Literaturrecherchen und Evidenztabellen für die Version 3 der S3-Leitlinie zum Endometriumkarzinom

Inhaltsverzeichnis

1. Methodisches Vorgehen

1.1. Leitlinienrecherche

In der aktuellen Version wurde keine Leitlinienrecherche durchgeführt.

1.2. Systematische Literaturrecherche

1.2.1. Formulierung von Schlüsselfragen

Es wurden insgesamt 59 Fragestellungen recherchiert.

Die Suchen zu den Schlüsselfragen wurden nicht überarbeitet und für die aktuelle Version übernommen. Lediglich der Suchzeitraumes wurde angepasst, um den Zeitraum nach der Recherche der vorhergehenden Version abdecken zu können.

Die Auflistung der Schlüsselfragen mit genauer Beschreibung des PICO-Schemas für die de-novo Fragestellungen finden sich im Kapitel 2.

1.2.2. Durchführung der Recherche

Die systematische Literaturrecherche wurde in der Medline Datenbank über die PubMed Suchoberfläche https://pubmed.ncbi.nlm.nih.gov/ durchgeführt. Zusätzlich erfolgten Recherchen in der Cochrane Library https://www.cochranelibrary.com/ .

Es wurden Studien die ab September 2021 veröffentlich wurden, berücksichtigt, was an die Recherche der vorhergehenden Version anknüpft.
Bis einschließlich September 2022 publizierte Studien wurden in die eigeschlossen, was in Summe einem Suchzeitraum von einem Jahr entspricht.

Die Recherchen erfolgten zwischen dem 06 und 07. Oktober 2022.

Es wurden 2122 Suchtreffer in PubMed / Medline und 97 in der Cochrane Library Datenbank erzielt. Die Suchtreffer wurden kombiniert und die Duplikate wurden entfernt, was schließlich zu 2218 Treffern führte.

Die Ergebnisse der Suchen zu den einzelnen Datenbanken sind in Tabelle 1 aufgelistet. Die detaillierten Darstellungen der Recherchen sind im Anhang A zur jeweiligen Schlüsselfrage dargestellt.

Tabelle 1 Ergebnisse der Literaturrecherche nach Kapitel und Datenbank

	PubMed	Cochrane Library	Kombiniert ohne Duplikate
SF 01	45	1	46
SF 02	26	7	33
SF 03	38	0	38
SF 04	38	0	38
SF 05	3	0	3
SF 06	2	0	2
SF 07	100	7	107
SF 08	49	7	56
SF 09	100	7	107
SF 10	100	7	107
SF 11	100	7	107
SF 12	49	7	56
SF 13	8	0	8
SF 14	12	4	16
SF 15	12	4	16
SF 16	42	1	43
SF 17	27	0	27
SF 18	15	4	19
SF 19	21	0	21
SF 20	64	1	65

	PubMed	Cochrane Library	Kombiniert ohne Duplikate
SF 21	64	1	65
SF 22	64	1	65
SF 23	64	1	65
SF 24	64	1	65
SF 25	64	1	65
SF 26	64	1	65
SF 27	64	1	65
SF 28	64	1	65
SF 29	64	1	65
SF 30	64	1	65
SF 31	64	1	65
SF 32	21	2	23
SF 33	64	1	65
SF 34	64	1	65
SF 35	21	2	23
SF 36	64	1	65
SF 37	12	0	12
SF 38	9	0	9
SF 39	9	0	9
SF 40	5	0	5
SF 41	8	0	8

	PubMed	Cochrane Library	Kombiniert ohne Duplikate
SF 42	31	0	31
SF 43	31	0	31
SF 44	31	0	31
SF 45	25	0	25
SF 46	25	0	25
SF 47	25	0	25
SF 48	7	0	7
SF 49	7	0	7
SF 50	7	0	7
SF 51	7	0	7
SF 52	7	0	7
SF 53	45	7	52
SF 54	1	7	8
SF 55	11	1	12
SF 56	4	0	4
SF 57	9	0	8
SF 58	17	0	17
SF 59	0	0	0
Summe	2122	97	2218

1.2.3. Auswahl der Evidenz

Die Literaturarbeit wurde über das Leitlinienportal der Clinical Guideline Services GmbH (CGS) durchgeführt. Die in den Suchen identifizierten Literaturstellen wurden nach dem Deduplizieren als Literatursammlungen für jede PICO Frage als Literatursammlung im Leitlinienportal (https://www.guideline-service.de) hinterlegt. Die Literatursammlungen waren der Leitliniengruppe zu jedem Zeitpunkt zur Einsicht verfügbar.

1.2.3.1. Ein- und Ausschlussgründe

Folgende Ein- und Ausschlussgründe wurden für die Recherche und Auswahl der Evidenz festgelegt:

- Deutsche und englische Veröffentlichungen
- Systematische Übersichtsarbeit / Meta-Analyse/ RCT/Kohortenstudien
- Veröffentlichung ab 01.09.2021

Generelle Ausschlussgründe wurden ebenfalls zur Auswahl herangezogen:

- Nicht relevante Population
- Nicht relevante Intervention / Comparison
- Nicht relevante Outcomes
- Nicht relevante Studientypen (siehe Einschlussgründe)
- Nicht relevante Fragestellung
- Kein Volltext / nur Abstract
- Publikation ohne Ergebnisse / Protokoll
- Einzelpublikation in Meta-Analyse enthalten
- Nicht relevanter Suchzeitraum
- Nicht relevante Sprache

1.2.3.2. Screening

Die Auswahl der Evidenz erfolgte durch ein mehrstufiges Screening im Leitlinienportal (https://www.guideline-service.de). Im ersten Schritt, dem Titel-Abstract Screening wurden die Suchtreffer anhand der PICO-Vorgaben und der Ein- und Ausschlussgründe auf potentielle Relevanz gesichtet. Die Auswahl wurde von den Mitgliedern der Leitlinienkoordination getroffen und selbst im Leitlinienportal durchgeführt.

Die Auswahl erfolgte in diesem Schritt jeweils durch zwei Personen, die verblindet waren hinsichtlich der Auswahl der anderen Person.

Durch unterschiedliche Auswahl der beiden Screener*Innen entstand für jede Sammlung eine Anzahl von Artikeln, die als unklar markiert wurden. Die Entscheidung über den Verbleib dieser Literaturstellen wurde von der Leitlinienkoordination getroffen.

Alle im Titel-Abstract als relevant für die jeweilige Fragestellung identifizierten Artikel wurden daraufhin als Volltext akquiriert.

Im zweiten Schritt des Screenings, dem sogenannten Volltext-Screening, wurden die Volltexte der ausgewählten Publikationen auf die Erfüllung der o.g. Ausschlussgründe überprüft. Die Auswahl wurde von den Mitgliedern der Leitlinienkoordination getroffen und selbst im Leitlinienportal in einem zweistufigen Verfahren durchgeführt.

Aufgrund der Überlappung der Fragestellungen waren einige Artikel in mehreren Sammlungen vorhanden. Am Ende des Auswahlprozesses lagen 40 einzigartige Texte aus der Recherche vor.

Die Teilschritte des Screenings sind im Anhang A zur jeweiligen Recherche grafisch als PRISMA Flussdiagram dargestellt.

1.2.4. Bewertung der Evidenz

Die Literaturbewertung wurde nach der Evidenzklassifizierung des *Oxford Centre for Evidence-Based Medicine 2011*[1] (Tabelle 2) für Interventions-, diagnostische und prognostische Studien durchgeführt. Die methodische Qualität der Literaturstelle wurde mit Hilfe von Checklisten überprüft und die gefundenen Mängel im „Notes" Bereich der Evidenztabellen festgehalten. Als Checklisten wurden die *AMSTAR 2* Checkliste[2] *für* Systematische Übersichtsarbeiten und Meta-Analysen*;* das *Cochrane risk of bias tool 1*[3] für randomisierte kontrollierte Studien, bzw. die *Newcastle-Ottawa Scale* [4] für nicht-randomisierte Studien (Kohorten und Fallkontrollstudien), sowie das QUADAS-2 tool[5] herangezogen.

Studien mit bedeutenden methodischen Schwächen und/ oder bedeutsamer Heterogenität wurden um eine Note abgewertet. Eine entsprechende detaillierte Begründung findet sich in der Evidenztabelle im Feld „Notes".

Nach der Bewertung der Literaturstellen wurden diese der jeweils passenden Schlüsselfrage zugeordnet.

Die Teilschritte des Screenings sind im Kapitel 2 zur jeweiligen Recherche grafisch als PRISMA Flussdiagram dargestellt.

Aus allen eingeschlossenen Literaturstellen wurden im nächsten Schritt Daten extrahiert und in Form von Evidenztabellen zusammengefasst. In Summe wurden 38 von insgesamt 40 Literaturstellen bewertet.

Es folgt eine Auflistung und Begründung des Ausschlusses:

- Griffith, T. et al. The role for vaginal cuff brachytherapy boost after external beam radiation therapy in endometrial cancer. Brachytherapy. 21. 177-185. 2022
  Ausschluss, weil Artikel kein systematisches Review ist.
  Aus Schlüsselfrage 35
- Liu, Y. et al. Comparison of the outcomes between laparoscopic surgery and conventional open surgery in treating patients with stage II endometrial carcinoma: A protocol for systematic review and meta-analysis. Medicine (Baltimore). 100. e27148. 2021
  Ausschluss, weil es sich lediglich um ein Protokoll eines systematischen Reviews handelt.
  Aus Schlüsselfrage 39

Tabelle 2: Evidenzklassifizierung nach Oxford 2011

Fragestellung	Schritt 1 (Level 1*)	Schritt 2 (Level 2*)	Schritt 3 (Level 3*)	Schritt 4 (Level 4*)	Schritt 5 (Level 5*)
Wie häufig ist das Problem	Lokale und aktuelle randomisierte Proben aus Umfragen (oder Volkszählungen)	Systematische Reviews von Umfragen die eine Anpassung an die örtlichen Gegebenheiten ermöglichen**	Lokale Nicht-Zufalls Probe	Fall-Serie**	Nicht verfügbar
Ist der diagnostische oder Monitoring Test akkurat? (Diagnose)	Systematische Reviews von Querschnittsstudien mit konsistent applizierten Referenzstandard und Verblindung	Einzelne Querschnitts-Studien mit konsistent applizierten Referenzstandard und Verblindung	Nicht konsekutive Studien oder Studien ohne konsistent applizierten Referenzstandard**	Fall-Kontroll Studien, oder minderwertiger, nicht unabhängiger Referenz Standard**	Mechanismus-basierte Argumentation
Was wird ohne Therapie passieren? (Prognose)	Systematische Reviews von Inzeptions-Kohorten Studien	Inzeptions-Kohorten Studien	Kohortenstudien oder Kontrollarme von randomisierten Studien*	Fall Serien oder Fall-Kontroll Studien, oder minderwertiger prognostische Kohortenstudien	Nicht verfügbar
Hilft die Intervention? Behandlungsvorteil	Systematische Reviews von randomisierten Studien oder n=1 Studien	Randomisierte Studien oder Observationsstudien mit dramatischem Effekt	Nicht-randomisierte kontrollierte Kohorten/Follow-up Studien**	Fall Serien oder Fall-Kontroll Studien, oder historische kontrollierte Studien	Mechanismus-basierte Argumentation

Fragestellung	Schritt 1 (Level 1*)	Schritt 2 (Level 2*)	Schritt 3 (Level 3*)	Schritt 4 (Level 4*)	Schritt 5 (Level 5*)
Was sind die häufigen Nachteile/ Schäden durch die Intervention? Behandlungsnachteil	Systematische Reviews von randomisierten Studien oder Nested Fall Kontroll Studien, n=1 Studien, oder Observationsstudien mit dramatischem Effekt	Randomisierte Studien oder (herausragende) Observationsstudien mit dramatischem Effekt	Nicht-randomisierte kontrollierte Kohorten / Follow-up Studien (Beobachtung nach Marktzulassung), ausreichende Fallzahl vorausgesetzt um häufige Schäden auszuschließen (Für Langzeit Schäden muss die Nachfolgezeit ausreichend sein)	Fall Serien oder Fall-Kontroll Studien, oder historische kontrollierte Studien	Mechanismus-basierte Argumentation
Was sind die seltenen Nachteile/ Schäden durch die Intervention? Behandlungsnachteil	Systematische Reviews von randomisierten Studien oder n=1 Studien	Randomisierte Studien oder herausragende Observationsstudien mit dramtischem Effekt		Fall Serien oder Fall-Kontroll Studien, oder historische kontrollierte Studien	Mechanismus-basierte Argumentation
Ist der (frühe Detektion) Test lohnenswert? (Screening)	Systematische Reviews von randomisierten Studien	Randomisierte Studien	Nicht-randomisierte kontrollierte Kohorten / Follow-up Studien**	Fall Serien oder Fall-Kontroll Studien, oder historische kontrollierte Studien	Mechanismus-basierte Argumentation

* Das Evidenzlevel kann herabgestuft werden auf Grund der Studienqualität, Ungenauigkeit, Indirektheit (Studien PICO passt nicht genau zur Frage PICO), Inkonsistenz zwischen Studien, oder weil die absolute Effektgröße sehr klein ist. Das Evidenzlevel kann hochgestuft werden, wenn der beobachtete Effekt groß oder sehr groß ist.

** Wie immer ist ein Systematisches Review generell besser als eine einzelne Studie

1 Entwickelt von OCEBM Table of Evidence Working Group = Jeremy Howick, Iain Chalmers (James Lind Library), Paul Glasziou, Trish Greenhalgh, Carl Heneghan, Alessandro Liberati, Ivan Moschetti, Bob Phillips, Hazel Thornton, Olive Goddard and Mary Hodgkinson

2011. Übersetzt und angepasst von CGS Usergroup 2020.

1.3. Erstellung von Evidenztabellen

Aus allen eingeschlossenen Literaturstellen wurden nach der Bewertung die wichtigsten Daten extrahiert.

Diese sind je nach Studientyp unterschiedlich (Diagnostik, Intervention, Beobachtung, Übersichtsarbeit) beinhalten aber in jedem Falle eine Beschreibung der Population, Intervention/ Exposure, Endpunkte, Resultate inklusive Zahlenwerte, Konklusion der Autor*innen und einer Auflistung der bei der Durchsicht offenkundigen methodischen Mängel.

Diese Daten sind in Form von Evidenztabellen geordnet und nach Studientyp im Leitlinienportal zusammengefasst.

Die Evidenztabellen sind in Kapitel **Fehler! Verweisquelle konnte nicht gefunden werden.** zu den jeweiligen PICO-Schlüsselfragen dargestellt. Ebenfalls wurden Inhaltsverzeichnisse zu den Evidenztabellen erstellt. Diese beinhalten eine Auflistung der Literaturstellen der zugeordneten Literatur, das Evidenzlevel und die Angabe des Studientypes.

2. Ergebnisse der Literaturrecherchen

2.1. Schlüsselfrage 01

Beeinflussen Alter, Hormonexposition, reproduktive/ metabolische/ physikalische/ ethnische/ genetische Faktoren, Körpergewicht, Rauchen und/oder Arbeits-bedingungen das Risiko für das Auftreten eines Endometriumkarzinoms?
Population Frauen Intervention: Exposition von Risikofaktoren Comparison: Keine Risikofaktoren Outcomes: Auftreten von EC

(06.10.2022)

Population		
#1	"Endometrial Neoplasms"[Mesh] OR ((endometria*[tiab] OR endometrium[tiab] OR "Endometrium"[Mesh]) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR "Carcinoma"[Mesh] OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR "Neoplasms"[Mesh]))	51.539
Intervention bzw. Exposure		
#2	Risk Factors[Mesh] OR risk factor*[tiab] OR population at risk[tiab]	1.320.778
#3	Age Factors[Mesh] OR age factor OR age reporting[tiab]	1.414.506
#4	hormone exposure[tiab]	619
#5	metabolic factor*[tiab]	3.938
#6	Reproductive History[Mesh] OR reproductive histor*[tiab] OR contraceptive histor*[tiab] OR pregnancy history[tiab] OR birth history[tiab]	32.572
#7	Ethnic Groups[Mesh] OR ethnic group[tiab] OR ethnicit*[tiab] OR nationality[tiab]	181.208
#8	genetic risk factor*[tiab] OR genetic factor*[tiab]	50.361
#9	Body Weight[Mesh] OR body weight*[tiab]	667.047
#10	Smoking[Mesh] OR smoking[tiab]	312.029

#11	Sedentary Behavior[Mesh] OR Sedentary Behavior[tiab] OR Behavior, Sedentary[tiab] OR Sedentary Behaviors[tiab] OR Sedentary Lifestyle[tiab] OR Lifestyle, Sedentary[tiab] OR Physical Inactivity[tiab] OR Inactivity, Physical[tiab]	27.383
#12	working condition*[tiab] OR "Shift Work Schedule"[Mesh] OR Shift Work Schedule[tiab] OR Schedule, Shift Work[tiab] OR Schedules, Shift Work[tiab] OR Work Schedule, Shift[tiab] OR Night Shift Work[tiab] OR Shift Work, Night[tiab] OR Rotating Shift Work[tiab] OR Shift Work, Rotating[tiab]	14.513
#13	#2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12	3.127.412
Kombiniert mit und ohne Filter		
#14	#1 AND #13	9.100
#15	#14 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	45

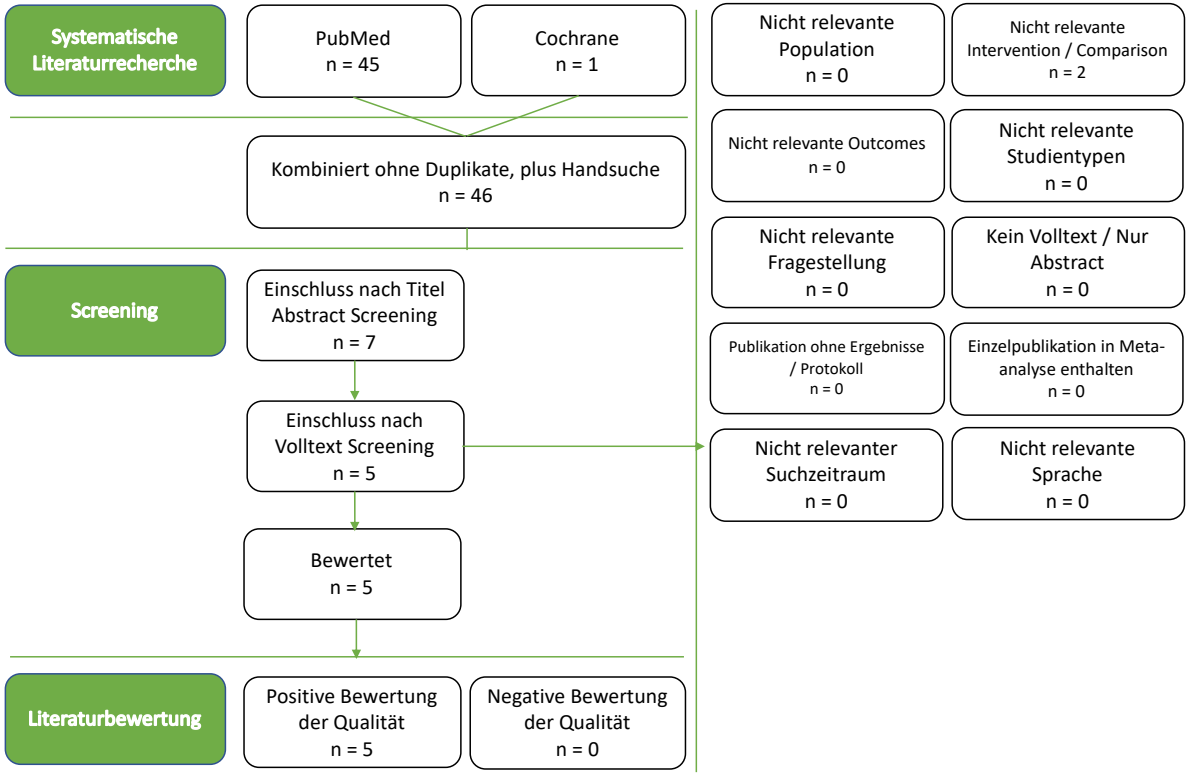
Recherche in Cochrane Library (06.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244532
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89822
#8	#5 OR #6 OR #7	254736
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR	3267

	"Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	
#12	#10 OR #11	3480
#13	(Risk Factors OR risk factor* OR population at risk):ti,ab,kw	132085
#14	MeSH descriptor: [Risk Factors] explode all trees	26361
#15	(Age Factors OR age factor OR age reporting):ti,ab,kw	80977
#16	MeSH descriptor: [Age Factors] explode all trees	10396
#17	(hormone exposure OR metabolic factor*):ti,ab,kw	13554
#18	(Reproductive History OR reproductive histor* OR contraceptive histor* OR pregnancy history OR birth history):ti,ab,kw	9341
#19	MeSH descriptor: [Reproductive History] explode all trees	1025
#20	(Ethnic Groups OR ethnic group OR ethnicit* OR nationality):ti,ab,kw	10833
#21	MeSH descriptor: [Ethnicity] explode all trees	2477
#22	(genetic risk factor* OR genetic factor*)ti,ab,kw	198
#23	MeSH descriptor: [Body Weight] explode all trees	31558
#24	(Body Weight OR body weight*):ti,ab,kw	75209
#25	(Smok* OR smoking):ti,ab,kw	41766
#26	MeSH descriptor: [Smoke] explode all trees	440
#27	(Sedentary Behavior OR Sedentary Behavior OR Behavior, Sedentary OR Sedentary Behaviors OR Sedentary Lifestyle OR Lifestyle, Sedentary OR Physical Inactivity OR Inactivity, Physical):ti,ab,kw	6736
#28	MeSH descriptor: [Sedentary Behavior] explode all trees	1350

#29	(working condition* OR "Shift Work Schedule" OR Shift Work Schedule OR Schedule, Shift Work OR Schedules, Shift Work OR Work Schedule, Shift OR Night Shift Work OR Shift Work, Night OR Rotating Shift Work OR Shift Work, Rotating):ti,ab,kw	7276
#30	MeSH descriptor: [Shift Work Schedule] explode all trees	35
#31	Shift Work Schedule:ti,ab,kw	256
#32	#13 OR #14 OR #15 OR 14 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31	512935
#33	#12 AND #32	1208
#34	#33 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 01



2.2. Schlüsselfrage 02

Kann durch Modifikation der o. g. Risikofaktoren bzw. präventive medikamentöse oder operative Intervention das Risiko für das Auftreten eines Endometriumkarzinoms gesenkt werden?
Population Frauen Intervention: Präventive Maßnahmen Comparison: Keine Prävention Outcomes: Auftreten von EC

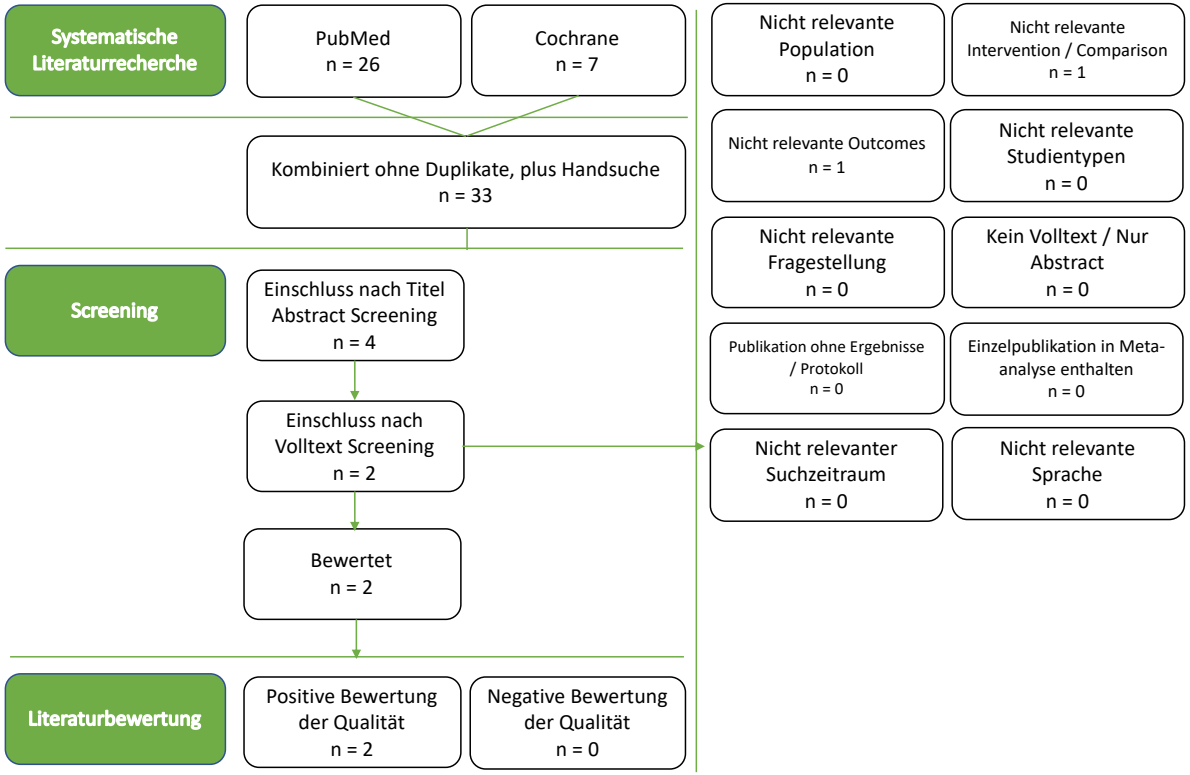
Recherche in PubMed (06.10.2022)

Population		
#1	"Endometrial Neoplasms"[Mesh] OR ((endometria*[tiab] OR endometrium[tiab] OR "Endometrium"[Mesh]) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR "Carcinoma"[Mesh] OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR "Neoplasms"[Mesh]))	51.546
Intervention bzw. Exposure		
#2	prevention	2.963.132
Kombiniert mit und ohne Filter		
#3	#1 AND #2	4.965
#4	#3 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	26

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	7

Schlüsselfrage 02



2.3. Schlüsselfrage 03

Welche Verfahren wie beispielsweise transvaginale Sonographie, zytologische Beurteilung, Endometriumbiopsie mittels Aspiration, Hysteroskopie oder **Tumormarker-Bestimmung an Aspiraten, HPV-Bestimmung, Familienanamnese** sind bei der asymptomatischen Frau mit normalem Risiko geeignet zur Früherkennung des Endometriumkarzinoms im Hinblick auf Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population asymptomatische Frau mit normalem Risiko für EC Intervention: Screening auf EC mittels Ultraschall zytolog. Beurteilung Endometriumbiopsie mittels Aspiration Hysteroskopie **Tumormarker-Bestimmung an Aspiraten** **HPV-Bestimmung** **Familienanamnese** Comparison: kein Screening Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	"Endometrial Neoplasms"[Mesh] OR ((endometria*[tiab] OR endometrium[tiab] OR "Endometrium"[Mesh]) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR "Carcinoma"[Mesh] OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR "Neoplasms"[Mesh]))	51.539
Intervention bzw. Exposure		
#2	transvaginal sonography[tiab] OR (("Ultrasonography"[Mesh] OR ultrasound[tiab] OR ultrasonic[tiab] OR ultrasonograph*[tiab] OR echograph*[tiab] OR echotom*[tiab]) AND (transvaginal[tiab] OR trans vaginal[tiab]))	10.729
#3	"cytology" [Subheading] OR cytology[tiab]	1.511.253
#4	Biopsy[Mesh] OR biops*[tiab]	605.449

#5	(Histology[Mesh] OR histolog*[tiab]) AND (Biomarkers, Tumor[Mesh] OR tumor biomarkers[tiab] OR ((marker[tiab] OR biomarker[tiab]) AND (tumor OR carcinogen[tiab] OR neoplasm*[tiab] OR cancer*[tiab])))	86.438
#6	(Immunohistochemistry[Mesh] OR immunohistochemistry[tiab] OR Immunolabeling[tiab] OR Immunogold[tiab] OR Immunocytochemistry[tiab]) AND (Biomarkers, Tumor[Mesh] OR tumor biomarkers[tiab] OR ((marker[tiab] OR biomarker[tiab]) AND (tumor OR carcinogen[tiab] OR neoplasm*[tiab] OR cancer*[tiab])))	97.991
#7	aspirat*[tiab] AND (Biomarkers, Tumor[Mesh] OR tumor biomarkers[tiab] OR ((marker[tiab] OR biomarker[tiab]) AND (tumor OR carcinogen[tiab] OR neoplasm*[tiab] OR cancer*[tiab])))	4.274
#8	Papillomaviridae[Mesh] OR papillomaviridae[tiab] OR Human Papilloma Virus[tiab] OR HPV[tiab]	60.747
#9	Medical History Taking[Mesh] OR family histor*[tiab] OR family health histor*[tiab] OR family medical histor*[tiab]	89.943
#10	#2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #7 OR #8 OR #9 OR #10	2.296.920
Kombiniert mit und ohne Filter		
#11	#1 AND #10	12.368
#12	#11 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	38

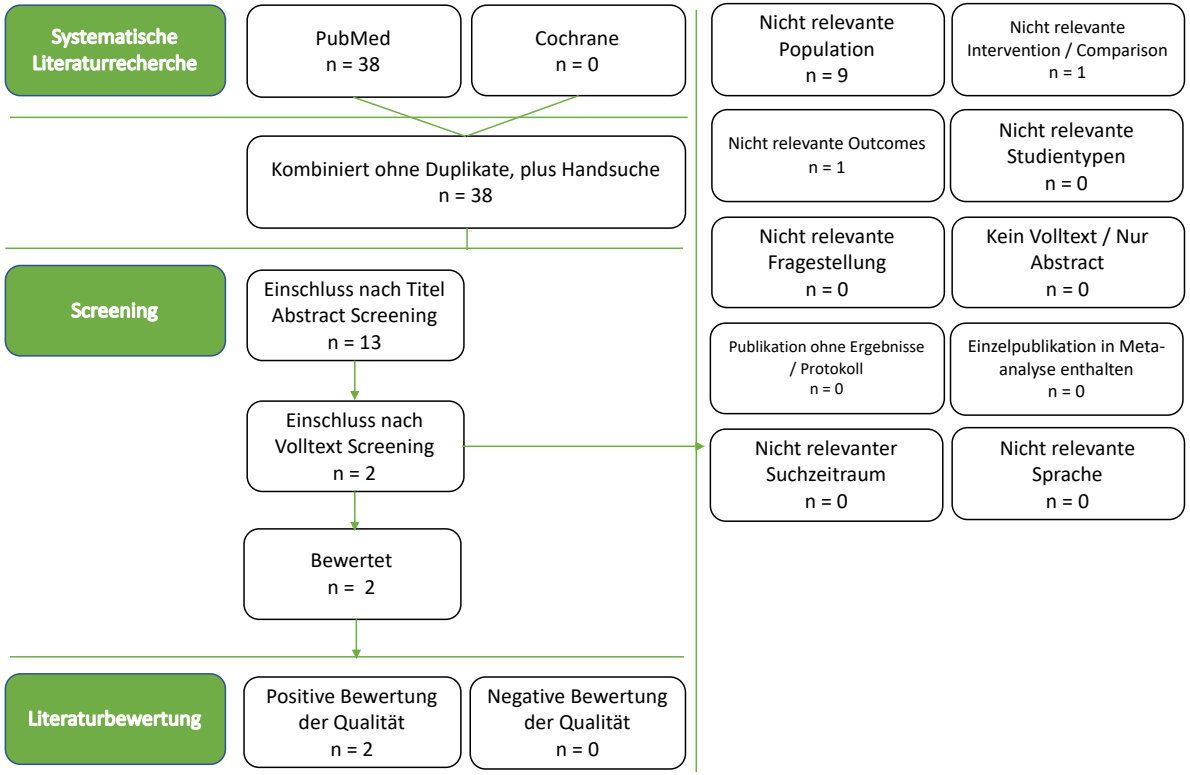
Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244533
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89822

#8	#5 OR #6 OR #7	254737
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(transvaginal sonography OR (("Ultrasonography" OR ultrasound OR ultrasonic OR ultrasonograph* OR echograph* OR echotom*) AND (transvaginal OR trans vaginal))):ti,ab,kw	2360
#14	MeSH descriptor: [Ultrasonography] explode all trees	14906
#15	(transvaginal OR trans vaginal):ti,ab,kw	3176
#16	#14 AND #15	377
#17	#13 OR #16	2366
#18	cytology:ti,ab,kw	6871
#19	(biopsy OR biopsies):ti,ab,kw	33639
#20	MeSH descriptor: [Biopsy] explode all trees	6036
#21	((Histology OR histolog*) AND (Biomarkers, Tumor OR tumor biomarkers OR ((marker OR biomarker) AND (tumor OR carcinogen OR neoplasm* OR cancer*)))):ti,ab,kw	1875
#22	MeSH descriptor: [Histology] explode all trees	1381
#23	((Immunohistochemistry OR immunohistochemistry OR Immunolabeling OR Immunogold OR Immunocytochemistry) AND (Biomarkers, Tumor OR tumor biomarkers OR ((marker OR biomarker) AND (tumor OR carcinogen OR neoplasm* OR cancer*)))):ti,ab,kw	1431

#24	MeSH descriptor: [Biomarkers, Tumor] explode all trees	5116
#25	#22 AND #24	328
#26	aspirat*:ti,ab,kw	11922
#27	#26 AND #24	44
#28	(aspirat* AND (Biomarkers, Tumor OR tumor biomarkers OR ((marker OR biomarker) AND (tumor OR carcinogen OR neoplasm* OR cancer*))):ti,ab,kw	142
#29	(Papillomaviridae OR papillomaviridae OR Human Papilloma Virus OR HPV):ti,ab,kw	3547
#30	MeSH descriptor: [Papillomaviridae] explode all trees	690
#31	(Medical History Taking OR family histor* OR family health histor* OR family medical histor*):ti,ab,kw	8216
#32	MeSH descriptor: [Medical History Taking] explode all trees	322
#33	#17 OR #18 OR #19 OR #20 OR #21 OR #23 OR #25 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32	54900
#34	#12 AND #33	664
#35	#34 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 03



2.4. Schlüsselfrage 04

Welche Verfahren wie beispielsweise transvaginale Sonographie, zytologische Beurteilung, Endometriumbiopsie mittels Aspiration, Hysteroskopie oder **Tumormarker-Bestimmung an Aspiraten, HPV-Bestimmung, Familienanamnese** sind bei der asymptomatischen Frau mit hohem Risiko geeignet zur Früherkennung des Endometriumkarzinoms im Hinblick auf Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population asymptomatische Frau mit hohem Risiko für EC; ohne genetische Disposition (hohes Risiko = Adipositas, polyzystisches Ovarial-Syndrom (englisch polycystic ovary syndrome; PCO-Syndrom, Tamoxifen-Einnahme) Intervention: Screening auf EC mittels Ultraschall zytolog. Beurteilung Endometriumbiopsie mittels Aspiration Hysteroskopie **Tumormarker-Bestimmung an Aspiraten** **HPV-Bestimmung** **Familienanamnese** Comparison: kein Screening Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	"Endometrial Neoplasms"[Mesh] OR ((endometria*[tiab] OR endometrium[tiab] OR "Endometrium"[Mesh]) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR "Carcinoma"[Mesh] OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR "Neoplasms"[Mesh]))	51.539
Intervention bzw. Exposure		
#2	transvaginal sonography[tiab] OR (("Ultrasonography"[Mesh] OR ultrasound[tiab] OR ultrasonic[tiab] OR ultrasonograph*[tiab] OR echograph*[tiab] OR echotom*[tiab]) AND (transvaginal[tiab] OR trans vaginal[tiab]))	10.729
#3	"cytology" [Subheading] OR cytology[tiab]	1.511.253

#4	Biopsy[Mesh] OR biops*[tiab]	605.449
#5	(Histology[Mesh] OR histolog*[tiab]) AND (Biomarkers, Tumor[Mesh] OR tumor biomarkers[tiab] OR ((marker[tiab] OR biomarker[tiab]) AND (tumor OR carcinogen[tiab] OR neoplasm*[tiab] OR cancer*[tiab])))	86.438
#6	(Immunohistochemistry[Mesh] OR immunohistochemistry[tiab] OR Immunolabeling[tiab] OR Immunogold[tiab] OR Immunocytochemistry[tiab]) AND (Biomarkers, Tumor[Mesh] OR tumor biomarkers[tiab] OR ((marker[tiab] OR biomarker[tiab]) AND (tumor OR carcinogen[tiab] OR neoplasm*[tiab] OR cancer*[tiab])))	97.991
#7	aspirat*[tiab] AND (Biomarkers, Tumor[Mesh] OR tumor biomarkers[tiab] OR ((marker[tiab] OR biomarker[tiab]) AND (tumor OR carcinogen[tiab] OR neoplasm*[tiab] OR cancer*[tiab])))	4.274
#8	Papillomaviridae[Mesh] OR papillomaviridae[tiab] OR Human Papilloma Virus[tiab] OR HPV[tiab]	60.747
#9	Medical History Taking[Mesh] OR family histor*[tiab] OR family health histor*[tiab] OR family medical histor*[tiab]	89.943
#10	#2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #7 OR #8 OR #9 OR #10	2.296.920
Kombiniert mit und ohne Filter		
#11	#1 AND #10	12.368
#12	#11 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	38

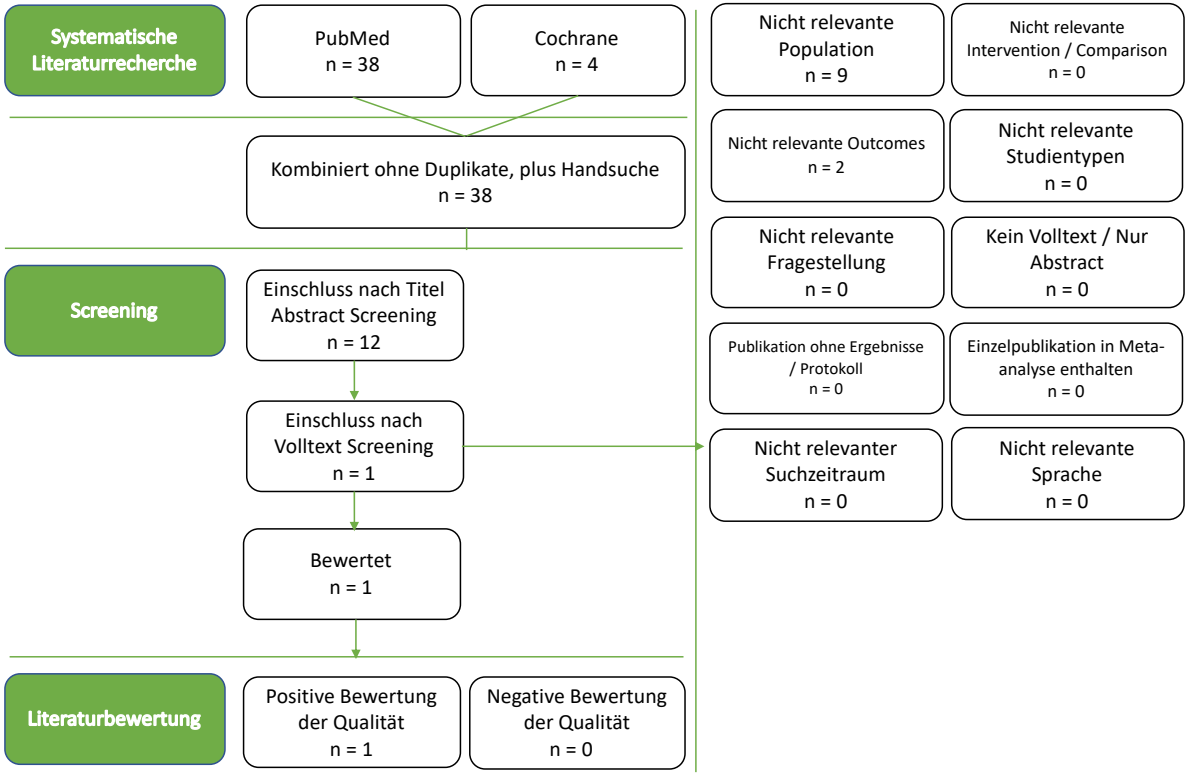
Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244533
#6	MeSH descriptor: [Carcinoma] explode all trees	15104

#7	MeSH descriptor: [Neoplasms] explode all trees	89822
#8	#5 OR #6 OR #7	254737
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(transvaginal sonography OR (("Ultrasonography" OR ultrasound OR ultrasonic OR ultrasonograph* OR echograph* OR echotom*) AND (transvaginal OR trans vaginal))):ti,ab,kw	2360
#14	MeSH descriptor: [Ultrasonography] explode all trees	14906
#15	(transvaginal OR trans vaginal):ti,ab,kw	3176
#16	#14 AND #15	377
#17	#13 OR #16	2366
#18	cytology:ti,ab,kw	6871
#19	(biopsy OR biopsies):ti,ab,kw	33639
#20	MeSH descriptor: [Biopsy] explode all trees	6036
#21	((Histology OR histolog*) AND (Biomarkers, Tumor OR tumor biomarkers OR ((marker OR biomarker) AND (tumor OR carcinogen OR neoplasm* OR cancer*)))):ti,ab,kw	1875
#22	MeSH descriptor: [Histology] explode all trees	1381
#23	((Immunohistochemistry OR immunohistochemistry OR Immunolabeling OR Immunogold OR Immunocytochemistry) AND (Biomarkers, Tumor OR tumor	1431

	biomarkers OR ((marker OR biomarker) AND (tumor OR carcinogen OR neoplasm* OR cancer*))):ti,ab,kw	
#24	MeSH descriptor: [Biomarkers, Tumor] explode all trees	5116
#25	#22 AND #24	328
#26	aspirat*:ti,ab,kw	11922
#27	#26 AND #24	44
#28	(aspirat* AND (Biomarkers, Tumor OR tumor biomarkers OR ((marker OR biomarker) AND (tumor OR carcinogen OR neoplasm* OR cancer*))):ti,ab,kw	142
#29	(Papillomaviridae OR papillomaviridae OR Human Papilloma Virus OR HPV):ti,ab,kw	3547
#30	MeSH descriptor: [Papillomaviridae] explode all trees	690
#31	(Medical History Taking OR family histor* OR family health histor* OR family medical histor*):ti,ab,kw	8216
#32	MeSH descriptor: [Medical History Taking] explode all trees	322
#33	#17 OR #18 OR #19 OR #20 OR #21 OR #23 OR #25 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32	54900
#34	#12 AND #33	664
#35	#34 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 04



2.5. Schlüsselfrage 05

Beeinflussen genetische Faktoren das Risiko für das Auftreten eines Endometriumkarzinoms?
Population Frauen/asymptomatische Frau mit genetischer Disposition/ symptomatische Frau mit genetischer Disposition/an EC erkrankte Frau mit genetischer Disposition Intervention: genetische Disposition Comparison: keine genetische Disposition Outcomes: Endometriumkarzinom

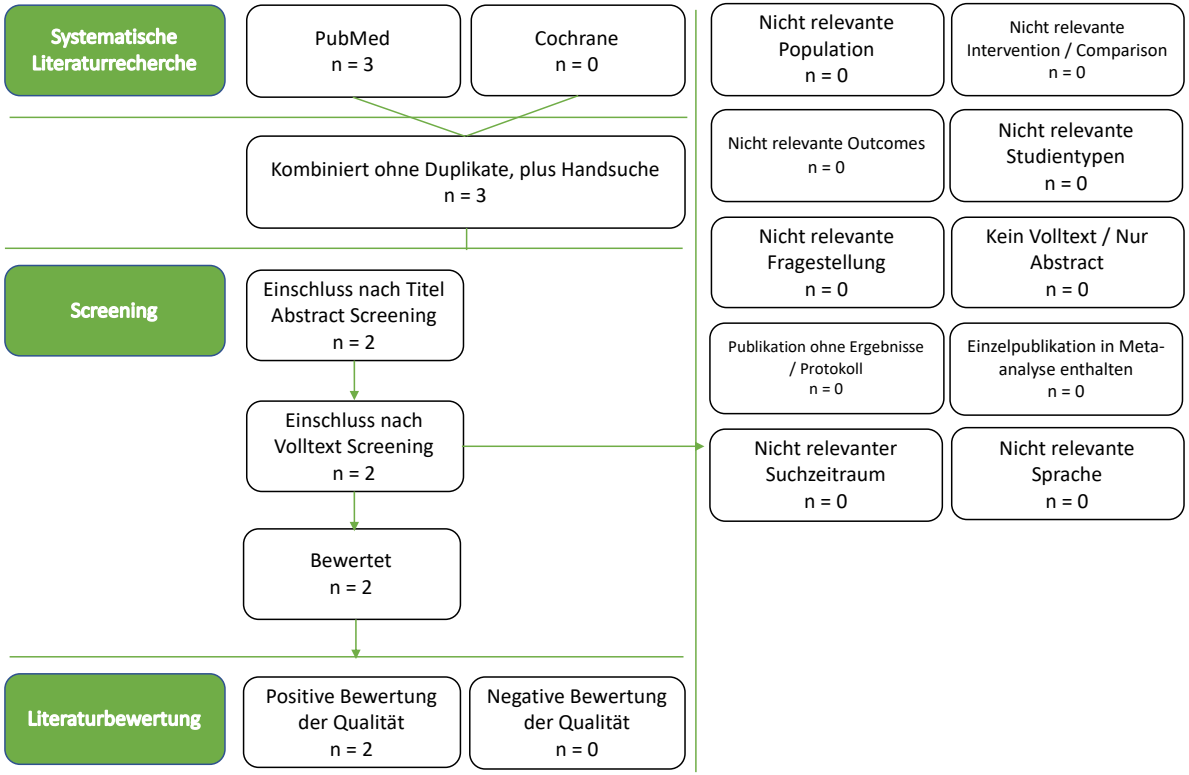
Recherche in PubMed (06.10.2022)

Population		
#1	"Endometrial Neoplasms"[Mesh] OR ((endometria*[tiab] OR endometrium[tiab] OR "Endometrium"[Mesh]) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR "Carcinoma"[Mesh] OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR "Neoplasms"[Mesh]))	51.546
Intervention bzw. Exposure		
#2	hnpcc	2.860
#3	lynch syndrome	8.686
#4	(cowden syndrome) OR (cowden disease)	2.762
#5	"Colorectal Neoplasms, Hereditary Nonpolyposis"[Mesh]	5.174
#6	#2 OR #3 OR #4 OR #5	11.470
Kombiniert ohne Filter		
#7	#1 AND #6	1.590
Kombiniert mit Filter		
#8	#7 AND Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	3

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	hnpcc	52
#3	lynch syndrome	253
#4	cowden disease	16
#5	cowden syndrome	7
#6	#2 OR #3 OR #4 OR #5	310
#7	#1 AND #6	31
#8	#7 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 05



2.6. Schlüsselfrage 06

Welche Verfahren sind bei der asymptomatischen Frau mit genetischer Disposition geeignet zur Früherkennung des Endometriumkarzinoms im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben?
Population Frauen Intervention: genetische Faktoren Comparison: keine genetische Disposition Outcomes: Auftreten eines EC

Recherche in PubMed (06.10.2022)

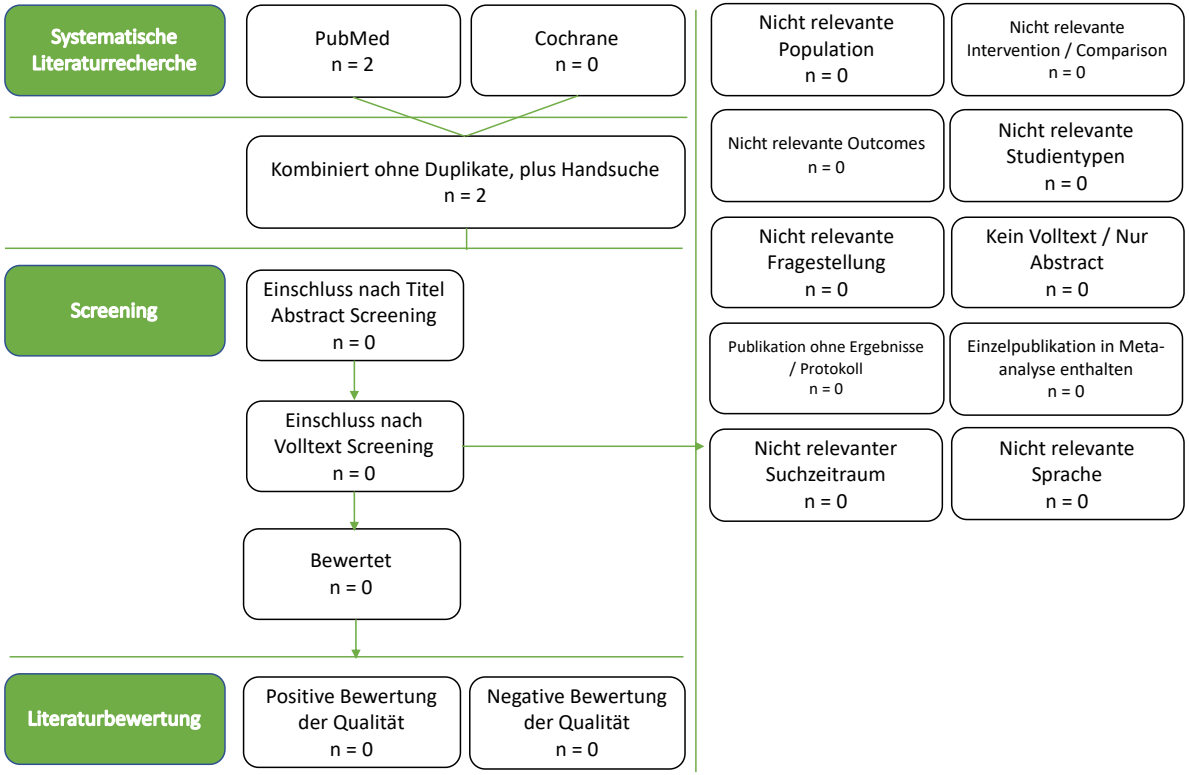
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
Intervention bzw. Exposure		
#2	**Genetic Predisposition to Disease[Mesh]** OR Genetic Susceptibilit*[tiab] OR Genetic Predisposition*[tiab] OR genetical disposition[tiab]	171.499
#3	screen*[tiab] OR early detection[tiab] OR early diagnos*[tiab] OR **"Early Diagnosis"[Mesh]**	1.080.386
Kombiniert mit und ohne Filter		
#4	#1 AND #2 AND #3	209
#5	#4 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	2

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136

#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244533
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89822
#8	#5 OR #6 OR #7	254737
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Genetic Predisposition to Disease OR Genetic Susceptibilit* OR Genetic Predisposition* OR genetical disposition):ti,ab,kw	5200
#14	MeSH descriptor: [Genetic Predisposition to Disease] explode all trees	1124
#15	#13 OR #14	5200
#16	(screen* OR early detection OR early diagnos* OR "Early Diagnosis"):ti,ab,kw	115525
#17	MeSH descriptor: [Early Diagnosis] explode all trees	2054
#18	#16 OR #17	115525
#19	#12 AND #15 AND #18	6
#20	#19 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 06



2.7. Schlüsselfrage 07

Welchen Stellenwert hat die transvaginale Sonographie in der Diagnostik der symptomatischen Frau mit normalem Risiko zum Nachweis eines Endometriumkarzinoms im Hinblick auf Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population symptomatische Frau mit 1.normalem Risiko für EC 2.erhöhtem Risiko für EC (Adipositas, PCO, TAM-Einnahme, DM) ohne genetische Disposition Intervention: Diagnostik des Endometriumkarzinomsmittels 1.Ultraschall 2.Aspiration Comparison: Diagnostik des Endometriumkarzinomsmittels 1.frakt. Abrasio ohne HSK 2.frakt. Abrasio mit HSK Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifischesund Gesamtüberleben

