cancers of the uterus lining (endometrium) and muscle tissue (myometrium)

### Endometrial cancer

(95% of uterine cancers)[4,5]

affects the uterus lining (endometrium).

In 2020, uterine cancer is estimated to account for 49.6% of gynaecological cancers.[3]

Endometrial cancer accounts for approximately 95% of uterine cancer cases.[4,5]

References: 1. Cheewakriangkrai C, Kietpeerakool C, Aue-aungkul A et al. Health education interventions to promote early presentation and referral for women with symptoms of endometrial cancer. Cochrane Database Syst Rev 2019;(1). 2. Australian Institute of Health and Welfare & Cancer Australia 2012. Gynaecological cancers in Australia: an overview. Cancer series no. 70. Cat. no. CAN 66. Canberra: AIHW. 3. Australian Institute of Health and Welfare (AIHW). Cancer Data in Australia. Accessed July 2020; www.aihw.gov.au/reports/cancer/cancer-data-in-australia/contents/summary. 4. Nowak R, Bi J, Koohestani F et al. Female Reproductive C: Uterine Tumors and the Environment. Comprehensive Toxicology. 2018;438–69. 5. Dolly D, Mihai A, Rimel BJ et al. A delay from diagnosis to treatment is associated with a decreased overall survival for patients with endometrial cancer. Front Oncol. 2016;6:31.

# Snapshot

**Incidence rates** of uterine cancer in Australia are **increasing**[1]

90%
50+

In 2020, **89.3% of women** estimated to be diagnosed with uterine cancer will be **aged of 50 years or older**[2]

**Mortality rates** for uterine cancer in Australia are **expected to remain stable**[1]

**Indigenous Australian women experience higher rates of mortality** than non-Indigenous Australian women for uterine cancer[2]

In 2012–2016, the **5-year relative survival rate for uterine cancer was 83.1%**.[1] In 2015, there were 10,763 women living who had been diagnosed with uterine cancer in the previous five years.[1]

References: 1. Australian Institute of Health and Welfare (AIHW). Cancer Data in Australia. Accessed July 2020; www.aihw.gov.au/reports/cancer/cancer-data-in-australia/contents/summary. 2. Australian Institute of Health and Welfare (AIHW). Cancer in Aboriginal & Torres Strait Islander people of Australia. Accessed April 2019; https://www.aihw.gov.au/reports/cancer/cancer-in-indigenous-australians/contents/cancer-type/uterine-cancer-c54-c55.

# Risk of recurrence for low-risk endometrial cancer

Women who have been treated for **low-risk endometrial cancer** are at risk of local, regional or distant recurrence. The risk of recurrence for low-risk endometrial cancer is:

Less than 5%, usually occurring within the first two to three years after diagnosis[1]

<5%

Minimal for women who have been asymptomatic for more than five years

5Y

Recurrences usually occur locally, are symptomatic, and are usually treatable.

**Further information and resources**

**Summary of evidence: Shared follow-up and survivorship care for women with low-risk endometrial cancer**

References: 1. Cancer Australia. Follow-up care for women with low-risk endometrial cancer: A guide for General Practitioners. Surry Hills, NSW: Cancer Australia; 2020.

# Co-morbidities and treatment-related side effects

Many women with low-risk endometrial cancer experience a range of co-morbidities, including:

**obesity-related issues**

**hypertension**

**diabetes**

**cardiovascular disease***

These conditions are often associated with modifiable risk factors such as weight gain, obesity, physical activity and diet. Addressing underlying risk factors for these conditions may have the greatest potential to improve outcomes of women affected by endometrial cancer.[1]

Psychosocial and psychosexual wellbeing of women may be affected during treatment for low-risk endometrial cancer. A holistic approach to identifying, monitoring and managing treatment-related side effects is required to address supportive care needs.

**Further information and resources**

**Summary of evidence: Shared follow-up and survivorship care for women with low-risk endometrial cancer**

*Evidence suggests that cardiovascular disease is the leading cause of death among women with localised or low-grade endometrial cancer endometrial cancer[2,3,3].