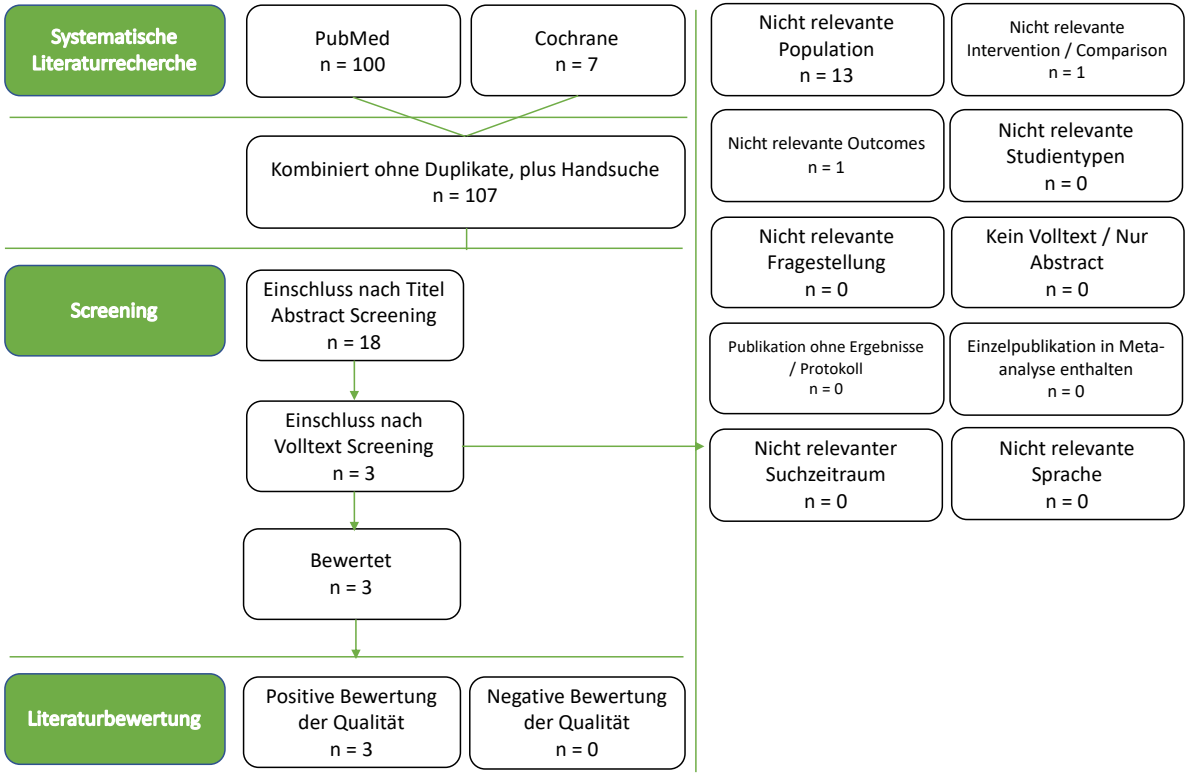
Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**diagnosis**	11.180.338
Kombiniert mit und ohne Filter		
#3	#1 AND #2	30.469
#4	#3 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	100

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	7

Schlüsselfrage 07



2.8. Schlüsselfrage 08

Gibt es bei V. a. Endometriumkarzinom einen sinnvollen Algorithmus von transvaginaler Sonographie, Endometriumbiopsie mittels Aspiration, Abrasio uteri oder Hysteroskopie für die Diagnostik zum Nachweis eines Endometriumkarzinoms bei Frauen mit genetischer Disposition?
Population asymptomatische Frau mit 1.normalem Risiko für EC 2.erhöhtem Risiko für EC (Adipositas, PCO, TAM-Einnahme, DM) ohne genetische Disposition Intervention: Screening auf EC mittels 1.Ultraschall 2.zytolog. Beurteilung 3.Endometriumbiopsie mittels Aspiration 4.Hysteroskopie 5.Tumormarker-Bestimmun Comparison: kein Screening Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

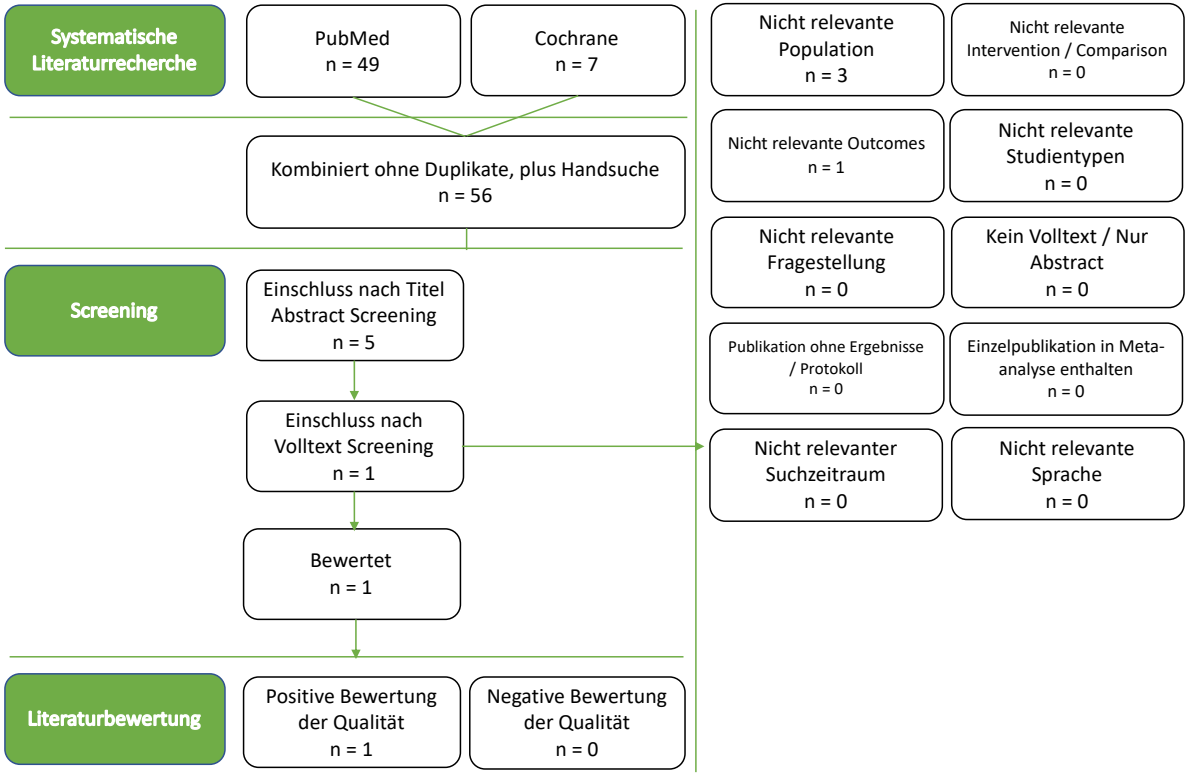
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	genetic	4.758.052
#3	gene	3.173.891
#4	mutation	1.217.819
#5	hnpcc	6.359
#6	predispositions	291.967
#7	screening	5.720.343
#8	#2 OR #3 OR #4 OR #5 OR #6	5.571.894
#9	#5 AND #7	3.570

Kombiniert ohne Filter		
#10	#8 AND #1	13.664
#11	#10 OR #9	16.461
Kombiniert mit Filter		
#12	#11 AND Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	**49**

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	7

Schlüsselfrage 08



2.9. Schlüsselfrage 09

Welche Bedeutung hat die Endometriumbiopsie mittels Aspiration in der Diagnostik zum Nachweis des Endometriumkarzinoms im Vergleich zur frakt. Abrasio +/– HSK im Hinblick auf Sensitivität/Spezifität/prädiktiven Wert und die möglichen Nebenwirkungen und Risiken?
Population symptomatische Frau mit 1.normalem Risiko für EC 2.erhöhtem Risiko für EC (Adipositas, PCO, TAM-Einnahme, DM) ohne genetische Disposition Intervention: Diagnostik des Endometriumkarzinomsmittels 1.Ultraschall 2.Aspiration Comparison: Diagnostik des Endometriumkarzinomsmittels 1.frakt. Abrasio ohne HSK 2.frakt. Abrasio mit HSK Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifischesund Gesamtüberleben

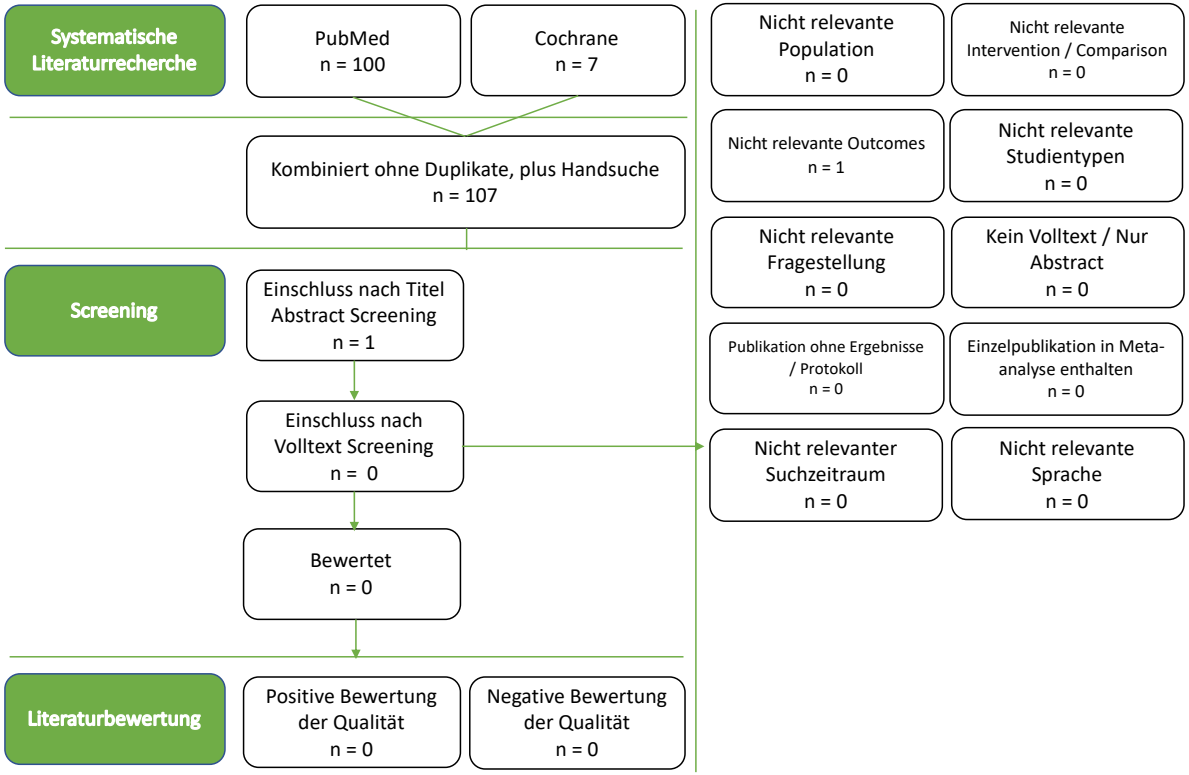
Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**diagnosis**	11.180.338
Kombiniert mit und ohne Filter		
#3	#1 AND #2	30.469
#4	#3 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	100

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	7

Schlüsselfrage 09



2.10. Schlüsselfrage 10

Gibt es bei V.a. Endometriumkarzinom einen sinnvollen Algorithmus von transvaginaler Sonographie, Endometriumbiopsie mittels Aspiration, Abrasio uteri oder Hysteroskopie für die Diagnostik zum Nachweis eines Endometriumkarzinoms bei Frauen mit normalem Risiko?
Population symptomatische Frau mit 1.normalem Risiko für EC 2.erhöhtem Risiko für EC (Adipositas, PCO, TAM-Einnahme, DM) ohne genetische Disposition Intervention: Diagnostik des Endometriumkarzinomsmittels 1.Ultraschall 2.Aspiration Comparison: Diagnostik des Endometriumkarzinomsmittels 1.frakt. Abrasio ohne HSK 2.frakt. Abrasio mit HSK Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifischesund Gesamtüberleben

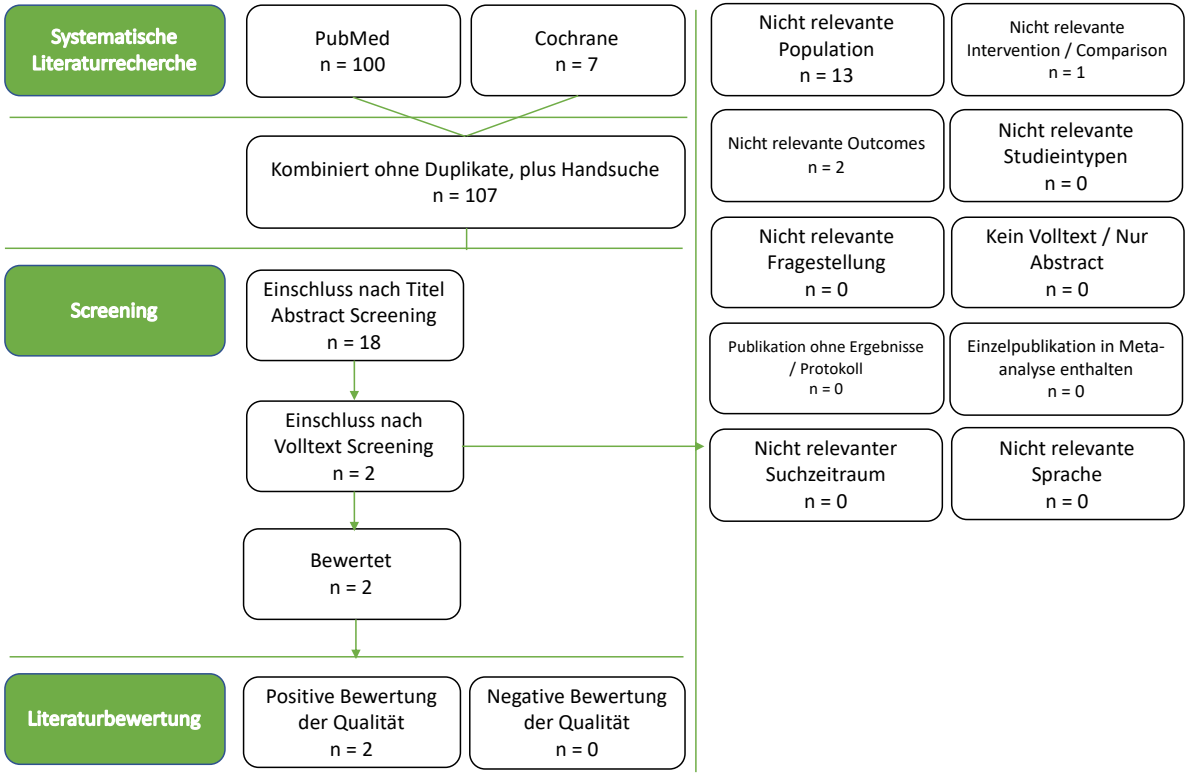
Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**diagnosis**	11.180.338
Kombiniert mit und ohne Filter		
#3	#1 AND #2	30.469
#4	#3 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	100

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	7

Schlüsselfrage 10



2.11. Schlüsselfrage 11

Gibt es bei V.a. Endometriumkarzinom einen sinnvollen Algorithmus von transvaginaler Sonographie, Endometriumbiopsie mittels Aspiration, Abrasio uteri oder Hysteroskopie für die Diagnostik zum Nachweis eines Endometriumkarzinoms bei Frauen mit hohem Risiko?
Population symptomatische Frau mit 1.normalem Risiko für EC 2.erhöhtem Risiko für EC (Adipositas, PCO, TAM-Einnahme, DM) ohne genetische Disposition Intervention: Diagnostik des Endometriumkarzinomsmittels 1.Ultraschall 2.Aspiration Comparison: Diagnostik des Endometriumkarzinomsmittels 1.frakt. Abrasio ohne HSK 2.frakt. Abrasio mit HSK Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifischesund Gesamtüberleben

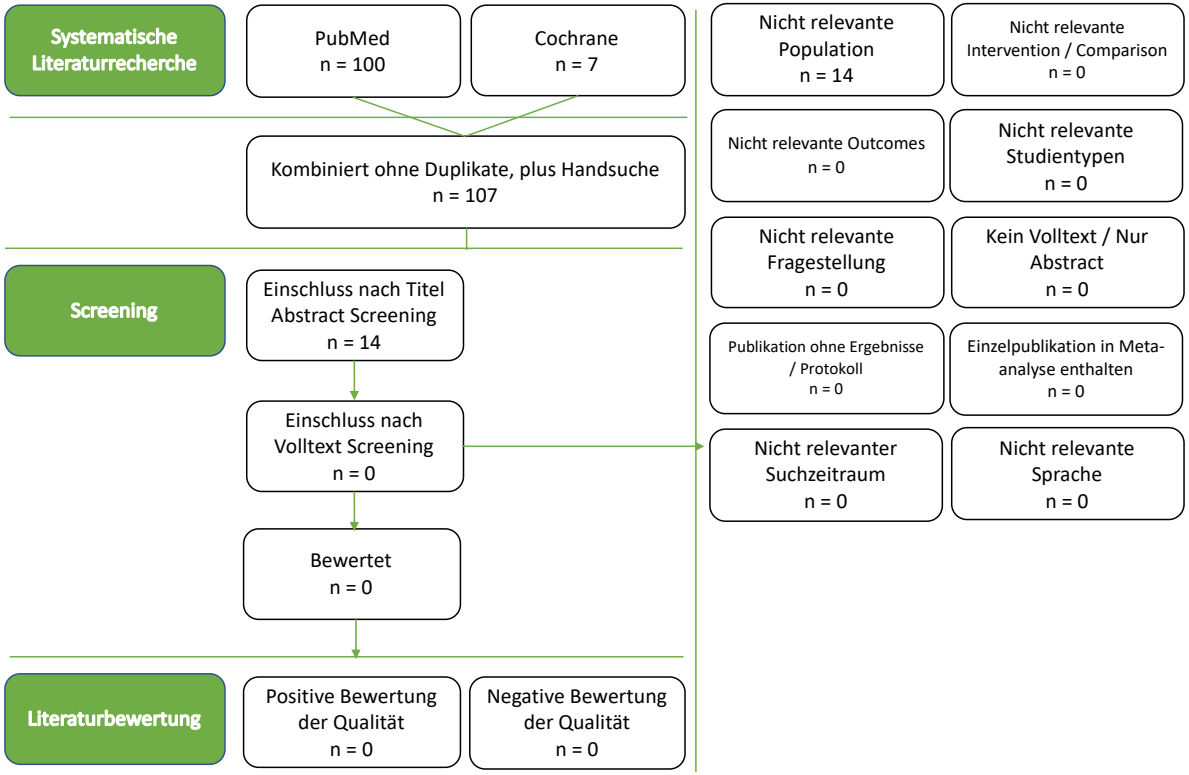
Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**diagnosis**	11.180.338
Kombiniert mit und ohne Filter		
#3	#1 AND #2	30.469
#4	#3 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	100

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	7

Schlüsselfrage 11



2.12. Schlüsselfrage 12

Gibt es bei V.a. Endometriumkarzinom einen sinnvollen Algorithmus von transvaginaler Sonographie, Endometriumbiopsie mittels Aspiration, Abrasio uteri oder Hysteroskopie für die Diagnostik zum Nachweis eines Endometriumkarzinoms bei Frauen mit normalem oder erhöhtem Risiko?
Population asymptomatische Frau mit 1.normalem Risiko für EC 2.erhöhtem Risiko für EC (Adipositas, PCO, TAM-Einnahme, DM) ohne genetische Disposition Intervention: Screening auf EC mittels 1.Ultraschall 2.zytolog. Beurteilung 3.Endometriumbiopsie mittels Aspiration 4.Hysteroskopie 5.Tumormarker-Bestimmun Comparison: kein Screening Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

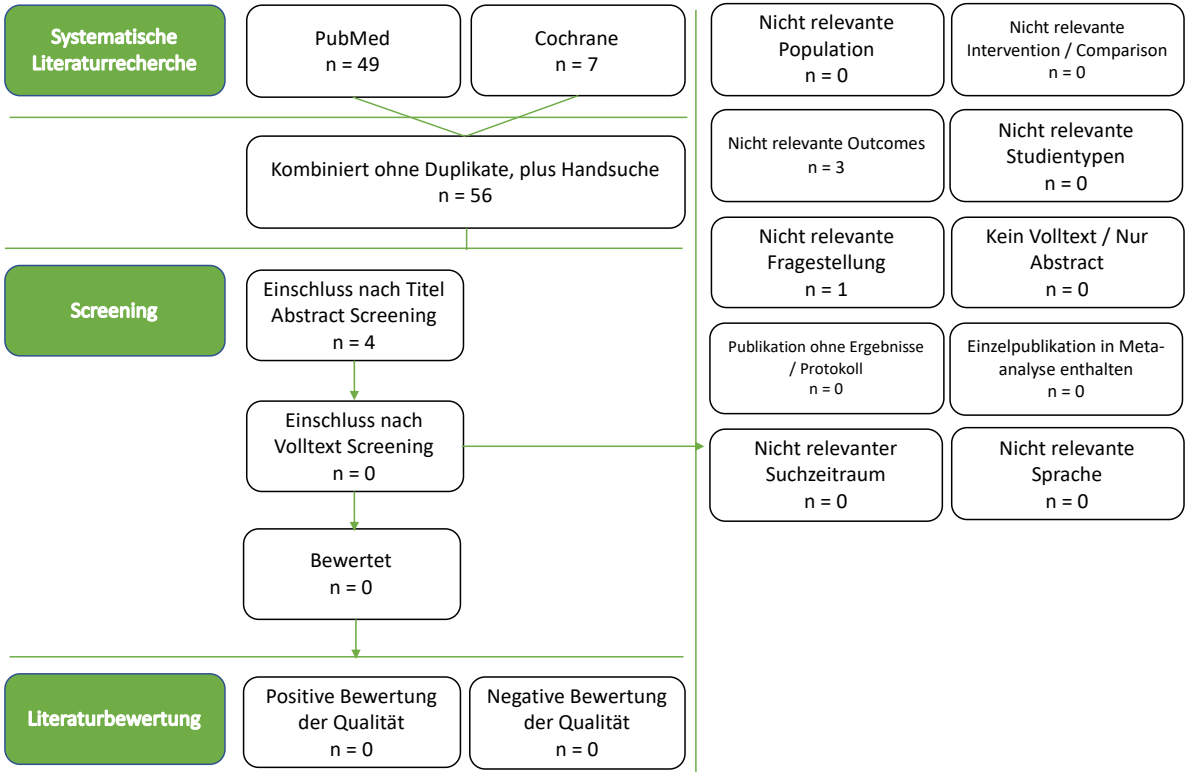
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	genetic	4.758.052
#3	gene	3.173.891
#4	mutation	1.217.819
#5	hnpcc	6.359
#6	predispositions	291.967
#7	screening	5.720.343
#8	#2 OR #3 OR #4 OR #5 OR #6	5.571.894

#9	#5 AND #7	3.570
Kombiniert ohne Filter		
#10	#8 AND #1	13.664
#11	#10 OR #9	16.461
Kombiniert mit Filter		
#12	#11 AND Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	**49**

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	7

Schlüsselfrage 12



2.13. Schlüsselfrage 13

Welchen Stellenwert haben bildgebende Verfahren wie MRT, CT, PET-CT, **PET-MRT** und US präoperativ für die lokale und systemische Ausbreitungsdiagnostik des histologisch gesicherten primären Endometriumkarzinoms im Hinblick auf eine Änderung der operativen Strategie sowie auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: Frauen mit histologisch gesichertem EC Intervention: präoperative lokale und systemische Ausbreitungsdiagnostik mittels MRT CT PET-CT US **PET-MRT** Comparison: keine Ausbreitungs-diagnostik Outcomes: Änderung der operativen Strategie Änderung Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben

Recherche in PubMed (02.09.2021)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
Intervention bzw. Exposure		
#2	preoperative staging[tiab] OR pre-operative staging[tiab] OR staging, pre-operative OR staging, preoperative[tiab] OR (("Neoplasm Staging"[Mesh] OR staging[tiab] OR classification[tiab]) AND (pre-operative[tiab] OR preoperative[tiab]))	34.610
Kombiniert mit und ohne Filter		
#3	#1 AND #2	1.023

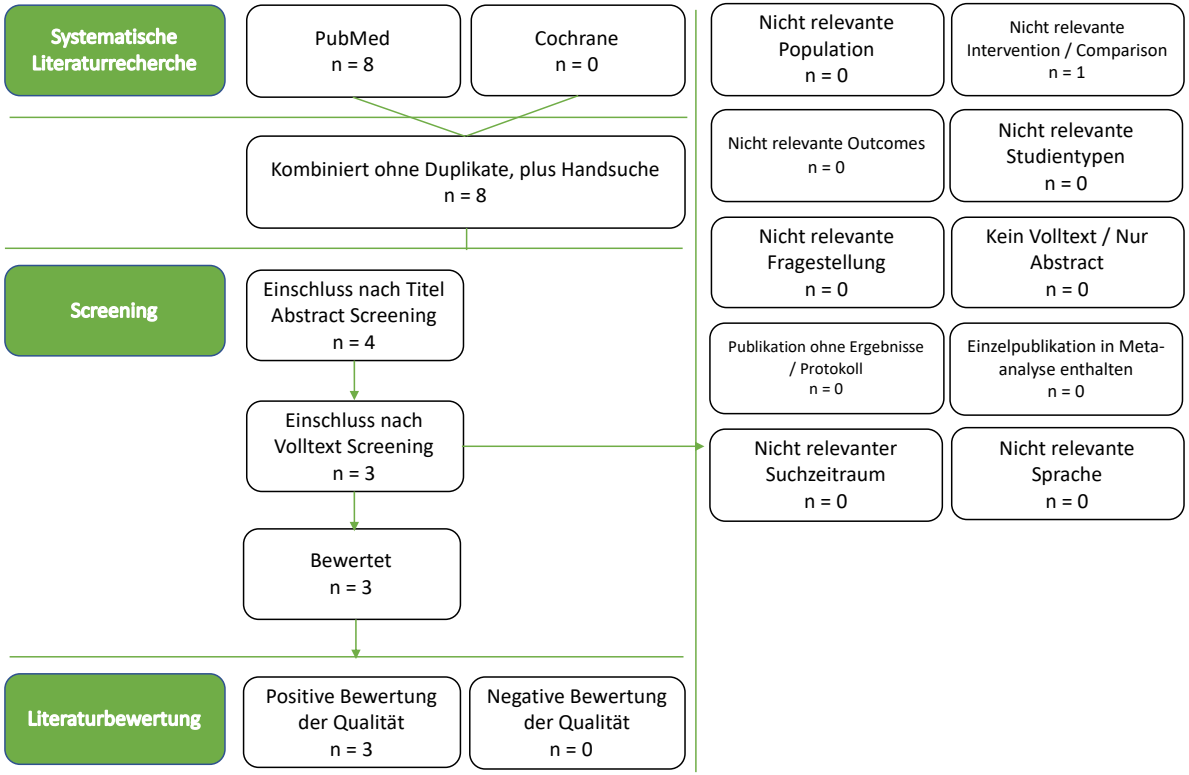
#4	#3 Filters:Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	8

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244533
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89822
#8	#5 OR #6 OR #7	254737
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(preoperative staging OR pre-operative staging OR staging, pre-operative OR staging, preoperative):ti,ab,kw	1773
#14	(Neoplasm Staging OR staging OR classification):ti,ab,kw	71956
#15	MeSH descriptor: [Neoplasm Staging] explode all trees	6865
#16	#14 OR #15	71956
#17	(pre-operative OR preoperative):ti,ab,kw	41602
#18	#16 AND #17	3256
#19	#13 OR #18	3256

#20	#12 AND #19	58
#21	#20 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 13



2.14. Schlüsselfrage 14

Welches operative Standardverfahren ist bei Vorliegen einer atypischen Hyperplasie indiziert?
Population Frauen mit atypischer Hyperplasie Intervention: Hysterektomie cum Adnexexstirpation bds. Comparison: Konservative TherapieHysterektomie sine Adnexexstirpation Outcomes: Morbidität, Mortalität, Lebensqualität

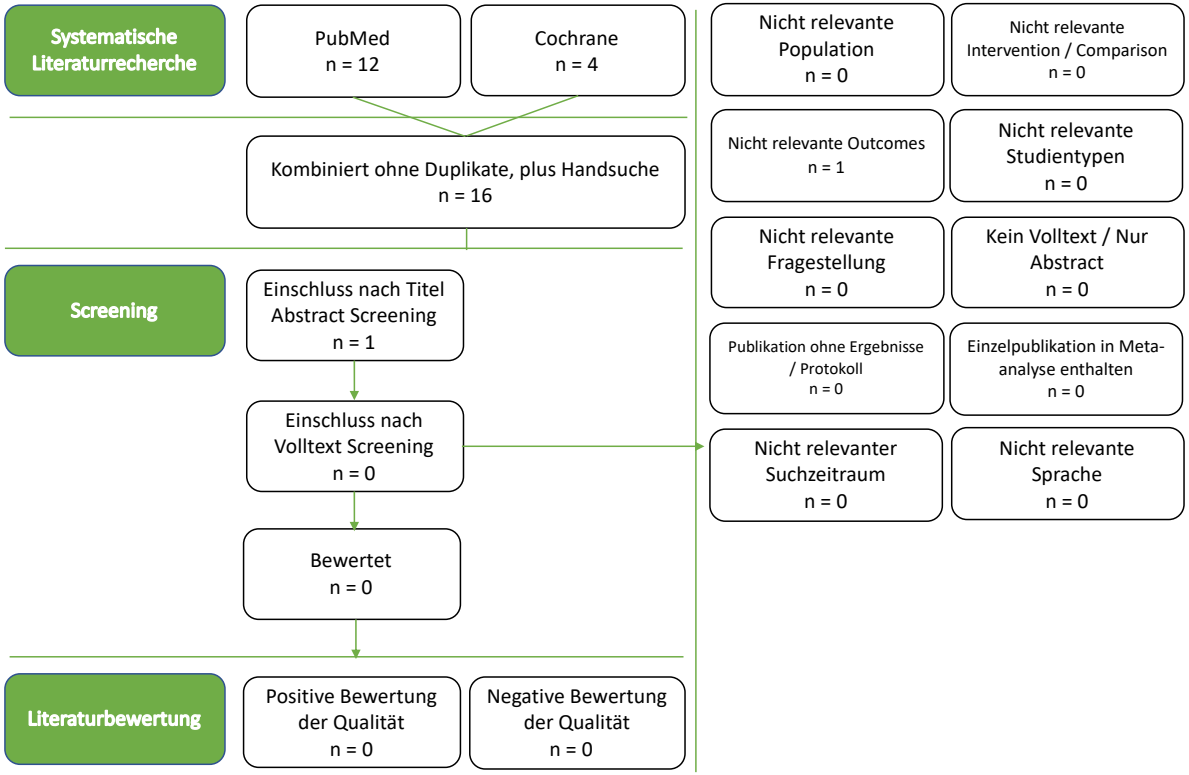
Recherche in PubMed (06.10.2022)

Population		
#1	atypical hyperplasia	7.323
#2	#1 Filters: Publication date from 09/2021 to 09/2022 Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	12

Recherche in Cochrane Library (06.10.2022)

ID	Search	Hits
#1	atypical hyperplasia	278
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	4

Schlüsselfrage 14



2.15. Schlüsselfrage 15

Unter welchen Voraussetzungen können bei Vorliegen einer atypischen Hyperplasie die Adnexe belassen werden im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit atypischer Hyperplasie Intervention: Hysterektomie cum Adnexexstirpation bds. Comparison: Konservative TherapieHysterektomie sine Adnexexstirpation Outcomes: Morbidität, Mortalität, Lebensqualität

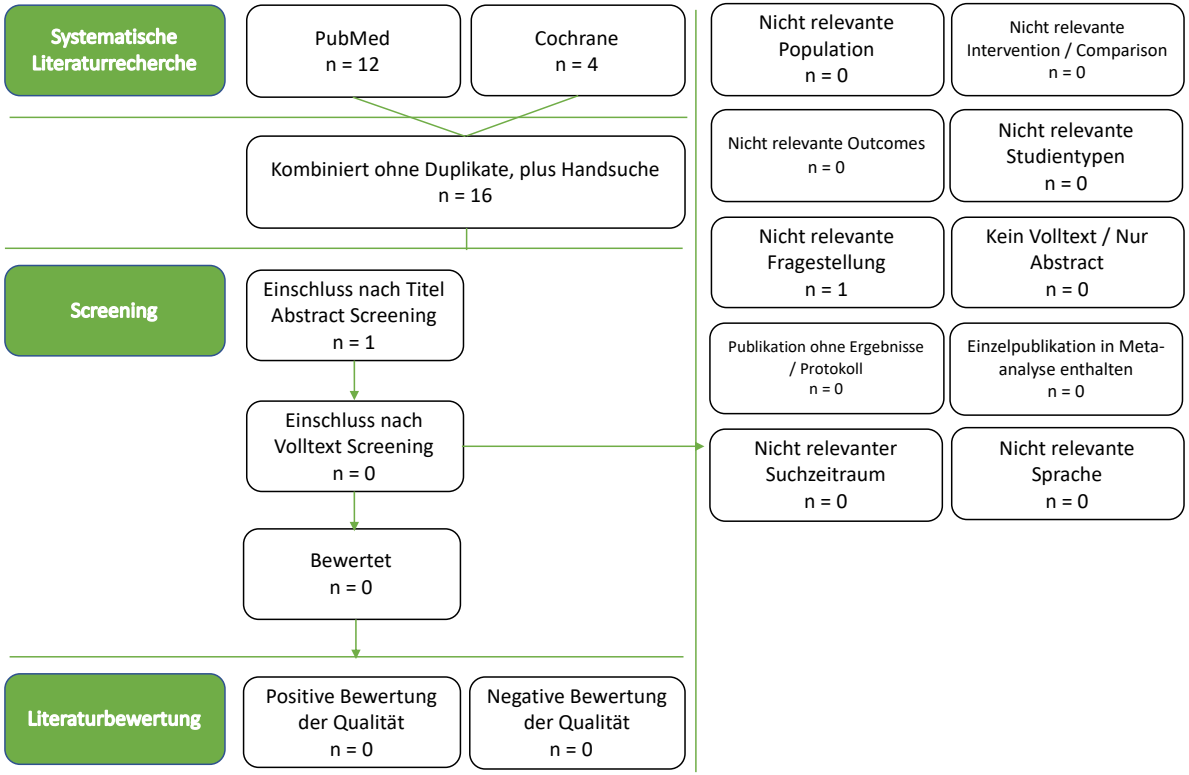
Recherche in PubMed (06.10.2022)

Population		
#1	atypical hyperplasia	7.323
#2	#1 Filters: Publication date from 09/2021 to 09/2022 Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	12

Recherche in Cochrane Library (06.10.2022)

ID	Search	Hits
#1	atypical hyperplasia	278
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	4

Schlüsselfrage 15



2.16. Schlüsselfrage 16

Welches operative Standardverfahren ist bei Vorliegen eines frühen Endometriumkarzinoms (**Typ 1, G1, G2, pT1a**) indiziert?
Population Frauen mit frühem EC (**frühes EC = Typ-I-EC G1, G2, pt1a**), Frauen mit atypischer Hyperplasie Intervention: Hysterektomie cum Adnexexstirpation, beidseitig Comparison: konservative Therapie Hysterektomie sine Adnexexstirpation Outcomes: Morbidität, Lebensqualität, Rezidivhäufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed 06.10.2022)

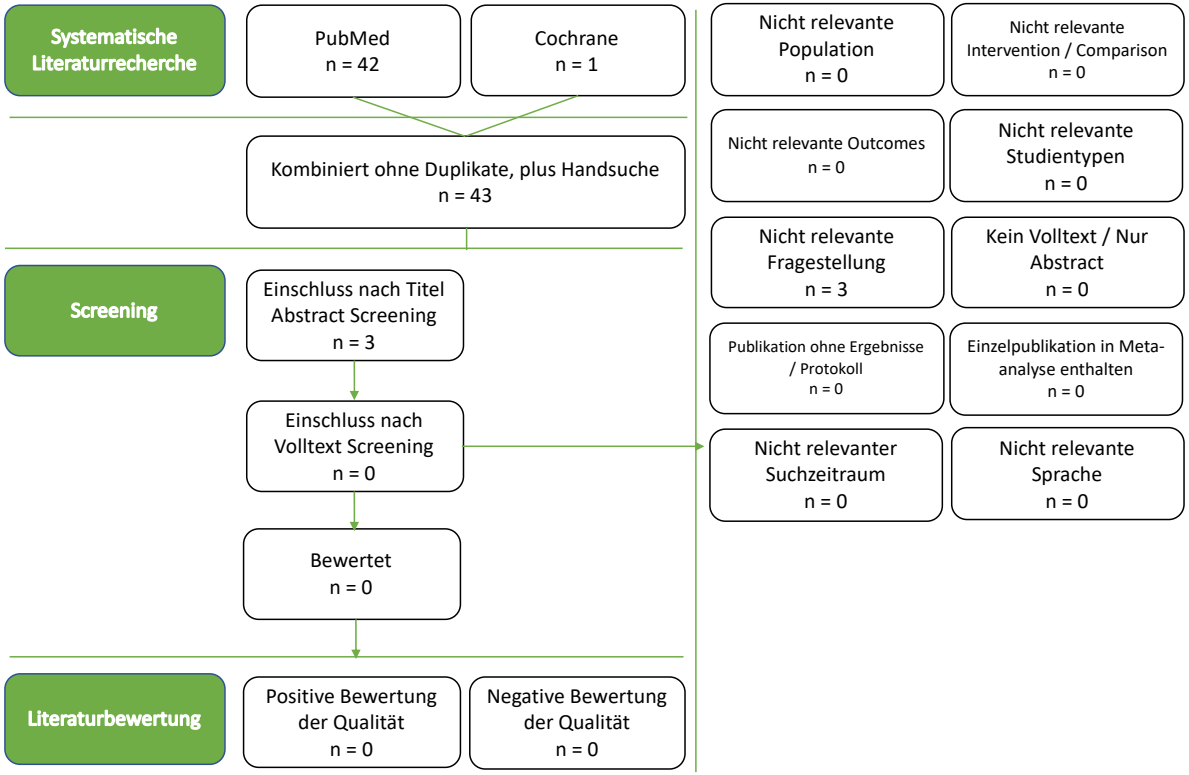
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
Intervention bzw. Exposure		
#2	General Surgery[Mesh] OR surger*[tiab] OR surgical[tiab]	2.133.347
Kombiniert mit und ohne Filter		
#3	#1 AND #2	9.679
#4	#3 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	42

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716

#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244534
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89822
#8	#5 OR #6 OR #7	254738
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(General Surgery OR surger* OR operat* OR surgical):ti,ab,kw	317823
#14	MeSH descriptor: [General Surgery] explode all trees	366
#15	#13 OR #14	317823
#16	#12 AND #15	1291
#17	#16 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 16



2.17. Schlüsselfrage 17

Unter welchen Voraussetzungen können bei **prä-, peri- und postmenopausalen Frauen** mit Endometriumkarzinom die Ovarien belassen werden im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen -prämenopausal -perimenopausal -postmenopausal mit atypischer Hyperplasie Frauen -prämenopausal, -perimenopausal, -postmenopausal mit frühem EC Intervention: Hysterektomie cum Adnexexstirpation, beidseitig Comparison: konservative Therapie Hysterektomie sine Adnexexstirpation Outcomes: Morbidität, Lebensqualität, Rezidivhäufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

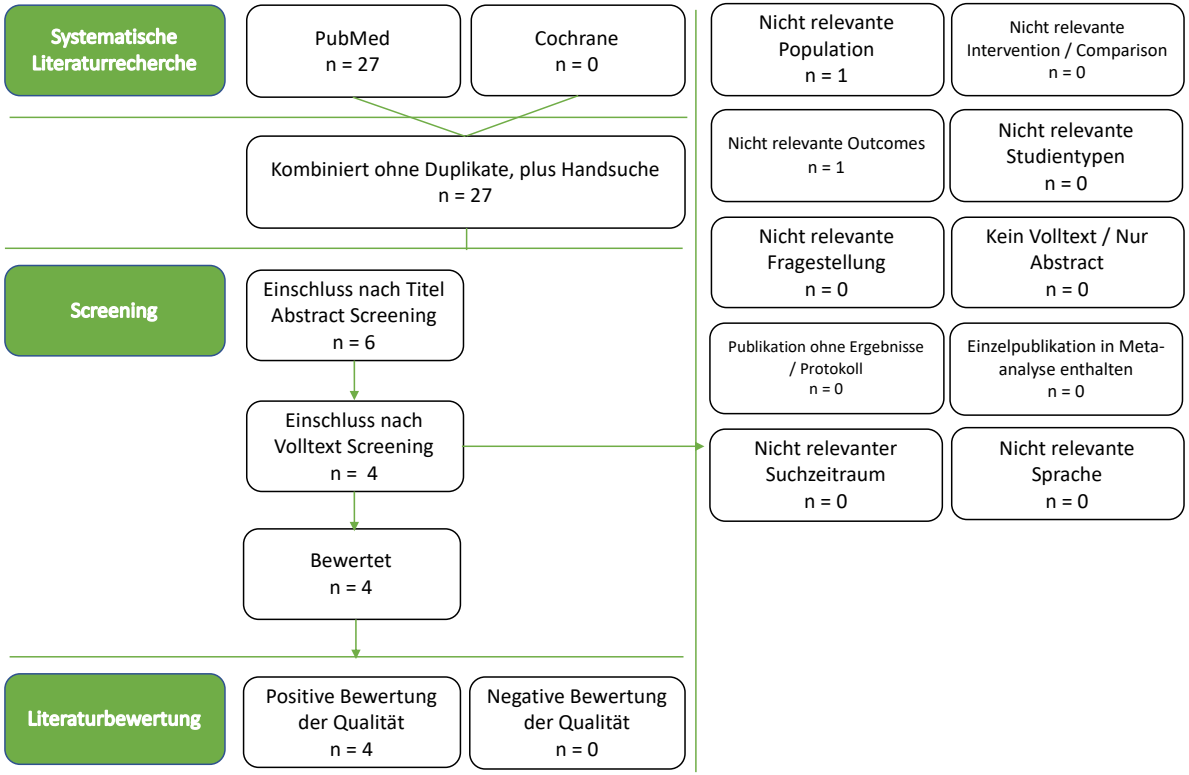
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	**Endometrial Hyperplasia[Mesh]** OR endometrial hyperplas*[tiab]	5.551
#3	#1 OR #2	52.991
Intervention bzw. Exposure		
#4	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#5	**Fertility Preservation[Mesh]** OR fertility preservation[tiab] OR fertility sparing treatment[tiab] OR ovarian preservation*[tiab] OR ovary preservation[tiab] OR ovary sparing[tiab] OR ovarian sparing[tiab]	6.529
#6	#4 OR #5	59.047
Kombiniert mit und ohne Filter		
#7	#3 AND #6	7.480
#8	#7 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	27

Recherche in Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Endometrial Hyperplasia OR endometrial hyperplas*):ti,ab,kw	702
#14	MeSH descriptor: [Endometrial Hyperplasia] explode all trees	171
#15	#12 OR #13 OR #14	3795
#16	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#17	MeSH descriptor: [Hysterectomy] explode all trees	1908
#18	(Fertility Preservation OR fertility preservation OR fertility sparing treatment OR ovarian preservation* OR ovary preservation OR ovary sparing OR ovarian sparing):ti,ab,kw	427
#19	MeSH descriptor: [Fertility Preservation] explode all trees	31

#20	#16 OR #17 OR #18 OR #19	8527
#21	#15 AND #20	552
#22	#21 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 17



2.18. Schlüsselfrage 18

Unter welchen Voraussetzungen können bei Vorliegen eines frühen Endometriumkarzinoms (Typ 1, G1, G2, pT1a) Uterus und Adnexe belassen werden im Hinblick auf Lebensqualität, Kurzzeit/-Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit frühem EC Intervention: Hysterektomie cum Adnexexstirpation bds Comparison: Konservative Therapie-Hysterektomie sine Adnexexstirpation Outcomes: Morbidität, Mortalität, Lebensqualität

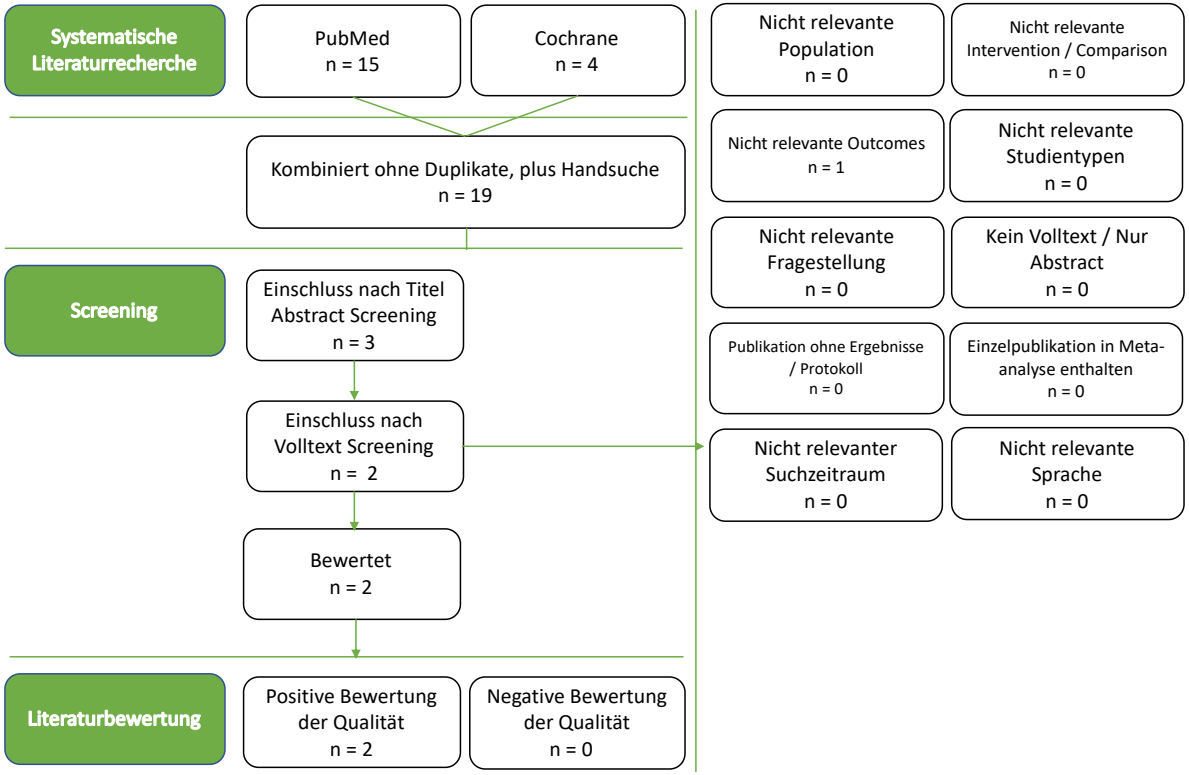
Recherche in PubMed (06.10.2022)

Population		
#1	endometrial hyperplasia	7.072
#2	#1 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	15

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	endometrial hyperplasia	744
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	4

Schlüsselfrage 18



2.19. Schlüsselfrage 19

Ist beim Endometriumkarzinom Stadium pT2 die radikale (**Piver II oder III)** oder einfache Hysterektomie **(Piver I)** sinnvoller im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: Frauen mit EC pT2 Intervention: Radikale Hyster-ektomie **gemäß PIVER II oder PIVER III** Comparison: Einfache Hysterektomie **gemäß PIVER I** Outcomes: Morbidität, Lebensqualität, Rezidivhäufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

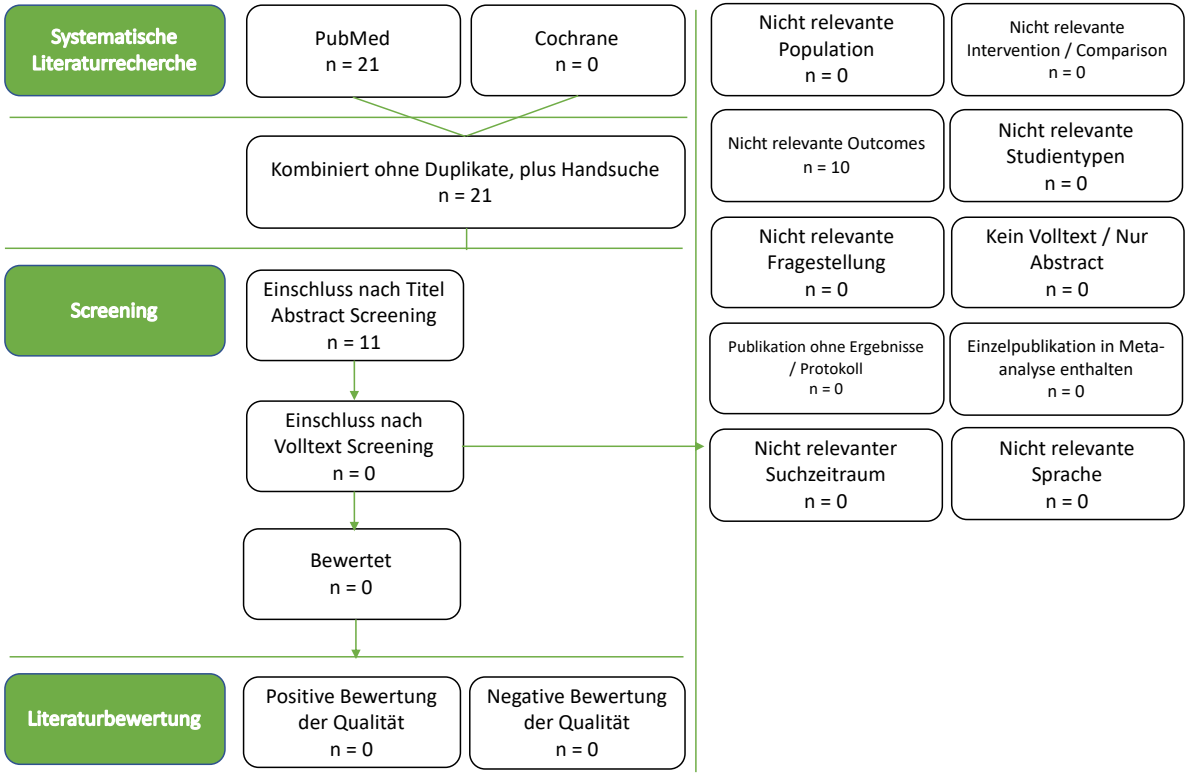
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
Intervention bzw. Exposure		
#2	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
Kombiniert mit und ohne Filter		
#3	#1 AND #2	6.949
#4	#3 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	21

Recherche in der Cochrane Library (07.10.2022)

D	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599

#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#14	MeSH descriptor: [Hysterectomy] explode all trees	1908
#15	#13 OR #14	8161
#16	#12 AND #15	489
#17	#16 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 19



2.20. Schlüsselfrage 20

Ist beim Endometriumkarzinom (Typ I, pT1a, G1/2) die systematische pelvine bzw. pelvine plus paraaortale Lymphonodektomie (LNE) bei makroskopisch unauffälligen LK sinnvoll im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit mit Lymphgefäßinvasion Intervention: systematische paraaortale und pelvine Lymphonodektomie (LNE) Comparison: keine LNE Outcomes: Morbidität, Lebensqualität, Rezidivhäufigkeit, krankheitsspezifisches Überleben, Gesamtüberleben

Recherche in PubMed (07.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271

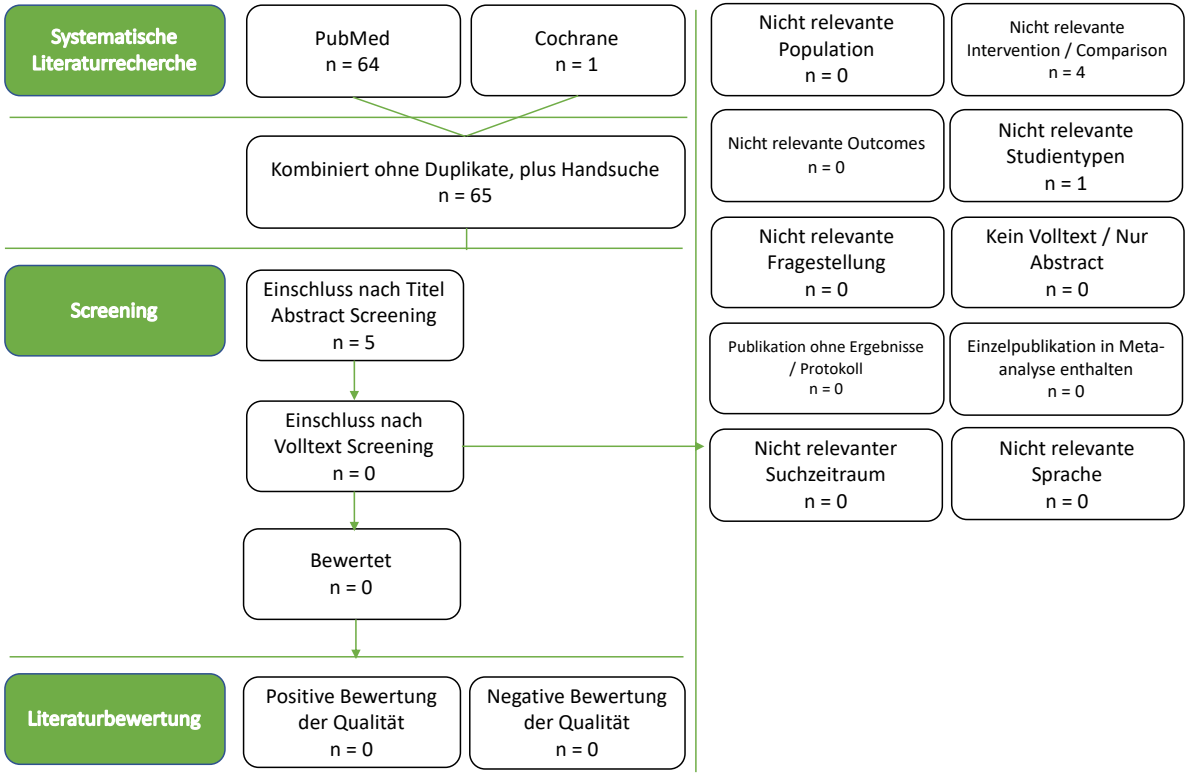
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (03.09.2021)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480

#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 20



2.21. Schlüsselfrage 21

Ist beim Endometriumkarzinom (Typ I, pT1a, G1/2) die SLN bei makroskopisch unauffälligen LK sinnvoll im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben? (S. Schlüsselfrage 34)
Population Frauen mit EC (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit mit Lymphgefäßinvasion Intervention: Sentinel-Lymphknotenbiopsie (SLN) Comparison: keine LNE bei Frauen mit Typ-I-EC, pT1a, G1/2) und makroskopisch unauffälligen LK LNE bei Frauen mit EC der folgenden Typ-Bestimmungen Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit LNE bei Frauen mit EC und mit Lymphgefäßinvasion Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		

#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in PubMed (07.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429

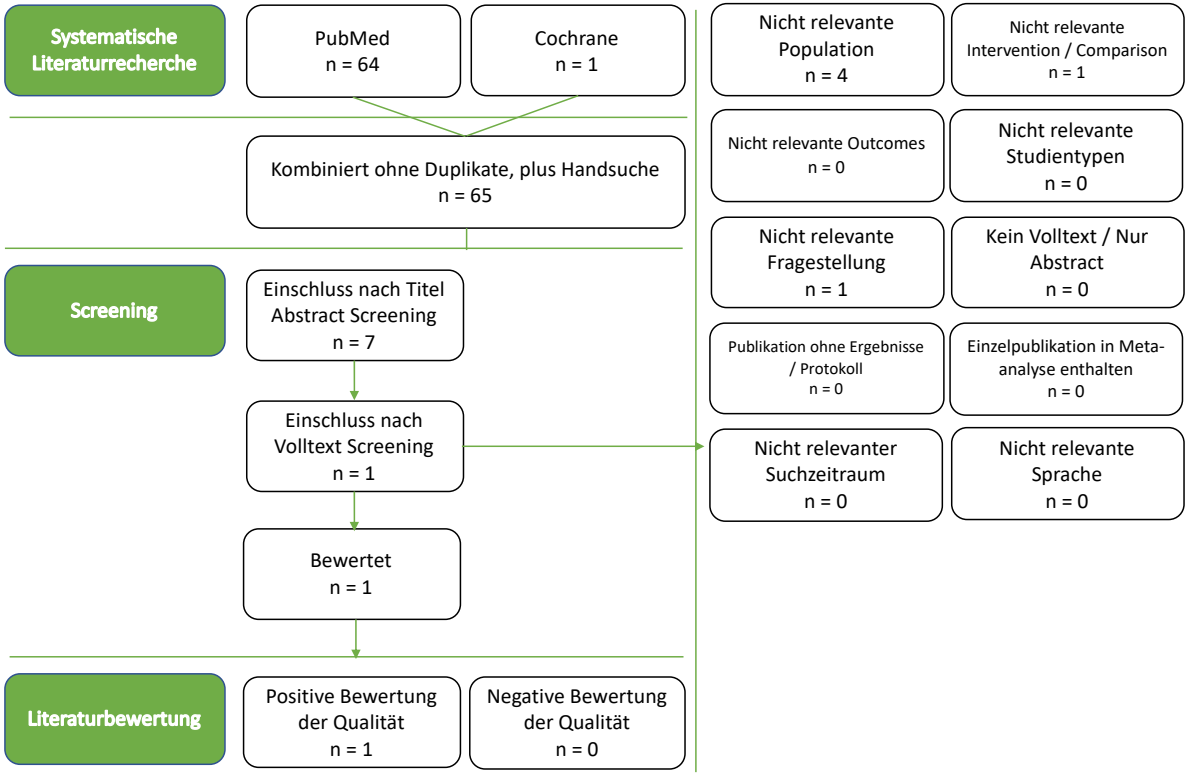
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (03.09.2021)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR	3267

	"Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	
#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 21



2.22. Schlüsselfrage 22

Ist beim Endometriumkarzinom (Typ I, pT1a, G3; pT1 b, G1/2) die systematische pelvine bzw. pelvine plus paraaortale Lymphonodektomie (LNE) bei makroskopisch unauffälligen LK sinnvoll im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit mit Lymphgefäßinvasion Intervention: systematische paraaortale und pelvine Lympho-nodektomie (LNE) Comparison: keine LNE Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271

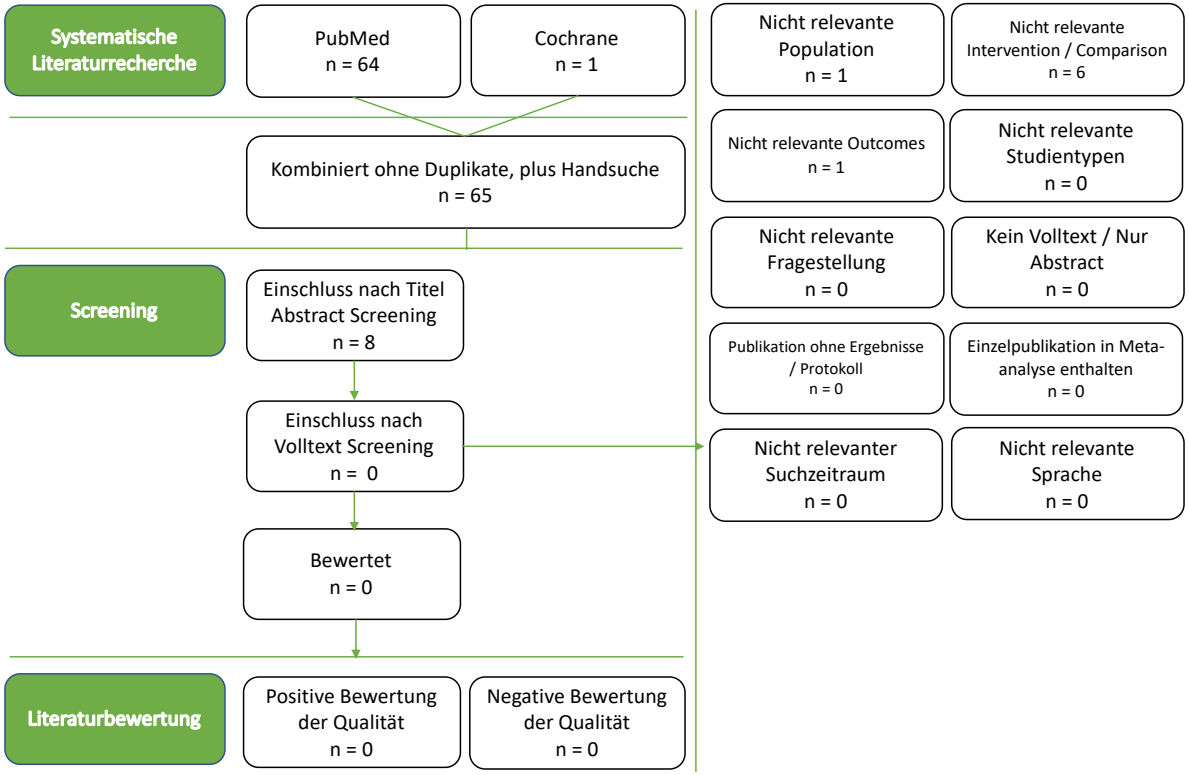
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480

#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 22



2.23. Schlüsselfrage 23

Ist beim Endometriumkarzinom (Typ I, pT1a, G3; pT1 b, G1/2) die SLN bei makroskopisch unauffälligen LK sinnvoll im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit mit Lymphgefäßinvasion Intervention: Sentinel-Lymphknotenbiopsie (SLN) Comparison: keine LNE bei Frauen mit Typ-I-EC, pT1a, G1/2) und makroskopisch unauffälligen LK LNE bei Frauen mit EC der folgenden Typ-Bestimmungen Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit LNE bei Frauen mit EC und mit Lymphgefäßinvasion Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		

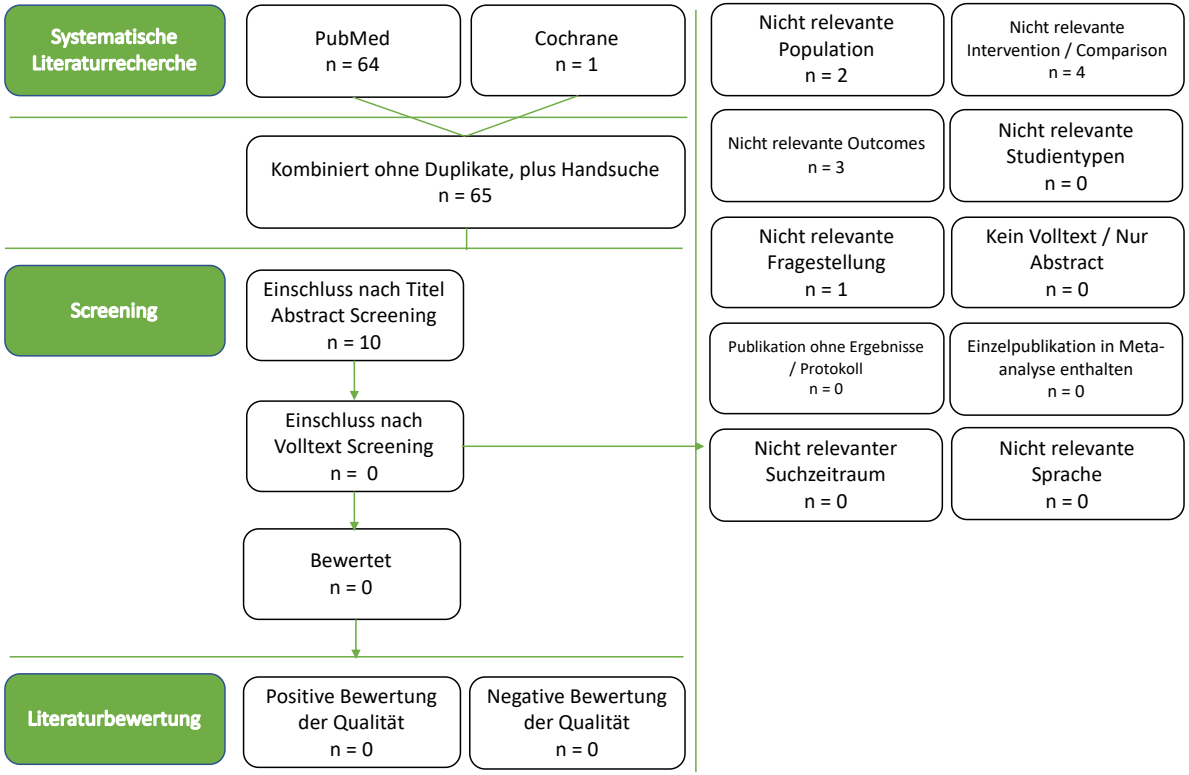
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436

#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 23



2.24. Schlüsselfrage 24

Ist beim Endometriumkarzinom (Typ I, pT1b, G3) die systematische pelvine bzw. pelvine plus paraaortale Lymphonodektomie (LNE) sinnvoll, wenn makroskopisch Tumorfreiheit erzielt werden kann im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit mit Lymphgefäßinvasion Intervention: systematische paraaortale und pelvine Lympho-nodektomie (LNE) Comparison: keine LNE Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271

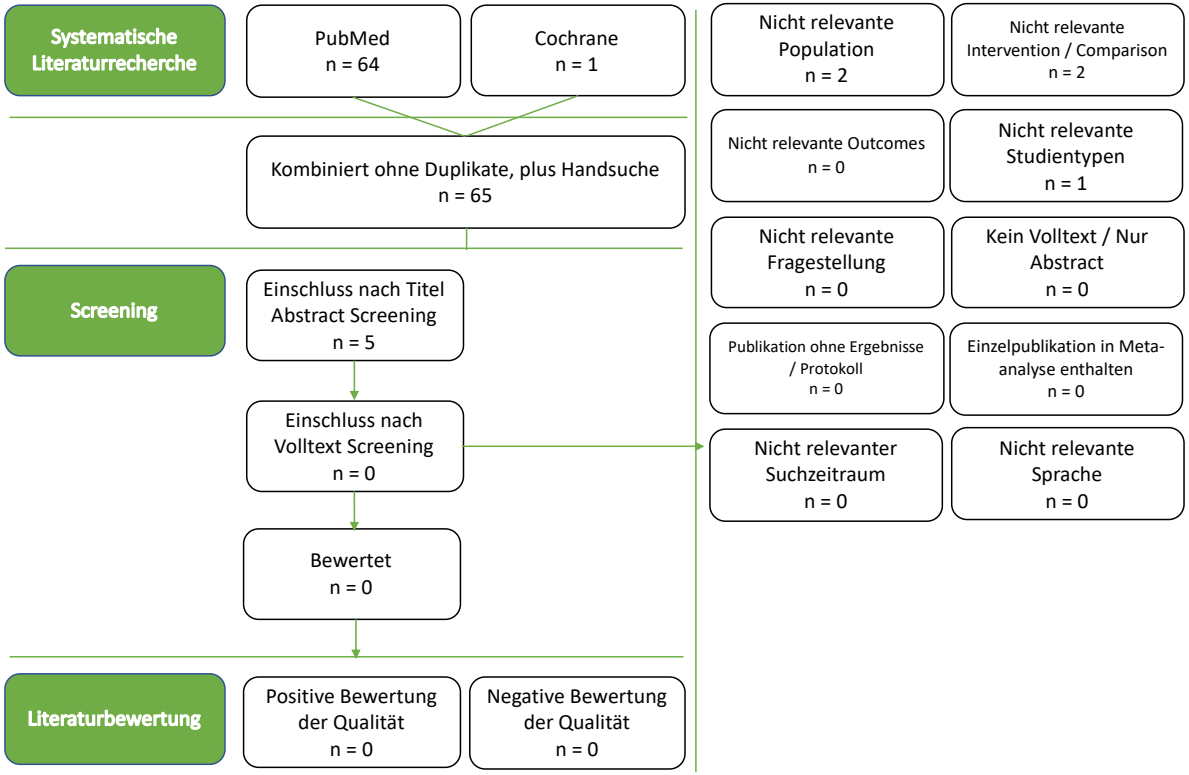
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267

#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 24



2.25. Schlüsselfrage 25

Ist beim Endometriumkarzinom (Typ I, pT1b, G3) die SLN sinnvoll, wenn makroskopisch Tumorfreiheit erzielt werden kann im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit mit Lymphgefäßinvasion Intervention: Sentinel-Lymphknotenbiopsie (SLN) Comparison: keine LNE bei Frauen mit Typ-I-EC, pT1a, G1/2) und makroskopisch unauffälligen LK LNE bei Frauen mit EC der folgenden Typ-Bestimmungen Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit LNE bei Frauen mit EC und mit Lymphgefäßinvasion Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

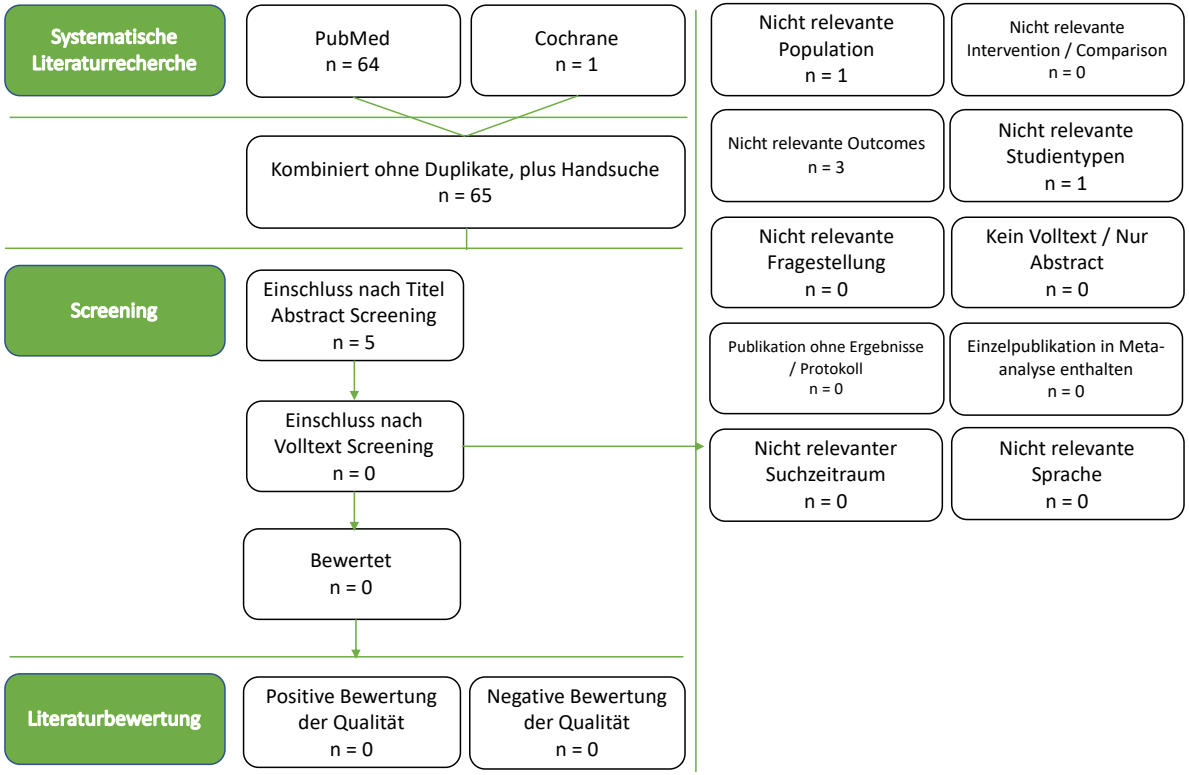
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081

#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 25



2.26. Schlüsselfrage 26

Ist beim Endometriumkarzinom (Typ I, pT2 bis pTIV b, G1-3) die systematische pelvine bzw. pelvine plus paraaortale Lymphonodektomie (LNE) sinnvoll, wenn makroskopisch Tumorfreiheit erzielt werden kann im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit mit Lymphgefäßinvasion Intervention: systematische paraaortale und pelvine Lympho-nodektomie (LNE) Comparison: keine LNE Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271

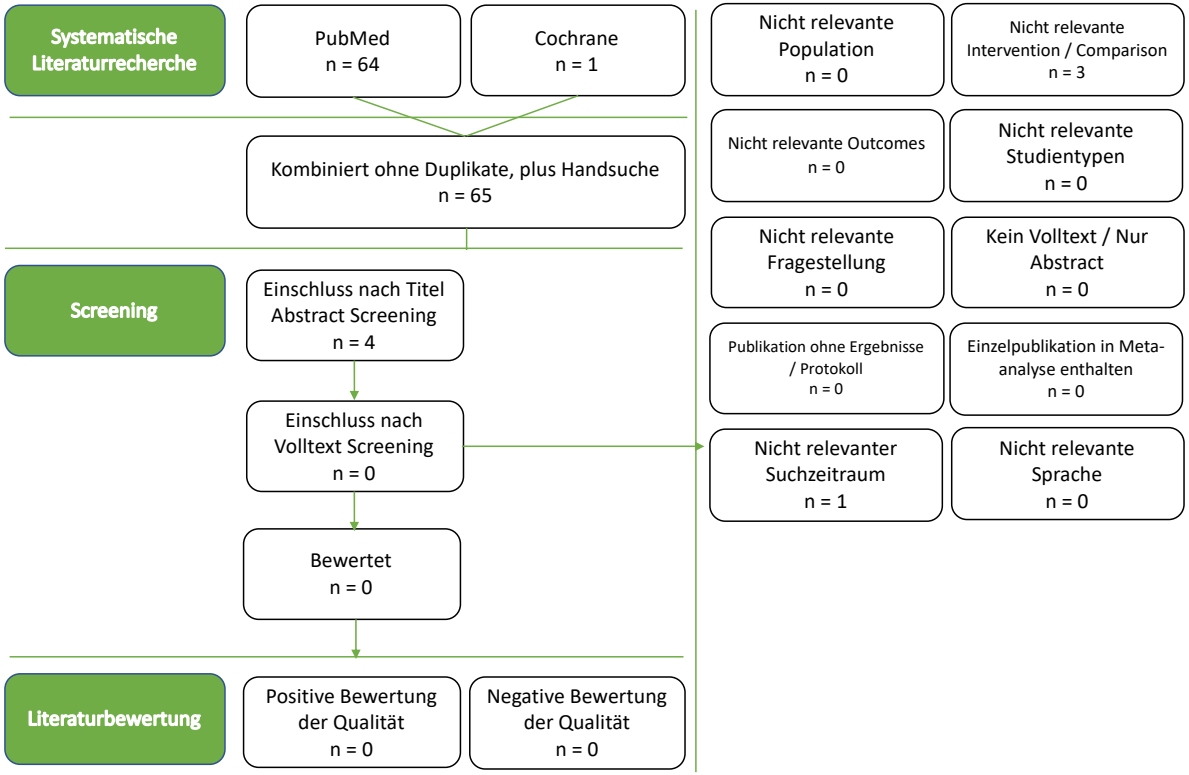
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267

#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 26



2.27. Schlüsselfrage 27

Ist beim Endometriumkarzinom (Typ I, pT2 bis pTIV b, G1-3) die SLN sinnvoll, wenn makroskopisch Tumorfreiheit erzielt werden kann im Hinblick auf Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit mit Lymphgefäßinvasion Intervention: Sentinel-Lymphknotenbiopsie (SLN) Comparison: keine LNE bei Frauen mit Typ-I-EC, pT1a, G1/2) und makroskopisch unauffälligen LK LNE bei Frauen mit EC der folgenden Typ-Bestimmungen Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit LNE bei Frauen mit EC und mit Lymphgefäßinvasion Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		

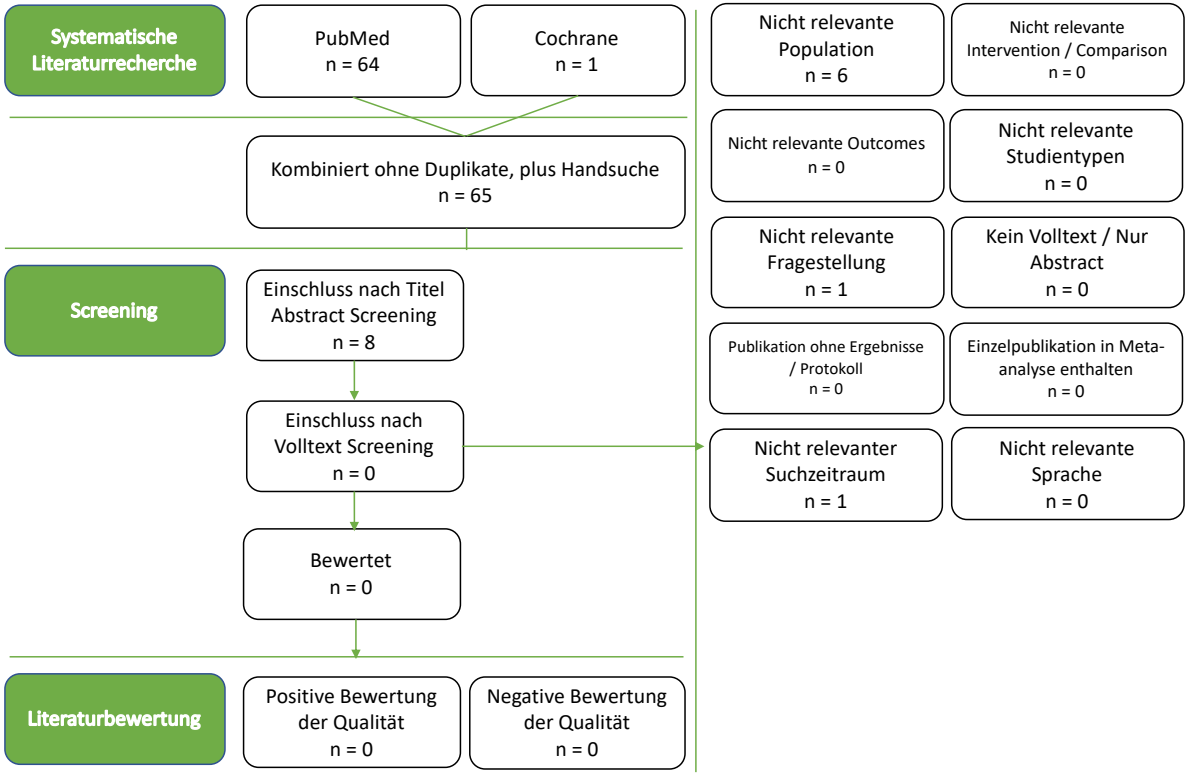
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774

#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 27



2.28. Schlüsselfrage 28

Ist beim Endometriumkarzinom Typ II die systematische pelvine bzw. pelvine plus paraaortale Lymphonodektomie (LNE) sinnvoll, wenn makroskopisch Tumorfreiheit erzielt werden kann im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit mit Lymphgefäßinvasion Intervention: systematische paraaortale und pelvine Lympho-nodektomie (LNE) Comparison: keine LNE Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271

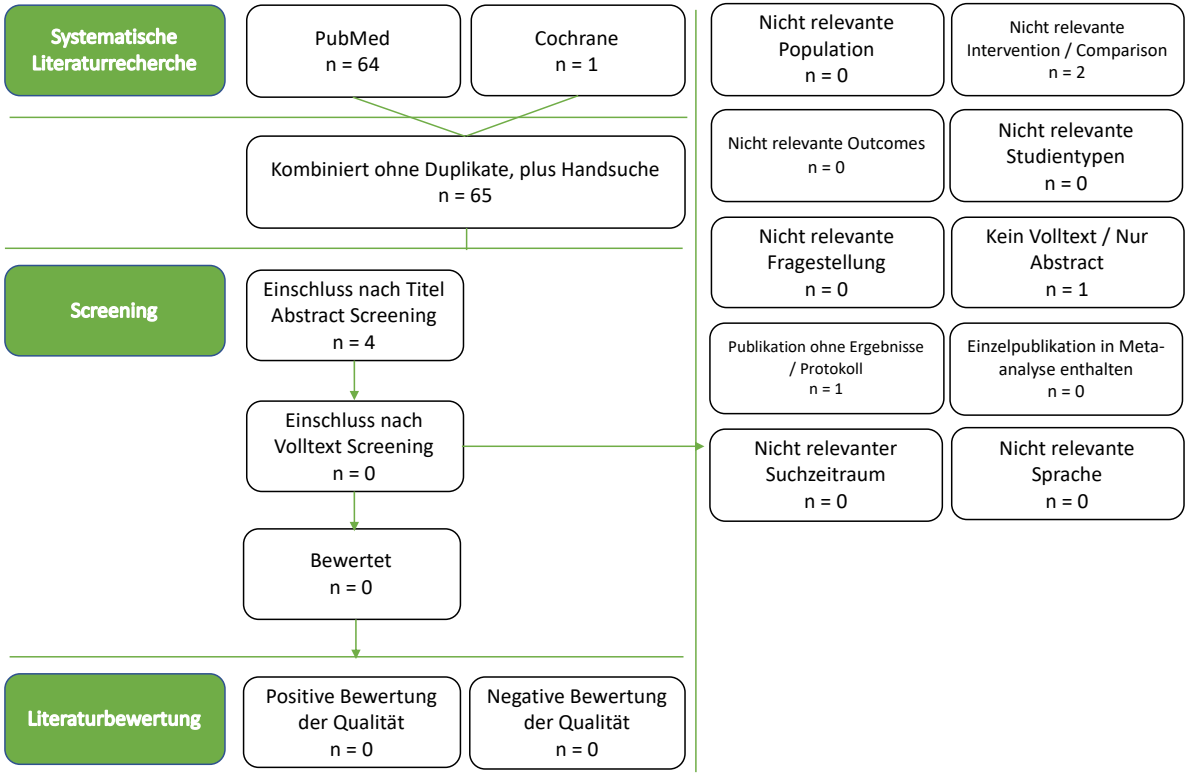
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480

#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 28



2.29. Schlüsselfrage 29

Ist beim Endometriumkarzinom Typ II die SLN sinnvoll, wenn makroskopisch Tumorfreiheit erzielt werden kann im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit mit Lymphgefäßinvasion Intervention: Sentinel-Lymphknotenbiopsie (SLN) Comparison: keine LNE bei Frauen mit Typ-I-EC, pT1a, G1/2) und makroskopisch unauffälligen LK LNE bei Frauen mit EC der folgenden Typ-Bestimmungen Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit (Typ II) und erreichbarer makroskopischer Tumorfreiheit LNE bei Frauen mit EC und mit Lymphgefäßinvasion Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		

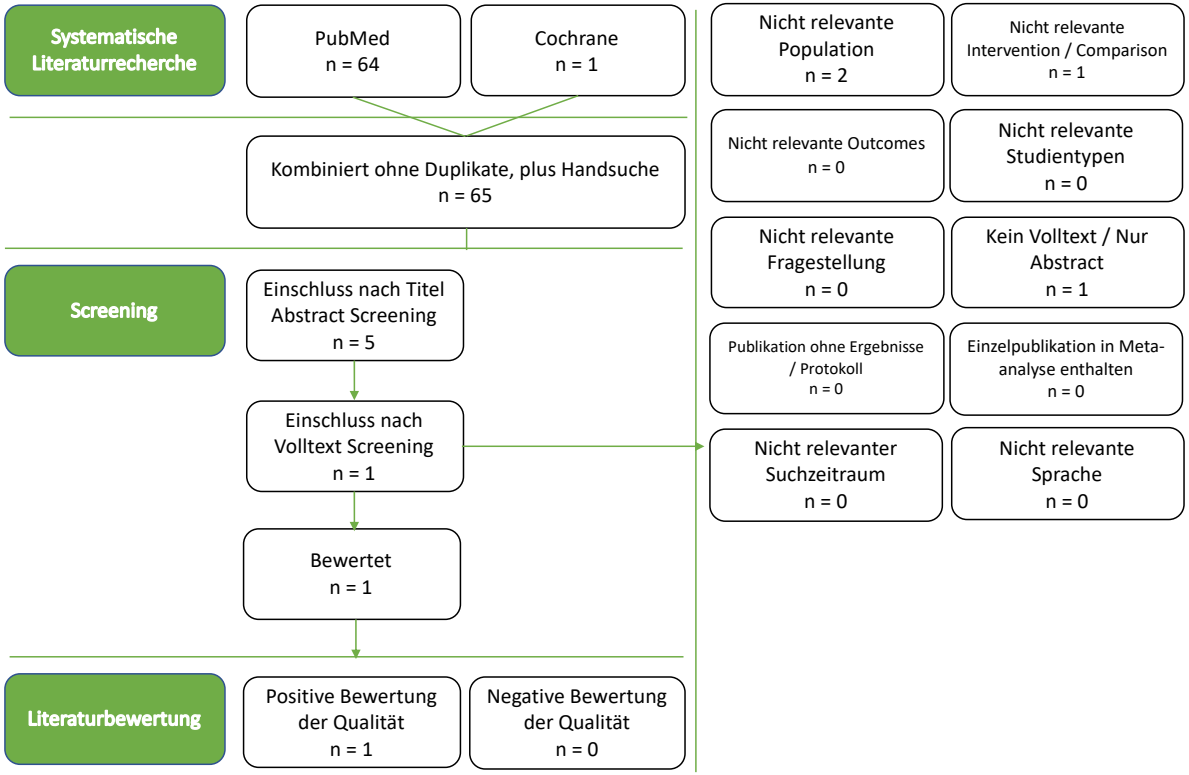
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480

#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 29



2.30. Schlüsselfrage 30

Ist bei Karzinosarkomen die systematische pelvine bzw. pelvine plus paraaortale Lymphonodektomie (LNE) sinnvoll, wenn makroskopisch Tumorfreiheit erzielt werden kann im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit Karzinosarkomen Intervention: systematische paraaortale und pelvine Lympho-nodektomie (LNE) Comparison: Sentinel-Lymphknotenbiopsie (SLN) Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162

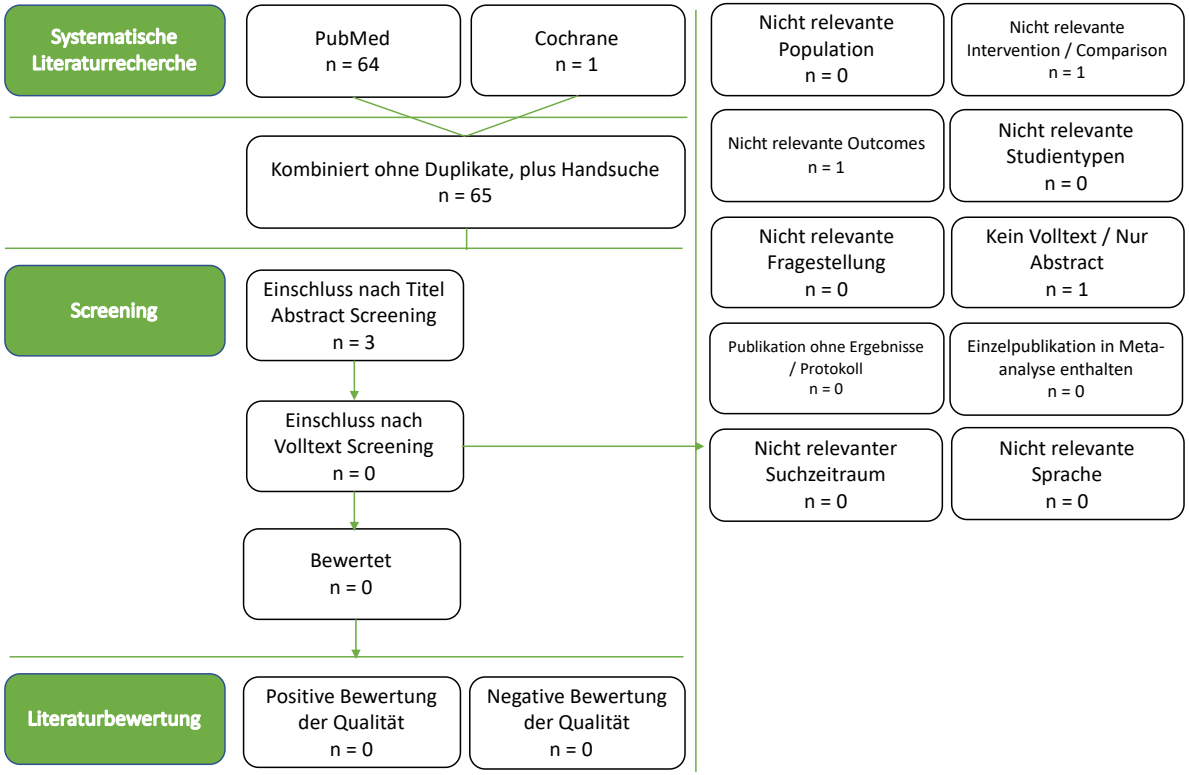
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387

#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 30



2.31. Schlüsselfrage 31

Ist bei Karzinosarkomen die SLN sinnvoll, wenn makroskopisch Tumorfreiheit erzielt werden kann im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit Karzinosarkomen Intervention: Sentinel-Lymphknotenbiopsie (SLN) Comparison: keine Sentinel-Lymphknotenbiopsie (SLN) Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927

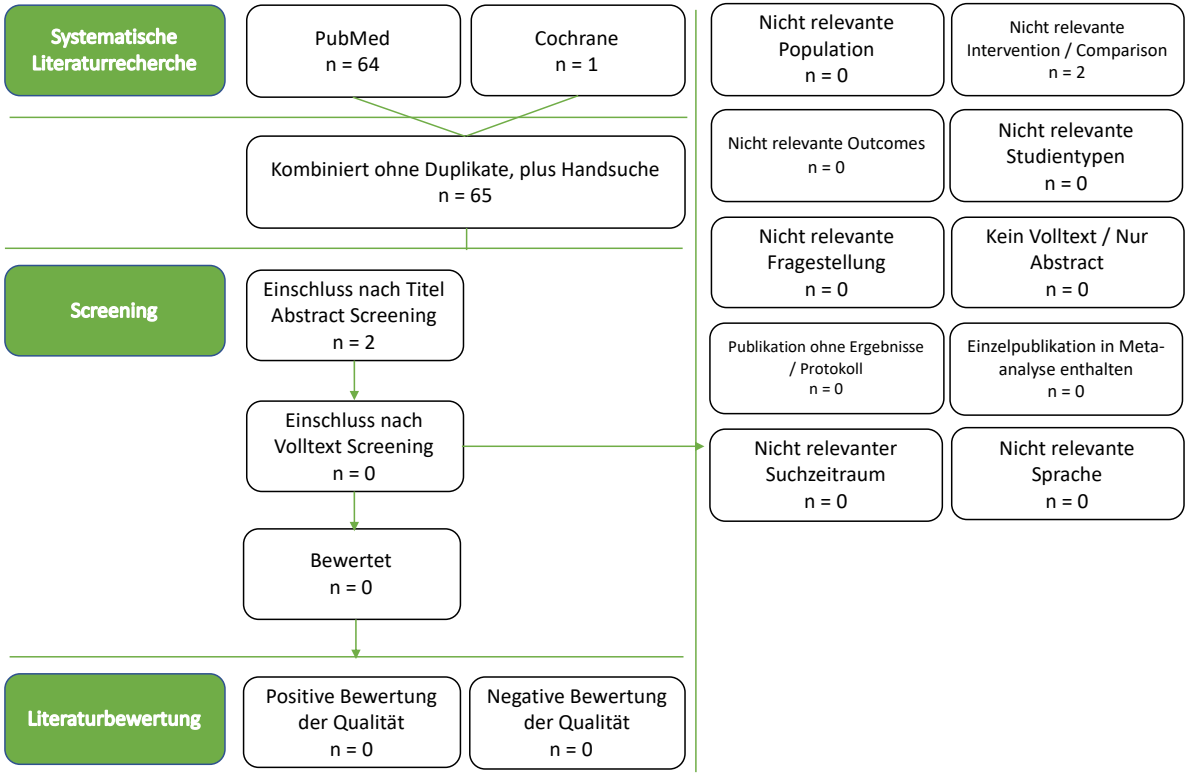
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462

#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 31



2.32. Schlüsselfrage 32

Wie sollte beim Endometriumkarzinom eine LNE durchgeführt werden, um eine Verbesserung zu erreichen im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC Intervention: Paraaortale und pelvine LNE Comparison: PelvineLNE Outcomes: Morbidität, Mortalität, Lebensqualität

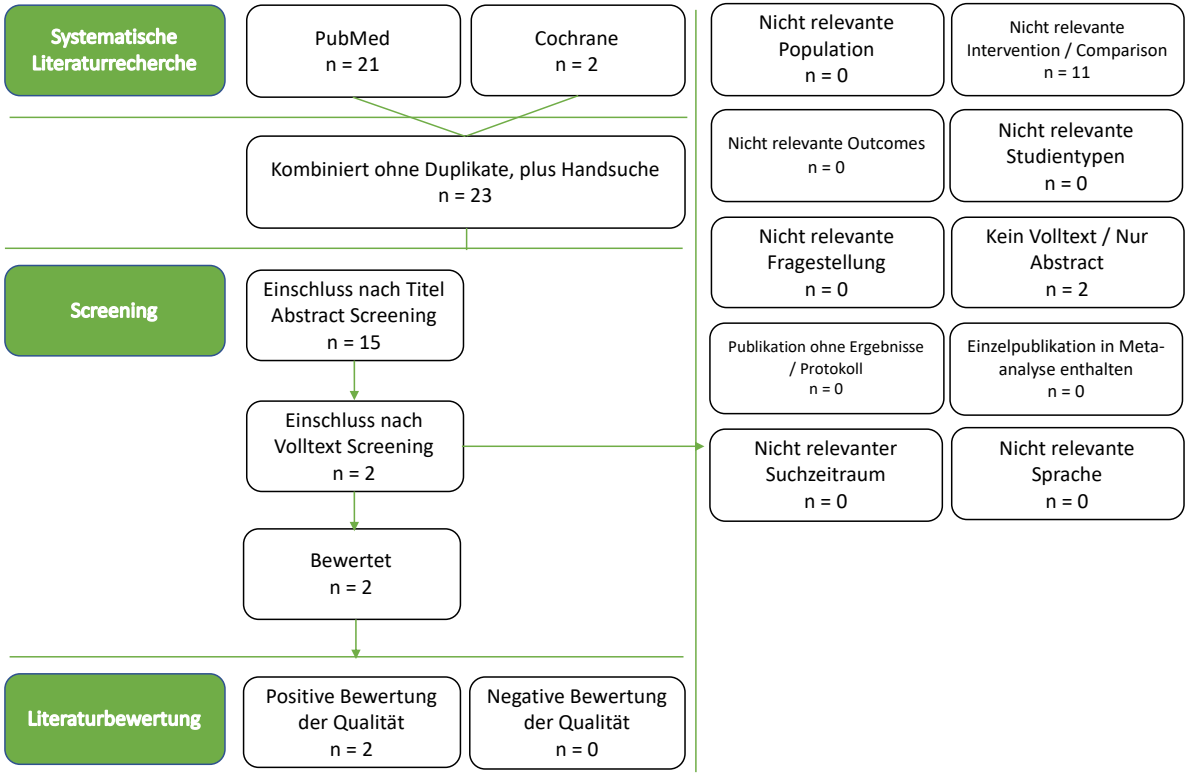
Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	lymphadenectomy	65.835
#3	laparoscopy	130.104
#4	#2 OR #3	190.887
Kombiniert mit und ohne Filter		
#5	#1 AND #4	3.949
#6	#5 Filters: Publication date from 09/2021 to 09/2022 Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	21

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	lymphadenectomy	1904
#3	laparoscopy	9288
#4	#2 OR #3	11007
#5	#1 AND #4	333
#6	#5 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	2

Schlüsselfrage 32



2.33. Schlüsselfrage 33

Wie sollte beim Endometriumkarzinom eine SLN durchgeführt werden, um eine Verbesserung zu erreichen im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits- spezifisches und Gesamtüberleben?
Population Frauen mit EC Intervention: SNB Comparison: Systemische LNE Outcomes: Morbidität, Mortalität, Lebensqualität

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162

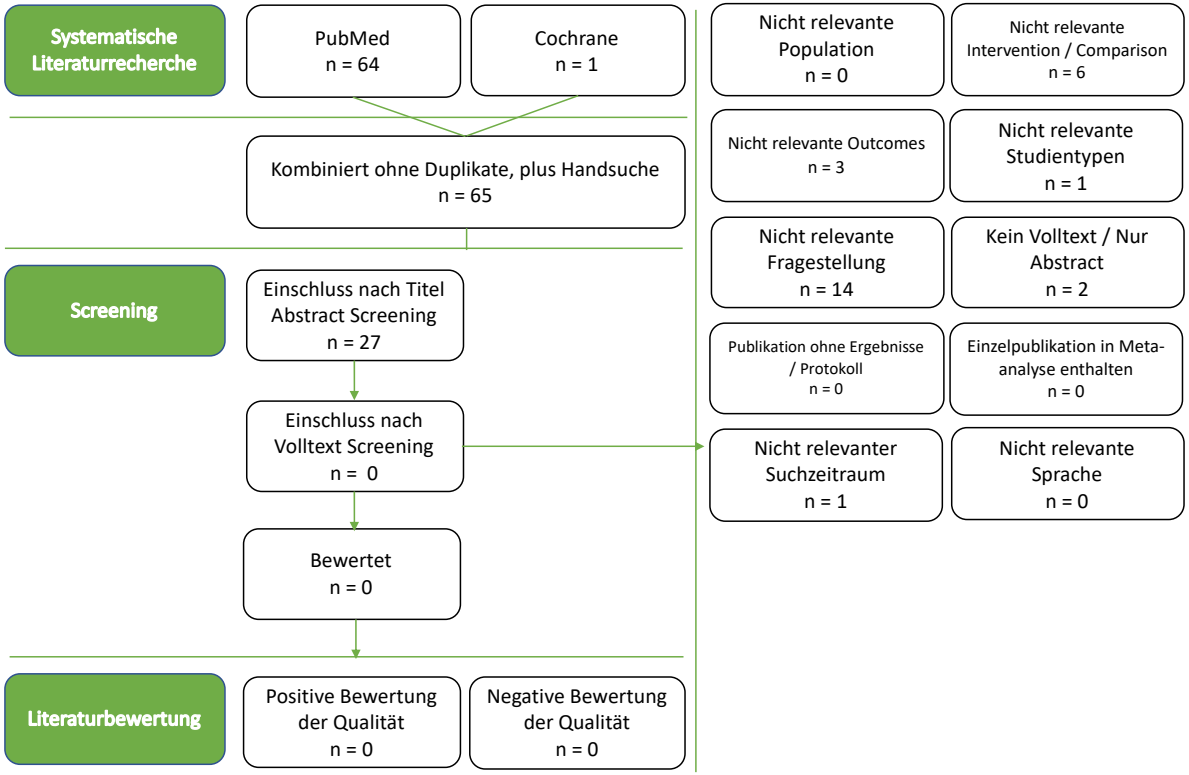
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525

#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462
#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 33



2.34. Schlüsselfrage 34

Sollte beim Endometriumkarzinom bei positivem Sentinel eine anschließende systematische SLN durchgeführt werden, um eine Verbesserung zu erreichen im Hinblick auf Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC Intervention: SNB Comparison: Systemische LNE Outcomes: Morbidität, Mortalität, Lebensqualität

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927

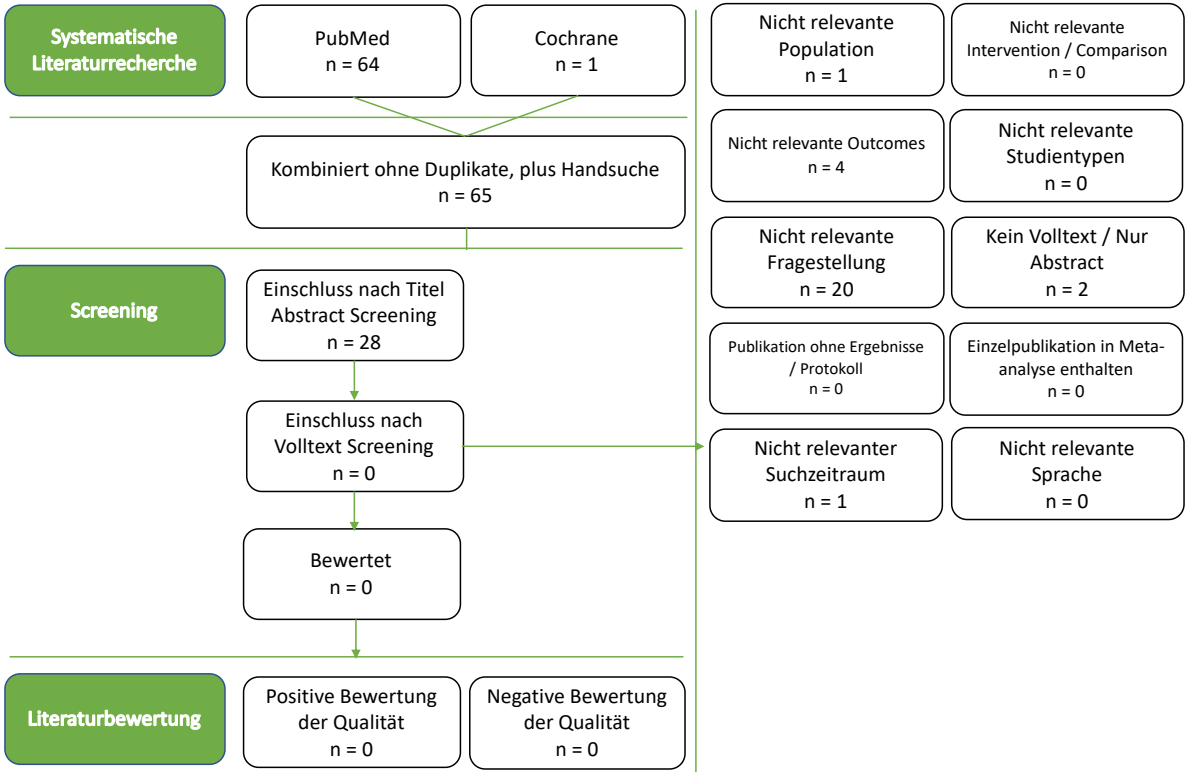
Kombiniert mit und ohne Filter		
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462

#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 34



2.35. Schlüsselfrage 35

Wie ist der Stellenwert laparoskopischer Verfahren beim Endometriumkarzinom im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC Intervention: Laparotomie Comparison: Laparoskopie-Roboter-gestützte OP Outcomes: Morbidität, Mortalität, Lebensqualität

Recherche in PubMed (06.10.2022)

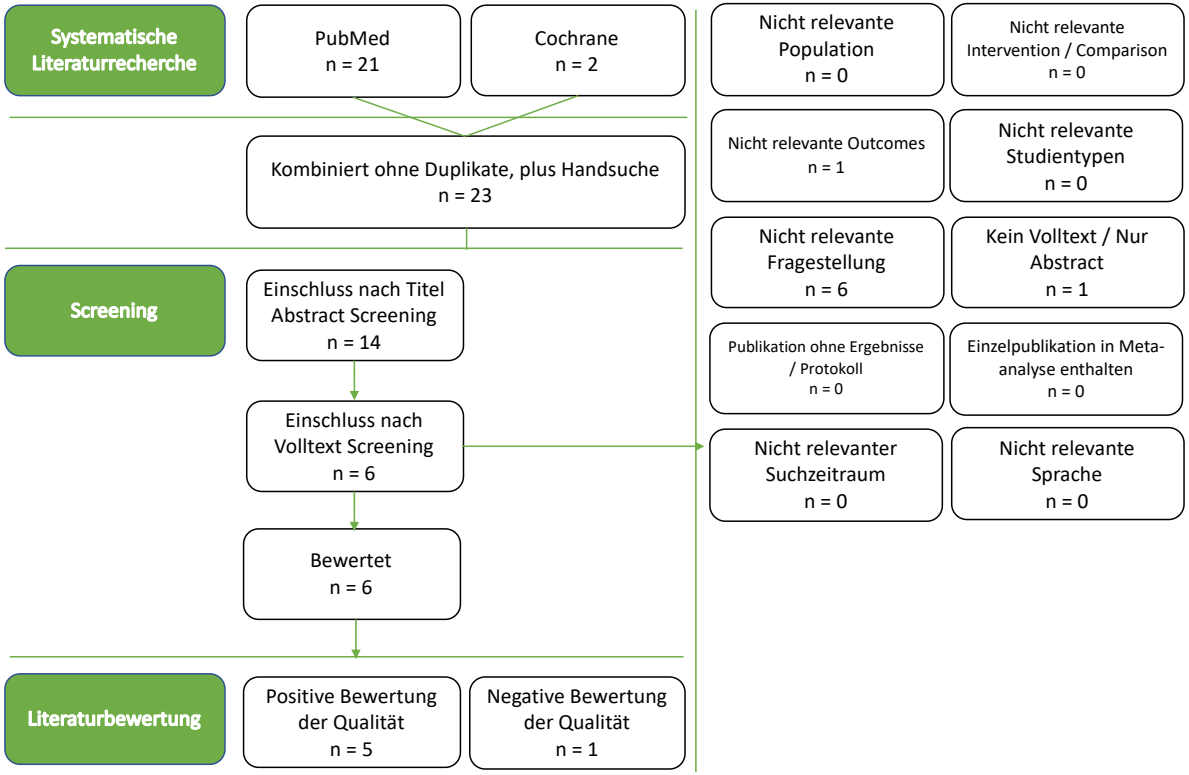
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	lymphadenectomy	65.835
#3	laparoscopy	130.104
#4	#2 OR #3	190.887
Kombiniert mit und ohne Filter		
#5	#1 AND #4	3.949
#6	#5 Filters: Publication date from 09/2021 to 09/2022 Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	21

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	lymphadenectomy	1904

#3	laparoscopy	9288
#4	#2 OR #3	11007
#5	#1 AND #4	333
#6	#5 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	2