References: 1. Cancer Australia. Follow-up care for women with low-risk endometrial cancer: A guide for General Practitioners. Surry Hills, NSW: Cancer Australia; 2019. 2. Ward KK, Shah NR, Saenz CC et al. Cardiovascular disease is the leading cause of death among endometrial cancer patients. Gynecol Oncol. 2012;126(1):176–9. 3. Felix AS, Bower JK, Pfeiffer RM, et al. High cardiovascular disease mortality after endometrial cancer diagnosis: Results from the Surveillance, Epidemiology, and End Results (SEER) Database. Int J Cancer. 2017; 140:555-564. 4. Cancer Australia. Summary of evidence: Shared follow-up and survivorship care for women with low-risk endometrial cancer. Surry Hills, NSW: Cancer Australia; 2020.

# Care teams

Follow-up and survivorship care is recommended after completion of active treatment for low-risk endometrial cancer and may be undertaken by the **specialist team** or **primary care practitioner/s**. Given the increased risk of recurrence within the first two to three years after treatment, more frequent follow-up is recommended within this time period.

**The specialist team may include:**

- gynaecological oncologist(s)
- specialist nurse(s)
- allied health professional(s)
- gynaecologist(s)

**The primary care practitioner/s may include:**

- the General Practitioner (GP)
- primary health care nurse(s)

## What is the purpose of follow-up and survivorship care?

**Early detection**
of local, regional or distant recurrence

**Identification, monitoring and management**
of treatment-related side effects, co-morbidities (such as overweight/obesity, hypertension and diabetes) and secondary prevention

**Screening, assessment and management**
of supportive care needs (such as psychosocial distress, anxiety or depression and impact on sexual wellbeing)

**Reviewing and updating family history information**
relating to endometrial cancer and co-morbidities

**Providing holistic care**
including treatments for co-morbidities

**Exploring and managing the woman's expectations**
and supporting her to openly discuss the care, support and information she needs

**Further information and resources**

Summary of evidence: Shared follow-up and survivorship care for women with low-risk endometrial cancer

# What is shared follow-up and survivorship care?

In Australia, follow-up and survivorship care are predominantly carried out in tertiary settings by specialist clinicians. In the context of growing numbers of cancer survivors and limited resources, some of these approaches may be unsustainable.

A new approach to follow-up care for women with low-risk endometrial cancer is required which delivers safe, effective, person-centred care, optimising available resources.[1]

Shared follow-up and survivorship care is the joint participation of **primary care practitioner/s** and **specialist teams** in the planned delivery of patient care.[2] Shared care has been successfully and safely implemented across a range of health settings and conditions including diabetes, paediatric oncology and obstetric care.

References: 1. Cancer Australia: National Framework for Gynaecological Cancer Control. Surry Hills, NSW: Cancer Australia; 2016. 2. Smith SM, Allwright S, T. OD. Effectiveness of shared care across the interface between primary and specialty care in chronic disease management. Cochrane Database Syst Rev. 2007;18(3).

# Principles

Shared follow-up and survivorship care for low-risk endometrial cancer by health professionals and health services should be guided by the following principles:

- **Person-centred care**
- **Care delivered according to best practice**
- **Coordination of care**
- **Support for living well**
- **Support for primary care providers**
- **Support for specialist treatment team**
- **Care is informed and improved by data**

**Further information and resources**

Principles of Shared Follow-up Care for Endometrial Cancer

# What are the benefits of shared follow-up and survivorship care?

**Benefits of care by the specialist team** + **Continuity of the primary care practitioner/s** = **Accessible, safe and effective care**

Shared follow-up and survivorship care provides patients the benefits of care by a specialist team combined with continuity of care and ongoing management from the primary care practitioner/s.

Shared follow-up and survivorship care has the potential to provide a safe and effective service delivery model while helping to address equity of access issues for women with low-risk endometrial cancer in Australia.[1]

## Potential benefits of a shared follow-up and survivorship care model for low-risk endometrial cancer may include:[2]

- **improved access** to holistic and accessible care (including management of comorbidities and supportive care needs)
- **strengthened care coordination** between specialist and primary care practitioner/s
- **increased capacity** for specialist teams to manage and support high-risk patients
- **improvements** in patient choice and shared decision-making.

**Further information and resources**

**Summary of evidence: Shared follow-up and survivorship care for women with low-risk endometrial cancer**

References: 1. Cancer Australia Shared care demonstration project: Evaluation report. Cancer Australia, Surry Hills, NSW: Cancer Australia; 2013 (draft unpublished). 2. Cancer Australia. Feasibility study: shared follow-up care for women with low-risk endometrial cancer. Surry Hills, NSW: Cancer Australia; 2016 (draft unpublished).