Schlüsselfrage 35



2.36. Schlüsselfrage 36

Wie ist der Stellenwert robotergestützter operativer Verfahren beim Endometriumkarzinom im Hinblick auf auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben
Population Frauen mit EC Intervention: Laparotomie Comparison: Laparoskopie-Roboter-gestützte OP Outcomes: Morbidität, Mortalität, Lebensqualität

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
#2	uterine carcinosarcoma[tiab] OR **(("Carcinosarcoma"[Mesh]** OR carcinosarcoma[tiab]) AND (**"Uterus"[Mesh]** OR Uter*[tiab] OR womb[tiab]))	1.266
#3	#1 OR #2	52.201
Intervention bzw. Exposure		
#4	**Lymph Node Excision[Mesh]** OR Lymph Node Excision*[tiab] OR Lymph Node dissection*[tiab] OR Lymphadenectom*[tiab]	71.429
#5	**Sentinel Lymph Node[Mesh]** OR Sentinel Lymph Node[tiab] OR Lymph Node, Sentinel[tiab] OR Lymph Nodes, Sentinel[tiab] OR Sentinel Lymph Nodes[tiab] OR Sentinel Node[tiab] OR Node, Sentinel[tiab] OR Nodes, Sentinel[tiab] OR Sentinel Nodes[tiab]	17.271
#6	**General Surgery[Mesh]** OR surger*[tiab] OR surg*[tiab] OR **"Surgical Procedures, Operative"[Mesh]** OR operative[tiab] OR **"Laparoscopy"[Mesh]** OR laparoscop*[tiab] OR **"Robotic Surgical Procedures"[Mesh]** OR robot*[tiab]	4.701.548
#7	**Hysterectomy[Mesh]** OR hysterectom*[tiab]	53.162
#8	#4 OR #5 OR #6 OR #7	4.714.927
Kombiniert mit und ohne Filter		

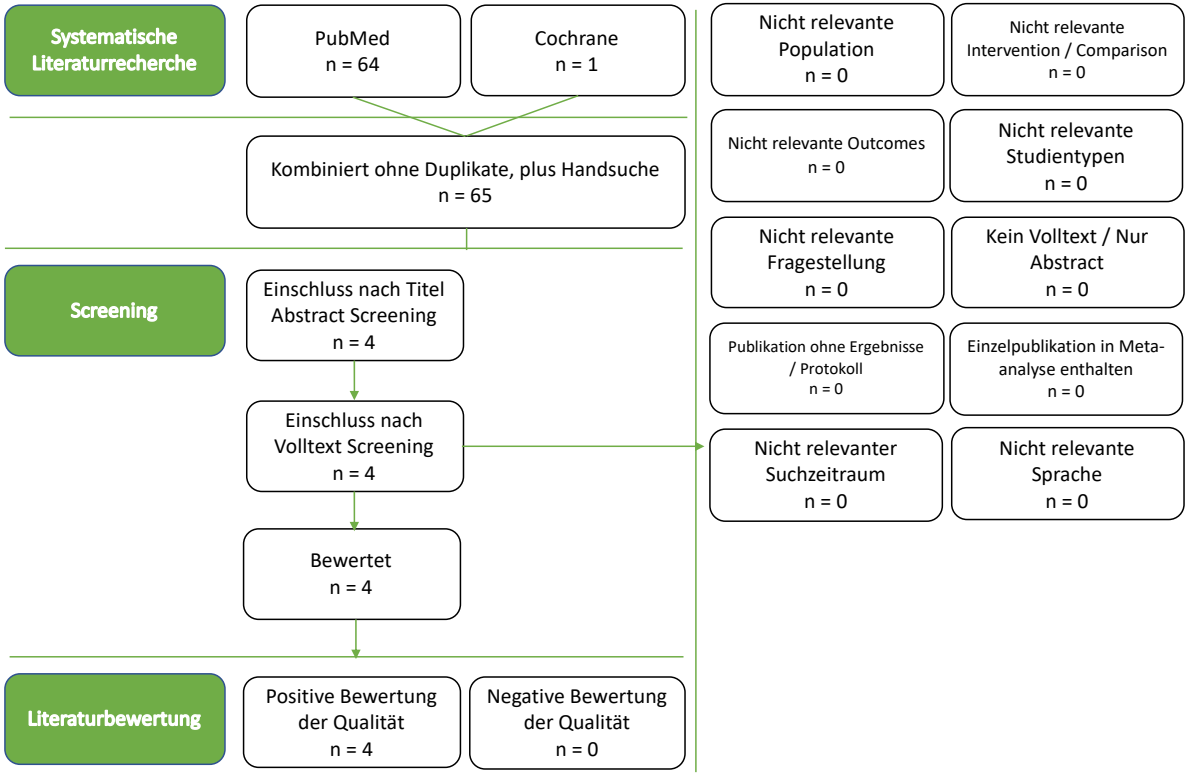
#9	#3 AND #8	18.980
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	64

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244570
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254774
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(uterine carcinosarcoma OR (("Carcinosarcoma" OR carcinosarcoma) AND ("Uterus" OR Uter* OR womb))):ti,ab,kw	75
#14	#12 OR #13	3525
#15	(Lymph Node Excision OR Lymph Node Excision* OR Lymph Node dissection* OR Lymphadenectom*):ti,ab,kw	5387
#16	MeSH descriptor: [Lymph Node Excision] explode all trees	1462

#17	(Sentinel Lymph Node OR Sentinel Lymph Node OR Lymph Node, Sentinel OR Lymph Nodes, Sentinel OR Sentinel Lymph Nodes OR Sentinel Node OR Node, Sentinel OR Nodes, Sentinel OR Sentinel Nodes):ti,ab,kw	1653
#18	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#19	(General Surgery OR surger* OR surg* OR "Surgical Procedures, Operative" OR operative OR "Laparoscopy" OR laparoscop* OR "Robotic Surgical Procedures" OR robot*):ti,ab,kw	303081
#20	MeSH descriptor: [General Surgery] explode all trees	366
#21	MeSH descriptor: [Surgical Procedures, Operative] explode all trees	129938
#22	MeSH descriptor: [Laparoscopy] explode all trees	6546
#23	MeSH descriptor: [Robotic Surgical Procedures] explode all trees	421
#24	(Hysterectomy OR hysterectom*):ti,ab,kw	8161
#25	MeSH descriptor: [Hysterectomy] explode all trees	1908
#26	#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25	350798
#27	#14 AND #26	1543
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 36



2.37. Schlüsselfrage 37

Beeinflussen Tools des geriatrischen Assessments operative, systemtherapeutische und radioonkologische Therapieentscheidungen?
Population: Frauen mit EC Intervention: Geriatrisches Assessment im Bereich: Operation Systemtherapie Radioonkologie Comparison: Kein geriatrisches Assessment Outcomes: Morbidität, Lebensqualität, Rezidivhäufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

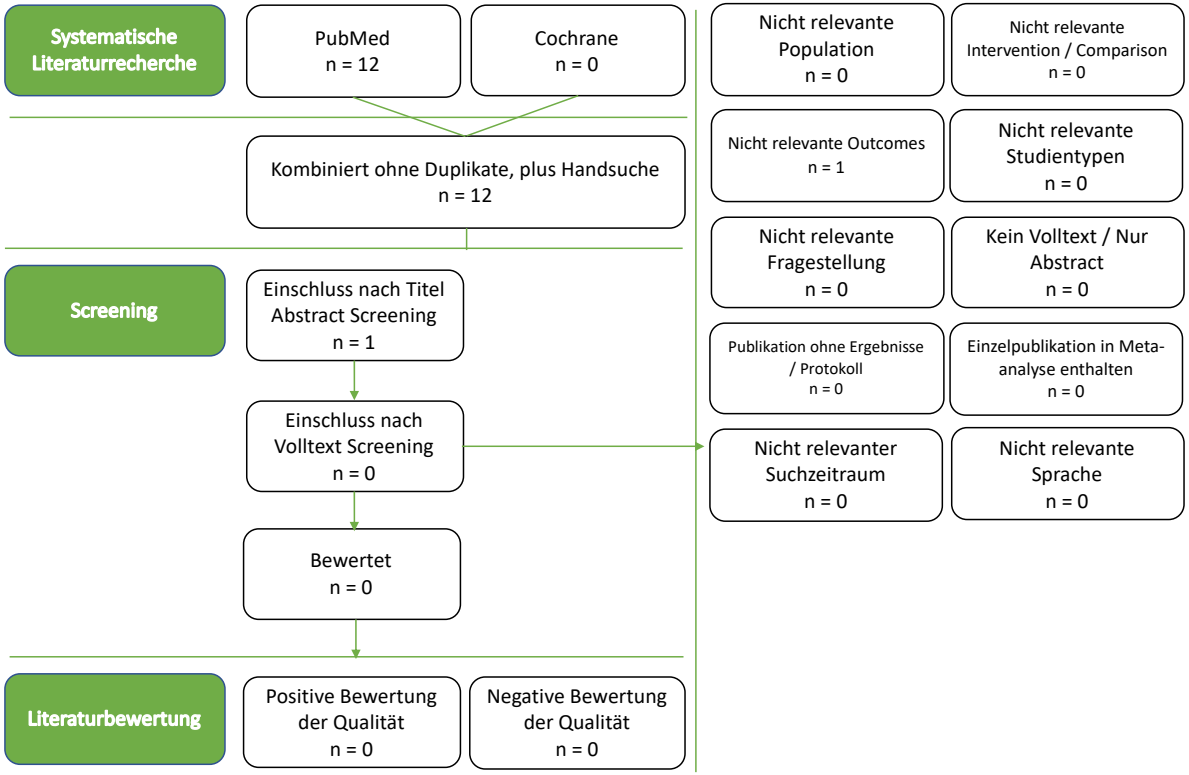
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
Intervention bzw. Exposure		
#2	**Geriatr* OR "Geriatric Assessment"[Mesh]**	255.157
Kombiniert mit und ohne Filter		
#3	#1 AND #2	176
#4	#3 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Humans	12

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585

#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Geriatric Assessment OR geriatric assessment OR Assessment, Geriatric OR Assessments, Geriatric OR Geriatric Assessments):ti,ab,kw	4635
#14	MeSH descriptor: [Geriatric Assessment] explode all trees	1590
#15	#13 OR #14	4635
#16	#12 AND #15	1
#17	#16 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 37



2.38. Schlüsselfrage 38

Bei welchen Stadien bzw. histolog. Typen des Endometriumkarzinoms ist eine adjuvante externe Strahlentherapie (perkutan allein) indiziert im Hinblick auf Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: Frauen mit EC: Typ I, pT1a, G1/2 Typ I, pT1a, G3; pT1 b, G1/2 Typ I, pT1b, G3 Typ I, pT2 bis pTIV b, G1-3 Typ II Intervention: adjuvante Strahlen-therapie (perkutan) Comparison: keine adjuvante Strahlentherapie (perkutan) Outcomes: Verbesserung Lebensqualität, Kurzzeit-/ Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
# 1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539

#2	**Brachytherapy[Mesh]** OR brachytherap*[tiab] OR Curietherapy[tiab] OR Plaque Therapy, Radioisotope[tiab] OR Radioisotope Plaque Therapy[tiab] OR Therapy, Radioisotope Plaque[tiab] OR Surface Radiotherapy[tiab] OR Radiotherapy, Surface[tiab] OR Radiotherapy, Intracavity[tiab] OR Intracavity Radiotherapy[tiab] OR Radiotherapy, Interstitial[tiab] OR Interstitial Radiotherapy[tiab] OR Radiotherapy, Implant[tiab] OR Implant Radiotherapy OR **"Radiotherapy"[Mesh]** OR Radiotherap*[tiab] OR Radiation Therap*[tiab] OR Therapies, Radiation[tiab] OR Therapy, Radiation[tiab] OR Radiation Treatment*[tiab] OR Treatment, Radiation[tiab] OR Radiotherapy, Targeted[tiab] OR Radiotherapies, Targeted[tiab] OR Targeted Radiotherap*[tiab] OR Targeted Radiation Therap*[tiab] OR Radiation Therapies, Targeted[tiab] OR Targeted Radiation Therapies[tiab] OR Therapies, Targeted Radiation[tiab] OR Therapy, Targeted Radiation[tiab] OR Radiation Therapy, Targeted OR **"Proton Therapy"[Mesh]** OR Proton Therapies[tiab] OR Therapies, Proton[tiab] OR Therapy, Proton[tiab] OR Proton Beam Therap*[tiab] OR Therapies, Proton Beam[tiab] OR Therapy, Proton Beam[tiab] OR Proton Beam Radiation Therapy[tiab] OR external beam therapy[tiab]	451.133
#3	adjuvant[tiab]	161.569
#4	#2 AND #3	37.284
#5	**Radiotherapy, Adjuvant[Mesh]** OR adjuvant radiotherap*[tiab]	29.262
#6	#4 OR #5	51.999
Kombiniert mit und ohne Filter		
#7	#1 AND #6	1.929
#8	#7 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	9

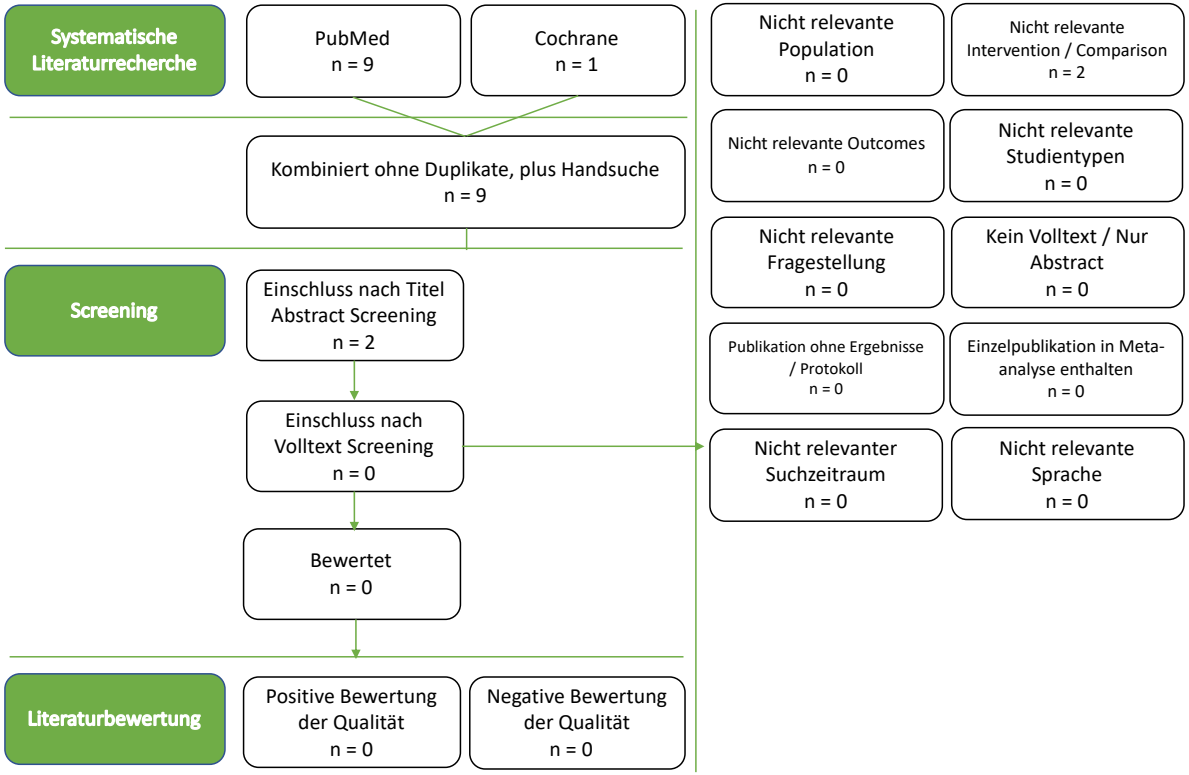
Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585

#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Brachytherapy OR brachytherap* OR Curietherapy OR Plaque Therapy, Radioisotope OR Radioisotope Plaque Therapy OR Therapy, Radioisotope Plaque OR Surface Radiotherapy OR Radiotherapy, Surface OR Radiotherapy, Intracavity OR Intracavity Radiotherapy OR Radiotherapy, Interstitial OR Interstitial Radiotherapy OR Radiotherapy, Implant OR Implant Radiotherapy OR "Radiotherapy" OR Radiotherap* OR Radiation Therap* OR Therapies, Radiation OR Therapy, Radiation OR Radiation Treatment* OR Treatment, Radiation OR Radiotherapy, Targeted OR Radiotherapies, Targeted OR Targeted Radiotherap* OR Targeted Radiation Therap* OR Radiation Therapies, Targeted OR Targeted Radiation Therapies OR Therapies, Targeted Radiation OR Therapy, Targeted Radiation OR Radiation Therapy, Targeted OR "Proton Therapy" OR Proton Therapies OR Therapies, Proton OR Therapy, Proton OR Proton Beam Therap* OR Therapies, Proton Beam OR Therapy, Proton Beam OR Proton Beam Radiation Therapy OR external beam therapy):ti,ab,kw	52042
#14	MeSH descriptor: [Brachytherapy] explode all trees	728
#15	MeSH descriptor: [Radiotherapy] explode all trees	6687
#16	MeSH descriptor: [Proton Therapy] explode all trees	56
#17	#13 OR #14 OR #15 OR #16	52387

#18	#12 AND #17	609
#19	#18 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 38



2.39. Schlüsselfrage 39

Bei welchen Stadien bzw. histolog. Typen des Endometriumkarzinoms ist eine adjuvante externe (perkutane) Strahlentherapie in Kombination mit Brachytherapie indiziert im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: Frauen mit EC: Typ I, pT1a, G1/2 Typ I, pT1a, G3; pT1 b, G1/2 Typ I, pT1b, G3 Typ I, pT2 bis pTIV b, G1-3 Typ II Intervention: Adjuvante kombinierte Strahlentherapie (perkutan) + Brachytherapie Comparison: nur perkutane Strahlentherapie Outcomes: Verbesserung Lebensqualität, Kurzzeit-/ Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
# 1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
Intervention bzw. Exposure		

#2	**Brachytherapy[Mesh]** OR brachytherap*[tiab] OR Curietherapy[tiab] OR Plaque Therapy, Radioisotope[tiab] OR Radioisotope Plaque Therapy[tiab] OR Therapy, Radioisotope Plaque[tiab] OR Surface Radiotherapy[tiab] OR Radiotherapy, Surface[tiab] OR Radiotherapy, Intracavity[tiab] OR Intracavity Radiotherapy[tiab] OR Radiotherapy, Interstitial[tiab] OR Interstitial Radiotherapy[tiab] OR Radiotherapy, Implant[tiab] OR Implant Radiotherapy OR **"Radiotherapy"[Mesh]** OR Radiotherap*[tiab] OR Radiation Therap*[tiab] OR Therapies, Radiation[tiab] OR Therapy, Radiation[tiab] OR Radiation Treatment*[tiab] OR Treatment, Radiation[tiab] OR Radiotherapy, Targeted[tiab] OR Radiotherapies, Targeted[tiab] OR Targeted Radiotherap*[tiab] OR Targeted Radiation Therap*[tiab] OR Radiation Therapies, Targeted[tiab] OR Targeted Radiation Therapies[tiab] OR Therapies, Targeted Radiation[tiab] OR Therapy, Targeted Radiation[tiab] OR Radiation Therapy, Targeted OR **"Proton Therapy"[Mesh]** OR Proton Therapies[tiab] OR Therapies, Proton[tiab] OR Therapy, Proton[tiab] OR Proton Beam Therap*[tiab] OR Therapies, Proton Beam[tiab] OR Therapy, Proton Beam[tiab] OR Proton Beam Radiation Therapy[tiab] OR external beam therapy[tiab]	451.133
#3	adjuvant[tiab]	161.569
#4	#2 AND #3	37.284
#5	**Radiotherapy, Adjuvant[Mesh]** OR adjuvant radiotherap*[tiab]	29.262
#6	#4 OR #5	51.999
Kombiniert mit und ohne Filter		
#7	#1 AND #6	1.929
#8	#7 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	9

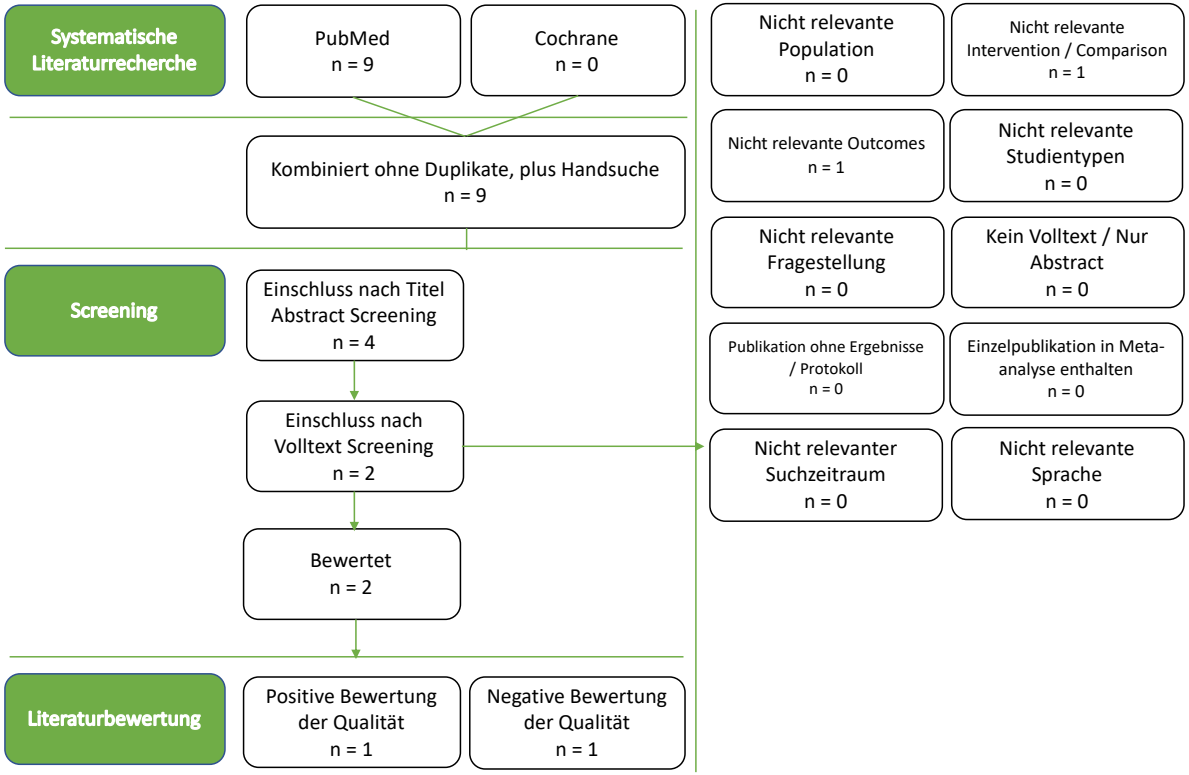
Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136

#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Brachytherapy OR brachytherap* OR Curietherapy OR Plaque Therapy, Radioisotope OR Radioisotope Plaque Therapy OR Therapy, Radioisotope Plaque OR Surface Radiotherapy OR Radiotherapy, Surface OR Radiotherapy, Intracavity OR Intracavity Radiotherapy OR Radiotherapy, Interstitial OR Interstitial Radiotherapy OR Radiotherapy, Implant OR Implant Radiotherapy OR "Radiotherapy" OR Radiotherap* OR Radiation Therap* OR Therapies, Radiation OR Therapy, Radiation OR Radiation Treatment* OR Treatment, Radiation OR Radiotherapy, Targeted OR Radiotherapies, Targeted OR Targeted Radiotherap* OR Targeted Radiation Therap* OR Radiation Therapies, Targeted OR Targeted Radiation Therapies OR Therapies, Targeted Radiation OR Therapy, Targeted Radiation OR Radiation Therapy, Targeted OR "Proton Therapy" OR Proton Therapies OR Therapies, Proton OR Therapy, Proton OR Proton Beam Therap* OR Therapies, Proton Beam OR Therapy, Proton Beam OR Proton Beam Radiation Therapy OR external beam therapy):ti,ab,kw	52042
#14	MeSH descriptor: [Brachytherapy] explode all trees	728
#15	MeSH descriptor: [Radiotherapy] explode all trees	6687
#16	MeSH descriptor: [Proton Therapy] explode all trees	56

#17	#13 OR #14 OR #15 OR #16	52387
#18	#12 AND #17	609
#19	#18 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 39



2.40. Schlüsselfrage 40

Welchen Einfluss hat die alleinige adjuvante Brachytherapie beim Endometriumkarzinom im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population Frauen mit EC Intervention: Brachytherapie, Internal radiation therapy“ Comparison: keine Brachytherapie Outcomes: Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?

Recherche in PubMed (06.10.2022)

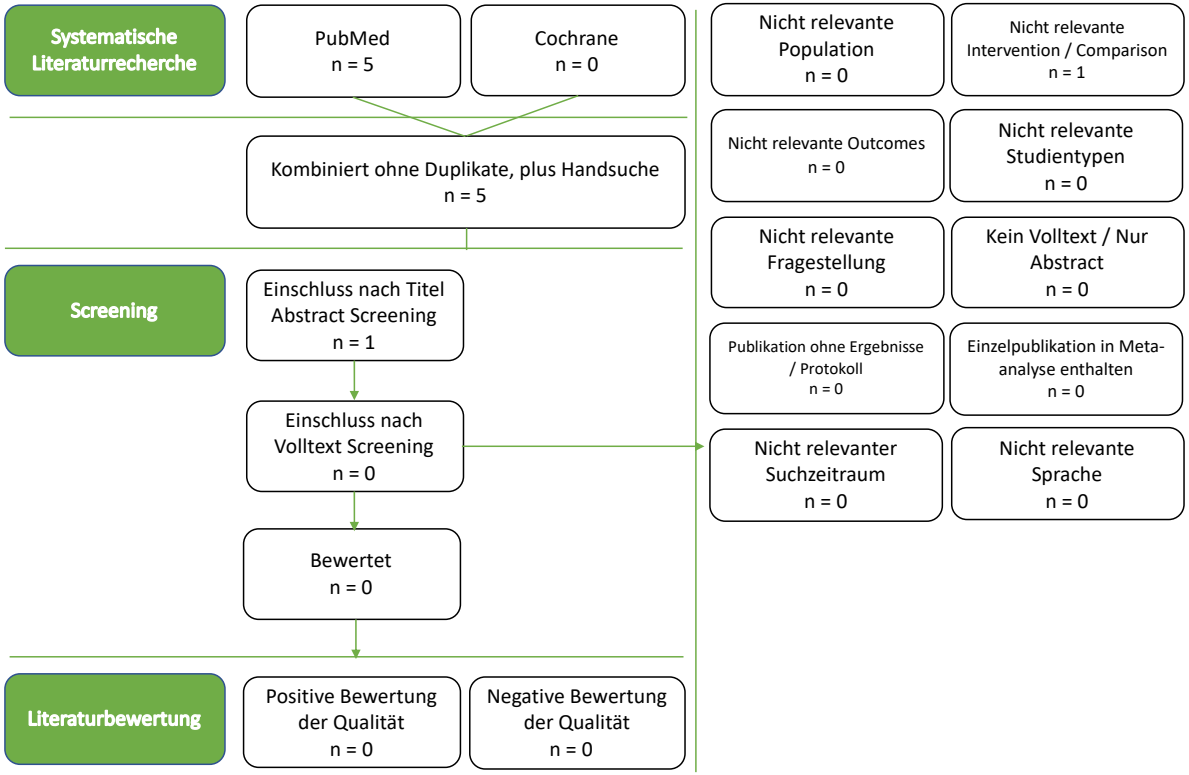
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	brachytherapy	27.877
#3	internal radiation therapy	37.752
#4	#2 OR #3	37.757
Kombiniert mit und ohne Filter		
#5	#1 AND #4	1.347
#6	#5 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	5

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	brachytherapy	2510

#3	internal radiation therapy	1161
#4	#2 OR #3	3566
#5	#1 AND #4	195
#6	#5 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 40



2.41. Schlüsselfrage 41

Welchen Stellenwert hat eine kombinierte Radiochemotherapie (sequenziell/simultan) im Vergleich zu anderen Verfahren (alleinige Radiatio, pelvin +/- paraaortale Bestrahlung, Abdomenganzbestrahlung, **alleinige Chemotherapie**) beim Endometriumkarzinom in Bezug auf Kurzzeit-/ Langzeitmorbidität, krankheitsspezifisches Gesamtüberleben und Rezidivhäufigkeit?
Population: Frauen mit EC Intervention: adjuvante kombinierte Radio-chemotherapie (sequenziell/simul-tan) Comparison: adjuvante Strahlentherapie adjuvante pelvine +/- paraaortale Bestrahlung adjuvante Abdomenganz-bestrahlung alleinige adjuvante Chemotherapie Outcomes: Verbesserung Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspe-zifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
# 1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.539
Intervention bzw. Exposure		
# 2	**"Radiotherapy"[Mesh]** OR Radiotherap*[tiab] OR Radiation Therap*[tiab] OR Therapies, Radiation[tiab] OR Therapy, Radiation[tiab] OR Radiation Treatment*[tiab] OR Treatment, Radiation[tiab] OR Radiotherapy, Targeted[tiab] OR Radiotherapies, Targeted[tiab] OR Targeted Radiotherap*[tiab] OR Targeted Radiation Therap*[tiab] OR Radiation Therapies, Targeted[tiab] OR Targeted Radiation Therapies[tiab] OR Therapies, Targeted Radiation[tiab] OR Therapy, Targeted Radiation[tiab] OR Radiation Therapy, Targeted[tiab]	375.150
# 3	**Drug Therapy[Mesh]** OR Therapy, Drug[tiab] OR Drug Therapies[tiab] OR Therapies, Drug[tiab] OR Chemotherapy[tiab] OR Chemotherapies[tiab] OR Pharmacotherapy[tiab] OR Pharmacotherapies[tiab]	1.791.153
Kombiniert mit und ohne Filter		

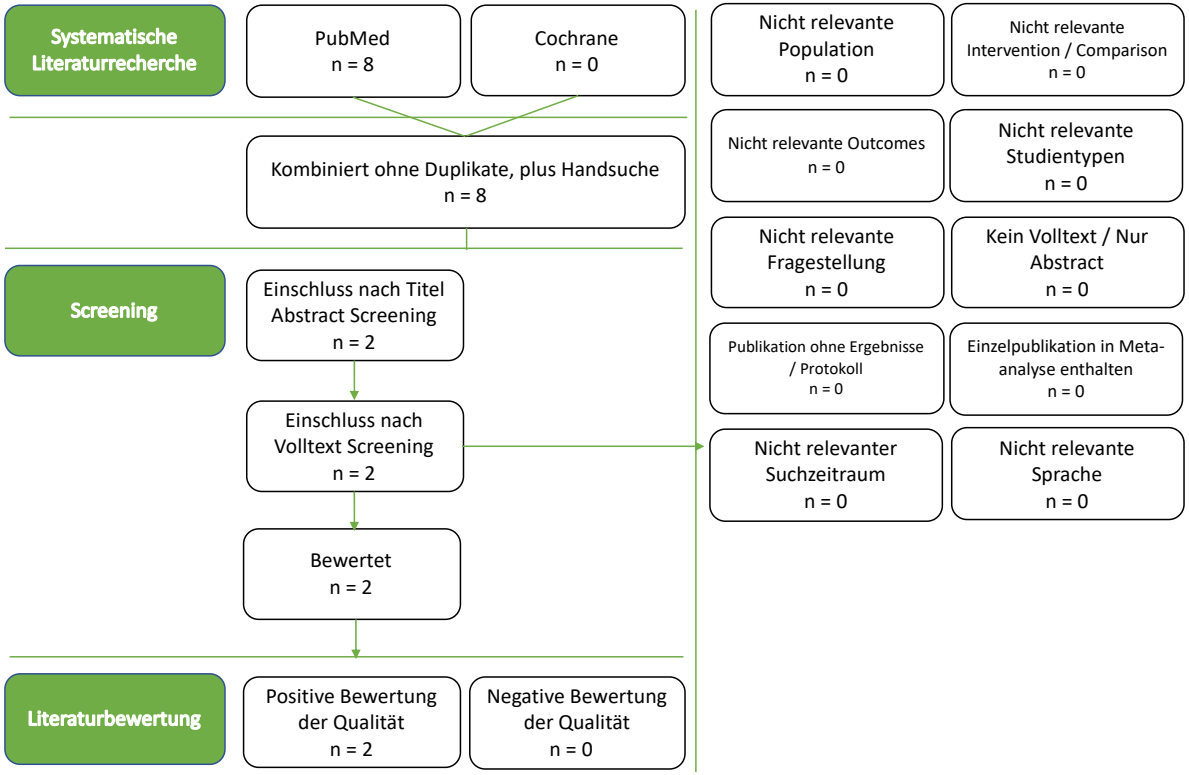
#4	#1 AND #2 AND #3	1.695
#5	#4 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	8

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Radiotherapy OR Radiotherap* OR Radiation Therap* OR Therapies, Radiation OR Therapy, Radiation OR Radiation Treatment* OR Treatment, Radiation OR Radiotherapy, Targeted OR Radiotherapies, Targeted OR Targeted Radiotherap* OR Targeted Radiation Therap* OR Radiation Therapies, Targeted OR Targeted Radiation Therapies OR Therapies, Targeted Radiation OR Therapy, Targeted Radiation OR Radiation Therapy, Targeted):ti,ab,kw	47751

#14	MeSH descriptor: [Radiotherapy] explode all trees	6687
#15	#13 OR #14	48135
#16	(Drug Therapy OR Therapy, Drug OR Drug Therapies OR Therapies, Drug OR Chemotherapy OR Chemotherapies OR Pharmacotherapy OR Pharmacotherapies):ti,ab,kw	525258
#17	MeSH descriptor: [Drug Therapy] explode all trees	148465
#18	#16 OR #17	562780
#19	#12 AND #15 AND #18	359
#20	#19 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 41



2.42. Schlüsselfrage 42

Welchen Stellenwert hat eine **adjuvante endokrine** Therapie beim Endometriumkarzinom im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: Frauen mit EC Intervention: **adjuvante endokrine Therapie** Comparison: keine adjuvante endokrine Therapie Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

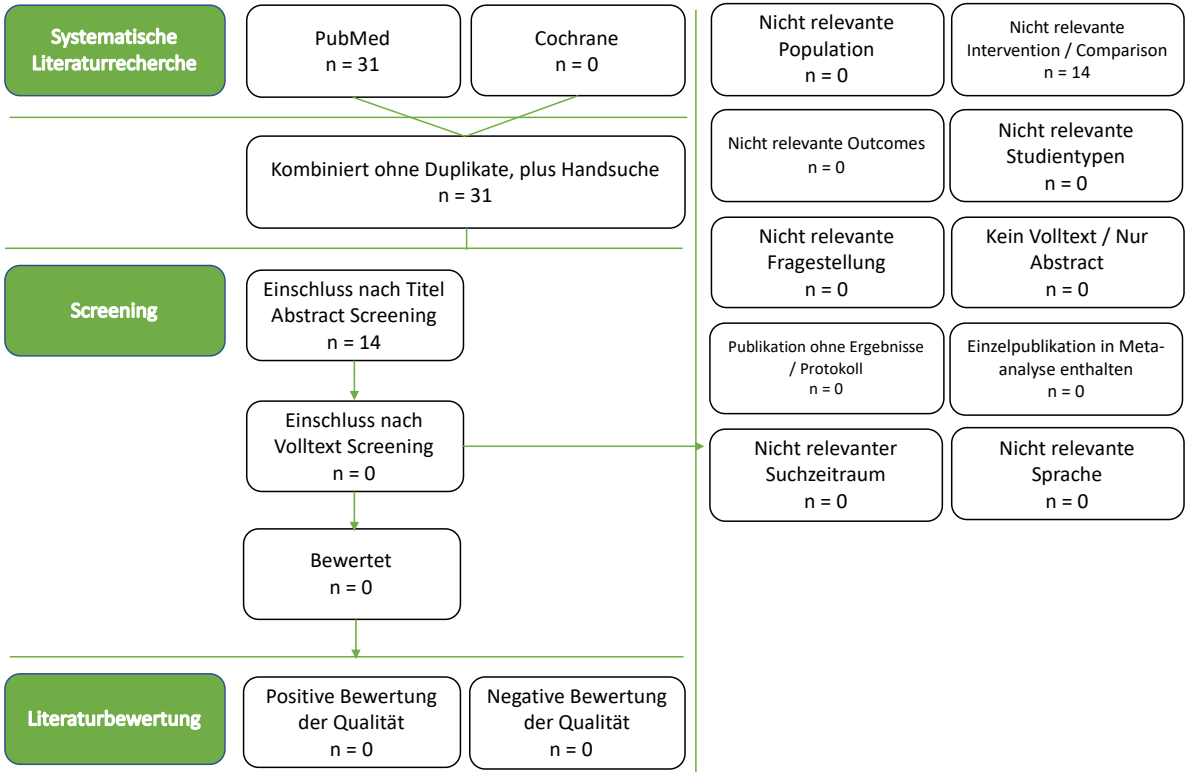
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**Drug Therapy[Mesh]** OR Therapy, Drug[tiab] OR Drug Therapies[tiab] OR Therapies, Drug[tiab] OR Chemotherapy[tiab] OR Chemotherapies[tiab] OR Pharmacotherapy[tiab] OR Pharmacotherapies[tiab]	1.791.199
#3	targeted therap*[tiab]	65.812
#4	endocrine therap*[tiab] OR hormone therap*[tiab] OR **"Hormone Replacement Therapy"[Mesh]**	48.317
#5	#2 OR #3 OR #4	1.847.678
Kombiniert mit und ohne Filter		
#6	#1 AND #5	7.411
#7	#6 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	31

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Drug Therapy OR Therapy, Drug OR Drug Therapies OR Therapies, Drug OR Chemotherapy OR Chemotherapies OR Pharmacotherapy OR Pharmacotherapies):ti,ab,kw	525258
#14	MeSH descriptor: [Drug Therapy] explode all trees	148465
#15	(targeted therap*):ti,ab,kw	14235
#16	(endocrine therap* OR hormone therap* OR "Hormone Replacement Therapy"):ti,ab,kw	31545
#17	MeSH descriptor: [Hormone Replacement Therapy] explode all trees	3018
#18	#13 OR #14 OR #15 OR #16 OR #17	576895
#19	#12 AND #18	1745

#20	#19 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 42



2.43. Schlüsselfrage 43

Wie ist der Stellenwert der adjuvanten Chemotherapie beim Endometriumkarzinom im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: Frauen mit EC Intervention: **adjuvante Chemotherapie** Comparison: keine adjuvante Chemotherapie Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

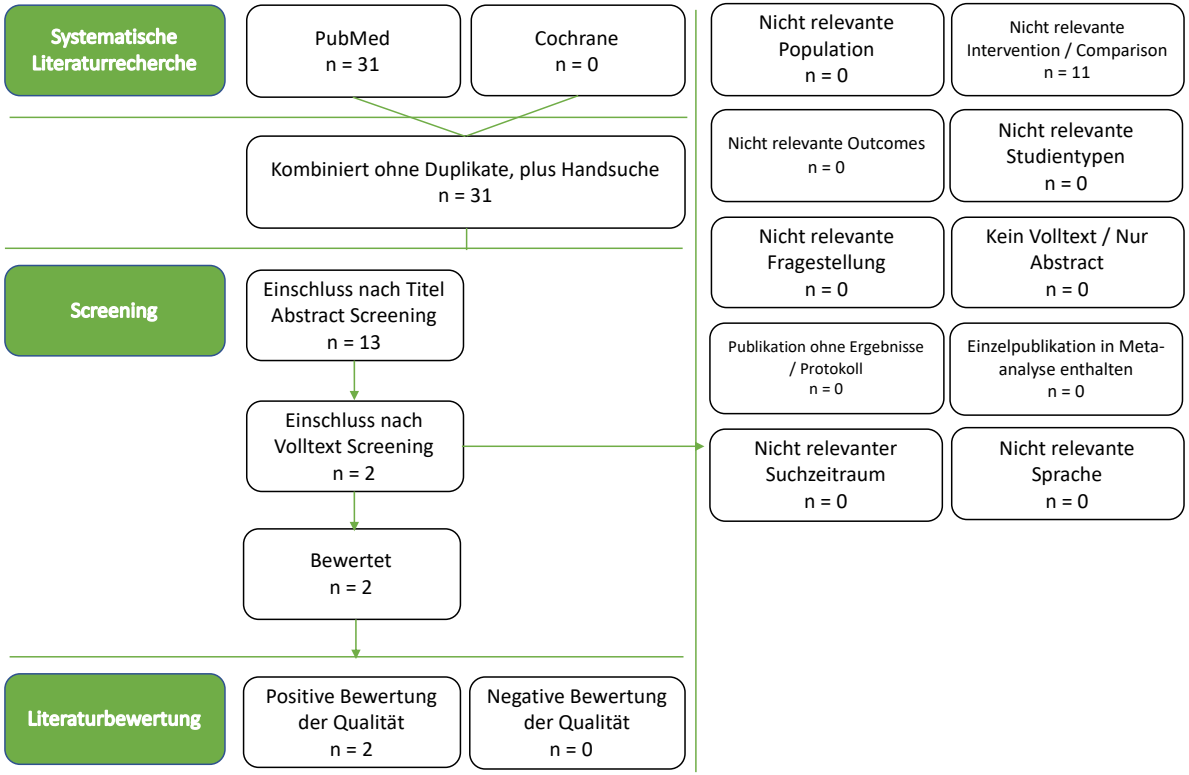
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**Drug Therapy[Mesh]** OR Therapy, Drug[tiab] OR Drug Therapies[tiab] OR Therapies, Drug[tiab] OR Chemotherapy[tiab] OR Chemotherapies[tiab] OR Pharmacotherapy[tiab] OR Pharmacotherapies[tiab]	1.791.199
#3	targeted therap*[tiab]	65.812
#4	endocrine therap*[tiab] OR hormone therap*[tiab] OR **"Hormone Replacement Therapy"[Mesh]**	48.317
#5	#2 OR #3 OR #4	1.847.678
Kombiniert mit und ohne Filter		
#6	#1 AND #5	7.411
#7	#6 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	31

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Drug Therapy OR Therapy, Drug OR Drug Therapies OR Therapies, Drug OR Chemotherapy OR Chemotherapies OR Pharmacotherapy OR Pharmacotherapies):ti,ab,kw	525258
#14	MeSH descriptor: [Drug Therapy] explode all trees	148465
#15	(targeted therap*):ti,ab,kw	14235
#16	(endocrine therap* OR hormone therap* OR "Hormone Replacement Therapy"):ti,ab,kw	31545
#17	MeSH descriptor: [Hormone Replacement Therapy] explode all trees	3018
#18	#13 OR #14 OR #15 OR #16 OR #17	576895
#19	#12 AND #18	1745

#20	#19 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 43



2.44. Schlüsselfrage 44

Wie ist der Stellenwert der adjuvanten zielgerichteten Therapie beim Endometriumkarzinom im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: Frauen mit EC Intervention: **adjuvante zielgerichtete Therapie** Comparison: keine zielgerichtete Therapie Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

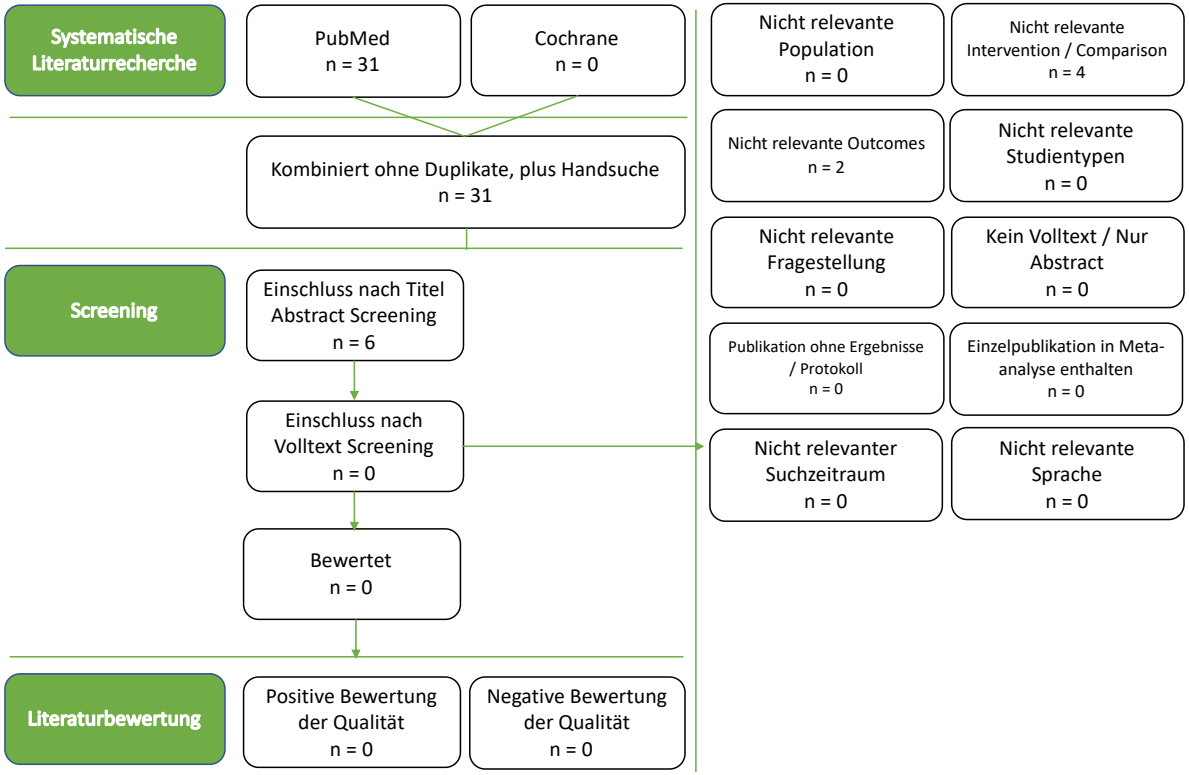
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**Drug Therapy[Mesh]** OR Therapy, Drug[tiab] OR Drug Therapies[tiab] OR Therapies, Drug[tiab] OR Chemotherapy[tiab] OR Chemotherapies[tiab] OR Pharmacotherapy[tiab] OR Pharmacotherapies[tiab]	1.791.199
#3	targeted therap*[tiab]	65.812
#4	endocrine therap*[tiab] OR hormone therap*[tiab] OR **"Hormone Replacement Therapy"[Mesh]**	48.317
#5	#2 OR #3 OR #4	1.847.678
Kombiniert mit und ohne Filter		
#6	#1 AND #5	7.411
#7	#6 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	31

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Drug Therapy OR Therapy, Drug OR Drug Therapies OR Therapies, Drug OR Chemotherapy OR Chemotherapies OR Pharmacotherapy OR Pharmacotherapies):ti,ab,kw	525258
#14	MeSH descriptor: [Drug Therapy] explode all trees	148465
#15	(targeted therap*):ti,ab,kw	14235
#16	(endocrine therap* OR hormone therap* OR "Hormone Replacement Therapy"):ti,ab,kw	31545
#17	MeSH descriptor: [Hormone Replacement Therapy] explode all trees	3018
#18	#13 OR #14 OR #15 OR #16 OR #17	576895
#19	#12 AND #18	1745

#20	#19 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 44



2.45. Schlüsselfrage 45

Welchen Stellenwert haben gynäkologische Untersuchung, zytologischer Abstrich, vaginale/abdominale/retroperitoneale Sonographie, Bestimmung von Tumormarkern, MRT, CT und PET-CT, PET-MRT in der Nachsorge der asymptomatischen Patientin im Hinblick auf Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: asymptoma-tische EC-Patientin in der Nachsorge Intervention: bimanuelle gynäkologische Untersuchung einschließlich rektaler Untersuchung -zytologischer Abstrich -vaginale/ abdominale/retroperitoneale Sonographie -Bestimmung von Tumor-markern -Bildgebung mittels MRT, CT, PET-CT, **PET-MRT** Comparison: keine Untersuchung Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**"Neoplasm Metastasis"[Mesh]** OR Metastases, Neoplasm[tiab] OR Neoplasm Metastases[tiab] OR Metastasis[tiab] OR Metastases[tiab] OR Metastasis, Neoplasm[tiab]	524.404
#3	**Recurrence[Mesh]** OR Recurrences[tiab] OR Recrudescence[tiab] OR Recrudescences[tiab] OR Relapse[tiab] OR Relapses[tiab]	369.804
#4	#2 OR #3	864.274
Kombiniert mit und ohne Filter		
#5	#1 AND #4	7.907

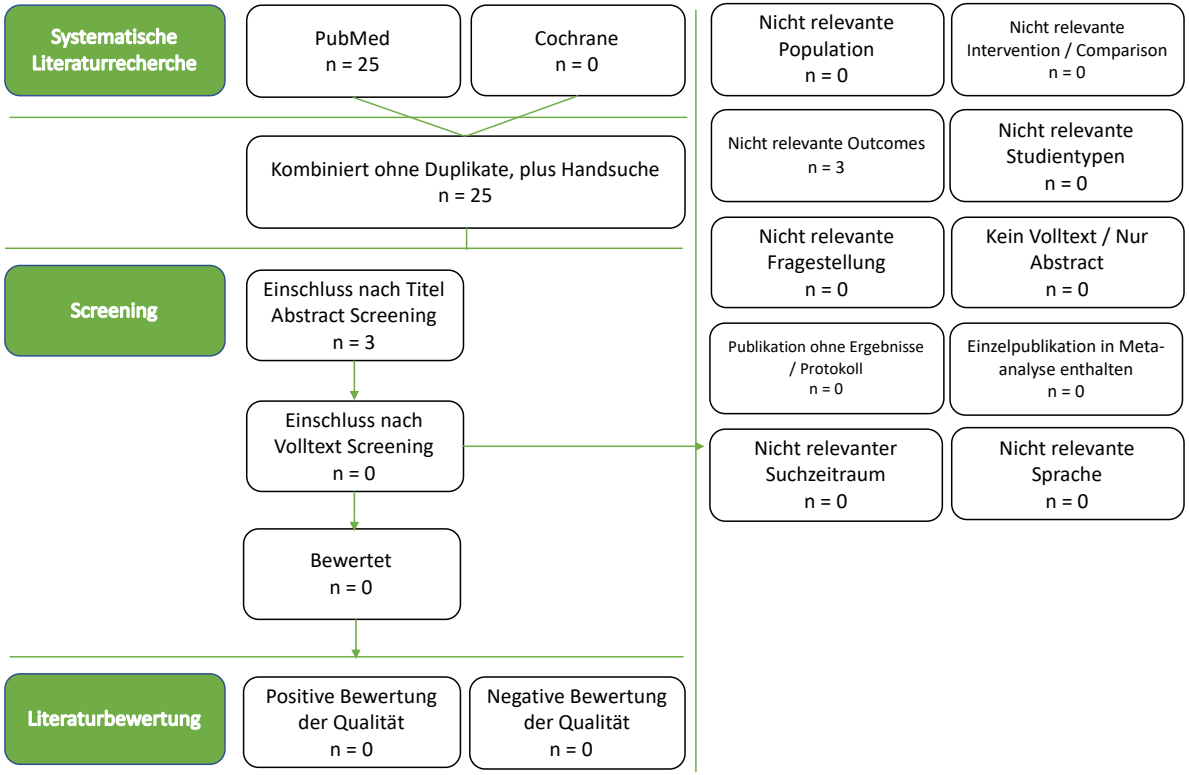
#6	#5 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	25

Recherche in der Cochrane library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Neoplasm Metastasis OR Metastases, Neoplasm OR Neoplasm Metastases OR Metastasis OR Metastases OR Metastasis, Neoplasm):ti,ab,kw	27658
#14	MeSH descriptor: [Neoplasm Metastasis] explode all trees	5497
#15	(Recurrence OR Recurrences OR Recrudescence OR Recrudescences OR Relapse OR Relapses):ti,ab,kw	79630
#16	MeSH descriptor: [Recurrence] explode all trees	12873
#17	#13 OR #14 OR #15 OR #16	100176
#18	#12 AND #17	819

#19	#18 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 45



2.46. Schlüsselfrage 46

Welchen Stellenwert haben gynäkologische Untersuchung, zytologischer Abstrich, vaginale Sonographie und Bestimmung von Tumormarkern, MRT, CT und PET-CT, **PET-MRT** in der Nachsorge der symptomatischen Patientin im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: symptoma-tische EC-Patientin in der Nachsorge Intervention: bimanuelle gynäkologische Untersuchung einschließlich rektaler Untersuchung -zytologischer Abstrich -vaginale/ abdominale/retroperitoneale Sonographie -Bestimmung von Tumor-markern -Bildgebung mittels MRT, CT, PET-CT, **PET-MRT** Comparison: keine Untersuchung Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**"Neoplasm Metastasis"[Mesh]** OR Metastases, Neoplasm[tiab] OR Neoplasm Metastases[tiab] OR Metastasis[tiab] OR Metastases[tiab] OR Metastasis, Neoplasm[tiab]	524.404
#3	**Recurrence[Mesh]** OR Recurrences[tiab] OR Recrudescence[tiab] OR Recrudescences[tiab] OR Relapse[tiab] OR Relapses[tiab]	369.804
#4	#2 OR #3	864.274
Kombiniert mit und ohne Filter		
#5	#1 AND #4	7.907

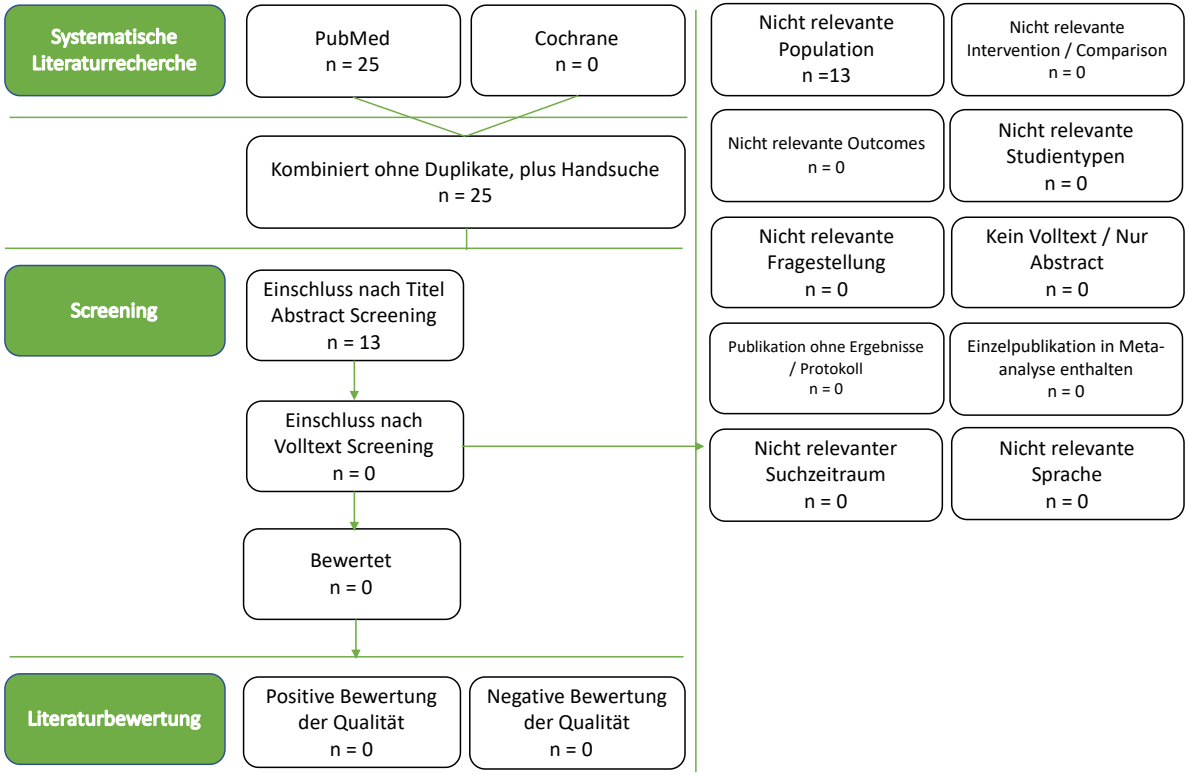
#6	#5 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	25

Recherche in der Cochrane library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Neoplasm Metastasis OR Metastases, Neoplasm OR Neoplasm Metastases OR Metastasis OR Metastases OR Metastasis, Neoplasm):ti,ab,kw	27658
#14	MeSH descriptor: [Neoplasm Metastasis] explode all trees	5497
#15	(Recurrence OR Recurrences OR Recrudescence OR Recrudescences OR Relapse OR Relapses):ti,ab,kw	79630
#16	MeSH descriptor: [Recurrence] explode all trees	12873
#17	#13 OR #14 OR #15 OR #16	100176
#18	#12 AND #17	819

#19	#18 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 46



2.47. Schlüsselfrage 47

Welchen Stellenwert haben die operative Therapie, die Chemotherapie, die endokrine Therapie, die **zielgerichtete Therapie** und die Strahlentherapie in der Behandlung von Rezidiv und Metastasen beim Endometriumkarzinom im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: EC-Patientin mit Rezidiv EC-Patientin mit Metastasen Intervention: operative Therapie Chemo-therapie endokrine Therapie Strahlen-therapie zielgerichtete Therapie Comparison: keine Therapie Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**"Neoplasm Metastasis"[Mesh]** OR Metastases, Neoplasm[tiab] OR Neoplasm Metastases[tiab] OR Metastasis[tiab] OR Metastases[tiab] OR Metastasis, Neoplasm[tiab]	524.404
#3	**Recurrence[Mesh]** OR Recurrences[tiab] OR Recrudescence[tiab] OR Recrudescences[tiab] OR Relapse[tiab] OR Relapses[tiab]	369.804
#4	#2 OR #3	864.274
Kombiniert mit und ohne Filter		

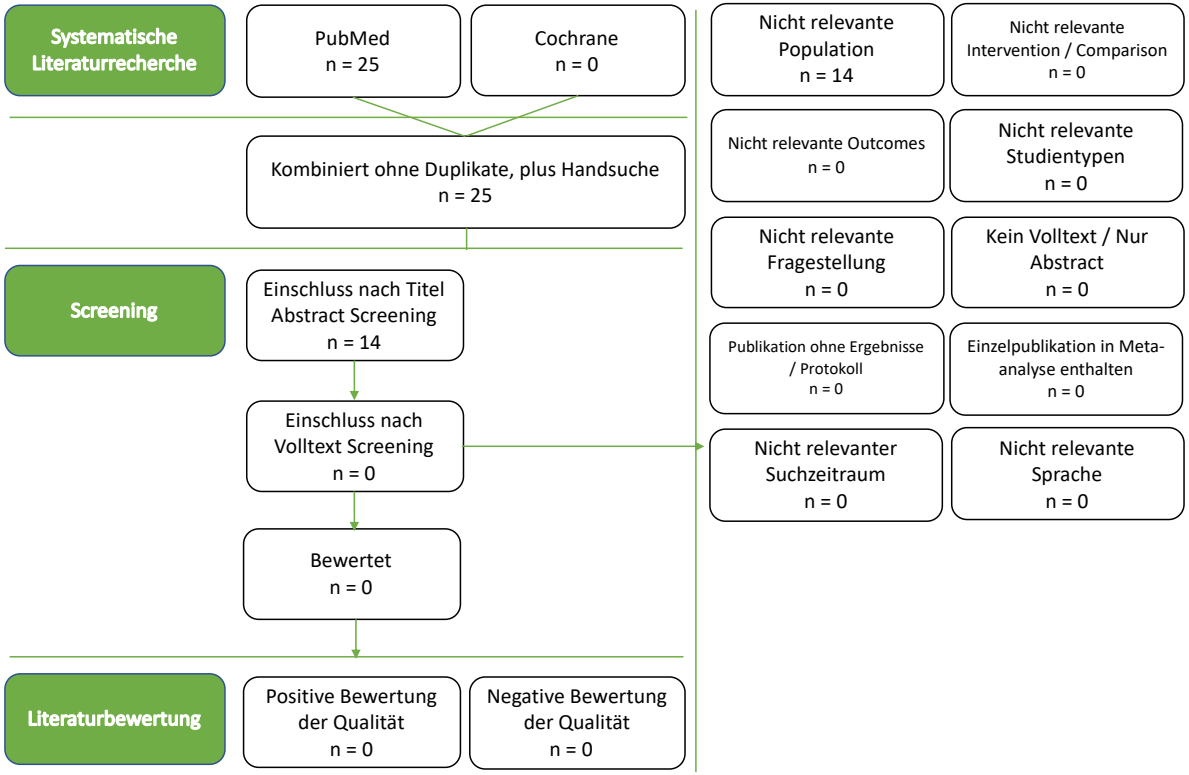
#5	#1 AND #4	7.907
#6	#5 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	25

Recherche in der Cochrane library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Neoplasm Metastasis OR Metastases, Neoplasm OR Neoplasm Metastases OR Metastasis OR Metastases OR Metastasis, Neoplasm):ti,ab,kw	27658
#14	MeSH descriptor: [Neoplasm Metastasis] explode all trees	5497
#15	(Recurrence OR Recurrences OR Recrudescence OR Recrudescences OR Relapse OR Relapses):ti,ab,kw	79630
#16	MeSH descriptor: [Recurrence] explode all trees	12873
#17	#13 OR #14 OR #15 OR #16	100176

#18	#12 AND #17	819
#19	#18 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 47



2.48. Schlüsselfrage 48

Wie ist der Stellenwert der supportiven Mitbehandlung und Betreuung in Bezug auf Kurzzeit-/ Langzeitmorbidität, krankheitsspezifisches Gesamtüberleben und weiteres Rezidiv?
Population: Frauen mit EC Intervention: supportive Mitbehandlung und Betreuung Comparison: keine supportive Mitbehandlung und Betreuung Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	best supportive care[tiab]	2.630
#3	Palliative Care[Mesh] OR Care, Palliative[tiab] OR Palliative Treatment[tiab] OR Palliative Treatments[tiab] OR Treatment, Palliative[tiab] OR Treatments, Palliative[tiab] OR Therapy, Palliative[tiab] OR Palliative Therapy[tiab] OR Palliative Supportive Care[tiab] OR Supportive Care, Palliative[tiab] OR Palliative Surgery[tiab] OR Surgery, Palliative[tiab]	68.404
#4	psycho-oncological care[tiab] OR psycho oncological care[tiab] OR psychosocial care OR psycho-social care[tiab]	68.900
#5	Rehabilitation[Mesh] OR rehabilitation[tiab] OR habilitation[tiab]	481.444
#6	vaginal dryness[tiab] OR vaginal laser therap*[tiab] OR vaginal atrophy[tiab] OR ((**"Vagina"[Mesh]** OR vagina[tiab]) AND (dryn*[tiab] OR laser[tiab] OR atroph*[tiab] OR **"Atrophy"[Mesh]**))	2.840

#7	sexual function[tiab] OR **"Sexual Dysfunction, Physiological"[Mesh]** OR Physiological Sexual Dysfunction[tiab] OR Physiological Sexual Dysfunctions[tiab] OR Sexual Dysfunctions, Physiological[tiab] OR Sexual Disorders, Physiological[tiab] OR Physiological Sexual Disorder[tiab] OR Physiological Sexual Disorders[tiab] OR Sexual Disorder, Physiological[tiab] OR Sex Disorders[tiab] OR painful intercourse[tiab]	42.555
#8	#2 OR #3 OR #4 OR #5 OR #6 OR #7	645.228
Kombiniert mit und ohne Filter		
#9	#1 AND #8	697
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	7

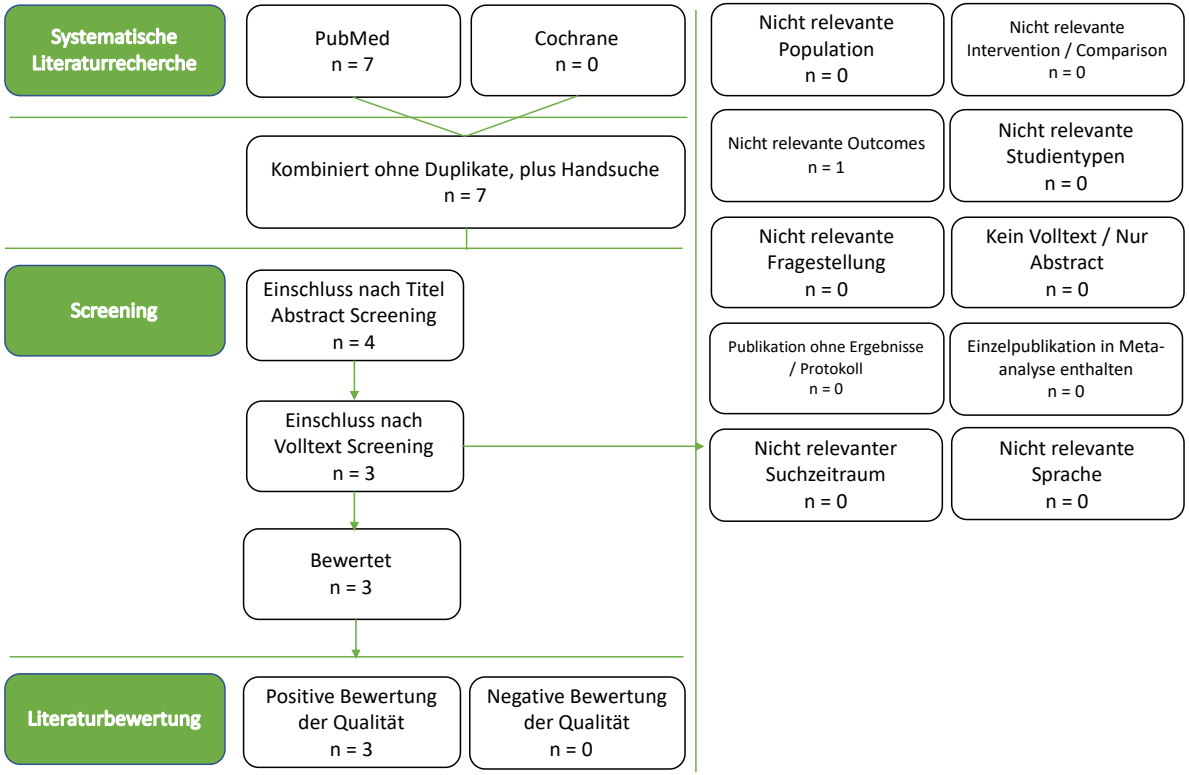
Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480

#13	(best supportive care):ti,ab,kw	1713
#14	(Palliative Care OR Care, Palliative OR Palliative Treatment OR Palliative Treatments OR Treatment, Palliative OR Treatments, Palliative OR Therapy, Palliative OR Palliative Therapy OR Palliative Supportive Care OR Supportive Care, Palliative OR Palliative Surgery OR Surgery, Palliative):ti,ab,kw	8149
#15	MeSH descriptor: [Palliative Care] explode all trees	1792
#16	(psycho-oncological care OR psycho oncological care OR psychosocial care OR psycho-social care):ti,ab,kw	7985
#17	(Rehabilitation OR rehabilitation OR habilitation):ti,ab,kw	58692
#18	MeSH descriptor: [Rehabilitation] explode all trees	41262
#19	(vaginal dryness OR vaginal laser therap* OR vaginal atrophy OR (("Vagina" OR vagina) AND (dry* OR laser OR atroph* OR "Atrophy"))):ti,ab,kw	1443
#20	MeSH descriptor: [Vagina] explode all trees	1414
#21	(vagina OR vaginal):ti,ab,kw	21109
#22	#20 OR #21	21109
#23	(atroph* OR dry*):ti,ab,kw	28347
#24	MeSH descriptor: [Atrophy] explode all trees	2019
#25	#23 OR #24	28944
#26	#22 AND #25	1456
#27	#19 OR #26	1600
#28	(sexual function OR "Sexual Dysfunction, Physiological" OR Physiological Sexual Dysfunction OR Physiological Sexual Dysfunctions OR Sexual Dysfunctions, Physiological OR Sexual Disorders, Physiological OR Physiological Sexual Disorder OR Physiological Sexual Disorders OR Sexual Disorder, Physiological OR Sex Disorders OR painful intercourse):ti,ab,kw	10560

#29	MeSH descriptor: [Sexual Dysfunction, Physiological] explode all trees	2413
#30	#13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #27 OR #28 OR #29	114044
#31	#12 AND #30	205
#32	#31 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 48



2.49. Schlüsselfrage 49

Wie ist der Stellenwert der palliativen Mitbehandlung und Betreuung in Bezug auf Kurzzeit-/ Langzeitmorbidität, krankheitsspezifisches Gesamtüberleben und weiteres Rezidiv?
Population: Frauen mit EC Intervention: palliative Mitbehandlung und Betreuung Comparison: keine palliative Mitbehandlung und Betreuung Outcomes: Verbesserung Lebensqualität, Kurzzeit-/ Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	best supportive care[tiab]	2.630
#3	Palliative Care[Mesh] OR Care, Palliative[tiab] OR Palliative Treatment[tiab] OR Palliative Treatments[tiab] OR Treatment, Palliative[tiab] OR Treatments, Palliative[tiab] OR Therapy, Palliative[tiab] OR Palliative Therapy[tiab] OR Palliative Supportive Care[tiab] OR Supportive Care, Palliative[tiab] OR Palliative Surgery[tiab] OR Surgery, Palliative[tiab]	68.404
#4	psycho-oncological care[tiab] OR psycho oncological care[tiab] OR psychosocial care OR psycho-social care[tiab]	68.900
#5	Rehabilitation[Mesh] OR rehabilitation[tiab] OR habilitation[tiab]	481.444
#6	vaginal dryness[tiab] OR vaginal laser therap*[tiab] OR vaginal atrophy[tiab] OR (("**Vagina"[Mesh]** OR vagina[tiab]) AND (dryn*[tiab] OR laser[tiab] OR atroph*[tiab] OR **"Atrophy"[Mesh]**))	2.840

#7	sexual function[tiab] OR **"Sexual Dysfunction, Physiological"[Mesh]** OR Physiological Sexual Dysfunction[tiab] OR Physiological Sexual Dysfunctions[tiab] OR Sexual Dysfunctions, Physiological[tiab] OR Sexual Disorders, Physiological[tiab] OR Physiological Sexual Disorder[tiab] OR Physiological Sexual Disorders[tiab] OR Sexual Disorder, Physiological[tiab] OR Sex Disorders[tiab] OR painful intercourse[tiab]	42.555
#8	#2 OR #3 OR #4 OR #5 OR #6 OR #7	645.228
Kombiniert mit und ohne Filter		
#9	#1 AND #8	697
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	7

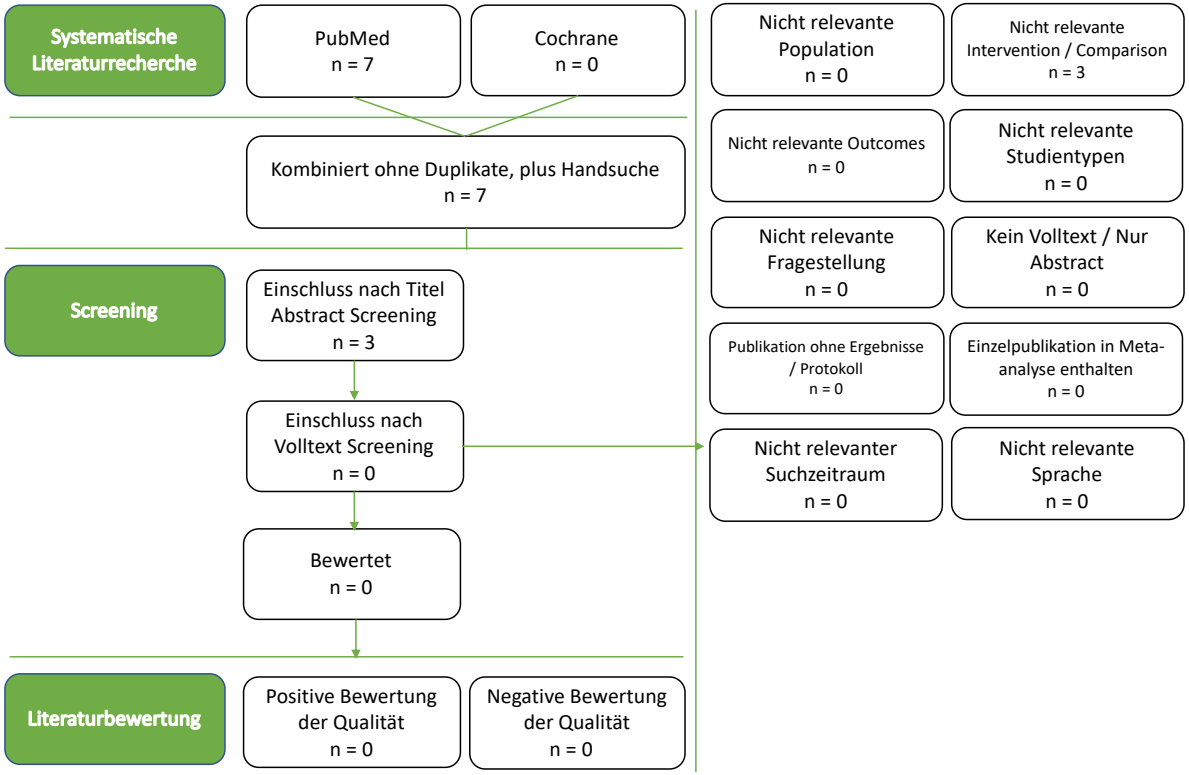
Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267

#12	#10 OR #11	3480
#13	(best supportive care):ti,ab,kw	1713
#14	(Palliative Care OR Care, Palliative OR Palliative Treatment OR Palliative Treatments OR Treatment, Palliative OR Treatments, Palliative OR Therapy, Palliative OR Palliative Therapy OR Palliative Supportive Care OR Supportive Care, Palliative OR Palliative Surgery OR Surgery, Palliative):ti,ab,kw	8149
#15	MeSH descriptor: [Palliative Care] explode all trees	1792
#16	(psycho-oncological care OR psycho oncological care OR psychosocial care OR psycho-social care):ti,ab,kw	7985
#17	(Rehabilitation OR rehabilitation OR habilitation):ti,ab,kw	58692
#18	MeSH descriptor: [Rehabilitation] explode all trees	41262
#19	(vaginal dryness OR vaginal laser therap* OR vaginal atrophy OR (("Vagina" OR vagina) AND (dry* OR laser OR atroph* OR "Atrophy"))):ti,ab,kw	1443
#20	MeSH descriptor: [Vagina] explode all trees	1414
#21	(vagina OR vaginal):ti,ab,kw	21109
#22	#20 OR #21	21109
#23	(atroph* OR dry*):ti,ab,kw	28347
#24	MeSH descriptor: [Atrophy] explode all trees	2019
#25	#23 OR #24	28944
#26	#22 AND #25	1456
#27	#19 OR #26	1600
#28	(sexual function OR "Sexual Dysfunction, Physiological" OR Physiological Sexual Dysfunction OR Physiological Sexual Dysfunctions OR Sexual Dysfunctions, Physiological OR Sexual Disorders, Physiological OR	10560

	Physiological Sexual Disorder OR Physiological Sexual Disorders OR Sexual Disorder, Physiological OR Sex Disorders OR painful intercourse):ti,ab,kw	
#29	MeSH descriptor: [Sexual Dysfunction, Physiological] explode all trees	2413
#30	#13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #27 OR #28 OR #29	114044
#31	#12 AND #30	205
#32	#31 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 49



2.50. Schlüsselfrage 50

Wie ist der Stellenwert der psychoonkologischen Mitbehandlung und Betreuung in Bezug auf Kurzzeit-/Langzeitmorbidität, krankheitsspezifisches Gesamtüberleben und weiteres Rezidiv?
Population: Frauen mit EC Intervention: psychoonkologische Mitbehandlung und Betreuung Comparison: keine psychoonkologische Mitbehandlung und Betreuung Outcomes: Verbesserung Lebensqualität, Kurzzeit-/ Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	best supportive care[tiab]	2.630
#3	Palliative Care[Mesh] OR Care, Palliative[tiab] OR Palliative Treatment[tiab] OR Palliative Treatments[tiab] OR Treatment, Palliative[tiab] OR Treatments, Palliative[tiab] OR Therapy, Palliative[tiab] OR Palliative Therapy[tiab] OR Palliative Supportive Care[tiab] OR Supportive Care, Palliative[tiab] OR Palliative Surgery[tiab] OR Surgery, Palliative[tiab]	68.404
#4	psycho-oncological care[tiab] OR psycho oncological care[tiab] OR psychosocial care OR psycho-social care[tiab]	68.900
#5	Rehabilitation[Mesh] OR rehabilitation[tiab] OR habilitation[tiab]	481.444
#6	vaginal dryness[tiab] OR vaginal laser therap*[tiab] OR vaginal atrophy[tiab] OR (("**Vagina"[Mesh]** OR vagina[tiab]) AND (dryn*[tiab] OR laser[tiab] OR atroph*[tiab] OR **"Atrophy"[Mesh]**))	2.840

#7	sexual function[tiab] OR **"Sexual Dysfunction, Physiological"[Mesh]** OR Physiological Sexual Dysfunction[tiab] OR Physiological Sexual Dysfunctions[tiab] OR Sexual Dysfunctions, Physiological[tiab] OR Sexual Disorders, Physiological[tiab] OR Physiological Sexual Disorder[tiab] OR Physiological Sexual Disorders[tiab] OR Sexual Disorder, Physiological[tiab] OR Sex Disorders[tiab] OR painful intercourse[tiab]	42.555
#8	#2 OR #3 OR #4 OR #5 OR #6 OR #7	645.228
Kombiniert mit und ohne Filter		
#9	#1 AND #8	697
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	7

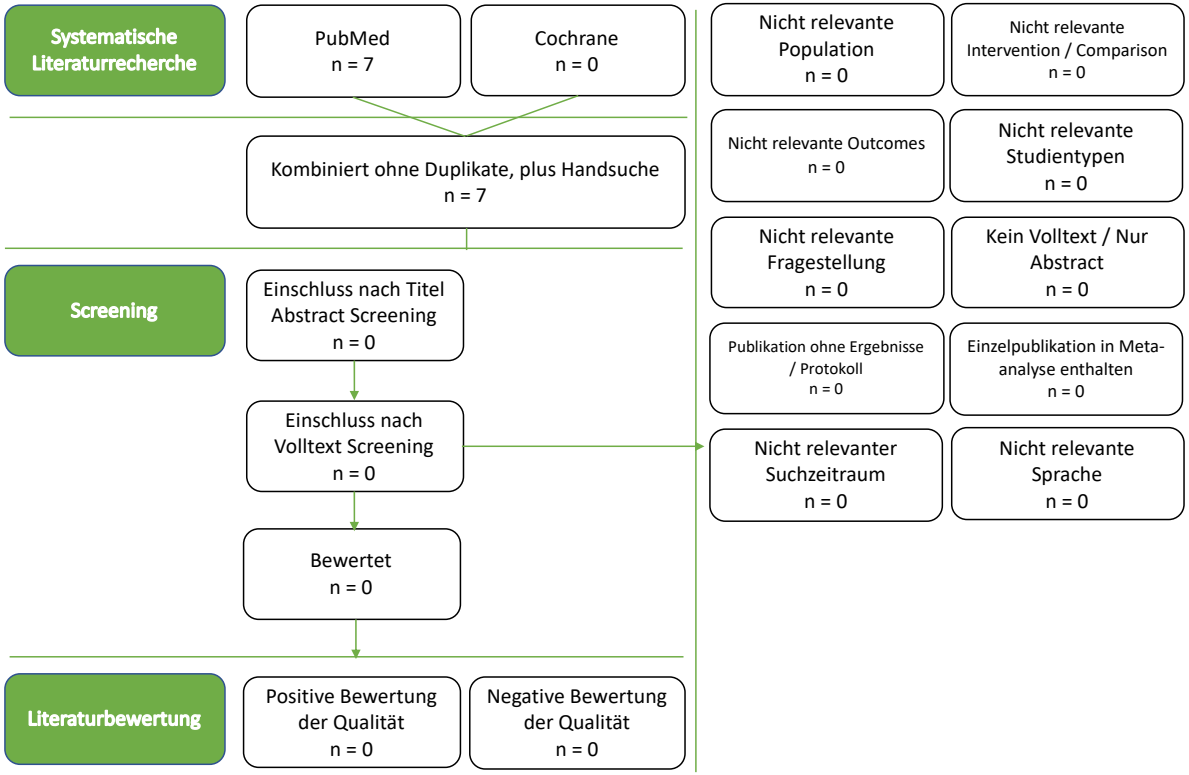
Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267

#12	#10 OR #11	3480
#13	(best supportive care):ti,ab,kw	1713
#14	(Palliative Care OR Care, Palliative OR Palliative Treatment OR Palliative Treatments OR Treatment, Palliative OR Treatments, Palliative OR Therapy, Palliative OR Palliative Therapy OR Palliative Supportive Care OR Supportive Care, Palliative OR Palliative Surgery OR Surgery, Palliative):ti,ab,kw	8149
#15	MeSH descriptor: [Palliative Care] explode all trees	1792
#16	(psycho-oncological care OR psycho oncological care OR psychosocial care OR psycho-social care):ti,ab,kw	7985
#17	(Rehabilitation OR rehabilitation OR habilitation):ti,ab,kw	58692
#18	MeSH descriptor: [Rehabilitation] explode all trees	41262
#19	(vaginal dryness OR vaginal laser therap* OR vaginal atrophy OR (("Vagina" OR vagina) AND (dry* OR laser OR atroph* OR "Atrophy"))):ti,ab,kw	1443
#20	MeSH descriptor: [Vagina] explode all trees	1414
#21	(vagina OR vaginal):ti,ab,kw	21109
#22	#20 OR #21	21109
#23	(atroph* OR dry*):ti,ab,kw	28347
#24	MeSH descriptor: [Atrophy] explode all trees	2019
#25	#23 OR #24	28944
#26	#22 AND #25	1456
#27	#19 OR #26	1600
#28	(sexual function OR "Sexual Dysfunction, Physiological" OR Physiological Sexual Dysfunction OR Physiological Sexual Dysfunctions OR Sexual Dysfunctions, Physiological OR Sexual Disorders, Physiological OR	10560

	Physiological Sexual Disorder OR Physiological Sexual Disorders OR Sexual Disorder, Physiological OR Sex Disorders OR painful intercourse):ti,ab,kw	
#29	MeSH descriptor: [Sexual Dysfunction, Physiological] explode all trees	2413
#30	#13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #27 OR #28 OR #29	114044
#31	#12 AND #30	205
#32	#31 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 50



2.51. Schlüsselfrage 51

Wie ist der Stellenwert der psychosozialen Mitbehandlung und Betreuung und Rehabilitation in Bezug auf Kurzzeit-/Langzeitmorbidität, krankheitsspezifisches Gesamtüberleben und weiteres Rezidiv?
Population: Frauen mit EC Intervention: psychosoziale Mitbehandlung und Betreuung Comparison: keine psychosoziale Mitbehandlung und Betreuung Outcomes: Verbesserung Lebensqualität, Kurzzeit-/ Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	best supportive care[tiab]	2.630
#3	Palliative Care[Mesh] OR Care, Palliative[tiab] OR Palliative Treatment[tiab] OR Palliative Treatments[tiab] OR Treatment, Palliative[tiab] OR Treatments, Palliative[tiab] OR Therapy, Palliative[tiab] OR Palliative Therapy[tiab] OR Palliative Supportive Care[tiab] OR Supportive Care, Palliative[tiab] OR Palliative Surgery[tiab] OR Surgery, Palliative[tiab]	68.404
#4	psycho-oncological care[tiab] OR psycho oncological care[tiab] OR psychosocial care OR psycho-social care[tiab]	68.900
#5	Rehabilitation[Mesh] OR rehabilitation[tiab] OR habilitation[tiab]	481.444
#6	vaginal dryness[tiab] OR vaginal laser therap*[tiab] OR vaginal atrophy[tiab] OR (**"Vagina"[Mesh]** OR vagina[tiab]) AND (dryn*[tiab] OR laser[tiab] OR atroph*[tiab] OR **"Atrophy"[Mesh]**))	2.840

#7	sexual function[tiab] OR **"Sexual Dysfunction, Physiological"[Mesh]** OR Physiological Sexual Dysfunction[tiab] OR Physiological Sexual Dysfunctions[tiab] OR Sexual Dysfunctions, Physiological[tiab] OR Sexual Disorders, Physiological[tiab] OR Physiological Sexual Disorder[tiab] OR Physiological Sexual Disorders[tiab] OR Sexual Disorder, Physiological[tiab] OR Sex Disorders[tiab] OR painful intercourse[tiab]	42.555
#8	#2 OR #3 OR #4 OR #5 OR #6 OR #7	645.228
Kombiniert mit und ohne Filter		
#9	#1 AND #8	697
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	7

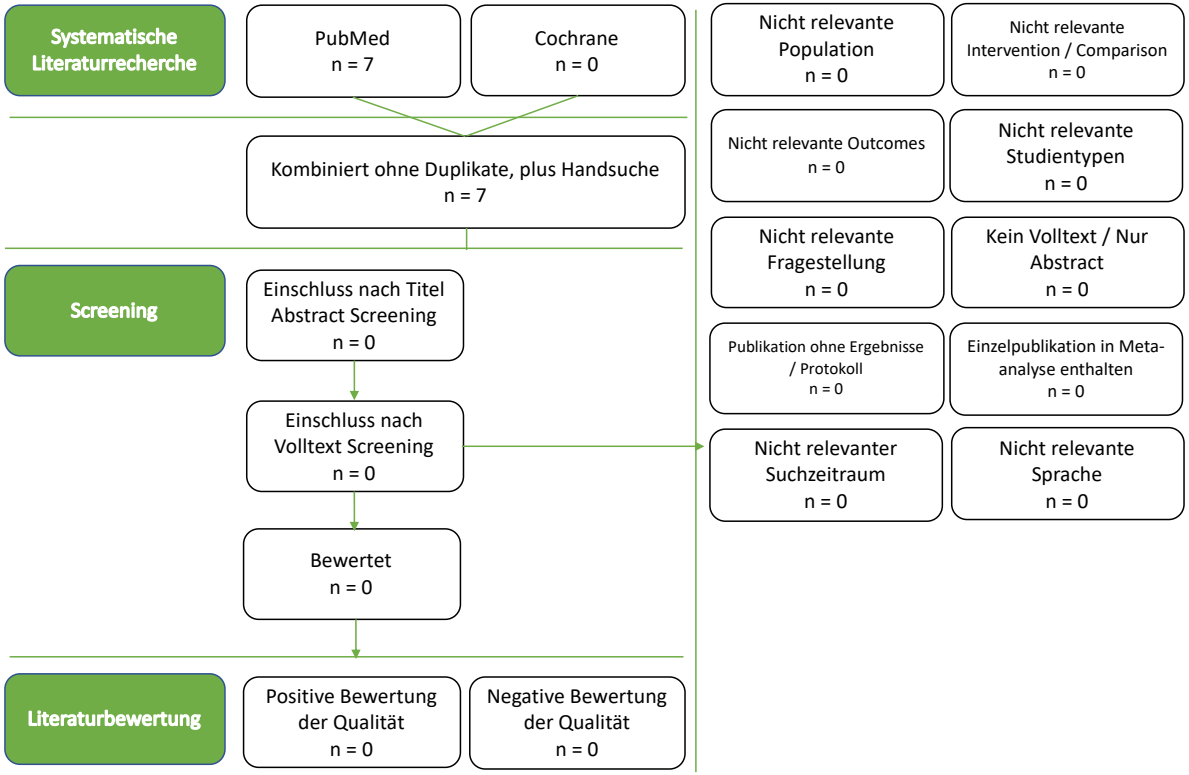
Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267

#12	#10 OR #11	3480
#13	(best supportive care):ti,ab,kw	1713
#14	(Palliative Care OR Care, Palliative OR Palliative Treatment OR Palliative Treatments OR Treatment, Palliative OR Treatments, Palliative OR Therapy, Palliative OR Palliative Therapy OR Palliative Supportive Care OR Supportive Care, Palliative OR Palliative Surgery OR Surgery, Palliative):ti,ab,kw	8149
#15	MeSH descriptor: [Palliative Care] explode all trees	1792
#16	(psycho-oncological care OR psycho oncological care OR psychosocial care OR psycho-social care):ti,ab,kw	7985
#17	(Rehabilitation OR rehabilitation OR habilitation):ti,ab,kw	58692
#18	MeSH descriptor: [Rehabilitation] explode all trees	41262
#19	(vaginal dryness OR vaginal laser therap* OR vaginal atrophy OR (("Vagina" OR vagina) AND (dry* OR laser OR atroph* OR "Atrophy"))):ti,ab,kw	1443
#20	MeSH descriptor: [Vagina] explode all trees	1414
#21	(vagina OR vaginal):ti,ab,kw	21109
#22	#20 OR #21	21109
#23	(atroph* OR dry*):ti,ab,kw	28347
#24	MeSH descriptor: [Atrophy] explode all trees	2019
#25	#23 OR #24	28944
#26	#22 AND #25	1456
#27	#19 OR #26	1600
#28	(sexual function OR "Sexual Dysfunction, Physiological" OR Physiological Sexual Dysfunction OR Physiological Sexual Dysfunctions OR Sexual Dysfunctions, Physiological OR Sexual Disorders, Physiological OR	10560

	Physiological Sexual Disorder OR Physiological Sexual Disorders OR Sexual Disorder, Physiological OR Sex Disorders OR painful intercourse):ti,ab,kw	
#29	MeSH descriptor: [Sexual Dysfunction, Physiological] explode all trees	2413
#30	#13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #27 OR #28 OR #29	114044
#31	#12 AND #30	205
#32	#31 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 51



2.52. Schlüsselfrage 52

Kann bei an Endometriumkarzinom erkrankten Patientinnen mit Trockenheit der Vagina diese durch die Applikation von inerten Gleitgelen oder Cremes oder **vaginaler Lasertherapie** vermindert werden, so dass sich die Lebensqualität verbessert in Bezug auf sexuelle Funktionsstörungen und vaginale Beschwerden?
Population: an EC erkrankte Patientinnen mit Trockenheit der Vagina Intervention: Applikation von inerten Gleitgelen oder Cremes Anwendung **vaginaler Lasertherapie** Comparison: keine Applikation von inerten Gleitgelen oder Cremes keine vaginale Lasertherapie Outcomes: Verbesserung der Lebensqualität in Bezug auf sexuelle Funktions-störungen und vaginale Beschwerden

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	best supportive care[tiab]	2.630
#3	Palliative Care[Mesh] OR Care, Palliative[tiab] OR Palliative Treatment[tiab] OR Palliative Treatments[tiab] OR Treatment, Palliative[tiab] OR Treatments, Palliative[tiab] OR Therapy, Palliative[tiab] OR Palliative Therapy[tiab] OR Palliative Supportive Care[tiab] OR Supportive Care, Palliative[tiab] OR Palliative Surgery[tiab] OR Surgery, Palliative[tiab]	68.404
#4	psycho-oncological care[tiab] OR psycho oncological care[tiab] OR psychosocial care OR psycho-social care[tiab]	68.900
#5	Rehabilitation[Mesh] OR rehabilitation[tiab] OR habilitation[tiab]	481.444

#6	vaginal dryness[tiab] OR vaginal laser therap*[tiab] OR vaginal atrophy[tiab] OR (("**Vagina"[Mesh]** OR vagina[tiab]) AND (dryn*[tiab] OR laser[tiab] OR atroph*[tiab] OR **"Atrophy"[Mesh]**))	2.840
#7	sexual function[tiab] OR **"Sexual Dysfunction, Physiological"[Mesh]** OR Physiological Sexual Dysfunction[tiab] OR Physiological Sexual Dysfunctions[tiab] OR Sexual Dysfunctions, Physiological[tiab] OR Sexual Disorders, Physiological[tiab] OR Physiological Sexual Disorder[tiab] OR Physiological Sexual Disorders[tiab] OR Sexual Disorder, Physiological[tiab] OR Sex Disorders[tiab] OR painful intercourse[tiab]	42.555
#8	#2 OR #3 OR #4 OR #5 OR #6 OR #7	645.228
Kombiniert mit und ohne Filter		
#9	#1 AND #8	697
#10	#9 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	7

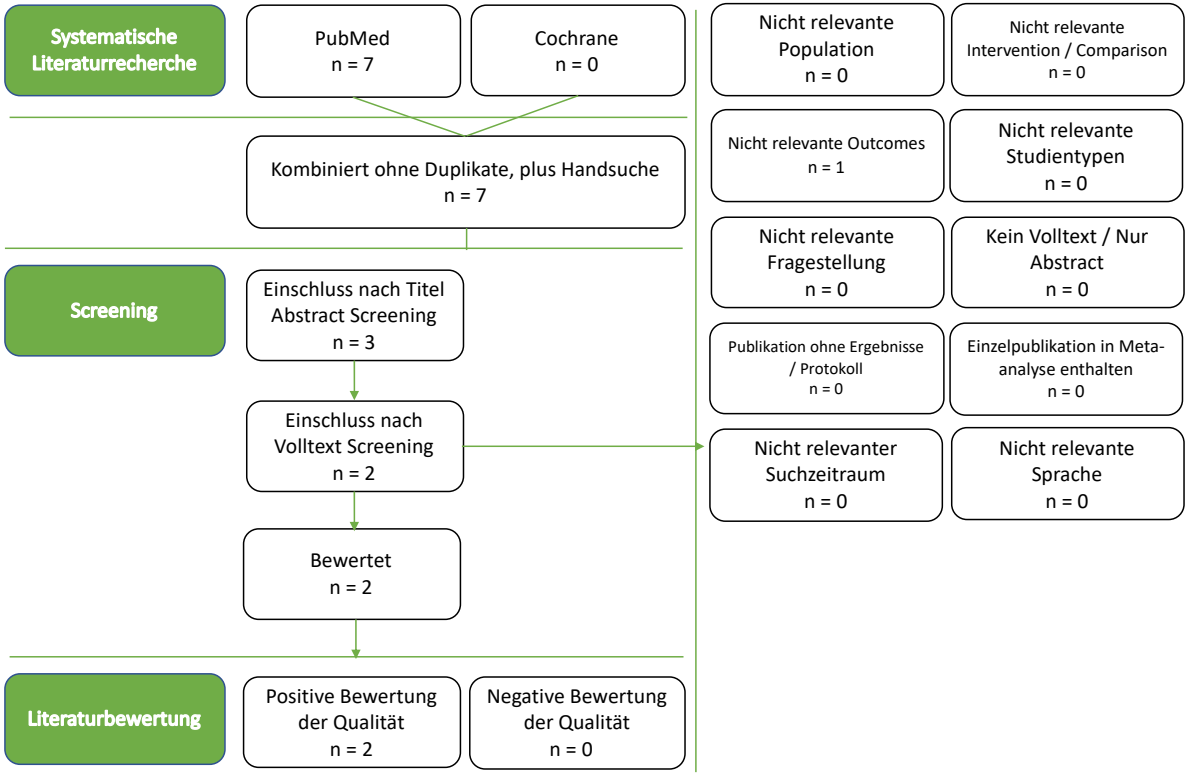
Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244572
#6	MeSH descriptor: [Carcinoma] explode all trees	15104
#7	MeSH descriptor: [Neoplasms] explode all trees	89823
#8	#5 OR #6 OR #7	254776
#9	#4 AND #8	3436
#10	#1 OR #9	3480

#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(best supportive care):ti,ab,kw	1713
#14	(Palliative Care OR Care, Palliative OR Palliative Treatment OR Palliative Treatments OR Treatment, Palliative OR Treatments, Palliative OR Therapy, Palliative OR Palliative Therapy OR Palliative Supportive Care OR Supportive Care, Palliative OR Palliative Surgery OR Surgery, Palliative):ti,ab,kw	8149
#15	MeSH descriptor: [Palliative Care] explode all trees	1792
#16	(psycho-oncological care OR psycho oncological care OR psychosocial care OR psycho-social care):ti,ab,kw	7985
#17	(Rehabilitation OR rehabilitation OR habilitation):ti,ab,kw	58692
#18	MeSH descriptor: [Rehabilitation] explode all trees	41262
#19	(vaginal dryness OR vaginal laser therap* OR vaginal atrophy OR (("Vagina" OR vagina) AND (dry* OR laser OR atroph* OR "Atrophy"))):ti,ab,kw	1443
#20	MeSH descriptor: [Vagina] explode all trees	1414
#21	(vagina OR vaginal):ti,ab,kw	21109
#22	#20 OR #21	21109
#23	(atroph* OR dry*):ti,ab,kw	28347
#24	MeSH descriptor: [Atrophy] explode all trees	2019
#25	#23 OR #24	28944
#26	#22 AND #25	1456

#27	#19 OR #26	1600
#28	(sexual function OR "Sexual Dysfunction, Physiological" OR Physiological Sexual Dysfunction OR Physiological Sexual Dysfunctions OR Sexual Dysfunctions, Physiological OR Sexual Disorders, Physiological OR Physiological Sexual Disorder OR Physiological Sexual Disorders OR Sexual Disorder, Physiological OR Sex Disorders OR painful intercourse):ti,ab,kw	10560
#29	MeSH descriptor: [Sexual Dysfunction, Physiological] explode all trees	2413
#30	#13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #27 OR #28 OR #29	114044
#31	#12 AND #30	205
#32	#31 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 52



2.53. Schlüsselfrage 53

Kann bei an Endometriumkarzinom erkrankten Patientinnen mit Trockenheit der Vagina, die durch inerte Cremes oder Gleitgele nicht befriedigend behandelbar ist, eine lokale Östrogenbehandlung durchgeführt werden, so dass sich die Lebensqualität verbessert in Bezug auf sexuelle Funktionsstörungen und vaginale Beschwerden?
Population EC-Patientin mit therapieresistenter (inerte Cremes, Gleitgele) mangelnder Lubrikation der Vagina Intervention: okale Östrogenbehandlung Comparison: keine lokale ÖstrogenbehandlungVerb Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

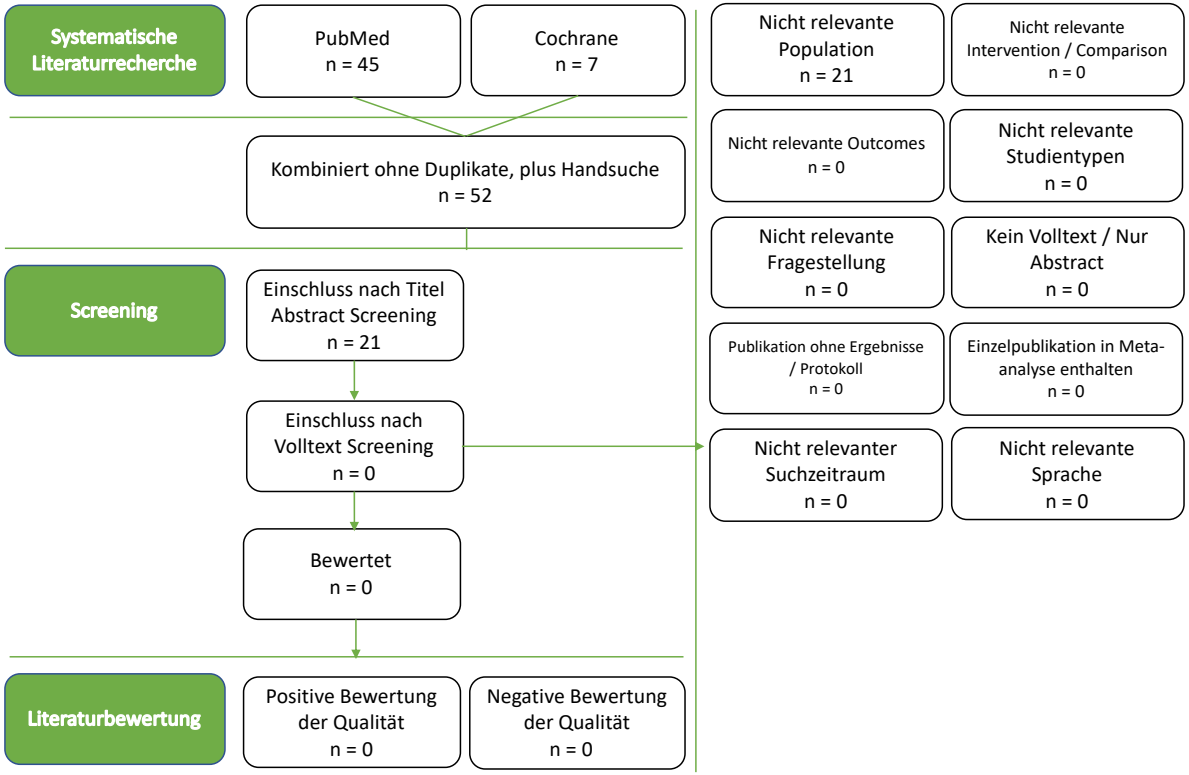
Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	estrogen	284.939
#3	follow up	1.406.273
#4	recurrence	785.247
#5	posttreatment	64.093
#6	**#2 OR #3 OR #4 OR #5**	2.303.164
Kombiniert mit und ohne Filter		
#7	#1 AND #6	17.354
#8	#7 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	45

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	7

Schlüsselfrage 53



2.54. Schlüsselfrage 54

Kann bei an Endometriumkarzinom erkrankten Patientinnen, die behandelt wurden mittels Strahlentherapie, welche die Vaginalregion einbezogen hat, eine mechanische Dilatation mittels Vaginaldilatatoren oder Tampons mit inerten Cremes ab vier bis sechs Wochen postoperativ eine Vaginalstenose verhindern, so dass die Lebensqualität erhalten bleibt in Bezug auf sexuelle Funktionsstörungen und vaginale Beschwerden?
Population EC-Patientinnen 4-6 Wochen postoperativ und im Zustand nach Radiatio der Vaginalregion Intervention: mechanische Dilatation mittels Vaginaldilatatoren oder Tampons mit inerten Cremes Comparison: keine mechanische Dilatation Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberlebe

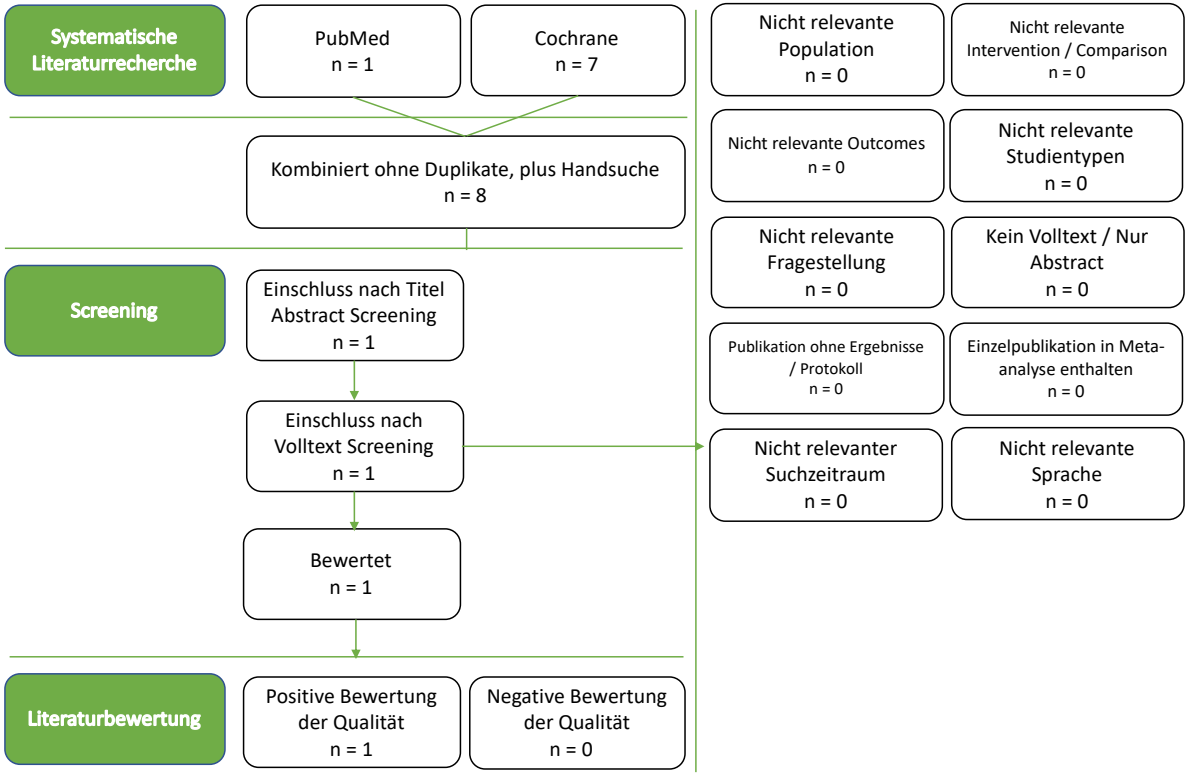
Recherche in PubMed (06.10.2022)

Population		
#1	vaginal radiotherapy	4.571
Intervention bzw. Exposure		
#2	dilator	172.954
Kombiniert mit und ohne Filter		
#3	#1 AND #2	118
#4	#3 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	1