# Overview

Key strategies and practical resources to guide implementation of best practice shared follow-up and survivorship care for low-risk endometrial cancer include:

## Adherence to clinical best practice

Deliver shared follow-up and survivorship care in accordance with best practice

## Multidisciplinary treatment planning and care management

Joint participation between the specialist team and primary care practitioner/s, with access to shared information

## Agreed roles and responsibilities

Agree on shared follow-up and survivorship care arrangements by specialist and primary care practitioner/s that are clearly communicated to the woman

## Timely and effective communication

Between specialist and primary care practitioner/s and the woman to support coordination of care and shared decision-making

## Rapid access to specialist services

Establish clear referral systems for rapid access to specialist teams for primary care practitioner/s

## Supportive care

Deliver supportive care through routine screening, assessment and management of the woman's needs

# Adherence to clinical best practice

## Deliver shared follow-up and survivorship care in accordance with best practice

The transition from active treatment to post-treatment care is a critical stage to long-term health. Best practice suggests the following care during follow-up visits.

### History

to check for any new, persistent or progressive symptoms that may indicate local or distant recurrence

### Physical examination

including abdominal, pelvic and gynaecological examinations; digital vaginal examination; and if feasible, examination with speculum

### Identify, monitor and manage

effects of treatment (including effects on menopause, bladder and bowel function and lymphoedema), co-morbidities and secondary prevention

### Assess level of distress

for the woman, carer and family. This may include effects on sexuality, fertility and relationships[1]

**Further information and resources**

- Guide for General Practitioners
- Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer
- Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer - Quick reference guide
- National Framework for Gynaecological Cancer Control
- Follow-up of survivors of endometrial cancer

### Suggested follow-up schedule for asymptomatic women following treatment for early stage **low-risk endometrial cancer**[1,2,3]

| Method | Years 1-2 | Year 3 | Years 4-5 |
|---|---|---|---|
| History and physical examination | Every 3–6 months | Every 6–12 months | Every 12 months |

References: 1. Cancer Australia. Follow-up care for women with low-risk endometrial cancer: A guide for General Practitioners. Surry Hills, NSW: Cancer Australia; 2020. 2. Cancer Council Australia (2016). Optimal care pathways for women with endometrial cancer. 3. Fung Kee Fung M, Dodge J, Elit L, et al. on behalf of the Cancer Care Ontario Program in Evidence-based Care Gynecology Cancer Disease Site Group. Follow-up after primary therapy for endometrial cancer: a systematic review. Gynecol Oncol 2006;101:520–9.

# Multidisciplinary treatment planning and care management

## Joint participation between the specialist and primary care practitioner/s in follow-up and survivorship care, with access to shared information

**Multidisciplinary care** is considered best practice when planning treatment and care for patients with cancer. Multidisciplinary care is an integrated team approach to healthcare in which healthcare providers consider all relevant treatment options and follow-up care requirements, and collaboratively develop an individual treatment and care plan for each woman.

A **Shared Care Plan** should be developed and agreed between the specialist and primary care practitioner/s and the woman to support multidisciplinary follow-up and survivorship care approaches.

For further information on multidisciplinary cancer care visit: **canceraustralia.gov.au/clinical-best-practice/multidisciplinary-care**

**Further information and resources**

- Roles and responsibilities for the delivery of care
- Shared Care Plan
- A guide for women on shared follow-up care

### Who is involved in multidisciplinary care?

**Core disciplines integral to the provision of good care should be part of the shared care team. Team membership will vary according to cancer type but should reflect both clinical and psychosocial aspects of care and the woman's primary care practitioner/s.**

**Ashared care team for women with low-risk endometrial cancer may include:**

- **gynaecological oncologist(s)**
- **gynaecologist(s)**
- **radiation oncologist(s)**
- **specialist nurses**
- **general practitioner(s)**
- **primary health care nurse(s)**
- **allied health professionals (including social workers, psychologists, physiotherapists and dietitians)**
- **counsellors in sexual health and/or genetics**
- **an expert in providing culturally appropriate care to Aboriginal and Torres Strait Islander people.***

### A Shared Care Plan

A Shared Care Plan is an individualised care plan that contains the key follow-up elements and schedule required to provide ongoing comprehensive care to a woman who has received treatment for low-risk endometrial cancer. A Shared Care Plan enables the specialist and primary care practitioner/s to manage follow-up care together.