Recherche in der Cochrane Library (06.10.2022)

ID	Search	Hits
#1	endometrial cancer	2618
#2	#1 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	7

Schlüsselfrage 54



2.55. Schlüsselfrage 55

Welchen Stellenwert hat die Narkoseuntersuchung mit Zystoskopie, Rektoskopie und diagnostischer Laparoskopie mit Spülflüssigkeit/Zytologie-Gewinnung für die lokale und systemische Ausbreitungsdiagnostik des histologisch gesicherten primären Endometriumkarzinoms im Hinblick auf eine Änderung der operativen Strategie sowie auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: Frauen mit histologisch gesichertem EC -Typ I -Typ II Intervention: Narkoseunter-suchung mit Zystoskopie Rektoskopie diagnostischer Laparoskopie mit Spülflüssigkeit/Zyto-logie-Gewinnung Comparison: keine Zystoskopie, Rektoskopie diagnostischer Laparoskopie mit Spülflüssigkeit/Zytologie-Gewinnung Outcomes: Morbidität, Lebensqualität, Rezidivhäufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

PubMed Recherche (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**Gynecological Examination[Mesh]** OR Examination, Gynecological[tiab] OR Examinations, Gynecological[tiab] OR Gynecological Examinations[tiab] OR Gynecological Exam[tiab] OR Exam, Gynecological[tiab] OR Exams, Gynecological[tiab] OR Gynecological Exams[tiab] OR Vaginal Examinations[tiab] OR Examination, Vaginal[tiab] OR Examinations, Vaginal[tiab] OR Vaginal Examination[tiab] OR Vaginal Exam[tiab] OR Exam, Vaginal[tiab] OR Exams, Vaginal[tiab] OR Vaginal Exams[tiab] OR Pelvic Examination[tiab] OR Examination, Pelvic[tiab] OR Examinations, Pelvic[tiab]	4.903

	OR Pelvic Examinations[tiab] OR Pelvic Exam[tiab] OR Exam, Pelvic[tiab] OR Exams, Pelvic[tiab] OR Pelvic Exams[tiab]	
#3	**Cystoscopy[Mesh]** OR Cystoscopies[tiab] OR Cystoscopic Surgical Procedures[tiab] OR Cystoscopic Surgical Procedure[tiab] OR Procedure, Cystoscopic Surgical[tiab] OR Procedures, Cystoscopic Surgical[tiab] OR Surgical Procedure, Cystoscopic[tiab] OR Surgery, Cystoscopic[tiab] OR Surgical Procedures, Cystoscopic[tiab] OR Cystoscopic Surgery[tiab] OR Cystoscopic Surgeries[tiab] OR Surgeries, Cystoscopic[tiab]	9.075
#4	rectoscopy[tiab] OR anoscopy[tiab]	928
#5	(**Laparoscopy[Mesh]** OR laparoscop*[tiab]) AND (**"Diagnosis"[Mesh]** OR diagnos*[tiab])	134.228
#6	wash cytology[tiab]	83
#7	#2 OR #3 OR #4 OR #5 OR #6	148.389
Kombiniert mit und ohne Filter		
#8	#1 AND #7	2.011
#9	#8 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	11

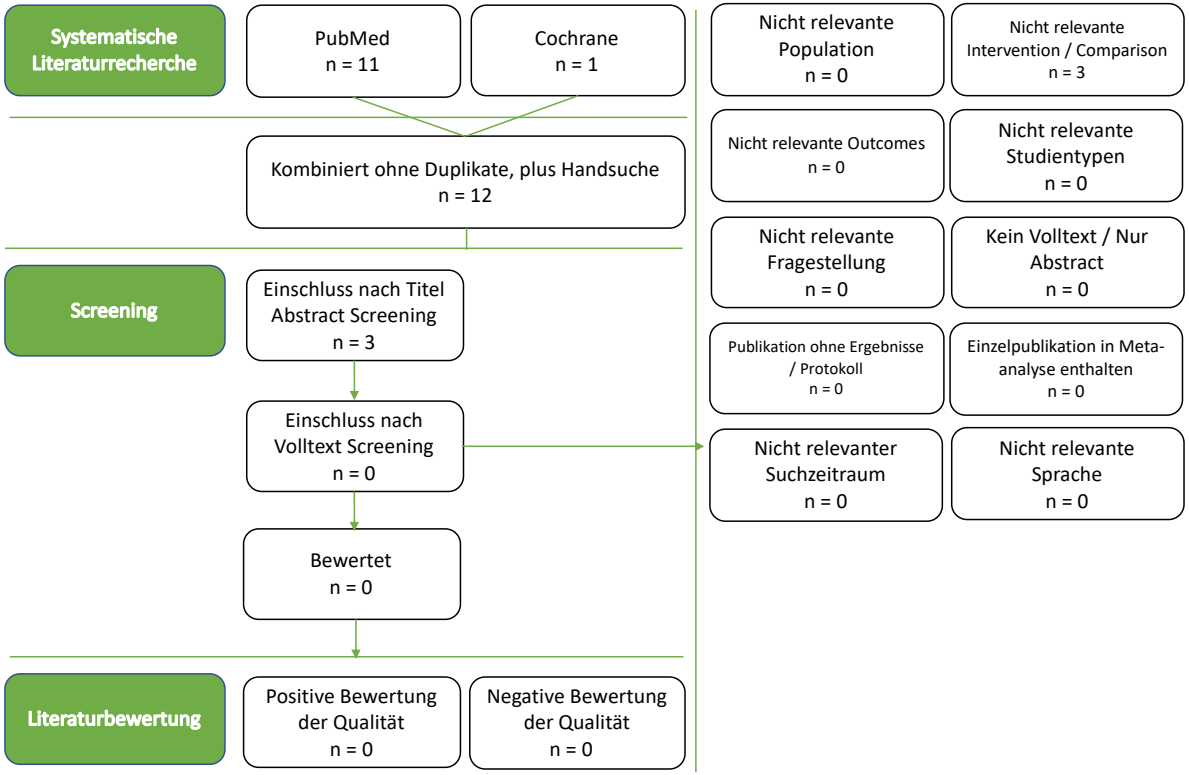
Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244571
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89822
#8	#5 OR #6 OR #7	254775

#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Gynecological Examination OR Examination, Gynecological OR Examinations, Gynecological OR Gynecological Examinations OR Gynecological Exam OR Exam, Gynecological OR Exams, Gynecological OR Gynecological Exams OR Vaginal Examinations OR Examination, Vaginal OR Examinations, Vaginal OR Vaginal Examination OR Vaginal Exam OR Exam, Vaginal OR Exams, Vaginal OR Vaginal Exams OR Pelvic Examination OR Examination, Pelvic OR Examinations, Pelvic OR Pelvic Examinations OR Pelvic Exam OR Exam, Pelvic OR Exams, Pelvic OR Pelvic Exams):ti,ab,kw	4027
#14	MeSH descriptor: [Gynecological Examination] explode all trees	31
#15	(Cystoscopy OR Cystoscopies OR Cystoscopic Surgical Procedures OR Cystoscopic Surgical Procedure OR Procedure, Cystoscopic Surgical OR Procedures, Cystoscopic Surgical OR Surgical Procedure, Cystoscopic OR Surgery, Cystoscopic OR Surgical Procedures, Cystoscopic OR Cystoscopic Surgery OR Cystoscopic Surgeries OR Surgeries, Cystoscopic):ti,ab,kw	1422
#16	MeSH descriptor: [Cystoscopy] explode all trees	320
#17	(rectoscopy OR anoscopy):ti,ab,kw	139
#18	(laparoscopy OR laparoscop*):ti,ab,kw	23958
#19	MeSH descriptor: [Laparoscopy] explode all trees	6546
#20	#18 OR #19	24073
#21	(Diagnosis OR diagnos*):ti,ab,kw	270181
#22	MeSH descriptor: [Diagnosis] explode all trees	354487

#23	#21 OR #22	532900
#24	#20 AND #23	8678
#25	(wash cytology):ti,ab,kw	46
#26	#13 OR #14 OR #15 OR #16 OR #17 OR #24 OR #25	14091
#27	#12 AND #26	276
#28	#27 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	1

Schlüsselfrage 55



2.56. Schlüsselfrage 56

Ändert die präoperative Bestimmung des L1CAM-Status und der molekularen Klassifikation (ProMisE) das operative Prozedere/die Radikalität des operativen Eingriffes?
Population: Frauen mit EC Intervention: präoperative Bestimmung des L1CAM-Status und präoperative molekulare Klassifikation nach ProMisE Comparison: keine präoperative Bestimmung des L1CAM-Status und keine präoperative molekulare Klassifikation nach ProMisE Outcomes: operatives Vorgehen bei EC

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**Neural Cell Adhesion Molecule L1[Mesh]** OR NILE Glycoprotein[tiab] OR Glycoprotein, NILE[tiab] OR Nerve Growth Factor-Inducible Large External Glycoprotein[tiab] OR Nerve Growth Factor Inducible Large External Glycoprotein[tiab] OR CALL Protein[tiab] OR CamL1 Gene Product[tiab] OR Neural Adhesion Molecule L1[tiab] OR L1 Cell Adhesion Molecule[tiab] OR L1CAM[tiab] OR NILE Protein[tiab] OR Cell Adhesion Molecule L1[tiab] OR Cell Surface Glycoprotein L1[tiab] OR NGF-Inducible Glycoprotein[tiab] OR Glycoprotein, NGF-Inducible[tiab] OR NGF Inducible Glycoprotein[tiab] OR F11 Glycoprotein[tiab]	2.254
#3	molecular classifier[tiab] OR **"Molecular Typing"[Mesh]**	18.419
#4	ProMisE[tiab]	118.017
#5	#2 OR #3 OR #4	138.599
Kombiniert mit und ohne Filter		

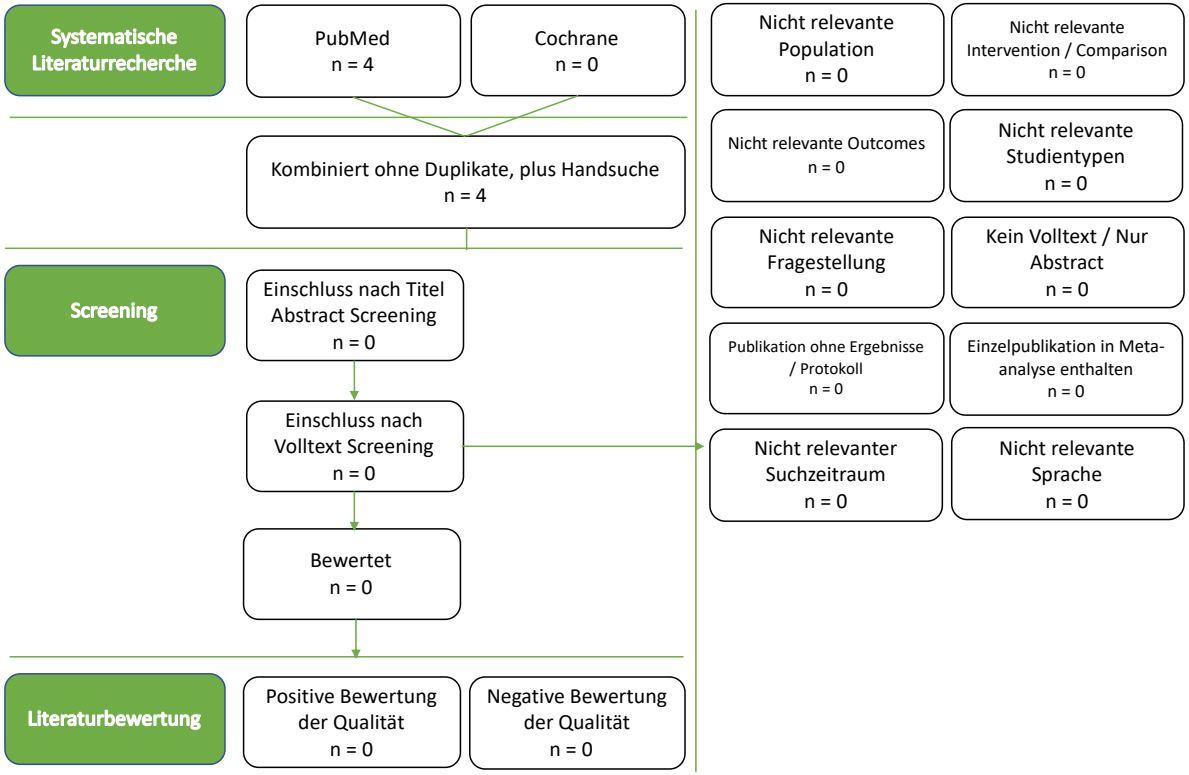
#6	#1 AND #5	350
#7	#6 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	4

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244571
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89822
#8	#5 OR #6 OR #7	254775
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Neural Cell Adhesion Molecule L1 OR NILE Glycoprotein OR Glycoprotein, NILE OR Nerve Growth Factor-Inducible Large External Glycoprotein OR Nerve Growth Factor Inducible Large External Glycoprotein OR CALL Protein OR CamL1 Gene Product OR Neural Adhesion Molecule L1 OR L1 Cell Adhesion Molecule OR L1CAM OR NILE Protein OR Cell Adhesion Molecule L1 OR Cell Surface Glycoprotein L1 OR NGF-Inducible Glycoprotein OR Glycoprotein, NGF-Inducible OR NGF Inducible Glycoprotein OR F11 Glycoprotein):ti,ab,kw	301

#14	MeSH descriptor: [Neural Cell Adhesion Molecule L1] explode all trees	2
#15	(molecular classifier OR Molecular Typing):ti,ab,kw	231
#16	ProMisE:ti,ab,kw	6868
#17	#13 OR #14 OR #15 OR #16	7393
#18	#12 AND #17	22
#19	#18 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 56



2.57. Schlüsselfrage 57

Ist beim frühen Endometriumkarzinom (Typ 1, G1, G2, pT1a) die Sentinel-Node-Entfernung prognostisch relevanter UND prädiktiver als der Verzicht auf ein solches chirurgisches Staging im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben?
Population: Frauen mit frühem EC,Typ 1, G1, G2, pT1a Intervention: Sentinel-Lymphknotenbiopsie (SLN) Comparison: keine Sentinel-Lymphknotenbiopsie (SLN) Outcomes: Morbidität, Lebensqualität, Rezidivhäufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

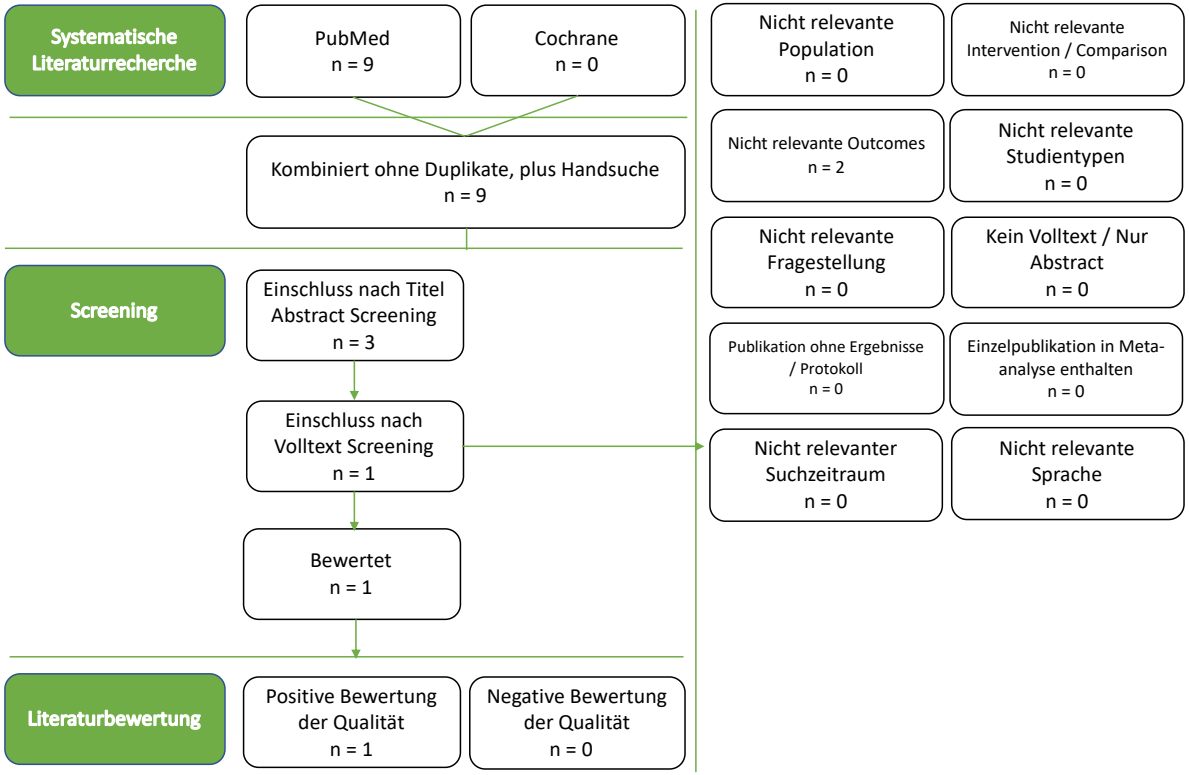
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	sentinel lymph node[tiab] OR "Sentinel Lymph Node Biopsy"[Mesh]	16.929
Kombiniert mit und ohne Filter		
#3	#1 AND #2	685
#4	#3 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	9

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585

#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244571
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89822
#8	#5 OR #6 OR #7	254775
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(sentinel lymph node):ti,ab,kw	1475
#14	MeSH descriptor: [Sentinel Lymph Node] explode all trees	49
#15	MeSH descriptor: [Sentinel Lymph Node Biopsy] explode all trees	303
#16	#13 OR #14 OR #15	1475
#17	#12 AND #16	71
#18	#17 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 57



2.58. Schlüsselfrage 58

Welchen Stellenwert hat die molekular-pathologische Klassifikation ProMisE hinsichtlich der Indikationsstellung der Strahlentherapie?
Population: Frauen mit EC, die bestrahlt werden sollen Intervention: molekular-pathologische Klassifikation gemäß ProMisE Comparison: keine molekular-pathologische Klassifikation gemäß ProMisE Outcomes: Morbidität, Lebensqualität, Rezidivhäufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

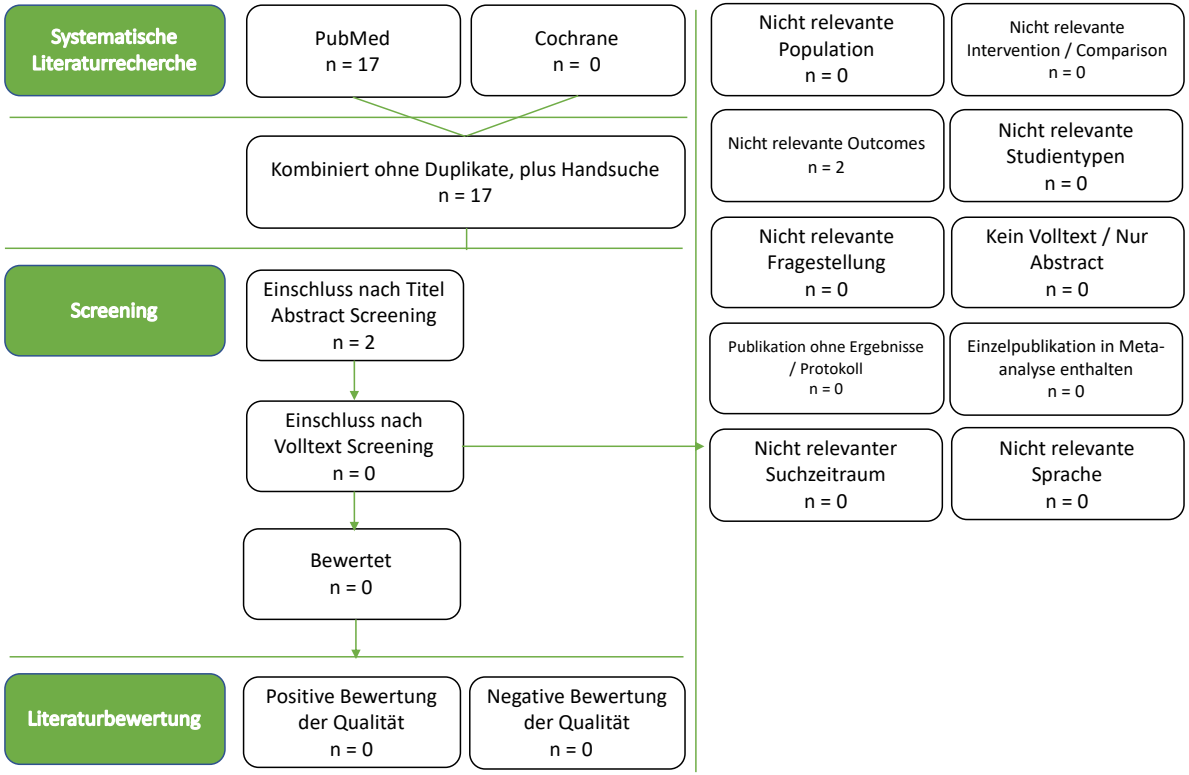
Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	**"Radiotherapy"[Mesh]** OR Radiotherap*[tiab] OR Radiation Therap*[tiab] OR Therapies, Radiation[tiab] OR Therapy, Radiation[tiab] OR Radiation Treatment*[tiab] OR Treatment, Radiation[tiab] OR Radiotherapy, Targeted[tiab] OR Radiotherapies, Targeted[tiab] OR Targeted Radiotherap*[tiab] OR Targeted Radiation Therap*[tiab] OR Radiation Therapies, Targeted[tiab] OR Targeted Radiation Therapies[tiab] OR Therapies, Targeted Radiation[tiab] OR Therapy, Targeted Radiation[tiab] OR Radiation Therapy, Targeted[tiab]	375.181
#3	molecular classifier[tiab] OR **"Molecular Typing"[Mesh]**	18.419
#4	#2 OR #3	393.598
Kombiniert mit und ohne Filter		
#5	#1 AND #4	4.166
#6	#5 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	17

Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits
#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244571
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89822
#8	#5 OR #6 OR #7	254775
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(Radiotherapy OR Radiotherap* OR Radiation Therap* OR Therapies, Radiation OR Therapy, Radiation OR Radiation Treatment* OR Treatment, Radiation OR Radiotherapy, Targeted OR Radiotherapies, Targeted OR Targeted Radiotherap* OR Targeted Radiation Therap* OR Radiation Therapies, Targeted OR Targeted Radiation Therapies OR Therapies, Targeted Radiation OR Therapy, Targeted Radiation OR Radiation Therapy, Targeted):ti,ab,kw	47751
#14	MeSH descriptor: [Radiotherapy] explode all trees	6687
#15	(molecular classifier OR Molecular Typing):ti,ab,kw	231
#16	MeSH descriptor: [Molecular Typing] explode all trees	25

#17	#13 OR #14 OR #15 OR #16	48356
#18	#12 AND #17	589
#19	#18 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 58



2.59. Schlüsselfrage 59

Welche zusätzlichen operativen Maßnahmen, z.B. Omentektomie, z.B. multipler peritoneale Biopsie, sind bei Typ-II-Karzinomen indiziert?
Population: Frauen mit Typ-II-EC Intervention: Omentektomie und/oder multiple peritoneale Biopsie Comparison: Keine zusätzlichen operativen Maßnahmen beim Typ-II-EC Outcomes: Morbidität, Lebensqualität, Rezidivhäufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Recherche in PubMed (06.10.2022)

Population		
#1	**"Endometrial Neoplasms"[Mesh]** OR ((endometria*[tiab] OR endometrium[tiab] OR **"Endometrium"[Mesh]**) AND (cancer[tiab] OR tumor[tiab] OR tumour[tiab] OR malignan*[tiab] OR **"Carcinoma"[Mesh]** OR Epithelioma*[tiab] OR carcinoma[tiab] OR neoplas*[tiab] OR **"Neoplasms"[Mesh]**))	51.546
Intervention bzw. Exposure		
#2	omentectomy[tiab]	1.434
#3	peritoneal biopsy[tiab] OR (("**Peritoneum"[Mesh]** OR peritoneum[tiab] OR parametrium[tiab]) AND ("Biopsy"[Mesh] OR biops*[tiab]))	2.658
#4	#2 OR #3	4.012
Kombiniert mit und ohne Filter		
#5	#1 AND #4	334
#6	#5 Filters: Publication date from 09/2021 to 09/2022, Language: English OR German; Article type: Systematic review OR Meta-Analysis OR RCT OR Observational study; Humans	0

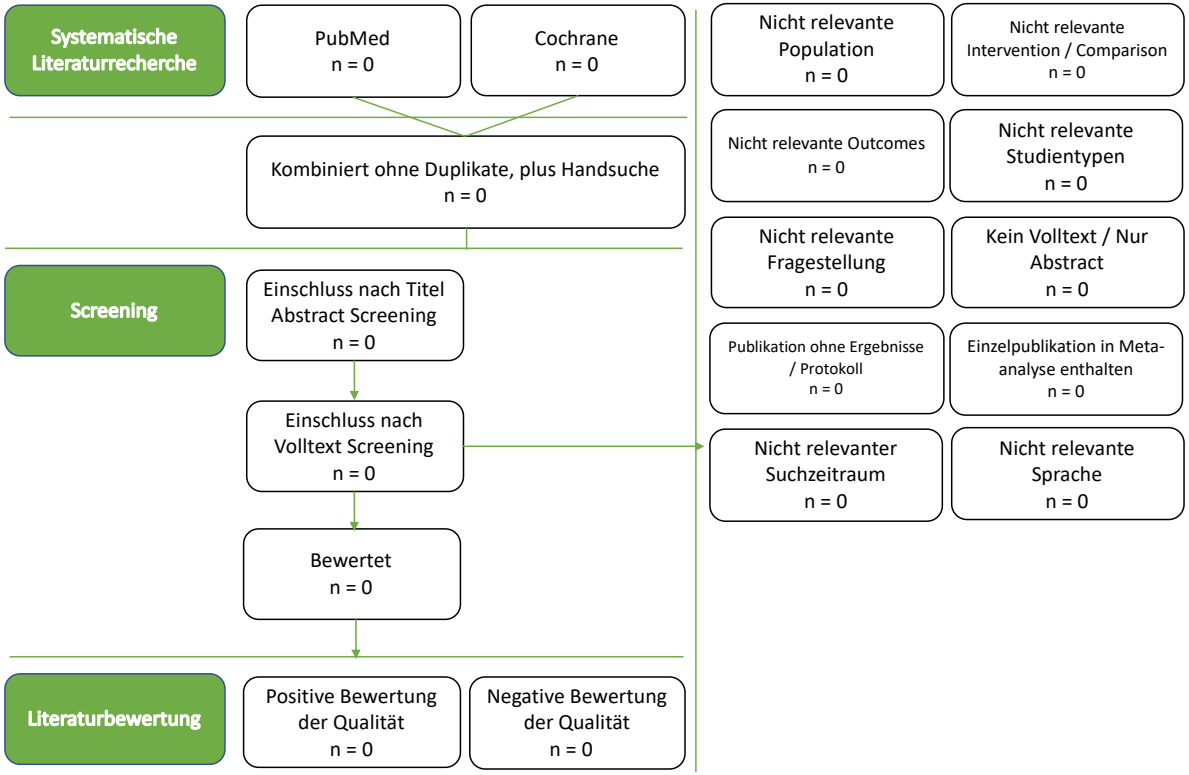
Recherche in der Cochrane Library (07.10.2022)

ID	Search	Hits

#1	MeSH descriptor: [Endometrial Neoplasms] explode all trees	716
#2	MeSH descriptor: [Endometrium] explode all trees	1136
#3	(endometria* OR endometrium):ti,ab,kw	8585
#4	#2 OR #3	8599
#5	(cancer OR tumor OR tumour OR malignan* OR Epithelioma* OR carcinoma OR neoplas*):ti,ab,kw	244571
#6	MeSH descriptor: [Carcinoma] explode all trees	15103
#7	MeSH descriptor: [Neoplasms] explode all trees	89822
#8	#5 OR #6 OR #7	254775
#9	#4 AND #8	3436
#10	#1 OR #9	3480
#11	(Endometrial Neoplasms OR ((endometria* OR endometrium OR "Endometrium") AND (cancer OR tumor OR tumour OR malignan* OR "Carcinoma" OR Epithelioma* OR carcinoma OR neoplas* OR "Neoplasms"))):ti,ab,kw	3267
#12	#10 OR #11	3480
#13	(omentectom* OR omentectomy):ti,ab,kw	109
#14	(peritoneal biopsy OR ((peritoneum OR parametrium) AND (Biopsy OR biops*))):ti,ab,kw	212
#15	MeSH descriptor: [Peritoneum] explode all trees	539
#16	(peritoneal OR peritoneum OR parametrium):ti,ab,kw	8068
#17	#15 OR #16	8176
#18	MeSH descriptor: [Biopsy] explode all trees	6036
#19	(biops* OR biopsy):ti,ab,kw	34865
#20	#18 OR #19	35885
#21	#17 AND #20	243
#22	#13 OR #14 OR #21	344
#23	#12 AND #22	15

#24	#23 with Cochrane Library publication date Between Sep 2021 and Sep 2022, in Cochrane Reviews	0

Schlüsselfrage 59



3. Evidenztabellen

3.1. Schlüsselfrage 01

Beeinflussen Alter, Hormonexposition, reproduktive/metabolische/physikalische/ethnische/genetische Faktoren, Körpergewicht, Rauchen und/oder Arbeitsbedingungen das Risiko für das Auftreten eines Endometriumkarzinoms?

Inhalt: *5 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Byun, D. 2022	2	SR and META (of 10 studies for endometrial cancer); dose-response meta-analysis.
Hermelink, R. 2022	2	SR and META (eleven observational studies included for endometrial cancer)
Kokts-Porietis, R. L. 2021	2	SR and META (40 observational studies)
Li, Z. 2022	2	SR and META (of 11 observational studies)
McVicker, L. 2022	2	SR and META (of 31 observational studies, 17 reporting endometrial cancer-specific survival)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *5 Bewertung(en)*

Byun, D. et al. Early-life body mass index and risks of breast, endometrial, and ovarian cancers: a dose-response meta-analysis of prospective studies. Br J Cancer. 126. 664-672. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 2 **Overall confidence in the results of the review:** AMSTAR II critical appraisal tool for systematic reviews: Two critical flaws (items 2 and 7), one non-critical flaw (items 10). Overall quality of evidence: Critically low **Oxford CEBM Levels of Evidence (2011):** Systematic review of cohort studies. Methodical Notes: - All studies received 7 or more scores (NOS), indicating high quality. - Small study effects, such as publication bias, were not evident with Egger's test (p = 0.63). - the magnitude of associations among studies, with RRs ranging from 1.07 to 1.95, there was no variation in the direction of associations. **Study type:** SR and META (of 10 studies for endometrial cancer); dose-response meta-analysis.	**Population:** Adult Women. **Intervention:** early-life (age ≤25 years) BMI (if possible age closest to 18 years reported, because BMI at age 18 was the most common variable reported in the studies). **Comparison:** -	**Primary:** Risk of breast, endometrial and ovarian cancer. **Secondary:** - **Results:** In total 37 prospective studies (21 for breast, 10 for endometrial and 6 for ovarian cancer). Most of the studies were from USA and Europe. **Endometrial cancer:** 4,539 endometrial cancer cases from 662,779 participants were included in the meta-analyses of early-life BMI and endometrial cancer risk (range of BMI: 15.3–32.5 kg/m2). **RR for 5-kg/m2 increase in early-life BMI: RR = 1.40, 95% CI = 1.25–1.57, I2=72.3%, p=0.000; 10 studies.** Subgroup analysis comparing adjusted vs unadjusted RR for adult BMI: unadjusted: 4 studies RR 1.62 (1.33, 1.96), I2=80.6%, p=0.001. adjusted: 4 studies RR 1.23 (0.91, 1.66), I2=90.9%, p=0.000. **Author's Conclusion:** With early-life	- Stevens VL, 2014, Cancer Cause Control. - Dougan MM, 2015, Int J Cancer. - Yang TYO,2012, Brit J Cancer. - Park SL, 2010, Int J cancer. - Sponholtz TR, 2016, Am J Epidemiol. - Canchola AJ, 2010, Cancer Cause Control. - Gapstur SM, 1993, Cancer Cause Control. - Schouten LJ, 2004, J Natl Cancer Inst. 2004. - Chang S-C, 2007, Cancer Epidemiol, Biomark Prev.	

Databases: Pubmed and Embase **Search period:** Until June 2020. **Inclusion Criteria:** - prospective studies - associations between early-life BMI **Exclusion Criteria:** - studies used data from cancer survivors or documented cancer mortality only. - Articles without full-text or not written in the English language. - overlapping cohorts or data - fewer than 3 BMI categories, - category-specific number of cases or person time not available - irrelevant type of article - not a prospective study design		adiposity, our data support an inverse association with breast cancer and positive associations with ovarian and endometrial cancer risks.	- Han X, 2014, Int J Cancer.	

Hermelink, R. et al. Sedentary behavior and cancer-an umbrella review and meta-analysis. Eur J Epidemiol. 37. 447-460. 2022

Evidence level/Study Types	**P - I - C**	**Outcomes/Results**	**Literature References**	
Evidence level: 2 **Overall confidence in the results of the review: AMSTAR II critical appraisal tool for systematic reviews:** No critical flaw, no non-critical flaw. Overall quality of evidence: High	**Population:** Adults **Intervention:** Type of sedentary behavior (total sitting, occupational sitting, recreational sitting, TV viewing time)	**Primary:** Summary risk estimate (RR, HR, or OR) of cancer incidence. **Secondary:** - **Results: Endometrial cancer:** 11 studies included (six cohort studies, five case control studies), 4561/281530 cases, p	Berger et al. Biller et al. Chan et al. Cong et al. Chong et al. Ekelund et al. Lynch et al.	

Oxford CEBM Levels of Evidence (2011): Systematic review of observational studies (achieved by an umbrella review). Methodical Notes: - Because the absolute risks of the studied outcomes are expected to be low in the general population, the 3 measures of association (OR, RR, HR) are also expected to produce comparable estimates. Therefore, all risk estimates were interpreted as relative risks (RRi) for simplicity. - In line with previous umbrella reviews, we classified the evidence of the included meta-analyses with statistically significant (p - Results for endometrial cancer were classified as "Suggestive (Class III)": >1000 cases, $<10^{-3}$ and class I-II criteria not met. **Study type:** SR and META (eleven observational studies included for endometrial cancer) **Databases:** PubMed, Web of Science, and the Cochrane Database of Systematic Reviews. **Search period:** Inception to October 2021 **Inclusion Criteria:** - association between sedentary behavior and risk of cancer incidence and mortality; - SR and META - individual studies (cohort and case control) not yet included in SR or META published between January 2014 and October 2021;	**Comparison:** -	RR = 1.29; 95% CI=1.16–1.45, I2= 14%. Subgroup analysis restricted to cohort studies only (six studies): RR = 1.35 (1.16- 1.55); 2273/272472 cases; p **Author's Conclusion:** Most associations between SB and specific cancer sites were supported by a “suggestive” level of evidence. High levels of SB are associated with increased risk of several types of cancer and increased cancer mortality risk.	Ma et al. Mahmood et al. Patterson et al. Schmid et al. Swain et al. Zhao et al. Zhou et al.

- SR that performed a quantitative analysis and provided a summary effect measure as well as the corresponding data from individual studies. **Exclusion Criteria:** - narrative reviews or systematic reviews that did not contain a quantitative synthesis; - meta-analyses if individual studies were already included or if physical inactivity was used as reference;				

Kokts-Porietis, R. L. et al. Obesity and mortality among endometrial cancer survivors: A systematic review and meta-analysis. Obes Rev. 22. e13337. 2021				
Evidence level/Study Types	**P - I - C**	**Outcomes/Results**	**Literature References**	
Evidence level: 2 **Overall confidence in the results of the review: AMSTAR II critical appraisal tool for systematic reviews:** One critical flaw (item 7), one non-critical flaw (item 10) Overall quality of evidence: Low **Oxford CEBM Levels of Evidence (2011):** Systematic review of a cohort studies. Methodological Notes: - adequate follow-up time for outcome assessment were defined as 3 years for recurrence endpoints	**Population:** Endometrial cancer survivors **Intervention:** Excess body fat at cancer diagnosis **Comparison:** -	**Primary:** All-cause mortality, endometrial cancer-specific mortality, and endometrial cancer recurrence. **Secondary:** If the potential association differs between Types I and II endometrial cancer survivors. **Results:** 46 articles were included in the current systematic review, and 40 articles included in the meta-analyses. Included studies were primarily of moderate quality (n = 26; scores 5–6). Most studies conducted in Europe (n=20) and North America (n=18).	Akbayir 2012, Alban 2020, Arem 2017, Benedetti Panici 2014, Bigby 2020, Billingsley 2016, Casarin 2020, Celik 2021, Chaves 2019 Chen 2020, Crosbie 2012,	

and a median of 5 years for mortality endpoints. - the current review considered NOS scores less than or equal to 4 points as low quality, 5 or 6 points as moderate quality, and 7 or more points as high quality. - Although there was some visual evidence from the funnel plots to suggest the presence of publication bias for all-cause mortality, endometrial cancer-specific mortality, and recurrence outcomes, only the endometrial cancer-specific mortality endpoint had a significant Egger's test results ($p < 0.05$). **Study type:** SR and META (40 observational studies) **Databases:** MEDLINE Ovid (1879 to present) and EMBASE Ovid (1947 to present) databases **Search period:** Start see Database until July 14, 2021. **Inclusion Criteria:** - excess body fat at cancer diagnosis among endometrial cancer survivors (1) original peer-reviewed publication type and cohort study design (2) study population of women with primary endometrial cancer as defined by the International Classification of Diseases (ICD) for Oncology; (3) either self-reported or measured body fat measurements taken within 3 years pre- or post-endometrial cancer diagnosis		If not otherwise stated, comparisons were highest BMI group vs ref. (generally at least >30 kg/m²). **All-cause mortality:** HR = 1.34, 95% CI = 1.12–1.59; I^2:55.0%, $p < 0.01$; 20 studies. **Recurrence of endometrial cancer:** HR = 1.28, 95% CI = 1.06–1.56; I^2: 0.0%, $p = 0.85$, 10 studies. **Endometrial cancer specific mortality:** HR = 1.11, 95% CI = 0.91–1.35; I^2: 25.1%, $p = 0.19$, 13 studies. Sensitivity analysis (exclusion of low quality studies) confirmed these estimates and diminished observed heterogeneity. <u>Endometrial cancer subgroups:</u> An association between higher BMI and recurrence was observed in the Type I (HR = 1.37, 95% CI = 1.03–1.84), I^2=0%, 6 studies; but not the Type II strata (HR = 1.21, 95% CI = 0.94–1.57), I^2= 0%, 4 studies. Null associations were noted between higher BMI with endometrial cancer-specific mortality in both Types I and II groups: Type I (HR = 1.05, 95% CI = 0.86–1.28), I^2= 20.6%, 11 studies;	Donkers 2021, Edlinger 2013, Felix 2015, Fucinari 2021, Gates 2006, Giannini 2020, Gillen 2019, Güzel 2020, Hein 2020, Jeong 2010, Kakkos 2021, Kawai 2021, Ko 2014, Kokts-Porietis 2020, Kolehmainen 2020, Kristensen 2017, Kurosu 2021, Lindemann 2015, Linkov 2008, Long 2012, Lutman 2006, Martra 2008, Matsuo 2016, Mauland 2011,	

(4) one or more measures of recurrence or survival outcome assessed >30 days after treatment. **Exclusion Criteria:** See inclusion criteria; missing informations.		Type II (HR = 1.62, 95% CI = 0.93–2.81), I^2=5.1%, 2 studies. **Author's Conclusion:** Obesity at endometrial cancer diagnosis was associated with increased cancer recurrence and all-cause mortality among endometrial cancer survivors but not endometrial cancer-specific mortality.	Mauland 2017, Modesitt 2007, Munstedt 2008, Nagle 2018, Nattenmuller 2018, Nicholas 2014, Temkin 2007, Todo 2014, Tuomi 2017, Van Arsdale 2019, Von Gruenigen 2006.

Li, Z. et al. Polycystic ovary syndrome and the risk of endometrial, ovarian and breast cancer: An updated meta-analysis. Scott Med J. 67. 109-120. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References
Evidence level: 2 **Overall confidence in the results of the review: AMSTAR II critical appraisal tool for systematic reviews:** Two critical flaws (items 2 and 7), one non-critical flaws (item 10)	**Population:** Women with polycystic ovary syndrome (PCOS) phenotype. **Intervention:** -	**Primary:** Risk of endometrial, breast, or ovarial cancer. **Secondary:** Subgroup of younger age, as PCOS phenotype ameliorates with aging. **Results:** In total 26 studies (extracted from 20 articles) were included in the quantitative analysis. 17 were	Endometrial cancer: Cohort studies: - Yin et al 2019 - Ding et al

Overall quality of evidence: Critically low **Oxford CEBM Levels of Evidence (2011):** Systematic review of cohort studies. Methodical Notes: - NOS scores between 6-9 were classified as of high quality; - stated in statistical section: "Since cancer is relatively rare in PCOS patients, differences between HR, RR, and OR can generally be ignored." - Sensitivity analysis performed and no outlier was found, suggesting that the results of the present pooled analyses were robust. - there was significant publication bias for endometrial cancer, and the funnel plot was asymmetric. But in the BMI-adjusted subgroup the funnel-plot was symmetric without significant publication bias (therefore no downgrades were performed). **Study type:** SR and META (of 11 observational studies) **Databases:** PubMed, Embase, Web of Science and Chinese Biological Medical Literature (CBM). **Search period:** until March 20, 2021. **Inclusion Criteria:** - exposure was PCOS; - outcome was endometrial, ovarian, or	**Comparison:** -	published in English and 3 in Chinese. Eleven studies examined the relationship between PCOS and endometrial cancer - three cohort studies and 8 case-control studies. **Association between PCOS and endometrial cancer:** Total: OR 3.66, 95%CI 2.05-6.54, p Cohort: OR 5.92, 95%CI 1.61-21.75, p=0.007, I2= 73.5%, 3 studies; Case-control: OR 3.12, 95%CI 1.63-5.96, p=0.001, I2= 91.4%, 8 studies. Subgroup: -High quality studies included only: ES 3.09, 95%CI 1.46-6.51, p=0.003, I2= 74.2%, 5 studies. Subgroup: - ≤ 54 years (or premenopause) ES 4,89, 95%CI 2.27-10.51, p< 0.001, I2= 94.2%, 9 studies. Subgroup: -adjusted for BMI: yes: ES 1.59, 95%CI 1.01-2.51, p=0.047, I2= 40.2%, 3 studies. no: ES 4.61, 95%CI 2.19-9.70, p **Author's Conclusion:** In conclusion, our results indicate that PCOS is a significant risk factor for endometrial cancer. Furthermore, the significant association between ovarian cancer and PCOS appeared to be limited to younger women (54 years or less or premenopausal). Larger well-deigned cohort studies	2018 - Wild et al 2000 Case-control studies: - Ma et al 2015 - Cen et al 2012 - Weng et al 2012 - Fearnley et al 2010 - Zucchetto et al 2009 - Iatrakis et al 2006 - Niwa et al 2000 - Escobedo et al 1991	

breast cancer; - cohort or case-control study; - HR, RR or OR with 95% CI for extraction or calculation available. **Exclusion Criteria:** - non-English or non-Chinese articles; - review articles, case reports, cross-sectional studies, conference abstracts, comments or editorials; - unrelated to PCOS or endometrial, breast, or ovarian cancer; - sample overlapped.		with adequate cofounding adjustments are needed to clarify the risk of the overall cancer spectrum among PCOS patients.		

McVicker, L. et al. Survival outcomes in endometrial cancer patients according to diabetes: a systematic review and meta-analysis. BMC Cancer. 22. 427. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 2 **Overall confidence in the results of the review: AMSTAR II critical appraisal tool for systematic reviews:** One critical flaw (item 7), one non-critical flaw (item 10) Overall quality of evidence: Low **Oxford CEBM Levels of Evidence (2011):** Systematic review of a cohort	**Population:** Women aged 18 or over who were diagnosed with endometrial cancer. **Intervention:** Diagnosis of diabetes mellitus (type 1 or type 2) before endometrial cancer, identifed by self-report or through medical records. **Comparison:** Endometrial cancer	**Primary:** Endometrial cancer-specifc survival. **Secondary:** Overall survival and progression or recurrence-free survival. **Results:** A total of 31 studies were included, of which 17 reported endometrial cancer-specific survival, 24 overall survival and 6 progression-free survival. Most studies were conducted in USA (15) or in European countries (9). All studies (except one) were cohort designs. Nine studies specifcally included patients with type	Björnsdottir (2020) Brandt (2019) Donkers (2021) Felix (2015) Folsom (2004) Kolehmainen (2020) Lam (2018) Lees (2021) Lindemann	

studies. Methodical Notes: - ORs and RRs were combined with HRs as ORs and RRs in this instance should roughly approximate a HR as endometrial cancer mortality is not a common outcome. - NOS Score ≥7 was classified as high quality. - The majority of studies had an NOS score of 5 or above. - In sensitivity analyses, excluding two studies that reported RRs or the exclusion of individual studies did not markedly change the pooled cancer-specifc mortality risk estimate. - There was no evidence of publication bias in the funnel plot for studies reporting endometrial cancer-specifc survival. **Study type:** SR and META (of 31 observational studies, 17 reporting endometrial cancer-specific survival) **Databases:** MEDLINE, Embase, and Web of Science. **Search period:** inception to 16. February 2022 **Inclusion Criteria:** - see PICO	patients without a diabetes diagnosis.	2 diabetes or “adult onset diabetes” and theremaining studies did not specify diabetes type for inclusion. The most common method of diabetes ascertainment was through medical records (n=17), while other methods included self-report (n=8) and a diabetes register (n=2). In all studies, diabetes status was ascertained at or before endometrial cancer diagnosis. **Endometrial cancer-specific survival:** 17 studies, 35,814 patients. HR 1.15, 95% CI 1.00–1.32), I2=62%; P Subgroup-analysis: Studies with a quality score of≤7: 13 studies, 11,762 patients, HR 1.17 (0.97–1.42), I2= 61.2, p Studies with a follow-up of Studies with a follow-up of≥5 years: 9 studies, 7,605 patients, HR 1.15 (0.88–1.49), I2= 65.1, p Adjusted for BMI: 6 studies, 6,887 patients, HR 0.94 (0.72–1.23), I2= 40.6, p=0.01. **Progression free or recurrence-free survival:** n=6 studies, HR 1.23, 95% CI 1.02–1.47, I 2=0%, P=0.88 **Overall Survival:** 24 studies, 26,352 patients, HR 1.42 (1.31–1.54), I2=46.3, p= 0.01. **Author's Conclusion:** In this systematic review and meta-analysis, we show that diabetes is associated	(2015) Nagle (2018) Olson (2012) Ribeiro (2021) Ruterbusch (2014) Simon (2021) Sung (2000) VanArsdale (2019) Zanders (2013)	

- no language restrictions - human studies **Exclusion Criteria:** - reviews - duplicate cohorts - used glucose measurement to identify diabetic patients		with a worse cancer-specific and overall survival in endometrial cancer patients.		

3.2. Schlüsselfrage 02

Kann durch Modifikation der o.g. Risikofaktoren bzw. präventive medikamentöse oder operative Intervention das Risiko für das Auftreten eines Endometriumkarzinoms gesenkt werden?

Inhalt: *2 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Chen, Y. 2022	3	SR and META (of 11 observational studies)
Liu, F. 2022	2	SR and META (of 8 observational studies)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *2 Bewertung(en)*

Chen, Y. et al. Association between statin use and the risk, prognosis of gynecologic cancer: A meta-analysis. Eur J Obstet Gynecol Reprod Biol. 268. 74-81. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References
Evidence level: 3 **Overall confidence in the results of the review: AMSTAR II critical appraisal tool for systematic reviews:** Four critical flaws (items 2, 7, 9, and 13), six non-critical flaws (items 5, 6, 8, 10, 12 and 14) Overall quality of evidence: Critically Low	**Population:** Women **Intervention:** Statin use **Comparison:** No statin use	**Primary:** Risk gynecological cancers **Secondary:** Mortality of gynecologic cancer **Results: Statin use and risk of endometrial cancer:** OR/RR = 0.81, 95% CI 0.70 to 0.94, I2 = 62.3%, p = 0.001, 11 studies.	Risk of endometrial cancer: Clearfield (2001) Strandberg (2004)

Oxford CEBM Levels of Evidence (2011): Systematic review of cohort studies. Downgraded one level due to serious methodological flaws to EL 3. <u>Methodological Notes:</u> - No quality assessment (e.g. NOS) for the included studies; - Screening and data extraction was not performed in duplicate; - no impact of ROB assessed during discussion or interpretation of the results; - heterogeneity assessed (I2 and Q statistics) but not discussed or interpreted - "statin users are obese people" is stated in discussion; adjustment to e.g. BMI is not stated but might be relevant for interpreting the results. - Begg's test, Egger's tests and funnel plots showed no significant risk of publication bias. **Study type:** SR and META (of 11 observational studies) **Databases:** PubMed, Web of Science, Medline, EMBASE and Google Scholar. **Search period:** Studies published before July 2021 **Inclusion Criteria:** (1) Odds ratios (ORs) in case-control studies or relative risks (RRs) in cohort, RCT studies and 95% confidence intervals (CIs) associated with statin use and risk of gynecologic cancer could be obtained from included studies; (2) Hazard ratios (HRs) and 95% CIs		<u>Subgroup - study type</u> Case-control studies: OR = 0.85, 95% CI 0.66 to 1.09; number of studies not known. Cohort studies: RR = 0.78, 95% CI 0.66 to 0.93, number of studies not known. <u>Subgroup population type:</u> Caucasian population: OR/RR = 0.83, 95% CI 0.72 to 0.96, number of studies not known. **Statin use and mortality rate due to endometrial cancer:** HR = 0.71, 95% CI 0.64 to 0.80, I2 = 31.9%, p = 0.144, 10 studies. <u>Subgroup - study type:</u> Cohort studies: HR = 0.72, 95% CI 0.64 to 0.80, number of studies not known. <u>Subgroup - population type:</u> Caucasian population: HR = 0.72, 95% CI 0.64 to 0.80, number of studies not known. **Author's Conclusion:** In conclusion, our findings indicated that statins use was inversely associated with the risk and mortality of gynecologic cancers. Meanwhile, we need more well-designed and high-quality studies with strong evidence for definite conclusions that determine clinical practice.	Kaye (2004) Coogan (2007) Yu (2009) Fortuny (2009) Jacob (2011) Lavie (2013) Sperling (2017) Arima (2017) Desai (2018) Mortality: Lavie (2013) Nevadunsky (2015) Yoon (2015) Arsdale (2015) Wang (2016) Feng (2016) Sanni (2017) Arsdale (2017) Sperling (2018) Arima (2017)	

associated with statins use and clinical outcome of gynecologic cancer could be obtained from included studies. **Exclusion Criteria:** Metaanalyses, reviews or case-reports.				

Liu, F. et al. Consumption of flavonoids and risk of hormone-related cancers: a systematic review and meta-analysis of observational studies. Nutr J. 21. 27. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 2 **Overall confidence in the results of the review: AMSTAR II critical appraisal tool for systematic reviews:** One critical flaws (items 7, excluded studies listed), one non-critical flaw (items 10, funding of included studies investigated) Overall quality of evidence: Low. **Oxford CEBM Levels of Evidence (2011):** Systematic review of cohort studies. Methodological Notes: - Next to endometrial cancer the authors also evaluated other cancer types (Hormone-related cancer (HRC) breast, ovarian, thyroid and prostate) in this	**Population:** Women with endometrial cancer. **Intervention:** Intake of flavonoids **Comparison:** No intake of flavonoids	**Primary:** Endometrial cancer risk. **Secondary:** - **Results: Endometrial cancer risk:** Three prospective and 5 case-control studies of total favonoids and/or isofavones subclass were conducted on endometrial cancer. Total flavonoids: OR=0.93; 95% CI, 0.67-1.27; I2=32.7%; p=0.223, 2 studies. Isoflavone: OR=0.81; 95% CI, 0.70-0.94; I2=22.7%; p=0.256; 7 studies. Isoflavone_prospective: OR=0.80; 95% CI, 0.51-1.25; I2=53.7%; p=0.142; 2 studies. Isoflavone_case-control: OR=0.82; 95% CI, 0.69-0.97; I2=24.6%; p=0.142; 5 studies. **Author's Conclusion:** In conclusion, there is a small amount of evidence that total favonoids, favonols,	- Wang L, Am J Clin Nutr. 2009. - Neill AS, Br J Nutr. 2014. - Horn-Ross PL, J Natl Cancer Inst. 2003. - Xu WH, Nutr Cancer. 2008. - Bandera EV, Cancer Causes Control. 2009. - Ollberding NJ, J Natl Cancer Inst. 2012. - Rossi M, Br J Cancer. 2013.	

analysis, but these were not specified in this evaluation. - all studies attained the score 5 or above, namely all included studies were of medium- or high-quality. **Study type:** SR and META (of 8 observational studies) **Databases:** PubMed, EMBASE, China National Knowledge Infrastructure (CNKI). **Search period:** January 1999 up to March 2022. **Inclusion Criteria:** (i) an observational study (cohort study or nested case–control study, or case–control study); (ii) the association between intake of total/subclass of/individual favonoids and the risk of any HRCs was evaluated; (iii) relative risks (RRs), odds ratios (ORs) or hazard ratios (HRs) with the corresponding 95% confidence intervals (CIs) for the highest category of exposure were reported; (iv) evaluating favonoids consumption by dietary questionnaires and measurement for serum, plasma and urine. **Exclusion Criteria:** (i) out of adequate statistics; (ii) incomplete evaluation on favonoids (no total and subclass of favonoids or less than		favones, favanones, favan3-ols and isofavones may be associated with a lower or higher risk of certain HRCs, which maybe provide guidance for diet guidelines to a certain extent in the future. Nonetheless, due to limited data, further prospective studies and a larger number of subjects are warranted to be verifed and provide stronger evidence.		

3 kinds of favonoid); (iii) unconfirmed comparison and comparison by per each increase for favonoids intake; (iv) reported as an abstract, summary, comments, review or editorial; (v) favonoids intake from sources other than dietary questionnaires, serum, plasma and urine; (vi) amount of soy protein or soy foods or soy supplements consumed as a representative of dietary isofavone intake.				

3.3. Schlüsselfrage 03

Welche Verfahren wie beispielsweise transvaginale Sonographie, zytologische Beurteilung, Endometriumbiopsie mittels Aspiration, Hysteroskopie oder Tumormarker-Bestimmung an Aspiraten, HPV-Bestimmung, Familienanamnese sind bei der asymptomatischen Frau mit normalem Risiko geeignet zur Fru?herkennung des Endometriumkarzinoms im Hinblick auf Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben?

Population: asymptomatische Frau mit normalem Risiko für EC
Intervention: Screening auf EC mittels
1. Ultraschall
2. zytolog. Beurteilung
3. Endometriumbiopsie mittels Aspiration
4. Hysteroskopie
5. Tumormarker-Bestimmung an Aspiraten
6. HPV-Bestimmung
7. Familienanamnese

Comparison: kein Screening
Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Inhalt: *2 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Heremans, R. 2022	4	Prospective cohort study
Li, J. X. L. 2022	3	Systematic review (11 cohort studies and one systematic review)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

Li, J. X. L. et al. Can a higher endometrial thickness threshold exclude endometrial cancer and atypical hyperplasia in asymptomatic postmenopausal women? A systematic review. Aust N Z J Obstet Gynaecol. 62. 190-197. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References
Evidence level: 3 **Overall confidence in the results of the review:** AMSTAR II critical appraisal tool for systematic reviews: 3 critical flaws (items 2,7,9), 4 non-critical flaws (items 5,6,10,14) Overall quality of evidence: Critically Low Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Diagnosis): 2 Systematic review and meta-analysis of (Non-consecutive studies, or studies without consistently applied reference standard) Downgrade to evidence level 3 **Study type:** Systematic review (11 cohort studies and one systematic review) **Databases:** Pubmed, EMBASE and Cochrane Database of Systematic Reviews	**Population:** asymptomatic postmenopausal women **Intervention:** alternative endometrial thickness thresholds for the diagnosis of: (1) endometrial cancer; and (2) endometrial cancer and atypical endometrial hyperplasia **Comparison:** /	**Primary:** Outcome data included the endometrial thickness thresholds recommended by study authors, area under the curve receiver operating characteristic (AUC ROC) or risk ratio (RR) estimates, sensitivity and specificity calculations, adverse events, and insufficient sample rates. **Secondary:** / **Results: Diagnostic threshold** Of seven studies (N = 2986), better evidence identified 12 mm as the optimal diagnostic threshold (area under the curve receiver operating characteristic (AUC ROC) 0.716, 95% CI 0.534–0.897, P = 0.019) for endometrial cancer in asymptomatic postmenopausal women. Two higher quality studies (n = 488 and n = 4751) identified 11 mm as optimal for diagnosing both endometrial carcinoma and atypical hyperplasia (AUC ROC 0.587, 95% CI 0.465–0.708, P = 0.144 and 2.59 relative risk, 95% CI 1.66–4.05, P < 0.001). **Adverse events** Only one study reported adverse events related to hysteroscopy and D&C; Li and Li	12 studies included: Li 2019, Alcazar 2018, Bracco Suarez 2020, Hefler (2018), Saccardi (2020), Kanmaz (2019), Louie (2016), Seckin (2016), Yasa (2016), Giannella (2020), Ozelci (2019), Ozelci (2019)¶

Search period: Between 2011 and 2021 **Inclusion Criteria:** Studies were eligible for inclusion if they reported TVUS endometrial thickness analysis in asymptomatic postmenopausal women **Exclusion Criteria:** studies were excluded if they were written in a non-English language.		reported 10/488 (2%) events of uterine perforation and 1/488 (0.2%) event of bowel perforation contributing to a combined 2.2% rate of serious adverse events. Their rate of uterine perforation is higher than previous studies reporting rates of 0.3 and 0.4% in hysteroscopic surgeries. Overall complication rates for hysteroscopic surgery are similar, having been reported previously at rates of 1.1 and 2.7%. As the procedural adverse event rates may vary between centres, improved reporting of complication rates in the literature will provide better understanding of adverse event rates in hysteroscopy and D&C. **Author's Conclusion:** Evidence for improved detection of endometrial premalignancies and malignancies using alternative endometrial thickness thresholds is not rigorous. Evidence for improved outcomes using alternative thresholds is inadequate. Observation of asymptomatic postmenopausal women without risk factors and with an endometrial thickness of less than 10 mm may be reasonable.		

NEWCASTLE - OTTAWA Checklist: Cohort: *1 Bewertung(en)*

Heremans, R. et al. Ultrasound features of endometrial pathology in women without abnormal uterine bleeding: results from the International Endometrial Tumor Analysis study (IETA3). Ultrasound Obstet Gynecol. 60. 243-255. 2022

Evidence level	Methodical Notes	Patient characteristics	Interventions
Evidence level: 4 **Study type:** Prospective cohort study	**Funding sources:** This study was supported by Flemish Governmental grant IWT: TBM IETA (grant no. 130256) and KU Leuven Internal Funds (grant no. C16/15/059). **Conflict of Interests:** None. **Randomization:** / **Blinding:** The pathologist was not blinded to clinical or ultrasound information. **Dropout rates:** /	**Total no. patients:** 1745 **Recruiting Phase:** 1 January 2011 and 31 December 2018 **Inclusion criteria:** Patients who denied abnormal uterine bleeding during the year preceding presentation were included in the study. **Exclusion criteria:** Aiming for consecutive inclusions and in order to avoid selection bias, patients from centers that contributed fewer than 50 women to the study were excluded. Other exclusion criteria were: double entries and women that were found in retrospect to have had abnormal bleeding, women with missing endometrial assessment, inconsistent or irretrievable data, pregnancy-related histology and missing histology if followed up for less	**Interventions:** ultrasound features of various endometrial and other intracavitary pathologies in women without abnormal uterine bleeding (AUB) using the International Endometrial Tumor Analysis (IETA) terminology. **Comparison:** The findings in our cohort of women without AUB were compared with those in a published cohort of women with AUB who were examined with transvaginal ultrasound between 2012 and 2015 using the same IETA examination technique and terminology.

		than 1 year and those lost to follow-up.	
Notes:	Newcastle-Ottawa Scale (NOS) for cohort studies: 5/9 stars. 0 points in the comparability domain. Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Diagnosis): 3 (Non-randomized controlled cohort/follow-up study) Downgrade to evidence level 4 due to risk of bias. **Author's conclusion:** We describe the typical ultrasound features of EC, polyps and other intracavitary histologies using IETA terminology in women without AUB. Our findings suggest that the presence of asymptomatic polyps or endometrial malignancy may be accompanied by thinner and less intensely vascularized endometria than their symptomatic counterparts.		
Outcome Measures/results	**Primary** endometrial atrophy, proliferative or secretory endometrium, endometrial hyperplasia without atypia, endometrial polyp, intracavitary leiomyoma, endometrial intraepithelial neoplasia (EIN), endometrial cancer (EC) and insufficient tissue. **Secondary** /	**Results:** In this study (IETA3), we included 1745 women without AUB who underwent a standardized transvaginal ultrasound examination followed by either endometrial sampling with histological diagnosis (n = 1537) or at least 1 year of clinical and ultrasound follow-up (n = 208). Of these, 858 (49.2%) women were premenopausal and 887 (50.8%) were postmenopausal. Histology showed the presence of EC and/or EIN in 29 (1.7%) women, endometrial polyps in 1028 (58.9%), intracavitary myomas in 66 (3.8%), proliferative or secretory changes or hyperplasia without atypia in 144 (8.3%), endometrial atrophy in 265 (15.2%) and insufficient tissue in five (0.3%). Most cases of EC or EIN (25/29 (86.2%)) were diagnosed after menopause. The mean endometrial thickness in women with EC or EIN was 11.2 mm (95% CI, 8.9–13.6 mm), being on average 2.4 mm (95% CI, 0.3–4.6 mm) thicker than their benign counterparts. Women with malignant endometrial pathology manifested more frequently non-uniform echogenicity (22/29 (75.9%)) than did those with benign endometrial pathology (929/1716 (54.1%)) (difference, +21.8% (95% CI, +4.2% to +39.2%)). Moderate to abundant vascularization (color score 3–4) was seen in 31.0% (9/29) of cases with EC or EIN compared with 12.8% (220/1716) of those with a benign outcome (difference, +18.2% (95% CI, −0.5% to +36.9%)). Multiple multifocal vessels were recorded in 24.1% (7/29) women with EC or EIN vs 4.0% (68/1716) of those with a benign outcome (difference, +20.2% (95% CI, +4.6% to +35.7%)). A regular endometrial–myometrial junction was seen less frequently in women with EC or EIN (19/29 (65.5%)) vs those with a benign

		outcome (1412/1716 (82.3%)) (difference, -16.8% (95% CI, -34.2% to +0.6%)). In women with endometrial polyps without AUB, a single dominant vessel was the most frequent vascular pattern (666/1028 (64.8%)). In women with EC, both in those with and those without AUB, the endometrium usually manifested heterogeneous echogenicity, but the endometrium was on average 8.6 mm (95% CI, 5.2–12.0 mm) thinner and less intensely vascularized (color score 3–4: difference, -26.8% (95% CI, -52.2% to -1.3%)) in women without compared to those with AUB. In both pre- and postmenopausal women, asymptomatic endometrial polyps were associated with a thinner endometrium, and they manifested more frequently a bright edge, a regular endometrial–myometrial junction and a single dominant vessel than did polyps in symptomatic women, and they were less intensely vascularized.

3.4. Schlüsselfrage 04

Welche Verfahren wie beispielsweise transvaginale Sonographie, zytologische Beurteilung, Endometriumbiopsie mittels Aspiration, Hysteroskopie oder Tumormarker-Bestimmung an Aspiraten, HPV-Bestimmung, Familienanamnese sind bei der asymptomatischen Frau mit hohem Risiko geeignet zur Früherkennung des Endometriumkarzinoms im Hinblick auf Lebensqualität, Kurzzeit-/
Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben?

Population asymptomatische Frau mit hohem Risiko für EC; ohne genetische Disposition
(hohes Risiko = Adipositas, polyzystisches Ovarial-Syndrom (englisch polycystic ovary syndrome; PCO-Syndrom, Tamoxifen-Einnahme)
Intervention: Screening auf EC mittels
1. Ultraschall
2. zytolog. Beurteilung
3. Endometriumbiopsie mittels Aspiration
4. Hysteroskopie
5. Tumormarker-Bestimmung an Aspiraten
6. HPV-Bestimmung
7. Familienanamnese
Comparison: kein Screening
Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Inhalt: *1 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Li, J. X. L. 2022	3	Systematic review (11 cohort studies and one systematic review)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

Li, J. X. L. et al. Can a higher endometrial thickness threshold exclude endometrial cancer and atypical hyperplasia in asymptomatic postmenopausal women? A systematic review. Aust N Z J Obstet Gynaecol. 62. 190-197. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References
Evidence level: 3 **Overall confidence in the results of the review:** AMSTAR II critical appraisal tool for systematic reviews: 3 critical flaws (items 2,7,9), 4 non-critical flaws (items 5,6,10,14) Overall quality of evidence: Critically Low Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Diagnosis): 2 Systematic review and meta-analysis of (Non-consecutive studies, or studies without consistently applied reference standard) Downgrade to evidence level 3 **Study type:** Systematic review (11 cohort studies and one systematic review) **Databases:** Pubmed, EMBASE and Cochrane Database of Systematic Reviews	**Population:** asymptomatic postmenopausal women **Intervention:** alternative endometrial thickness thresholds for the diagnosis of: (1) endometrial cancer; and (2) endometrial cancer and atypical endometrial hyperplasia **Comparison:** /	**Primary:** Outcome data included the endometrial thickness thresholds recommended by study authors, area under the curve receiver operating characteristic (AUC ROC) or risk ratio (RR) estimates, sensitivity and specificity calculations, adverse events, and insufficient sample rates. **Secondary:** / **Results: Diagnostic threshold** Of seven studies (N = 2986), better evidence identified 12 mm as the optimal diagnostic threshold (area under the curve receiver operating characteristic (AUC ROC) 0.716, 95% CI 0.534–0.897, P = 0.019) for endometrial cancer in asymptomatic postmenopausal women. Two higher quality studies (n = 488 and n = 4751) identified 11 mm as optimal for diagnosing both endometrial carcinoma and atypical hyperplasia (AUC ROC 0.587, 95% CI 0.465–0.708, P = 0.144 and 2.59 relative risk, 95% CI 1.66–4.05, P < 0.001). **Adverse events** Only one study reported adverse events related to hysteroscopy and D&C; Li and Li	12 studies included: Li 2019, Alcazar 2018, Bracco Suarez 2020, Hefler (2018), Saccardi (2020), Kanmaz (2019), Louie (2016), Seckin (2016), Yasa (2016), Giannella (2020), Ozelci (2019), Ozelci (2019)¶

Search period: Between 2011 and 2021 **Inclusion Criteria:** Studies were eligible for inclusion if they reported TVUS endometrial thickness analysis in asymptomatic postmenopausal women **Exclusion Criteria:** studies were excluded if they were written in a non-English language.		reported 10/488 (2%) events of uterine perforation and 1/488 (0.2%) event of bowel perforation contributing to a combined 2.2% rate of serious adverse events. Their rate of uterine perforation is higher than previous studies reporting rates of 0.3 and 0.4% in hysteroscopic surgeries. Overall complication rates for hysteroscopic surgery are similar, having been reported previously at rates of 1.1 and 2.7%. As the procedural adverse event rates may vary between centres, improved reporting of complication rates in the literature will provide better understanding of adverse event rates in hysteroscopy and D&C. **Author's Conclusion:** Evidence for improved detection of endometrial premalignancies and malignancies using alternative endometrial thickness thresholds is not rigorous. Evidence for improved outcomes using alternative thresholds is inadequate. Observation of asymptomatic postmenopausal women without risk factors and with an endometrial thickness of less than 10 mm may be reasonable.		

3.5. Schlüsselfrage 05

Beeinflussen genetische Faktoren das Risiko für das Auftreten eines Endometriumkarzinoms?

Population: Frauen/asymptomatische Frau mit genetischer Disposition/ symptomatische Frau mit genetischer Disposition/an EC erkrankte Frau mit genetischer Disposition
Intervention: genetische Disposition
Comparison: keine genetische Disposition
Outcomes: Endometriumkarzinom

Inhalt: *2 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Kunnackal John, G. 2022	3	Systematic review (111 cohort studies)
Lim, N. 2022	3	Systematic review of cohort studies.

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *2 Bewertung(en)*

Kunnackal John, G. et al. Comparison of universal screening in major lynch-associated tumors: a systematic review of literature. Fam Cancer. 21. 57-67. 2022				
Evidence level/Study Types	**P - I - C**	**Outcomes/Results**	**Literature References**	
Evidence level: 3 **Overall confidence in the results of**	**Population:** Unselected populations of colorectal (CRC), endometrial (EC), ovarian (OC),	**Primary:** Yield of screening, germline positivity. **Secondary:** -	133 studies included, see article for list.	

the review: Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Screening): 2 Systematic review and meta-analysis of (Non - randomized controlled cohort/follow-up study*) Downgrade to evidence level 3 due to the low quality. AMSTAR II critical appraisal tool for systematic reviews: 4 critical flaws (items 4,7,9,13), 4 non-critical flaws (items 1,3,5,10) Overall quality of evidence: Critically low **Study type:** Systematic review (111 cohort studies) **Databases:** MEDLINE **Search period:** Between 2005 to 2017 **Inclusion Criteria:** Studies performing universal screening for LS in unselected CRC, EC, OC, UT and ST. **Exclusion Criteria:** no description.	urinary (UT) and sebaceous tumors (ST). **Intervention:** Screening for lynch syndrome. **Comparison:** -	**Results: Pooled yield of universal LS screening** The overall pooled yield of universal LS screening and germline mismatch gene mutation was significantly different across the major LS-associated tumors (Mann Whitney test, $p < 0.001$). The pooled screening yield was highest in ST [52.5% (355/676), 95% CI 48.74–56.26%] followed by EC [22.65% (1142/5041), 95% CI 21.54–23.86%], CRC [11.9% (5649/47,545), 95% CI 11.61–12.19%], OC [11.29% (320/2833), 95% CI 10.13–12.47%] UT [11.2% (31/276), 95% CI 7.48–14.92%]. **Germline posivity** ST also had the highest pooled germline positivity for mismatch repair gene mutation [18.8%, 33/176, 95%CI 13.03–24.57], followed by EC [2.6% (97/3765), 95% CI 2.09–3.11] CRC [1.8% (682/37,220), 95% CI 1.66–1.94%] UT [1.8%(3/164), 95% CI − 0.24–3.83%] OC [0.83%(25/2983), 95% CI 0.48–1.12%]. LS screening in EC yielded significantly higher somatic mutations compared to CRC [pooled percentage 16.94% [(538/3176), 95%CI 15.60–18.20%] vs. 5.23% [(1639/26,152), 95% CI 4.93–5.47%], Mann Whitney test, $p < 0.0001$. Universal LS testing should be routinely performed in OC, UT and STs in addition to CRC and EC. **Author's Conclusion:** Our findings also support consideration for IHC and somatic mutation testing before germline testing in EC due to higher prevalence of somatic mutations as well as		

		germline testing in all patients with ST. Our results have implications for future design of LS screening programs and further studies are needed to assess the cost effectiveness and burden on genetic counselling services with expanded universal testing for LS.		

Lim, N. et al. Screening and risk reducing surgery for endometrial or ovarian cancers in Lynch syndrome: a systematic review. Int J Gynecol Cancer. 32. 646-655. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 3 **Overall confidence in the results of the review:** AMSTAR II critical appraisal tool for systematic reviews: 4critical flaws (items 2, 7, 9, 13), 6 non-critical flaws (items 5, 6, 10, 12, 14, 16) Overall quality of evidence: Critically Low Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Screening): 2 Systematic review and meta-analysis of (Non -randomized controlled cohort/follow-up study**) Downgrade to evidence level 3 **Study type:** Systematic review of cohort studies. **Databases:** Medline (Ovid), Embase, and PubMed databases	**Population:** women with Lynch syndrome either with a confirmed MMR mutation. **Intervention:** Screening methods: Endometrial biopsy, transvaginal ultrasound, or serum cancer antigen 125 (CA-125). **Comparison:** Risk reducing surgery.	**Primary:** Number of cancers, endometrial hyperplasia. **Secondary:** - **Results:** Rates of Endometrial Cancer Detected by Screening 18 studies of endometrial cancer screening detected a total of 104 cancers among 2688 women (3.9%), diagnosed between at ages 36–72 years. A total of 1193 of 2688 (44.4%) patients had confirmed mismatch repair/EPCAM mutations and 1495 of 2688 (55.6%) were identified through Amsterdam criteria. A total of 78 of 1193 (6.5%) mismatch repair/EPCAM carriers were diagnosed with endometrial cancer , representing 75% of all endometrial cancers found.	18 studies included: Dove-Edwin, Rijcken, Renkonen-Sinisalo, Lecuru, Gerritzen, Jarvinen, Lecuru, Guillen-Ponce, Bats, Arts-De Jong, Manchanda, Stuckless, Helder-Woolderink, Douay-Hauser, Ketabi, Tzortzatos, Gossert, Nebgen, Rosenthal, Rosenthal, Eikenboom.	

Search period: Inception - in November 2021. **Inclusion Criteria:** 1) The population included women with Lynch syndrome either with a confirmed MMR mutation or who fulfilled Amsterdam II Criteria 2) The intervention was risk-reducing hysterectomy and/or salpingo-oophorectomy 3) The outcome was endometrial or ovarian cancer incidence at the time of risk-reducing surgery in prophylactic specimens 4) The results were histological findings in prophylactic hysterectomy, salpingectomy, or oophorectomy specimens. **Exclusion Criteria:** 1) The population was not Lynch syndrome carriers but other hereditary cancer syndrome carriers 2) The outcomes were patient perception of the procedure 3) The outcomes were side effects about the procedure 4) The study was a review and not original data 5) The study was about cost-effectiveness of surgery 6) The article summarised guidelines in managing women predisposed to Lynch syndrome with risk-reducing surgery.		50/78 (64.1%) patients were detected through asymptomatic screening at their first or subse- quent screening visit, while the remainder were diagnosed due to symptoms at or between screening intervals (Figure 1). Twenty-six of 1495 women (1.7%) with Lynch syndrome diagnosed through Amsterdam criteria (or where genetic testing information was not published) were diagnosed with endometrial cancers, representing 25% of all endometrial cancers. Fourteen of 26 (53.8%) of these were through screening, while the remainder were diagnosed due to symptoms, or between screening intervals. 40/57 (70.2%) cases of endometrial hyperplasias were found in mismatch repair carriers, 50% of which were in MLH1 carriers (Online Supplemental Table 3). The number needed to screen, defined as the number of people needed to be screened for a diagnosis of cancer or hyperplasia, ranged between 4 and 135 (median 13) (Online Supplemental Table 4). This reduced to between 4 and 38 (median 7) when only mismatch repair carriers were included. In the mismatch repair carrier population, the sensi- tivity of screening to detect endometrial cancer (excluding hyper-plasia) was 66.7%. Combining studies		

		from Endometrial biopsy found 20 of 64 endo- metrial cancers detected via screening in total (65% stage I, 15% stage II, 5% stage III, remainder unreported) and 29 hyperplasias of 36 detected via screening in total. The sensitivity and specificity of endometrial biopsy in detecting cancer (excluding hyperplasia) were 57.1% and 97.7%. Number needed to screen, defined as the number of endometrial biopsies required to detect cancer or hyperplasia, ranged between 12 and 380 (median 19) and between 23 and 380 (median 78) in detecting cancer only. Transvaginal ultrasound detected 11 endometrial cancers (81.1% stage I, remainder unreported) and seven cases of hyperplasia in total. Sensitivity and specificity in detecting endometrial cancer was 34.4% and 87.1%, respectively. The number needed to screen to detect either endometrial cancer or hyperplasia by transvaginal ultrasound ranged between 35 and 973 (median 89); this range remained the same to detect cancer only, however, the median increased to 170 (Online Supplemental Table 4). In studies of		

		mismatch repair carriers only, two12 24 studies provided sufficient data to inform sensitivity. The sensitivity of endometrial biopsy and transvaginal ultrasound were 79.3% and 53.8%, respectively. In three studies 13 19 22 which specified cancers detected by hysteroscopy, no additional cancers were detected when hysteroscopy was performed with endometrial biopsy. **Author's Conclusion:** There is limited evidence to support screening for endometrial and ovarian cancer in Lynch syndrome and data on mortality reduction are not available. Further prospective, randomized trials comparing targeted screening methods are needed. Risk reducing surgery remains the most reliable way to reduce endometrial and ovarian cancer risk in Lynch syndrome.		

3.6. Schlüsselfrage 07

Welchen Stellenwert hat die transvaginale Sonographie in der Diagnostik der symptomatischen Frau mit normalem Risiko zum Nachweis eines Endometriumkarzinoms im Hinblick auf Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben?

Population: symptomatische Frau mit
- 1.normalem Risiko für EC
- 2.erhöhtem Risiko für EC (Adipositas, PCO, TAM-Einnahme, DM) ohne genetische Disposition

Intervention: Diagnostik des Endometriumkarzinomsmittels

· 1.Ultraschall
· 2.Aspiration
Comparison: Diagnostik des Endometriumkarzinomsmittels
· 1.frakt. Abrasio ohne HSK
· 2.frakt. Abrasio mit HSK
Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifischesund Gesamtüberleben

Inhalt: *3 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Ak??, S. 2022	3	Retrospective observational cohort study.
Verbakel, J. Y. 2022	3	Prospective observational cohort study
Xydias, E. M. 2022	2	Systematic review and meta-analysis

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

Xydias, E. M. et al. Comparison of 3D ultrasound, 2D ultrasound and 3D Doppler in the diagnosis of endometrial carcinoma in patients with uterine bleeding: A systematic review and meta-analysis. Eur J Obstet Gynecol Reprod Biol. 277. 42-52. 2022				
Evidence level/Study Types	**P - I - C**	**Outcomes/Results**	**Literature References**	
Evidence level: 2 **Overall confidence in the results of the review:** AMSTAR II critical appraisal tool	**Population:** Women with abnormal uterine bleeding. **Intervention:** Index tests:	**Primary:** Sensitivity and specificity of diagnosis of endometrial carcinoma. **Secondary:** -	10 sutdies included: Hanafi 2013, Liu 2019, Makled 2013, Mansour 2007,	

for systematic reviews: 3 critical flaws (items 2,7,13), 4 non-critical flaws (items 6,10,12,14,) Overall quality of evidence: Critically Low Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Diagnosis): 2 Systematic review and meta-analysis of (Non-consecutive studies, or studies without consistently applied reference standard) **Study type:** Systematic review and meta-analysis **Databases:** Web of Science, Scopus and MEDLINE/PubMed. **Search period:** Inception until February 20th, 2022 **Inclusion Criteria:** Eligible study population were adult women presenting with abnormal uterine bleeding, optionally with more symptoms as well. The index test examined in this review was three-dimensional transvaginal ultrasound (3D-US) and was necessarily assessed in all included reports. Other three-dimensional sonographic modalities, such as contrast enhancement or saline infusion, as well as other methodologies (i.e. transabdominal sonography) were not included. The	3D ultrasound, 2D ultrasound and 3D Doppler **Comparison:** reference standard: histo- pathologic diagnosis of endometrial malignancy	**Results:** Cochran's Q, p-value and I2 index were calculated for sensitivity and specificity for all five parameters. **EV:** sensitivity (Q = 95.39, df = 9, P < 0.001; I2 = 90.6%, 95%CI = 85.2%–93.4%), specificity (Q = 136.96, df = 9, P < 0.001; I2 = 93.4%, 95%CI = 90.5%–95.1%). **ET:** sensi- tivity (Q = 67.64, df = 7, P < 0.001; I2 = 89.7%, 95%CI = 82.1%– 93.1%), specificity (Q = 115.26, df = 7, P < 0.001; I2 = 93.9%, 95%CI = 90.9%–95.6%). For VI: sensitivity (Q = 18.95, df = 7, P = 0.008; I2 = 63.1%, 95%CI = 0.0%–81.0%), specificity (Q = 9.72, df = 7, P = 0.205; I2 = 28.0%, 95%CI = 0.0%–67.5%). **FI:** sensitivity (Q = 14.47, df = 7, P = 0.043; I2 = 51.6%, 95%CI = 0.0%–76.5%), specificity (Q = 67.64, df = 7, P < 0.001; I2 = 89.7%, 95%CI = 82.1%–93.1%). **VFI:** sensitivity (Q = 18.95, df = 7, P = 0.008; I2 = 63.1%, 95%CI = 0.0%– 81.0%), specificity (Q = 9.72, df = 7, P = 0.205; I2 = 28.0%, 95%CI = 0.0%–67.5%). The vast majority of the pooled estimates had statistically significant heterogeneity (I2 > 50%, p < 0.05). **Author's Conclusion:** While endometrial thickness remains a reliable predictor of uterine malignancy, endometrial volume appears promising as a method with higher specificity and more reliable measurements.	Dueholm 2015, Merce 2007, Opolskiene 2009, Pandey 2018, Rossi 2012, Yaman 2008.	

comparator tests examined were 2D-US and 3D-PDA, with at least one being compared to 3D-US in each included report. Histo- pathologic diagnosis of endometrial malignancy was the only acceptable reference standard for the verification of ultrasonographic imaging re- sults. The primary outcomes sought were sensitivity and specificity for the different parameters assessed by the three ultrasonographic methods, namely for endometrial volume (EV) measured by 3D-US, endometrial thickness (ET) measured by 2D-US and vascularization index (VI), flow index (FI) and vascularization-flow index (VFI) measured by 3D-PDA. Secondary outcomes were the diagnostic cut-off values of the main ultrasonographic parameters of each method. **Exclusion Criteria:** Were these parameters not reported, the study was excluded. Regarding study design, only primary, published studies were eligible. Secondary re- ports, other systematic or literature reviews and meta-analyses were excluded. Oral or written conference abstracts of unpublished studies were excluded as well as non-English articles, animal or cadaveric studies and studies on pediatric or adolescent populations.		Similarly, vascular indices seem as competent and even more sensitive than endometrial volume as predictors, with the added advantage of semi- automated and reproducible measurements that reflect the whole organ. More comparative studies with stan- dardized protocols should be established, so as reliable cut-off values can be determined and thus standardize and streamline the diagnostic algorithm via the implementation of the three-dimensional modalities in the settings that they are available.		

NEWCASTLE - OTTAWA Checklist: Cohort: *2 Bewertung(en)*

Ak??, S. et al. The clinical importance of polyp size measurement through two-dimensional saline infusion sonohysterography prior to hysteroscopic resection in predicting premalignant and malignant endometrial lesions. Int J Gynaecol Obstet. 157. 582-587. 2022

Evidence level	Methodical Notes	Patient characteristics	Interventions
Evidence level: 3 **Study type:** Retrospective observational cohort study.	**Funding sources:** Not declared. **Conflict of Interests:** Declared, none. **Randomization:** - **Blinding:** - **Dropout rates:** no description, retrospective study design.	**Total no. patients:** 365 patients who underwent hysteroscopy after pre-diagnosis of endometrial polyp on SIS. **Recruiting Phase:** March 2011 to March 2016. **Inclusion criteria:** Not described. **Exclusion criteria:** Not described.	**Interventions:** Predictor: Polyp size measure in SIS before hysteroscopy. **Comparison:** -
Notes:	Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Prognosis): 3 (Cohort study or control arm of randomized trial*). Newcastle-Ottawa Scale (NOS) for cohort studies: 8/9 stars. **Author's conclusion:** During the female reproductive years, endometrial polyps smaller than 10mm, as measured in SIS, can be followed, However when polyp size is 22,5 mm or more, espeically in postmenopausal women, treatment should be planned.		
Outcome Measures/results	**Primary** Distinguishing between benign, pre-malignant and malignant lesions.	**Results: Rates of malignancy:** 7,4% premalignant and 0.9% malignant. **Mean polyp size:** 17.7±0.5 mm in benign and 23.7 ±1.8 mm in premalignant/malignant patients (p<0.001). **Poly size and malignancy rate:**	

	Secondary -	0-10, 10-20, 20-30, >30 mm and 0.0, 4.8, 13.3 and 18.8% malignancy rate. **Cutoff Value for polyp size to be able to predict lesions** calculated at 22.5% (sensitivity 63%, Specificity 80%) on receiver operating characteristics curve analysis (p=0001, AUC 0.732). **Power of the study** calculated as 90.86%.

Verbakel, J. Y. et al. Risk assessment for endometrial cancer in women with abnormal vaginal bleeding: Results from the prospective IETA-1 cohort study. Int J Gynaecol Obstet. 159. 103-110. 2022

Evidence level	Methodical Notes	Patient characteristics	Interventions
Evidence level: 3 **Study type:** Prospective observational cohort study	**Funding sources:** Declared, governmental funding. **Conflict of Interests:** Declared, none. **Randomization:** - **Blinding:** not blinded. **Dropout rates:** -	**Total no. patients:** 2417 women with abnormal vaginal bleeding. **Recruiting Phase:** Between 2012 and December 31, 2015. **Inclusion criteria:** Abnormal, not pregnancy-related, uterine bleeding (i.e., postmenopausal bleeding, heavy menstrual bleeding, intermenstrual bleeding, bleeding during continuous com- bined estrogen-gestagen therapy, or abnormal bleeding during se- quential estrogen-gestagen therapy). **Exclusion criteria:** Failure to perform ultrasound examination, no initial endometrial thickness measurement result, missing histology combined with follow up of less than 1 year, pregnancy-related bleeding, or bleeding not origi- nating in the uterus, e.g., vaginal or cervical cancer.	**Interventions:** Exposure to risk factors: Age, BMI, Nulliparity, hormonal therapy, intrauterine contraceptive device therapy, age at menopause, endometrial thickness. **Comparison:** Non-Exposure to risk factors:
Notes:	Notes: Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Prognosis): 3 (Cohort study or control arm of randomized trial*).		

	Newcastle-Ottawa Scale (NOS) for cohort studies: 8/9 stars. **Author's conclusion:** Age, parity, and BMI help in the assessment of endometrial cancer risk in women with abnormal uterine bleeding. Other patient information adds little, whereas sonographic endometrial thickness substantially improves assessment.	
Outcome Measures/results	**Primary** Endometrial cancer or intrepithelial neoplasia. **Secondary** Subgroup analysis.	**Results: Association between risk factors and endometrial cancer and/or endometrial intraepithelial neoplasia n = 2417** Baseline Age Unit Per 5 years OR 1.56 (1.46 to 1.67) AUC optimism correected 0.82 R2 optimism corrected 21%, AIC 947.8 Body mass index Per 5 kg/m2, OR 1.13 (0.98 1.30) Nulliparity No versus Yes, OR 0.78 (0.48 1.29) Added value of non-sonographic characteristics (over baseline variables) (each statistic represents the performance of combination of the respective variable and the three baseline variables) Hormonal therapy Yes versus No, OR 0.42 (0.25 0.69), AUC optimism corrected 0.83 22% 936.4 Intrauterine contraceptive device present Yes versus No, OR 0.44 (0.06 to 3.25), AUC optimism corrected 0.82, R 2 optimism corrected 20%, AIC 949.0 Anticoagulant therapy Yes versus No, OR 0.71 (0.43 to 1.20), AUC optimism corrected 0.82, R 2 optimism corrected 21%, AIC 948.2 Age at menopause Per 5 years, OR 1.11 (0.87 to 1.41), AUC optimism corrected 0.82, R 2 optimism corrected 21%, AIC 949.1 Added value of endometrial thickness on ultrasound (over baseline variables) (each statistic represents the performance of combination of the respective variable and the three baseline variables) Added value of endometrial thickness on ultrasound (over baseline variables) Endometrial thickness Per 5 mm, OR 1.94 (1.71 to 2.20), AUC optimisim corrected 0.86, R2 optimism corrected 33%, AIC 820.1 Endometrial thickness unmeasurable Yes versus No OR 4.86 (2.70 to 8.76)

		Subgroup analysis see analysis.

3.7. Schlüsselfrage 08

Gibt es bei V. a. Endometriumkarzinom einen sinnvollen Algorithmus von transvaginaler Sonographie, Endometriumbiopsie mittels Aspiration, Abrasio uteri oder Hysteroskopie für die Diagnostik zum Nachweis eines Endometriumkarzinoms bei Frauen mit genetischer Disposition?

Population asymptomatische Frau mit
· 1.normalem Risiko für EC
· 2.erhöhtem Risiko für EC (Adipositas, PCO, TAM-Einnahme, DM) ohne genetische Disposition
Intervention: Screening auf EC mittels
· 1.Ultraschall
· 2.zytolog. Beurteilung
· 3.Endometriumbiopsie mittels Aspiration
· 4.Hysteroskopie
· 5.Tumormarker-Bestimmun
Comparison: kein Screening
Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Inhalt: *1 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Lim, N. 2022	3	Systematic review of cohort studies.

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

Lim, N. et al. Screening and risk reducing surgery for endometrial or ovarian cancers in Lynch syndrome: a systematic review. Int J Gynecol Cancer. 32. 646-655. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 3 **Overall confidence in the results of the review:** AMSTAR II critical appraisal tool for systematic reviews: 4critical flaws (items 2, 7, 9, 13), 6 non-critical flaws (items 5, 6, 10, 12, 14, 16) Overall quality of evidence: Critically Low Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Screening): 2 Systematic review and meta-analysis of (Non -randomized controlled cohort/follow-up study**) Downgrade to evidence level 3 **Study type:** Systematic review of cohort studies. **Databases:** Medline (Ovid), Embase, and PubMed databases **Search period:** Inception - in November 2021. **Inclusion Criteria:** 1) The population included women with Lynch syndrome either with a confirmed MMR mutation or who fulfilled Amsterdam II Criteria 2) The intervention was risk-reducing	**Population:** women with Lynch syndrome either with a confirmed MMR mutation. **Intervention:** Screening methods: Endometrial biopsy, transvaginal ultrasound, or serum cancer antigen 125 (CA-125). **Comparison:** Risk reducing surgery.	**Primary:** Number of cancers, endometrial hyperplasia. **Secondary:** - **Results:** Rates of Endometrial Cancer Detected by Screening 18 studies of endometrial cancer screening detected a total of 104 cancers among 2688 women (3.9%), diagnosed between at ages 36–72 years. A total of 1193 of 2688 (44.4%) patients had confirmed mismatch repair/EPCAM mutations and 1495 of 2688 (55.6%) were identified through Amsterdam criteria. A total of 78 of 1193 (6.5%) mismatch repair/EPCAM carriers were diagnosed with endometrial cancer , representing 75% of all endometrial cancers found. 50/78 (64.1%) patients were detected through asymptomatic screening at their first or subse- quent screening visit, while the remainder were diagnosed due to symptoms at or between screening intervals (Figure 1). Twenty-six of 1495 women (1.7%) with Lynch syndrome diagnosed through Amsterdam criteria (or where genetic testing information	18 studies included: Dove-Edwin, Rijcken, Renkonen-Sinisalo, Lecuru, Gerritzen, Jarvinen, Lecuru, Guillen-Ponce, Bats, Arts-De Jong, Manchanda, Stuckless, Helder-Woolderink, Douay-Hauser, Ketabi, Tzortzatos, Gossert, Nebgen, Rosenthal, Rosenthal, Eikenboom.	

hysterectomy and/or salpingo-oophorectomy 3) The outcome was endometrial or ovarian cancer incidence at the time of risk-reducing surgery in prophylactic specimens 4) The results were histological findings in prophylactic hysterectomy, salpingectomy, or oophorectomy specimens. **Exclusion Criteria:** 1) The population was not Lynch syndrome carriers but other hereditary cancer syndrome carriers 2) The outcomes were patient perception of the procedure 3) The outcomes were side effects about the procedure 4) The study was a review and not original data 5) The study was about cost-effectiveness of surgery 6) The article summarised guidelines in managing women predisposed to Lynch syndrome with risk-reducing surgery.		was not published) were diagnosed with endometrial cancers, representing 25% of all endometrial cancers. Fourteen of 26 (53.8%) of these were through screening, while the remainder were diagnosed due to symptoms, or between screening intervals. 40/57 (70.2%) cases of endometrial hyperplasias were found in mismatch repair carriers, 50% of which were in MLH1 carriers (Online Supplemental Table 3). The number needed to screen, defined as the number of people needed to be screened for a diagnosis of cancer or hyperplasia, ranged between 4 and 135 (median 13) (Online Supplemental Table 4). This reduced to between 4 and 38 (median 7) when only mismatch repair carriers were included. In the mismatch repair carrier population, the sensi- tivity of screening to detect endometrial cancer (excluding hyper-plasia) was 66.7%. Combining studies from Endometrial biopsy found 20 of 64 endo- metrial cancers detected via screening in total (65% stage I, 15% stage II, 5% stage III, remainder unreported) and 29 hyperplasias of 36 detected via screening in total.		

		The sensitivity and specificity of endometrial biopsy in detecting cancer (excluding hyperplasia) were 57.1% and 97.7%. Number needed to screen, defined as the number of endometrial biopsies required to detect cancer or hyperplasia, ranged between 12 and 380 (median 19) and between 23 and 380 (median 78) in detecting cancer only. Transvaginal ultrasound detected 11 endometrial cancers (81.1% stage I, remainder unreported) and seven cases of hyperplasia in total. Sensitivity and specificity in detecting endometrial cancer was 34.4% and 87.1%, respectively. The number needed to screen to detect either endometrial cancer or hyperplasia by transvaginal ultrasound ranged between 35 and 973 (median 89); this range remained the same to detect cancer only, however, the median increased to 170 (Online Supplemental Table 4). In studies of mismatch repair carriers only, two12 24 studies provided sufficient data to inform sensitivity. The sensitivity of endometrial biopsy and transvaginal ultrasound were 79.3% and 53.8%, respectively. In three studies 13 19 22 which specified cancers detected by hysteroscopy, no additional cancers were detected when hysteroscopy was		

		performed with endometrial biopsy. **Author's Conclusion:** There is limited evidence to support screening for endometrial and ovarian cancer in Lynch syndrome and data on mortality reduction are not available. Further prospective, randomized trials comparing targeted screening methods are needed. Risk reducing surgery remains the most reliable way to reduce endometrial and ovarian cancer risk in Lynch syndrome.		

3.8. Schlüsselfrage 10

Gibt es bei V.a. Endometriumkarzinom einen sinnvollen Algorithmus von transvaginaler Sonographie, Endometriumbiopsie mittels Aspiration, Abrasio uteri oder Hysteroskopie fu?r die Diagnostik zum Nachweis eines Endometriumkarzinoms bei Frauen mit normalem Risiko?

Population: symptomatische Frau mit
· 1.normalem Risiko für EC
· 2.erhöhtem Risiko für EC (Adipositas, PCO, TAM-Einnahme, DM) ohne genetische Disposition
Intervention: Diagnostik des Endometriumkarzinomsmittels
· 1.Ultraschall
· 2.Aspiration
Comparison: Diagnostik des Endometriumkarzinomsmittels
· 1.frakt. Abrasio ohne HSK
· 2.frakt. Abrasio mit HSK
Outcomes: Änderung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheits-spezifischesund Gesamtüberleben

Inhalt: *2 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Li, J. X. L. 2022	3	Systematic review (11 cohort studies and one systematic review)
Su, D. 2021	3	systematic review and meta-analysis of cohort studies.

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *2 Bewertung(en)*

Li, J. X. L. et al. Can a higher endometrial thickness threshold exclude endometrial cancer and atypical hyperplasia in asymptomatic postmenopausal women? A systematic review. Aust N Z J Obstet Gynaecol. 62. 190-197. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 3 **Overall confidence in the results of the review:** AMSTAR II critical appraisal tool for systematic reviews: 3 critical flaws (items 2,7,9), 4 non-critical flaws (items 5,6,10,14) Overall quality of evidence: Critically Low Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Diagnosis): 2 Systematic review and meta-analysis of (Non-consecutive studies, or studies without consistently applied reference standard) Downgrade to evidence level 3 **Study type:** Systematic review (11 cohort studies and one systematic review) **Databases:** Pubmed, EMBASE and Cochrane Database of Systematic Reviews **Search period:** Between 2011 and 2021	**Population:** asymptomatic postmenopausal women **Intervention:** alternative endometrial thickness thresholds for the diagnosis of: (1) endometrial cancer; and (2) endometrial cancer and atypical endometrial hyperplasia **Comparison:** /	**Primary:** Outcome data included the endometrial thickness thresholds recommended by study authors, area under the curve receiver operating characteristic (AUC ROC) or risk ratio (RR) estimates, sensitivity and specificity calculations, adverse events, and insufficient sample rates. **Secondary:** / **Results: Diagnostic threshold** Of seven studies (N = 2986), better evidence identified 12 mm as the optimal diagnostic threshold (area under the curve receiver operating characteristic (AUC ROC) 0.716, 95% CI 0.534–0.897, P = 0.019) for endometrial cancer in asymptomatic postmenopausal women. Two higher quality studies (n = 488 and n = 4751) identified 11 mm as optimal for diagnosing both endometrial carcinoma and atypical hyperplasia (AUC ROC 0.587, 95% CI 0.465–0.708, P = 0.144 and 2.59 relative risk, 95% CI 1.66–4.05, P < 0.001). **Adverse events** Only one study reported adverse events related to hysteroscopy and D&C; Li and Li reported 10/488 (2%) events of uterine perforation and 1/488 (0.2%) event of bowel perforation contributing to a combined 2.2%	12 studies included: Li 2019, Alcazar 2018, Bracco Suarez 2020, Hefler (2018), Saccardi (2020), Kanmaz (2019), Louie (2016), Seckin (2016), Yasa (2016), Giannella (2020), Ozelci (2019), Ozelci (2019)¶	

Inclusion Criteria: Studies were eligible for inclusion if they reported TVUS endometrial thickness analysis in asymptomatic postmenopausal women **Exclusion Criteria:** studies were excluded if they were written in a non-English language.		rate of serious adverse events. Their rate of uterine perforation is higher than previous studies reporting rates of 0.3 and 0.4% in hysteroscopic surgeries. Overall complication rates for hysteroscopic surgery are similar, having been reported previously at rates of 1.1 and 2.7%. As the procedural adverse event rates may vary between centres, improved reporting of complication rates in the literature will provide better understanding of adverse event rates in hysteroscopy and D&C. **Author's Conclusion:** Evidence for improved detection of endometrial premalignancies and malignancies using alternative endometrial thickness thresholds is not rigorous. Evidence for improved outcomes using alternative thresholds is inadequate. Observation of asymptomatic postmenopausal women without risk factors and with an endometrial thickness of less than 10 mm may be reasonable.		

Su, D. et al. Capacity of endometrial thickness measurement to diagnose endometrial carcinoma in asymptomatic postmenopausal women: a systematic review and meta-analysis. Ann Palliat Med. 10. 10840-10848. 2021

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 3 **Overall confidence in the results of the**	**Population:** Asymptomatic postmenopausal women.	**Primary:** Diagnosis of endometrial carcinoma, polyps, hyperplasia	Fang 2021, Fleischer 2001, Ghoubara 2018,	

review: AMSTAR II critical appraisal tool for systematic reviews: 5 critical flaws (items 2,4,7,9,13), 5 non-critical flaws (items 3,6,8,10,12) Overall quality of evidence: Critically Low Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Prognosis): 2 Systematic review and meta-analysis of (Cohort study or control arm of randomized trial) Downgrade to evidence level 3 **Study type:** systematic review and meta-analysis of cohort studies. **Databases:** Embase, PubMed, Web of Science, Cochrane Library, Wanfang, and China National Knowledge Infrastructure (CNKI). **Search period:** Inception - May 2021. **Inclusion Criteria:** Research on the relationship between ET and EC in asymptomatic postmenopausal women published in the above databases from database inception to May 2021. Prospective or retrospective study, participants were postmenopausal women (menstruation stopped completely for at least 12 months) who were not using hormone replacement therapy (HRT), had no vaginal bleeding, discharge, increased	**Intervention:** Endometrial thickness <5mm **Comparison:** Endometrial thickness ≥5mm	**Secondary:** - **Results: Endometrial thickness and endometrial carcinoma:** ET < 5mm (n = 1758) vs ET ≥ 5mm (n = 1862), 9 studies. OR 0.35 (95%CI 0.16 to 0.78); I^2 = 0%. **Endometrial thickness and endometrial hyperplasia:** ET < 5mm (n = 1758) vs ET ≥ 5mm (n = 1862), 9 studies. OR 0.39 (95%CI 0.18 to 0.87); I^2 = 0%. **Endometrial thickness and endometrial polyps:** ET < 5mm (n = 1758) vs ET ≥ 5mm (n = 1862), 9 studies. OR 0.41 (95%CI 0.21 to 0.81); I^2 = 0%. **Author's Conclusion:** The results of this meta-analysis show that when the ET is greater than 5 mm, the frequency of EC, EP, and EH is significantly increased. We therefore recommend using 5 mm as the cut-off value has high sensitivity for diagnosing all common types of endometrial lesions. Postmenopausal women with ET >5 mm have a significant prevalence of endometrial lesions such as EC and EH.	Gianella 2014, Gouveia 2007, Kasraeian 2011, Marello 2000, Tsuda 1997, Yasa 2016.	

vaginal discharge, and other symptoms. **Exclusion Criteria:** Case reports, abstracts, conferences, or reviews.				

3.9. Schlüsselfrage 13

Welchen Stellenwert haben bildgebende Verfahren wie MRT, CT, PET-CT, PET-MRT und US präoperativ für die lokale und systemische Ausbreitungsdiagnostik des histologisch gesicherten primären Endometriumkarzinoms im Hinblick auf eine Änderung der operativen Strategie sowie auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt Überleben?

Population: Frauen mit histologisch gesichertem EC
Intervention: präoperative lokale und systemische Ausbreitungsdiagnostik mittels
1. MRT
2. CT
3. PET-CT
4. US
5. PET-MRT
Comparison: keine Ausbreitungs-diagnostik
Outcomes:
1. Änderung der operativen Strategie
2. Änderung Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben

Inhalt: *3 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Cubo-Abert, M. 2021	2	Prospective conseccutive study
Gastón, B. 2022	2	Prospective diagnostic study with consecutive recruitment.
Rockall, A. G. 2021	n/a	Prospective diagnostic study.