*A culturally appropriate healthcare professional may be an Aboriginal and Torres Strait Islander Health Worker, Health Practitioner, or Hospital Liaison Officer

# Agreed roles and responsibilities

## Agree on shared follow-up and survivorship care arrangements by specialist and primary care practitioner/s that are clearly communicated to the woman

Discuss and agree on the roles and responsibilities of each member of the **shared care team** prior to commencing shared follow-up care.
Document these responsibilities in the Shared Care Plan and share with the woman.

The **Medicare Benefits Schedule (MBS)** includes Chronic Disease Management (CDM) items to financially support and enable the primary care practitioner/s to plan and coordinate multidisciplinary care of patients with chronic or terminal medical conditions.

Details of relevant MBS items can be accessed here:
**www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement**

**Further information and resources**

- Roles and responsibilities for the delivery of care
- Shared Care Plan

# Agreed roles and responsibilities

## Case conference

The **primary care practitioner/s** and **shared care teams** may hold a case conference at the commencement of shared follow-up and survivorship care to discuss the joint approach. This case conference provides an opportunity to:

- agree on the roles and responsibilities
- discuss the woman's individual **Shared Care Plan**
- agree on methods of communication between the shared care team throughout the woman's care, in particular, when follow-up raises a clinical issue that requires rapid access to specialist consultation.

### Further information and resources

- Roles and responsibilities for the delivery of care
- Shared Care Plan
- Rapid access request

# Timely and effective communication

## Timely, effective communication between specialist and primary care practitioner/s and the woman to support coordination of care and shared decision-making

Establishing an effective relationship and communication pathway among all **shared care team** members is essential in providing a comprehensive approach to care coordination, and achieving continuity of care.

### Care coordination and delivery should include:

- Shared care team meetings and shared care planning
- Supportive care screening/assessment
- Development of shared care/communication protocols
- Referral practices and rapid access
- Data collection
- Information provision and individual clinical treatment

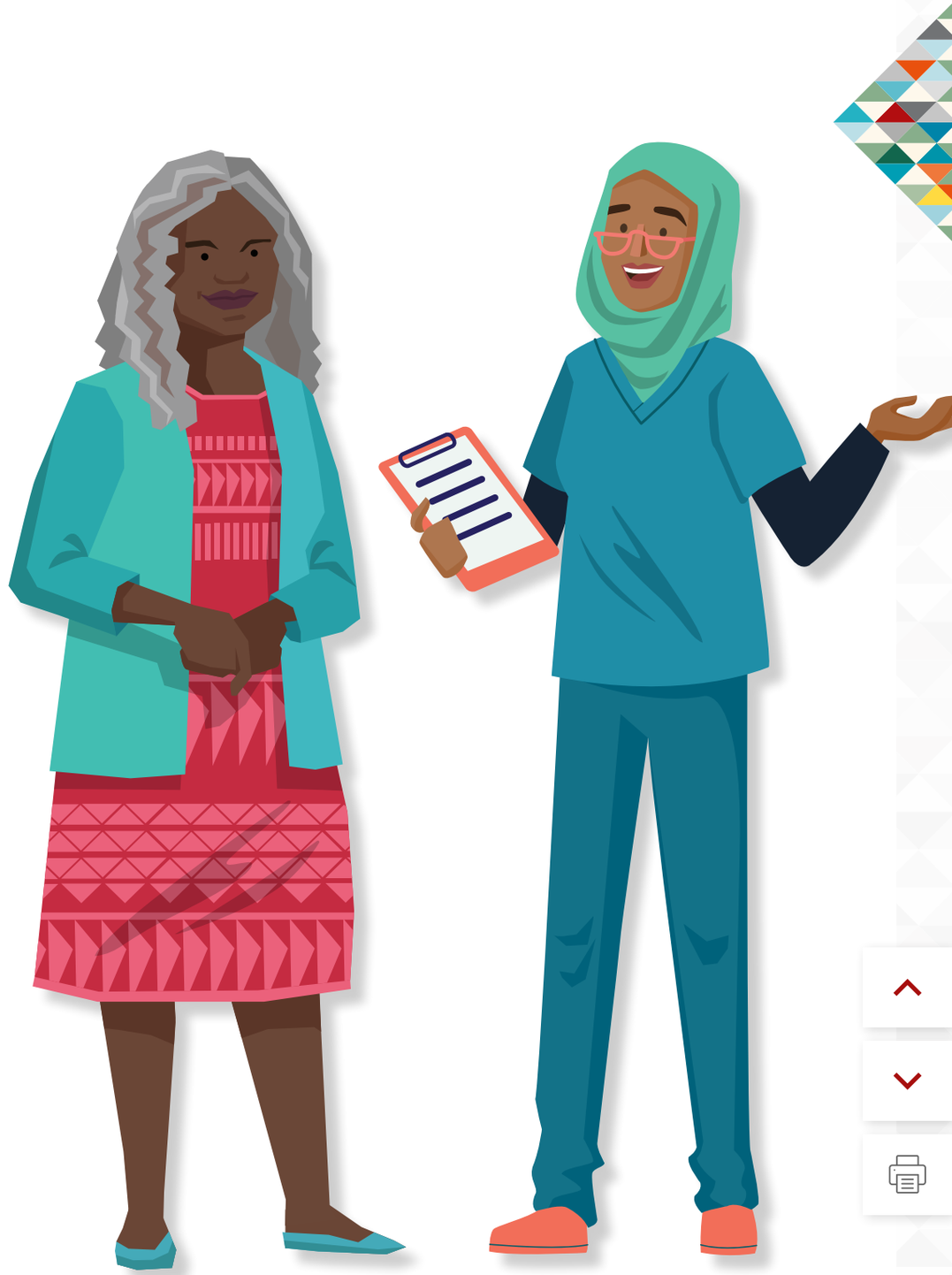
**Further information and resources**

- Roles and responsibilities for the delivery of care
- Shared Care Plan
- Rapid access request

# Timely and effective communication

Each woman with cancer has different communication needs, including cultural and language differences. Ensure these communication needs are met throughout follow-up and survivorship care.

After completion of initial treatment, provide the woman with a treatment summary and **Shared Care Plan** including a comprehensive list of individual care needs identified by all members of the shared care team.



### Further information and resources

- Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer
- Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer – Quick reference guide
- What to expect – Endometrial cancer
- Cancer – What to expect - Information for Aboriginal and Torres Strait Islander people who have cancer
- Checking for cancer – What to expect - Information for Aboriginal and Torres Strait Islander people who might have cancer

# Timely and effective communication

## Communication roles and responsibilities for shared follow-up and survivorship care

- The specialist team should ensure there is adequate discussion with the woman about the recommended follow-up care, including the intent of shared follow-up and survivorship care, and supportive care options available.
- The primary care practitioner/s and the woman should have open discussions during the provision of follow-up and survivorship care about signs and symptoms of recurrence, effects of treatment, management of co-morbidities, information on healthy lifestyles and the woman's psychosocial needs.
- The specialist, primary care practitioner/s and the woman should discuss and agree on the **Shared Care Plan**, establish clear roles and responsibilities for shared follow-up and survivorship care, including shared care/communication protocols and referral practices according to the woman's needs.
- The relevant shared care team member should record follow-up care visits and results, provided by either the primary care practitioner/s or specialist team, and should communicate the outcomes to the other team members. Rapid access to specialist advice and consultation should also be available to the primary care practitioner/s if any clinical issues arise.

**Further information and resources**

- Roles and responsibilities for the delivery of care
- Rapid access request
- A guide for women on shared follow-up care

# Rapid access to specialist service

## Establish clear referral systems for rapid access to the specialist for primary care practitioner/s

Access to urgent specialist consultation is an integral part of shared follow-up and survivorship care. This helps ensure that primary care practitioner/s and the woman are able to raise urgent clinical issues that require advice or consultation from the specialist.

Agree on the rapid access process between the primary care practitioner/s and specialist, and document the process that facilitates communication and referral.

### Further information and resources

- Roles and responsibilities for the delivery of care
- Rapid access request
- A guide for women on shared follow-up care

# Supportive care

## Deliver supportive care through routine screening, assessment and management of the woman's needs

A diagnosis of cancer can affect a person's physical, emotional, psychological, spiritual and social wellbeing. Some of these effects will resolve over time due to personal coping resources and social and professional support, and some needs may emerge later or increase over time.[1]

Women surviving gynaecological cancer experience a number of specific needs which if left unmet, may impact on their quality of life. In addition to the many common experiences of people with a cancer diagnosis (such as pain, fatigue, anxiety, financial stress and managing treatment regimens), women who have received treatment for low-risk endometrial cancer may face more specific problems associated with:[1]

- surgically or chemically induced menopause
- sexual health needs, sexual dysfunction, including vaginal dryness, bleeding and stenosis, and pain during intercourse
- emotional and psychological issues including body image, relationship and sexuality concerns
- bowel or bladder dysfunction (which may have been present prior to treatment or be exacerbated by treatment)
- loss of fertility
- lower leg lymphoedema, which can affect mobility (unlikely following treatment for low-risk endometrial cancer)

**Further information and resources**

- **Screening, assessment and management of supportive care needs of women**
- **Supporting self-management and living well**
- **The NCCN Distress Thermometer and Problem List for Patients**

Reference: 1. Cancer Council Australia (2016). Optimal care pathways for women with endometrial cancer.

# Supportive care

## Deliver supportive care through routine screening, assessment and management of the woman's needs

Assist women to self-manage and implement wellbeing strategies by providing high-quality information and support. Manage co-morbidities and modifiable lifestyle factors (if any) which may include weight gain, obesity, physical activity and diet.[1]

All members of the **shared care team** are responsible to help manage supportive care needs. During key points along the care pathway (including follow-up and survivorship care) identify the issues that the woman may require assistance with to optimise their health and quality of life outcomes.[1] This may be done by routine and systematic screening and assessment of the woman, their carer and family.[1]

**Further information and resources**

- Screening, assessment and management of supportive care needs of women
- Supporting self-management and living well
- The NCCN Distress Thermometer and Problem List for Patients

Reference: 1. Cancer Council Australia (2016). Optimal care pathways for women with endometrial cancer.

# Resource list for specialist and primary care practitioner/s

- **Optimal Care Pathway for women with endometrial cancer** and **Optimal Care Pathway for women with endometrial cancer - Quick reference guide**
  outlines best practice cancer care for women with endometrial cancer. The pathway is designed to promote a full understanding of the patient journey in order to foster quality cancer care from diagnosis.
- **Summary of evidence: Shared follow-up and survivorship care for women with low-risk endometrial cancer**
  outlines the evidence base that supports and informs Cancer Australia's shared follow-up and survivorship care model for women with low-risk endometrial cancer. The purpose is to provide the context, evidence base and, where applicable, the consensus base for Cancer Australia's shared follow-up care model and resources.
- **National Framework for Gynaecological Cancer Control**
  outlines future directions in national gynaecological cancer control to improve outcomes for women affected by gynaecological cancers.
- **Follow-up care for women with low-risk endometrial cancer: A guide for General Practitioners**
  provides guidance for GPs in managing aspects of follow-up and survivorship care for women following completion of active treatment for low-risk endometrial cancer.
- **Roles and responsibilities for the delivery of care**
  outlines key roles and responsibilities of the specialist and primary care practitioner/s in the delivery of shared follow-up and survivorship care for low-risk endometrial cancer.
- **Shared Care Plan**
  provides a template for contribution by the specialist and primary care practitioner/s and the women to produce an agreed individualised follow-up care plan.
- **Rapid Access Request**
  provides the primary care practitioner/s with a process to communicate when rapid access to specialist consultation is required.
- **Screening, assessment and management of supportive care needs of women with low-risk endometrial cancer**
  provides guidance to assist the shared care team in managing supportive care needs of women affected by low-risk endometrial cancer and their carers and families.
- **Principles of shared follow-up care for low-risk endometrial cancer**
  provides a list of principles that should guide the shared care team when treating women with low risk endometrial cancer.
- **NCCN Distress Thermometer and Problem List for Patients**
  measures distress and allows women to inform their doctor if they are having concerns in areas such as practical, family, emotional, spiritual and physical problems.
- **Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer** and **Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer - Quick reference guide**
  outlines the aspects of the cancer care pathway that need to be responsive to the needs of Aboriginal and Torres Strait Islander people with cancer. The pathway complements the best practice information provided in the tumour-specific pathways to facilitate the delivery of culturally safe and competent care.

# Resource list for women, their carers and families

- **A guide for Women on Shared Follow-up Care**
  provides information on what to expect during shared follow-up care.
- **Supporting Self-management and Living Well**
  provides guidance to women promoting health and wellbeing, self-management and living well.
- **Follow-up of survivors of endometrial cancer**
  is for women who have completed treatment for endometrial cancer. It explains why follow-up appointments with your health care team are important.
- **What to expect – Endometrial cancer**
  explains to women what to expect during each stage of treatment and beyond.
- **Cancer – What to expect - Information for Aboriginal and Torres Strait Islander people who have cancer**
  explains what to expect before, during and after your cancer treatment, and tells you about the care you should be offered. Carers, family and community might also find this information helpful.
- **Checking for cancer – What to expect - Information for Aboriginal and Torres Strait Islander people who might have cancer**
  explains what to expect while you're getting checked out. Carers, family and community might also find this information helpful.

# References

Australian Institute of Health and Welfare (AIHW). Cancer Data in Australia. Accessed April 2019; www.aihw.gov.au/reports/cancer/cancer-data-in-australia/contents/summary.

Australian Institute of Health and Welfare (AIHW). Cancer in Aboriginal & Torres Strait Islander people of Australia. Accessed April 2019; https://www.aihw.gov.au/reports/cancer/cancer-in-indigenous-australians/contents/cancer-type/uterine-cancer-c54-c55

Australian Institute of Health and Welfare (AIHW). Uterine Cancer Incidence and Mortality (ACIM) workbooks. Accessed April 2019; www.aihw.gov.au/reports/cancer/cancer-data-in-australia/acim-books.

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Cancer Australia. Shared care demonstration project: Evaluation report. Surry Hills, NSW: Cancer Australia; 2013 (draft unpublished).

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Dolly D, Mihai A, Rimel BJ, et al. A delay from diagnosis to treatment is associated with a decreased overall survival for patients with endometrial cancer. Front Oncol. 2016;6:31.

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Smith SM, Allwright S, T. OD. Effectiveness of shared care across the interface between primary and specialty care in chronic disease management. Cochrane Database Syst Rev. 2007;18(3).

Ward KK, Shah NR, Saenz CC et al. Cardiovascular disease is the leading cause of death among endometrial cancer patients. Gynecol Oncol. 2012;126(1):176–9.

# Glossary

### Specialist Team
The specialist team may include

- gynaecological oncologist(s)
- specialist nurse(s)
- allied health professional(s)
- gynaecologist(s)

### Primary Care Practitioner/s
The primary care practitioner/s may include

- the General Practitioner (GP)
- primary health care nurse(s)

### A Shared Care Plan
A Shared Care Plan is an individualised care plan that contains the key follow-up elements and schedule required to provide ongoing comprehensive care to a woman who has received treatment for low-risk endometrial cancer. A Shared Care Plan enables the specialist and primary care practitioner/s to manage follow-up care together.

### Multidisciplinary Care
Core disciplines integral to the provision of good care should be part of the shared care team. Team membership will vary according to cancer type but should reflect both clinical and psychosocial aspects of care and the woman's primary carepractitioner/s.

A shared care team for women with low-risk endometrial cancer may include:

- gynaecological oncologist(s)
- gynaecologist(s)
- radiation oncologist(s)
- specialist nurses
- general practitioner(s)
- primary health care nurses
- allied health professionals (including social workers, psychologists, physiotherapists and dietitians)
- counsellors in sexual health and/or genetics
- an expert in providing culturally appropriate care to Aboriginal and Torres Strait Islander people.*

### Low-risk Endometrial Cancer
The definition of 'low-risk endometrial cancer' may vary from one specialist gynaecological cancer service to another. Suitability of a woman with endometrial cancer to participate in shared follow-up care should be determined by the treating multidisciplinary team.

The International Federation of Gynaecology and Obstetrics (FIGO) endometrial cancer stage according to 2009 definitions can be found here: https://meteor.aihw.gov.au/content/index.phtml/itemId/424206

*A culturally appropriate healthcare professional may be an Aboriginal and Torres Strait Islander Health Worker, Health Practitioner, or Hospital Liaison Officer