OXFORD (2011) QUADAS-2: Diagnostic Accuracy Studies: *2 Bewertung(en)*

Cubo-Abert, M. et al. Diagnostic performance of transvaginal ultrasound and magnetic resonance imaging for preoperative evaluation of low-grade endometrioid endometrial carcinoma: prospective comparative study. Ultrasound Obstet Gynecol. 58. 469-475. 2021				
Evidence level/Study Types	**Population**	**Outcomes/Results**		
Evidence level: 2 **Study type:** Prospective conseccutive study	**Number of patients / samples:** 131 patients with low-grade EEC were included consecutively. **Inclusion criteria:** All patients diagnosed with EC on pipelle biopsy or hysteroscopic-directed biopsy prior to surgery were considered potentially eligible for inclusion. Patients with a diagnosis of EC on biopsy underwent preoperative staging with MRI and TVS. **Exclusion criteria:** Grade-3 EEC or non-endometrioid EC on preoperative biopsy, contraindication for surgical treatment and/or cases in which it was not possible to evaluate the endometrium by TVS and/or MRI **Patient population:** 131 patients with low-grade EEC were included consecutively. Recruited between October 2013 and July 2018 at the Gynecological Oncology Unit at the Vall d'Hebron Hospital, Barcelona, Spain **Index test:** Preoperative staging by TVS and MRI, followed by surgical staging. **Reference test:** was considered as the reference standard. **Blinding:** The sonographer was blinded to the MRI results and patient records, and the radiographers and pathologist were blinded to the TVS results.	**Key outcomes:** Sensitivity, specificity, likelihood ratios and diagnostic accuracy, disagreement index. **Results:** Deep myometrial invasion (TVS vs. MRI) Sensitivity (%) 68.89 (53.35–81.83) vs. 51.11 (35.77–66.30) Specificity (%) 87.21 (78.27–93.44) vs.90.70 (82.49–95.90) LR+ 5.39 (3.24–8.94) vs. 5.49 (2.94–10.29) LR– 0.36 (0.26–0.49) vs. 0.54 (0.43–0.68) Diagnostic accuracy (%) 80.92 (73.13–87.25) vs. 77.10 (68.95–83.98) Cervical stromal invasion (TVS vs. MRI) Sensitivity (%) 43.24 (27.10–60.51) 24.32 (11.77–41.20) Specificity (%) 96.81 (90.96–99.34) 96.81 (90.96–99.34) LR+ (positive likelihood ratio) 13.55 (5.65–32.50) 7.62 (2.64–21.97 LR– (negative likelihood ratio) 0.59 (0.49–0.70) 0.78 (0.69–0.89) Diagnostic accuracy (%) 81.68 (73.98–		

		87.89) 76.34 (68.12–83.32) Agreement index between the imaging techniques in the prediction of DMI was 0.84 (95% CI, 0.76–0.90).		
Methodical Notes				
Notes: Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Diagnosis): 2 (Individual cross sectional studies with consistently applied reference standard and blinding). QUADAS-2 tool for the assement of primary diagnostic accuracy studies. 0 questions(s) were answered with 'no' and considered to be of high risk of bias 2 questions(s) were answered with 'unclear' and considered to be of unclear risk of bias Overall assesment: LOW risk of bias				
Gastón, B. et al. Transvaginal Ultrasound Versus Magnetic Resonance Imaging for Assessing Myometrial Infiltration in Endometrioid Low Grade Endometrial Cancer: A Prospective Study. J Ultrasound Med. 41. 335-342. 2022				
Evidence level/Study Types	**Population**	**Outcomes/Results**		
Evidence level: 2 **Study type:** Prospective diagnostic study with consecutive recruitment.	**Number of patients / samples:** 156 consecutive patients **Inclusion criteria:** Consecutive cases with a diagnosis of well (G1) or moderately differentiated (G2) endometrioid carcinoma after preoperative endometrial sampling obtained either by blind aspiration or hysteroscopy were considered as eligible candidates for this study. **Exclusion criteria:** A preoperative biopsy result of high-risk endometrial cancer (poorly differentiated endometrioid carcinoma or nonendometrioid histology) and not being suitable for TVS or MRI	**Key outcomes:** Sensitvity, specificity, LR+, LR- **Results:** Diagnostic Performance of TVS (Subjective Impression) and MRI (Subjective Impression) for Detecting Cervical Invasion (Sensitivity ; Specificity) TVS 25% (1/4) 95.4% (145/152) MRI 75% (3/4) 98.7% (150/152) Diagnostic Performance of TVS (Subjective		

	were considered as exclusion criteria for this study. **Patient population:** Patients diagnosed by endometrial sampling as having an endometrioid grade 1/grade 2 endometrial cancer. **Index test:** Prior to surgical staging for assessing MI by TVS and MRI. During surgery, intraoperative assessment of MI. **Reference test:** Definitive pathological study considered as reference standard. **Blinding:** One blinded MRI radiologist - exclusively dedi- cated to the field of gynecology and with between ten and fifteen years of experience in gynecology oncology-, evaluated uterine and endometrial mea- sures the same way as by ultrasound. Macroscopic intraoperative study was performed by several pathologists, with more than ten years of experience in oncological gynecological pathology. All of them were blinded to the preoperative image find- ings.	Impression) and MRI (Subjective Impression) for Detecting Adnexal Involvement (Sensitivity ; Specificity) TVS 50% (2/4) 100% (152/152) MRI 50% (2/4) 99.3% (151/152) Diagnostic Performance of TVS (Subjective Impression) and Karlson method for detecting deep MI (Sensitivity ; Specificity, LR+, LR -): TVS: 75% (95% confidence interval [CI] = 53–89%), 73.5% (95% CI = 65–80%), 2.83 (95% CI = 1.94– 4.13), and 0.34 (95% CI = 0.16–0.73) Karlsson's method for detecting deep MI were 65% (95% confidence interval [CI] = 43–82%), 70% (95% CI = 62–77%), 2.16 (95% CI = 1.43–3.25), and 0.5 (95% CI = 0.27–0.92 No sensitivity and specificity between the two ultrasound methods was found (P = .54).		
Methodical Notes				
Notes: Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Diagnosis): 2 (Individual cross sectional studies with consistently applied reference standard and blinding). QUADAS-2 tool for the assement of primary diagnostic accuracy studies. 0 questions(s) were answered with 'no' and considered to be of high risk of bias 3 questions(s) were answered with 'unclear' and considered to be of unclear risk of bias Overall assesment: LOW risk of bias				

NEWCASTLE - OTTAWA Checklist: Cohort: *1 Bewertung(en)*

Rockall, A. G. et al. Diagnostic Accuracy of FEC-PET/CT, FDG-PET/CT, and Diffusion-Weighted MRI in Detection of Nodal Metastases in Surgically Treated Endometrial and Cervical Carcinoma. Clin Cancer Res. 27. 6457-6466. 2021			
Evidence level	**Methodical Notes**	**Patient characteristics**	**Interventions**
Evidence level: n/a **Study type:** Prospective diagnostic study.	**Funding sources:** **Conflict of Interests:** **Randomization:** **Blinding:** **Dropout rates:**	**Total no. patients:** **Recruiting Phase:** **Inclusion criteria:** **Exclusion criteria:**	**Interventions:** **Comparison:**
Notes:	**Author's conclusion:**		
Outcome Measures/results	**Primary** **Secondary**	**Results:**	

3.10. Schlüsselfrage 17

Unter welchen Voraussetzungen können bei prä-, peri- und postmenopausalen Frauen mit Endometriumkarzinom die Ovarien belassen werden im Hinblick auf Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben?

Population
· Frauen -prämenopausal -perimenopausal -postmenopausal
mit atypischer Hyperplasie
· Frauen -prämenopausal, -perimenopausal, -postmenopausal mit frühem EC
Intervention: Hysterektomie cum Adnexexstirpation, beidseitig
Comparison: konservative Therapie
Hysterektomie sine Adnexexstirpation
Outcomes: Morbidität, Lebensqualität, Rezidivhäufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Inhalt: *4 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
De Rocco, S. 2022	2	Systematic review and meta-analysis of 29 cohort studies
Lago, V. 2022	4	Retrospective cohort study
Liang, X. 2021	2	Systematic review and meta-analysis of cohort studies.
Liu, X. 2022	3	Retrospective cohort study

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *2 Bewertung(en)*

De Rocco, S. et al. Reproductive and pregnancy outcomes of fertility-sparing treatments for early-stage endometrial cancer or atypical hyperplasia: A systematic review and meta-analysis. Eur J Obstet Gynecol Reprod Biol. 273. 90-97. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References
Evidence level: 2 **Overall confidence in the results of the review:** Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Systematic review of Non-randomized controlled cohort/follow-up studies). AMSTAR II critical appraisal tool for systematic reviews: 2 critical flaws (items 7,13), non-critical flaws (items 10,12,14) Overall quality of evidence: Critically Low **Study type:** Systematic review and meta-analysis of 29 cohort studies **Databases:** Medline and Embase **Search period:** Inception - September 2020	**Population:** 1036 women undergoing fertility-sparing treatments for endometrial neoplasia **Intervention:** megestrol or medroxyprogesterone acetate alone; · megestrol or medroxyprogesterone acetate plus metformin; · levonorgestrel-releasing intrauterine device alone; · MPA plus levonorgestrel-releasing intrauterine device; · levonorgestrel-releasing intrauterine device plus gonadotropin-releasing hormone (GnRH) analogue; or · GnRHa and levonorgestrel-releasing intrauterine device or letrozole	**Primary:** pregnancy outcomes **Secondary:** - **Results:** Complete remission of early endometrial cancer or hyperplasia was achieved in 82.8% [95% confidence interval (CI) 72.3–91.2; I2 = 93.7%] of cases. The number of women who obtained complete remission and attempted to become pregnant was used as the denominator in this analysis. **Overall pregnancy rate** 56.1% (95% CI 46.4–65.6; I2 = 79.4%) **Overall miscarriage rate** was 20.6% (95% CI 16.5–24.9; I2 = 24%) **Overall livebirth rate** was 77.2% (95% CI 72.7–81.5; I2 = 25.8%). **The pregnancy rate per medication** was 56.3% (95% CI 41.6–70.5; 17 studies, I2 =1.5%) in megestrol or medroxyprogesterone acetate, 63.1% (95% CI 37.0–85.6; five studies, I2 = 82.6) in levonorgestrel-releasing intrauterine device	Mazzon et al. 2010, Mao et al. 2010, Minig et al. 2011, Shirali et al. 2011, Ricciardi et al. 2012, Cade et al. 2013, Kim et al. 2013, Shobeiri et al. 2013, Parlakgmus et al. 2013, Park et al. 2013 (2), Park et al. 2013 (4), Shan et al. 2014, Rossetti et al. 2014, Ohyagi-Hara et al. 2014, Zhou et al. 2015, De Marzi et al. 2015, Wang et al. 2015, Laurelli et al. 2016, Zhou et al. 2017, Hwang et al. 2017, Falcone et al. 2017, Wang et al. 2017, Tamauchi et al. 2017, Pal et al. 2017, Giampaolino et al. 2018, Chae et al. 2019, Mitsuhashi et al. 2019, Leonerobertimaggiore et al. 2019, B-Y Yang et al. 202

Inclusion Criteria: Studies reporting the pregnancy outcomes of women undergoing fertility-sparing treatments for endometrial neoplasia were included in this review. Only studies reporting pregnancy outcomes in premeno-pausal women affected by complex atypical endometrial hyperplasia or early endometrioid endometrial cancer, defined as well or moderately differentiated endometrial cancer (G1–2) with no or < 50% myometrial invasion (IA), treated with fertility-sparing management were included in this review. **Exclusion Criteria:** Studies concerning deep myometrial invasion carcinoma, simple hyperplasia, atypical treatment (i.e. photodynamic therapy) or poorly differentiated endometrial cancer were excluded. In addition, case reports, conference abstracts and case series with fewer than five cases were excluded.	**Comparison:** see intervention.	57.9% (95% CI 37.7–76.8; three studies, I2 = 73.7%) in megestrol or medroxyprogesterone acetate and metformin 59.8% (95% CI 48.3–70.7; four studies, I2 = 26.5%) in medrox-yprogesterone acetate and levonorgestrel-releasing intrauterine device 15.4% (95% CI 4.3–42.2; one study) in GnRH analogue combined with levonorgestrel-releasing intrauterine device or letrozole 40.7% (95% CI 24.5–59.3, one study) in levonorgestrel-releasing intrauterine device and GnRH analogue. **miscarriage rate per medication** 17.4% (95% CI 12.2–23.4; 17 studies, I2 = 17.5%) vs. 68.8% (95% CI 56.0–80.3; 17 studies, I2 = 0%) in megestrol or medroxyprogesterone acetate 14.3% (95% CI 6.4–24.7; five studies, I2 = 82.6) vs. in levonorgestrel-releasing intrauterine device 57.9% (95% CI 37.7–76.8; three studies, I2 = 73.7%) in megestrol or medroxyprogesterone acetate and metformin 26.9% (95% CI 14.6–39.3; I2 = 0%) in medroxyprogesterone acetate and levonorgestrel-releasing intrauterine		

		device, 100% (95% CI 34.0–100; one study) in women treated with GnRH analogue combined with levonorgestrel-releasing intrauterine device or letrozole 18.2% (95% CI 5.1–47.7, one study) in women treated with levonorgestrel-releasing intrauterine de- vice and GnRH analogue. **Author's Conclusion:** Fertility-sparing treatment in women with endometrial cancer or hyperplasia is associated with an overall good response to therapy, good chance of achieving pregnancy and a good livebirth rate. Diagnostic follow-up with hysteroscopy was associated with a higher pregnancy rate, although this requires confirmation in adequately powered randomized trials.		

Liang, X. et al. Ovarian metastasis risk factors in endometrial carcinoma: A systematic review and meta-analysis. Eur J Obstet Gynecol Reprod Biol. 267. 245-255. 2021

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 2 **Overall confidence in the results of the**	**Population:** Patients with pathologically confirmed EC	**Primary:** Ovarian metastasis risk of EC **Secondary:** -	7 retrospective cohort studies included:	

review: Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Systematic review of Non-randomized controlled cohort/follow-up studies). AMSTAR II critical appraisal tool for systematic reviews: 2 critical flaws (items 2,7), non-critical flaws (items 6,8,10) Overall quality of evidence: Critically low **Study type:** Systematic review and meta-analysis of cohort studies. **Databases:** PubMed, Cochrane database, Embase, Google Scholar, and WOS databas **Search period:** Inception - June 1st, 2021. **Inclusion Criteria:** (1) prospective and retrospective studies, reporting subjects were patients with pathologically confirmed EC; (2) the findings included at least one risk factor of ovarian metastasis; (3) literature that provides the odds ratio (OR) value and 95% confidence interval (CI), or those in which original data can be used to calculate the OR value and 95% CI, and (4) inclusion of over 10 patients with EC **Exclusion Criteria:** (1) unavailable full text, (2) case reports and reviews, (3) republished literature, (4) documents with incomplete	**Intervention:** Exposure to risk factors **Comparison:** Non-Exposure to risk factors	**Results: Myometrial invasion and risk of ovarian metastases** 5 studies, n = 3188 of which 132 had ovarian metastases OR for ovarian metastasis patients with myometrial invasion >1/2 was 18.19 (95% CI 5.34-61.96), (I2 = 73.50%, P = 0.005). **Pelvic lymph node invasion and risk of ovarian metastases** 5 studies, n = 904 of which 43 had ovarian metastases OR = 5.41, (95% CI 2.60–10.97), (I2 = 0.00%, P = 0.666 **Pathological grade and risk of ovarian metastases** 5 studies, n = 3763 of which 190 had ovarian metastases OR = 2.66, (95%CI 1.35–5.24) 5 studies, I2 = 57.70%, P = 0.051 **Histology type and risk of ovarian metastases** 3 studies, n = 3371 of which 163 had ovarian metastases OR = 6.46, 95% CI:3.25–12.83), I2 = 34.60%, P = 0.217. **Lymphatic vascular space invasion and risk of ovarian metastases** 4 studies, n = 2500 of which 88 had ovarian metastases OR = 5.48, 95%CI 1.85–16.28, I2 = 59.10%, P = 0.062 **Cervical invasion and risk of ovarian**	Ignatov 2018, Li 2018, Kinjyo 2015, Pan 2011, Gilani 2011, Lee 2007, Lee 2007, Takeshima 1998.	

original data and no corresponding data after con- tacting the author.		**metastases** 2 studies, n = 1114 of which 26 had ovarian metastases OR = 4.12, 95%CI 1.87–9.08), I2 = 0.0%, P = 0.740. **Age and risk of ovarian metastases** 2 studies, n = 1217 of which 32 had ovarian metastases OR = 2.01, 95%CI 0.29 to 14.11, I2 = 86.8%, P = 0.006. **Author's Conclusion:** About 4.95% of EC patients develop ovarian metastasis. Age >45, myometrial invasion >1/2, cervical invasion, PLNI, pathological type, G3 pathological grade, and LVSI were the high-risk factors for ovarian metastasis of EC. Ovarian preservation should be carefully selected for patients with EC, and preoperative and intraoperative evaluations should be entirely performed.		

NEWCASTLE - OTTAWA Checklist: Cohort: *2 Bewertung(en)*

Lago, V. et al. Fertility sparing treatment in patients with endometrial cancer (FERT-ENC): a multicentric retrospective study from the Spanish Investigational Network Gynecologic Oncology Group (SPAIN-GOG). Arch Gynecol Obstet. 306. 821-828. 2022

Evidence level	Methodical Notes	Patient characteristics	Interventions
Evidence level: 4 **Study**	**Funding sources:** Declared, none. **Conflict of Interests:** Declared, none.	**Total no. patients:** 73 patients with stage IA endometrioid adenocarcinoma of the uterus. **Recruiting Phase:** Between January 2010 and January 2020.	**Interventions:** Fertility preservation treatment.

type: Retrospective cohort study	**Randomization:** - **Blinding:** - **Dropout rates:** -	**Inclusion criteria:** Women with gestational desire and a diagnosis of early- stage endometrial cancer who underwent conservative fer- tility preservation treatment were included if they met the following inclusion criteria: (a) histologically confirmed diagnosis of endometrioid cancer, (b) aged < 40 years at diagnosis, (c) FIGO stage I (FIGO 2009 classification) based on ultrasound and/or MRI, (d) no evidence of lymph node involvement and/or other metastases at preoperative evaluation and (e) received fertility-sparing treatment. **Exclusion criteria:** Patients with missing information were excluded from the analysis.	**Comparison:** -
Notes:	Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 3 (Non-randomized controlled cohort/follow-up study) Downgrade to evidence level 4 due to risk of bias. Newcastle-Ottawa Scale (NOS) for cohort studies: 6/9 stars. 0 points in the comparabilty domain. **Author's conclusion:** Fertility-sparing management presented a high response rate in patients with endometrial cancer. LNG-IUD was associated with a better response rate compared to the other treatment options. Moreover, in patients using this management method, pregnancy could be achieved using reproductive techniques.		
Outcome Measures/results	**Primary** Response rate of conservative treatment. **Secondary** Oncological, fertility and obstetric outcomes.	**Results:** The levonorgestrel intrauterine device (LNG-IUD) was the most common fertility-sparing treatment (53.4%), followed by megestrol acetate (20.5%) and medroxyprogesterone acetate (16.4%). During the 24-month follow-up period, the rate of complete response to fertility-sparing management was 74% (n = 54), and 8.2% (n = 6) of patients presented a partial response. Additionally, 13 (17.8%) patients presented with persistent disease and six (8.2%) relapsed after response. The LNG-IUD was associated with a higher complete response rate than the other methods (87.2 vs. 58.8%; p = 0.01).	

		Surgical treatment (at least hysterectomy) was performed in 44 (60.3%) patients as the end of fertility-sparing treatment. Four (5.5%) patients presented relapse after surgery, associated with final FIGO stage III (p = 0.036), myometrial invasion > 50% (p = 0.018) and final tumour grade 2–3 (p = 0.018). The mean follow-up period was 57.8 (range 6–159) months. The 5-year relapse-free survival and overall survival rates were 92.6% [95% CI (81.3, 97.2)] and 93.5% [95% CI (80.7, 97.9)], respectively. During follow-up, three patients (4.1%) died of the disease after completion of surgical treatment. Up to 50.7% of patients included in the study attempted to get pregnant. Of these, the rate of pregnancy was 81.1% (n = 30/37), and reproductive techniques were used for this purpose in 78.4% of cases.

Liu, X. et al. Developing a validated nomogram for predicting ovarian metastasis in endometrial cancer patients: a retrospective research. Arch Gynecol Obstet. 305. 719-729. 2022

Evidence level	Methodical Notes	Patient characteristics	Interventions
Evidence level: 3 **Study type:** Retrospective cohort study	**Funding sources:** Not declared. **Conflict of Interests:** Declared, none. **Randomization:** Patients were randomly divided into two cohorts at a ratio of 7:3: training cohort (n = 1048) for developing a nomogram and validation cohort (n = 448) for testing. **Blinding:** - **Dropout rates:** no description, retrospective analysis	**Total no. patients:** 1496 endometrial cancer patients. **Recruiting Phase:** Between 2012 to 2018 at the Qilu Hospital of Shandong University, China. **Inclusion criteria:** Patients having received primary staging surgery for EC in Qilu Hospital of Shandong University from January 2012 to December 2018 were drawn into the research. Then, the clin- ical records of included patients from the database of Qilu Hospital of Shandong University were reviewed, abstracted, and arranged.(i) the resection scope included at least TH plus BSO and (ii) patients with- out neoadjuvant chemoradiotherapy, and (iii) patients with complete clinical records.	**Interventions:** Exposure to risk factors. **Comparison:** Non-exposure to risk factors.

		Exclusion criteria: 347 patients with- out receiving complete surgery, 98 without complete clinical records, 16 with other primary synchronous malignancies, and 2 having received neoadjuvant chemoradiotherapy.	
Notes:	Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Prognosis): 3 (Cohort study or control arm of randomized trial) Newcastle-Ottawa Scale (NOS) for cohort studies: 8/9 stars. **Author's conclusion:** We develop a nomogram with good performances for predicting ovarian metastasis in EC patients, which may help clinicians identify candidate patients appropriate for ovarian preservation in premenopausal EC patients.		
Outcome Measures/results	**Primary** Age, Non-endometrioid, High grade, Deep myometrial invasion, LVSI, Parametrium invasion, Lymph node metastasis, Oviduct metastasis. **Secondary** -	**Results:** Nomogram clinical prediciton model for ovarian metastasis in the training cohort Age non-significant non-endometrioid type (HR [hazard ratio] 5.87; 95% CI 2.91–11.72) grade 3 (HR 4.41; 95% CI 2.23–8.99) deep endometrial invasion (HR 4.11; 95% CI 2.08–8.22) LVSI (HR 4.26; 95% CI 1.90–8.91) parametrium invasion (HR 20.85; 95% CI 7.29–56.07) lymph node metastasis (HR 9.64; 95% CI 4.42–20.15) oviduct metastasis (HR 44.55; 95% CI 21.07–97.26) (P < 0.05). Nomogram clinical prediciton model for ovarian cancer in the training cohort non-endometrioid histologic type, had a 3.77-fold (95% CI 1.27–10.83; P < 0.001) lymph node metastasis 15.37-fold (95% CI 4.72–47.57; P < 0.001	

		oviduct involve- ment 5.45-fold (95% CI 1.17–18.95; P < 0.001 Deep myometrial invasion HR 2.44 (95% CI 0.80–6.93; P = 0.099 Multivariate logistic model (Training cohort ; Validation cohort) Parametrium invasion HR 2.30 95% CI 0.64–7.84 P = .189; HR 1.51 95% CI 0.06–16.36 P = 0.764 Lymph node metastasis HR 3.60 95% CI 1.38–9.16 P < 0.001; HR 12.77 95% CI 3.69–41.27 < P = 0.001 Oviduct metastasis HR 27.90 95% CI 12.09–65.36 P < 0.001; HR 3.22 95% CI 0.57–13.51 P = 0.139

3.11. Schlüsselfrage 18

Unter welchen Voraussetzungen können bei Vorliegen eines frühen Endometriumkarzinoms (Typ 1, G1, G2, pT1a) Uterus und Adnexe belassen werden im Hinblick auf Lebensqualität, Kurzzeit/-Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben?

Population Frauen mit frühem EC
Intervention: Hysterektomie cum Adnexexstirpation bds
Comparison: Konservative Therapie-Hysterektomie sine Adnexexstirpation
Outcomes: Morbidität, Mortalität, Lebensqualität

Inhalt: *2 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
De Rocco, S. 2022	2	Systematic review and meta-analysis of 29 cohort studies
Lago, V. 2022	4	Retrospective cohort study

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

De Rocco, S. et al. Reproductive and pregnancy outcomes of fertility-sparing treatments for early-stage endometrial cancer or atypical hyperplasia: A systematic review and meta-analysis. Eur J Obstet Gynecol Reprod Biol. 273. 90-97. 2022				
Evidence level/Study Types	**P - I - C**	**Outcomes/Results**	**Literature References**	
Evidence level: 2 **Overall confidence in the results of the review:** Oxford Centre for	**Population:** 1036 women undergoing fertility-sparing treatments for endometrial neoplasia	**Primary:** pregnancy outcomes **Secondary:** -	Mazzon et al. 2010, Mao et al. 2010, Minig et al. 2011, Shirali et al. 2011, Ricciardi et al. 2012, Cade et al. 2013, Kim et al. 2013, Shobeiri et al.	

Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Systematic review of Non-randomized controlled cohort/follow-up studies). AMSTAR II critical appraisal tool for systematic reviews: 2 critical flaws (items 7,13), non-critical flaws (items 10,12,14) Overall quality of evidence: Critically Low **Study type:** Systematic review and meta-analysis of 29 cohort studies **Databases:** Medline and Embase **Search period:** Inception - September 2020 **Inclusion Criteria:** Studies reporting the pregnancy outcomes of women undergoing fertility-sparing treatments for endometrial neoplasia were included in this review. Only studies reporting pregnancy outcomes in premeno-pausal women affected by complex atypical endometrial hyperplasia or early endometrioid endometrial	**Intervention:** megestrol or medroxyprogesterone acetate alone; · megestrol or medroxyprogesterone acetate plus metformin; · levonorgestrel-releasing intrauterine device alone; · MPA plus levonorgestrel-releasing intrauterine device; · levonorgestrel-releasing intrauterine device plus gonadotropin-releasing hormone (GnRH) analogue; or · GnRHa and levonorgestrel-releasing intrauterine device or letrozole **Comparison:** see intervention.	**Results:** Complete remission of early endometrial cancer or hyperplasia was achieved in 82.8% [95% confidence interval (CI) 72.3–91.2; I2 = 93.7%] of cases. The number of women who obtained complete remission and attempted to become pregnant was used as the denominator in this analysis. **Overall pregnancy rate** 56.1% (95% CI 46.4–65.6; I2 = 79.4%) **Overall miscarriage rate** was 20.6% (95% CI 16.5–24.9; I2 = 24%) **Overall livebirth rate** was 77.2% (95% CI 72.7–81.5; I2 = 25.8%). **The pregnancy rate per medication** was 56.3% (95% CI 41.6–70.5; 17 studies, I2 =1.5%) in megestrol or medroxyprogesterone acetate, 63.1% (95% CI 37.0–85.6; five studies, I2 = 82.6) in levonorgestrel-releasing intrauterine device 57.9% (95% CI 37.7–76.8; three studies, I2 = 73.7%) in megestrol or medroxyprogesterone acetate and metformin 59.8% (95% CI 48.3–70.7; four studies, I2 = 26.5%) in medrox-yprogesterone acetate and levonorgestrel-releasing intrauterine device 15.4% (95% CI 4.3–42.2; one study) in	2013, Parlakgmus et al. 2013, Park et al. 2013 (2), Park et al. 2013 (4), Shan et al. 2014, Rossetti et al. 2014, Ohyagi-Hara et al. 2014, Zhou et al. 2015, De Marzi et al. 2015, Wang et al. 2015, Laurelli et al. 2016, Zhou et al. 2017, Hwang et al. 2017, Falcone et al. 2017, Wang et al. 2017, Tamauchi et al. 2017, Pal et al. 2017, Giampaolino et al. 2018, Chae et al. 2019, Mitsuhashi et al. 2019, Leonerobertimaggiore et al. 2019, B-Y Yang et al. 202	

cancer, defined as well or moderately differentiated endometrial cancer (G1–2) with no or < 50% myometrial invasion (IA), treated with fertility-sparing management were included in this review. **Exclusion Criteria:** Studies concerning deep myometrial invasion carcinoma, simple hyperplasia, atypical treatment (i.e. photodynamic therapy) or poorly differentiated endometrial cancer were excluded. In addition, case reports, conference abstracts and case series with fewer than five cases were excluded.		GnRH analogue combined with levonorgestrel-releasing intrauterine device or letrozole 40.7% (95% CI 24.5–59.3, one study) in levonorgestrel-releasing intrauterine device and GnRH analogue. **miscarriage rate per medication** 17.4% (95% CI 12.2–23.4; 17 studies, I2 = 17.5%) vs. 68.8% (95% CI 56.0–80.3; 17 studies, I2 = 0%) in megestrol or medroxyprogesterone acetate 14.3% (95% CI 6.4–24.7; five studies, I2 = 82.6) vs. in levonorgestrel-releasing intrauterine device 57.9% (95% CI 37.7–76.8; three studies, I2 = 73.7%) in megestrol or medroxyprogesterone acetate and metformin 26.9% (95% CI 14.6–39.3; I2 = 0%) in medroxyprogesterone acetate and levonorgestrel-releasing intrauterine device, 100% (95% CI 34.0–100; one study) in women treated with GnRH analogue combined with levonorgestrel-releasing intrauterine device or letrozole 18.2% (95% CI 5.1–47.7, one study) in women treated with levonorgestrel-releasing intrauterine de- vice and GnRH analogue.		

		Author's Conclusion: Fertility-sparing treatment in women with endometrial cancer or hyperplasia is associated with an overall good response to therapy, good chance of achieving pregnancy and a good livebirth rate. Diagnostic follow-up with hysteroscopy was associated with a higher pregnancy rate, although this requires confirmation in adequately powered randomized trials.		

NEWCASTLE - OTTAWA Checklist: Cohort: *1 Bewertung(en)*

Lago, V. et al. Fertility sparing treatment in patients with endometrial cancer (FERT-ENC): a multicentric retrospective study from the Spanish Investigational Network Gynecologic Oncology Group (SPAIN-GOG). Arch Gynecol Obstet. 306. 821-828. 2022

Evidence level	Methodical Notes	Patient characteristics	Interventions
Evidence level: 4 **Study type:** Retrospective cohort study	**Funding sources:** Declared, none. **Conflict of Interests:** Declared, none. **Randomization:** - **Blinding:** - **Dropout rates:** -	**Total no. patients:** 73 patients with stage IA endometrioid adenocarcinoma of the uterus. **Recruiting Phase:** Between January 2010 and January 2020. **Inclusion criteria:** Women with gestational desire and a diagnosis of early- stage endometrial cancer who underwent conservative fer- tility preservation treatment were included if they met the following inclusion criteria: (a) histologically confirmed diagnosis of endometrioid cancer, (b) aged < 40 years at diagnosis, (c) FIGO stage I (FIGO 2009 classification) based on ultrasound and/or MRI, (d) no evidence of lymph node	**Interventions:** Fertility preservation treatment. **Comparison:** -

		involvement and/or other metastases at preoperative evaluation and (e) received fertility-sparing treatment. **Exclusion criteria:** Patients with missing information were excluded from the analysis.	
Notes:	Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 3 (Non-randomized controlled cohort/follow-up study) Downgrade to evidence level 4 due to risk of bias. Newcastle-Ottawa Scale (NOS) for cohort studies: 6/9 stars. 0 points in the comparabilty domain. **Author's conclusion:** Fertility-sparing management presented a high response rate in patients with endometrial cancer. LNG-IUD was associated with a better response rate compared to the other treatment options. Moreover, in patients using this management method, pregnancy could be achieved using reproductive techniques.		
Outcome Measures/results	**Primary** Response rate of conservative treatment. **Secondary** Oncological, fertility and obstetric outcomes.	**Results:** The levonorgestrel intrauterine device (LNG-IUD) was the most common fertility-sparing treatment (53.4%), followed by megestrol acetate (20.5%) and medroxyprogesterone acetate (16.4%). During the 24-month follow-up period, the rate of complete response to fertility-sparing management was 74% (n = 54), and 8.2% (n = 6) of patients presented a partial response. Additionally, 13 (17.8%) patients presented with persistent disease and six (8.2%) relapsed after response. The LNG-IUD was associated with a higher complete response rate than the other methods (87.2 vs. 58.8%; p = 0.01). Surgical treatment (at least hysterectomy) was performed in 44 (60.3%) patients as the end of fertility-sparing treatment. Four (5.5%) patients presented relapse after surgery, associated with final FIGO stage III (p = 0.036), myometrial invasion > 50% (p = 0.018) and final tumour grade 2–3 (p = 0.018). The mean follow-up period was 57.8 (range 6–159) months. The 5-year relapse-free survival and overall survival rates were 92.6% [95% CI (81.3, 97.2)] and 93.5% [95% CI (80.7, 97.9)], respectively.	

		During follow-up, three patients (4.1%) died of the disease after completion of surgical treatment. Up to 50.7% of patients included in the study attempted to get pregnant. Of these, the rate of pregnancy was 81.1% (n = 30/37), and reproductive techniques were used for this purpose in 78.4% of cases.

3.12. Schlüsselfrage 21

Ist beim Endometriumkarzinom (Typ I, pT1a, G1/2) die SLN bei makroskopisch unauffälligen LK sinnvoll im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben? (S. Schlüsselfrage 34)

Population Frauen mit EC
- (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK
- (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit
- (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit
- (Typ II) und erreichbarer makroskopischer Tumorfreiheit
- mit Lymphgefäßinvasion

Intervention: Sentinel-Lymphknotenbiopsie (SLN)
Comparison:
keine LNE bei Frauen mit Typ-I-EC, pT1a, G1/2) und makroskopisch unauffälligen LK
LNE bei Frauen mit EC der folgenden Typ-Bestimmungen
Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK
(Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit
(Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit
(Typ II) und erreichbarer makroskopischer Tumorfreiheit
LNE bei Frauen mit EC und mit Lymphgefäßinvasion
Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Inhalt: *1 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Burg, L. C. 2022	2	Systematic review and meta-analysis (13 observational studies, 1 RCT)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

Burg, L. C. et al. The added value of SLN mapping with indocyanine green in low- and intermediate-risk endometrial cancer management: a systematic review and meta-analysis. J Gynecol Oncol. 33. e66. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References
Evidence level: 2 **Overall confidence in the results of the review:** Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Screening): 2 Systematic review and meta-analysis of (Non - randomized controlled cohort/follow-up study) AMSTAR II critical appraisal tool for systematic reviews: 2 critical flaws (items 2,7), 4 non-critical flaws (items 5,6,10,14) Overall quality of evidence: Critically low Notes: predominantly observational studies (13) vs one RCTs included. **Study type:** Systematic review and meta-analysis (13 observational studies, 1 RCT) **Databases:** PubMed, Embase, Web of Science, the Cochrane Library and ClinicalTrials.gov	**Population:** Early stage, low- and intermediate-risk endometrial cancer (endometrioid histology, histological grade 1 and 2 **Intervention:** Cervical injection with ICG for detection of SLN metastasis **Comparison:** -	**Primary:** SLN detection rate in presumed early stage, low- and intermediate-risk endometrial cancers, the incidence of SLN metastases, negative predictive value of SLN mapping performed with indocyanine green (ICG). **Secondary:** - **Results: SLN detection rate:** 86.0% to 100% with a pooled average of 95.6% (95% CI=92.4%–97.9%) **Prediction interval** from 81.1% to 100% **The pooled average of no SLN detection** at all is therefore 4.4% **Bilateral detection rate of SLN mapping** ranged from 52.1% to 95.2%, with a pooled average of 76.5% (95% CI=68.1%–84.0%) and a prediction interval from 43.0% to 97.6%. **Unilateral detection rate of SLN mapping** ranged from 4.4% to 34.8%, with a pooled average of 18.2% (95% CI=12.2%–25.1%) and a prediction interval from 1.8% to 4.6% **Estimated pooled incidence of SLN metastases in studies including grade 1 and 2 endometrial cancer patients** was 9.6% (95% CI=5.1%–15.2%), with a range from 3.1%	14 studies: Backes 2019, Bogani 2020, Buda 2016, Clinton 2017, Cusimano 2021, Diniz 2021, Ditto 2020, Holloway 2016, Papdia 2016, Rossi 2017, Stephens 2020, Taskin 2020, Xue 2021, Ye 2019.

Search period: no filter on year of publication was set **Inclusion Criteria:** A) early stage, low- and intermediate-risk endometrial cancer (endometrioid histology, histological grade 1 and 2); B) cervical injection with ICG; C) a minimal number of twenty included patients per study. To assess the diagnostic value of SLN mapping, D) a subsequent (pelvic) lymph node dissection was an additional eligibility criterion **Exclusion Criteria:** Reviews and case reports were excluded.		to 24.0% and a prediction interval from 0.7% to 26.7% **In studies including grade 1, 2, and 3 endometrial cancer patients**, the estimated pooled incidence of SLN metastases was 11.8% (95% CI=8.1%–16.1%), with a range from 3.1% to 29.4% and a prediction interval from 1.7% to 29.1%. **estimated pooled negative predictive value in studies including only in grade 1 and 2** endometrial cancer patients was 100% (95% CI=98.8%–100%), but the prediction interval shows that in a future setting the true negative rate may be as low as 89.9%. **The estimated pooled negative predictive value in studies including grade 1, 2, and 3 endometrial cancer patients** was 99.2% (95% CI=97.9%–99.9%), with a range from 96.9% to 100% across studies. The prediction interval shows that in a future setting the true negative rate may be as low as 94.9%. **Author's Conclusion:** SLN mapping with ICG is feasible with a high detection rate and negative predictive value in low- and intermediate-risk endometrial cancers. Given the incidence of SLN metastases is approximately 10% in those patients, SLN mapping may lead to stage shifting with potential therapeutic consequences. Given the high negative predictive value with SLN mapping, routine lymphadenectomy should		

		be omitted in low- and intermediate- risk endometrial cancer		

3.13. Schlüsselfrage 29

Ist beim Endometriumkarzinom Typ II die SLN sinnvoll, wenn makroskopisch Tumorfreiheit erzielt werden kann im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben?

Population Frauen mit EC
- (Typ I, pT1a, G1/2) und makroskopisch unauffälligen LK(Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK
- (Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit
- (Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit
- (Typ II) und erreichbarer makroskopischer Tumorfreiheit
- mit Lymphgefäßinvasion

Intervention: Sentinel-Lymphknotenbiopsie (SLN)
Comparison:
keine LNE bei Frauen mit Typ-I-EC, pT1a, G1/2) und makroskopisch unauffälligen LK
LNE bei Frauen mit EC der folgenden Typ-Bestimmungen
Typ I, pT1a, G3; pT1b, G1/2) und makroskopisch unauffälligen LK
(Typ I, pT1b, G3) und erreichbarer makroskopischer Tumorfreiheit
(Typ I, pT2 bis pTIVb, G1-3) und erreichbarer makroskopischer Tumorfreiheit
(Typ II) und erreichbarer makroskopischer Tumorfreiheit
LNE bei Frauen mit EC und mit Lymphgefäßinvasion
Outcomes: Morbidität, Lebensqualität, Rezidiv-häufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Inhalt: *1 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Marchocki, Z. 2021	2	Systematic review and meta-analysis (16 prospective cohort studies)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

Marchocki, Z. et al. Sentinel lymph node biopsy in high-grade endometrial cancer: a systematic review and meta-analysis of performance characteristics. Am J Obstet Gynecol. . . 2021

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References
Evidence level: 2 **Overall confidence in the results of the review:** Amstar II Checklist: Overall quality: Low (1 critical flaw (items 15) and 2 noncritical flaws (items 6, 10) were observed) Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Systematic review of studies with consistently applied reference standard but no mention of blinding). **Study type:** Systematic review and meta-analysis (16 prospective cohort studies) **Databases:** MEDLINE, Epub ahead of print, MEDLINE In-Process & Other Non-Indexed Citations, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, and Embase, ClinicalTrials.gov **Search period:** January 1, 2000, to January 26, 2021 **Inclusion Criteria:** prospective cohort	**Population:** Clinical stage I, high-grade EC patients (defined as grade 3 endometrioid, serous, clear cell, carcinosarcoma, undifferentiated or dedifferentiated, mixed histology **Intervention:** Surgical staging with hysterectomy, SLNB, and a subsequent complete PLND (with or without PALND) **Comparison:** see intervention.	**Primary:** sensitivity of SLNBs in the detection of metastatic disease when compared with a complete lymphadenectomy in patients with highgrade EC. **Secondary:** (1) patient-specific detection rates (2) bilateral detection rate (3) node positivity rate (4) NPV (5) FNR **Results: Sentinel lymph node detection rates.** The pooled overall SLN detection rate per patient was 91% (95% CI, 85%-95%; I2 59%). The pooled bilateral SLN detection rate was 64% (95% CI, 53%-73%; I2 69%) **Sensitivity of sentinel lymph node** The pooled sensitivity of an SLN per patient was 92% (95% CI, 84% -96%; I2 0%) **Negative predictive value** The pooled NPV per patient was 97% (95% CI, 95% - 99%; I2 0%) The pooled NPV per hemipelvis was	16 prospective cohort studies: Backes 2019, Cabrera 2020, Cusimano 2020, Holloway 2017, How 2017, Ianieri 2019, Laios 2015, Lim 2020, Paley 2016, Persson 2019, Rossi 2013, Rossi 2017, Soliman 2017, Taskin 2017

studies that (1) evaluated SLNBs with cervical injection of ICG; (2) enrolled patients with clinical stage I, high-grade EC (defined as grade 3 endometrioid, serous, clear cell, carcinosarcoma, undifferentiated or dedifferentiated, mixed histology) undergoing surgical staging with hysterectomy, SLNB, and a subsequent complete PLND (with or without PALND); and (3) reported on either the diagnostic accuracy (sensitivity, false negative rate [FNR], or negative predictive value [NPV]) or detection rate (patient-specific or bilateral detection rate). **Exclusion Criteria:** (1) the SLNB was conducted without ICG (blue dye alone or technetium alone) or with a noncervical ICG injection; (2) patients did not undergo at least a PLND as a reference standard; or (3) only patients with low-grade histology (grade 1 and 2 endometrioid) or clinical stage II EC were enrolled. We also excluded case reports, case series, retrospective studies, and reviews or commentaries without original data. In addition, we excluded conference abstracts and non-English articles;		98% (95% CI, 96% - 99%; I2 8%) False negative rate. The pooled FNR per patient was 8% (95% CI, 4% - 16%; I2 0%) The pooled FNR per hemipelvis was 10% (95% CI, 6% - 17%; I2 0%) **Author's Conclusion:** Sentinel lymph node biopsy accurately detect lymph node metastases in patients with high-grade endometrial cancer with a false negative rate comparable with that observed in low-grade endometrial cancer... These findings suggest that sentinel lymph node biopsy can replace complete lymphadenectomies as the standard of care for surgical staging in patients with high-grade endometrial cancer.		

3.14. Schlüsselfrage 32

Wie sollte beim Endometriumkarzinom eine LNE durchgeführt werden, um eine Verbesserung zu erreichen im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben?

Population Frauen mit EC
Intervention: Paraaortale und pelvine LNE
Comparison: PelvineLNE
Outcomes: Morbidität, Mortalität, Lebensqualität

Inhalt: *2 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Bebia, V. 2021	2	Randomized open-label multicenter trial
Hwang, J. H. 2022	3	Systematic review and meta-analysis (33 cohort studies)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

Hwang, J. H. et al. The incidence of postoperative symptomatic lymphocele after pelvic lymphadenectomy between abdominal and laparoscopic approach: a systemic review and meta-analysis. Surg Endosc. 36. 7114-7125. 2022				
Evidence level/Study Types	**P - I - C**	**Outcomes/Results**	**Literature References**	
Evidence level: 3 **Overall confidence in the results of the review:** AMSTAR II critical	**Population:** Patients with uterine cervical and endometrial cancer	**Primary:** occurrence of symptomatic lymphoceles **Secondary:**	33 studies included: Malur 2001, Lee 2002, Eltabbakh 2002, Manolitsas 2002, Fregerio 2006, Li 2007,	

appraisal tool for systematic reviews: 2 critical flaws (items 7, 9), 1 non-critical flaw (item 10) Overall quality of evidence: Critically Low **Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits):** 2 Systematic review and meta-analysis of (Non - randomized controlled cohort/follow-up study) Downgrade to evidence level 3 due to low quality. No risk of bias assessment of the included studies was performed. **Study type:** Systematic review and meta-analysis (33 cohort studies) **Databases:** Ovid Medline, Ovid EMBASE, and the Cochrane library **Search period:** 2001 - 2019 **Inclusion Criteria:** We included comparative studies, observational	**Intervention:** Pelvic lymphadenectomy via laparoscopic approach (LPL) **Comparison:** abdominal pelvic lymphadenectomy (APL)	**Results: Risk of symptomatic lymphoceles** When all studies were pooled, the odds ratios (OR) of the laparoscopic approach (3,672 patients) for the risk of symptomatic lymphoceles compared to the abdominal approach (3,796 patients) was 0.58 [95% confidence interval (CI): 0.42–0.81, p=0.022, I-squared=0.0%]. There was no heterogeneity among studies of postoperative symptomatic lymphoceles (I-squared=0.0%, p=0.685). The risk of postoperative symptomatic lymphoceles in the laparoscopic group tended to decrease over time in the cumulative meta-analysis. In the subgroup analysis, there was no evidence for an association between cancer type, quality of the study methodology, hysterectomy type, and postoperative symptomatic lymphoceles. However, in a recently published article, being overweight (body mass index≥25) and studies conducted in oriental area were associated with a lower incidence of postoperative symptomatic lymphoceles. **Author's Conclusion:** Laparoscopic lymphadenectomy was associated with a signifcantly lower risk of postoperative	Ghezzi 2007, Cho 2007, Boggess 2008, Malzoni 2009, Malzoni 2009, Santi 2010, Eisenkop 2010, Hahn 2010, Tinelli 2011, Barnett 2011, Nam 2012, Ghezzi 2012, Coronado 2012, Van de Lande 2012, Terai 2014, Kong 2014, Ditto 2015, Laterza 2015, Chu 2016, Cai 2016, Wang 2016, Laterza 2016, Zhang 2017, Corrado 2018, Ruan 2018, Guo 2018, Yuan 2019	

studies, and randomized controlled studies to evaluate the occurrence of symptomatic lymphoceles following LPL and APL in uterine cervical cancer and endometrial cancer. The patients were treated with radical hysterectomy or simple hysterectomy in addition to pelvic±para-aortic lymphadenectomy. **Exclusion Criteria:** The pelvic lymphadenectomy using robotic approach was excluded. Literature review, a case report, editorials, letter to editor, and conference abstracts were excluded. We excluded studies with less than 20 patients and any identifed duplicate data published in the same hospital.		symptomatic lymphoceles than abdominal lymphadenectomy		

Cochrane Risk of Bias Tool 1 (RCT): *1 Bewertung(en)*

Bebia, V. et al. Robot-assisted Extraperitoneal Para-aortic Lymphadenectomy Is Associated with Fewer Surgical Complications: A Post Hoc Analysis of the STELLA-2 Randomized Trial. J Minim Invasive Gynecol. 28. 2004-2012.e1. 2021

Population	Intervention / Comparison	Outcomes/Results	Methodical Notes
Evidence level: 2 **Study type:** Randomized open-label multicenter trial **Number of Patients:** 203 **Recruiting Phase:** June 2012 -	**Intervention:** extraperitoneal approach for para-aortic lymphadenectomy (n = 103) using a minimally invasive approach (either laparoscopic (n = 68) or robot-	**Primary:** Surgical complications [Time Frame: intraoperatively, within 30 days after surgery, and past 30 days after surgery up to 3 months after surgery]	**Funding Sources:** This study was funded by Instituto de Salud Carlos III (grant number: PI14/01817) and cofunded by the European

January 2019 **Inclusion Criteria:** Patients diagnosed with either initial-stage endometrial cancer (patients with tumors invading ≥50% of the myometrium, elicited by magnetic resonance imaging and/or transvaginal ultrasonography; cervical stromal involvement; grade 3 endometrial tumors; or nonendometrioid tumors) or ovarian malignancy (clinical International Federation of Gynecology and Obstetrics stage I or II) with an indication of surgical staging were eligible to participate in the study. **Exclusion Criteria:** The exclusion criteria included previous PALND, pelvic and/or aortic radiotherapy, or perioperative suspicion of advancedstage disease	assisted(n = 35)) **Comparison:** transperitoneal approach for para-aortic lymphadenectomy (n = 100) using a minimally invasive approach (either laparoscopic (n = 62) or robot-assisted (n = 38))	**Secondary:** / **Results: Surgical complications** A reduced trend in complications was observed in the extraperitoneal robot-assisted arm when considering the primary end point (X-L: 25.0%, T-L: 24.2%, X-R: 5.7%, T-R: 28.9%; p = .073). In a multivariable analysis, age (odds ratio [OR] 1.05; 95% confidence interval [CI], 1.00−1.09), body mass index (OR 1.09; 95% CI, 1.03−1.16), and waist-to-hip ratio (OR 1.66; 95% CI, 1.12−2.47) were found to independently increase the risk of PALND complications, whereas the extraperitoneal robotic approach (OR 0.13; 95% CI, 0.02−0.64) was an independent protective factor for complication occurrence. **Author's Conclusion:** Robot-assisted extraperitoneal PALND is associated with fewer surgical complications, without compromising lymph node retrieval, operative time, or length of stay. Robot-enhanced 3D visualization, surgeon ergonomics, or hemostatic precision could explain our results.	Regional Development Fund/European Social Fund. **COI:** The authors declare that they have no conflict of interest. **Randomization:** The minimally invasive approaches were not subjected to randomization. **Blinding:** Single blinded (outcome assessor was blinded) **Dropout Rate/ITT-Analysis:** All patients were analyzed. No drop-outs. **Notes:** PICO 32 Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Randomized trial) PICO 32: Cochrane risk of bias tool (Rob)-1: 1 questions(s) were considered to be unclear risk of bias; 0 question(s) were considered to be high risk of bias Overall risk of bias: Low PICO 35 Oxford Centre for Evidence-Based Medicine

			2011 Levels of Evidence (Treatment benefits): 2 (Randomized trial) Downgraded due to risk of bias to evidence level 3 PICO 35: Cochrane risk of bias tool (Rob)-1: 1 questions(s) were considered to be unclear risk of bias; 2 question(s) were considered to be high risk of bias Overall risk of bias: High Post-hoc analysis of the STELLA-2 trial

3.15. Schlüsselfrage 35

Wie ist der Stellenwert laparoskopischer Verfahren beim Endometriumkarzinom im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben?

Population Frauen mit EC
Intervention: Laparotomie
Comparison: Laparoskopie-Roboter-gestützte OP
Outcomes: Morbidität, Mortalität, Lebensqualität

Inhalt: *5 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Bebia, V. 2021	3	Randomized open-label multicenter trial
Hwang, J. H. 2022	3	Systematic review and meta-analysis (33 cohort studies)
Kim, N. R. 2022	3	Systematic review and meta-analysis (8 retrospective studies, one post-hoc analysis of an RCT)
Raffone, A. 2022	3	Systematic review and meta-analysis (5 retrospective cohort studies, 7629 patients)
Reijntjes, B. 2022	2	Randomized trial

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *3 Bewertung(en)*

Hwang, J. H. et al. The incidence of postoperative symptomatic lymphocele after pelvic lymphadenectomy between abdominal and laparoscopic approach: a systemic review and meta-analysis. Surg Endosc. 36. 7114-7125. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 3 **Overall confidence in the results of the review:** AMSTAR II critical appraisal tool for systematic reviews: 2 critical flaws (items 7, 9), 1 non-critical flaw (item 10) Overall quality of evidence: Critically Low **Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits):** 2 Systematic review and meta-analysis of (Non - randomized controlled cohort/follow-up study) Downgrade to evidence level 3 due to low quality. No risk of bias assessment of the included studies was performed. **Study type:** Systematic review and meta-analysis (33 cohort studies)	**Population:** Patients with uterine cervical and endometrial cancer **Intervention:** Pelvic lymphadenectomy via laparoscopic approach (LPL) **Comparison:** abdominal pelvic lymphadenectomy (APL)	**Primary:** occurrence of symptomatic lymphoceles **Secondary:** **Results: Risk of symptomatic lymphoceles** When all studies were pooled, the odds ratios (OR) of the laparoscopic approach (3,672 patients) for the risk of symptomatic lymphoceles compared to the abdominal approach (3,796 patients) was 0.58 [95% confidence interval (CI): 0.42–0.81, p=0.022, I-squared=0.0%]. There was no heterogeneity among studies of postoperative symptomatic lymphoceles (I-squared=0.0%, p=0.685). The risk of postoperative symptomatic lymphoceles in the laparoscopic group tended to decrease over time in the cumulative meta-analysis. In the subgroup analysis, there was no evidence for an association between cancer type, quality of the study methodology, hysterectomy type, and postoperative symptomatic lymphoceles. However, in a recently published article, being overweight (body mass index≥25) and studies conducted in oriental area were associated with a lower	33 studies included: Malur 2001, Lee 2002, Eltabbakh 2002, Manolitsas 2002, Fregerio 2006, Li 2007, Ghezzi 2007, Cho 2007, Boggess 2008, Malzoni 2009, Malzoni 2009, Santi 2010, Eisenkop 2010, Hahn 2010, Tinelli 2011, Barnett 2011, Nam 2012, Ghezzi 2012, Coronado 2012, Van de Lande 2012, Terai 2014, Kong 2014, Ditto 2015, Laterza 2015, Chu 2016, Cai 2016, Wang 2016, Laterza 2016, Zhang 2017, Corrado 2018, Ruan 2018, Guo 2018, Yuan 2019	

Databases: Ovid Medline, Ovid EMBASE, and the Cochrane library **Search period:** 2001 - 2019 **Inclusion Criteria:** We included comparative studies, observational studies, and randomized controlled studies to evaluate the occurrence of symptomatic lymphoceles following LPL and APL in uterine cervical cancer and endometrial cancer. The patients were treated with radical hysterectomy or simple hysterectomy in addition to pelvic±para-aortic lymphadenectomy. **Exclusion Criteria:** The pelvic lymphadenectomy using robotic approach was excluded. Literature review, a case report, editorials, letter to editor, and conference abstracts were excluded. We excluded studies with less than 20 patients and any identifed duplicate data published in the same hospital.		incidence of postoperative symptomatic lymphoceles. **Author's Conclusion:** Laparoscopic lymphadenectomy was associated with a signifcantly lower risk of postoperative symptomatic lymphoceles than abdominal lymphadenectomy		
Kim, N. R. et al. Minimally invasive surgery versus open surgery in high-risk histologic endometrial cancer patients: A meta-analysis. Gynecol Oncol. 166. 236-244. 2022				

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 3 **Overall confidence in the results of the review:** AMSTAR II critical appraisal tool for systematic reviews: 3 critical flaws (items 2,7,11), 2 non-critical flaws (items 10,12) Overall quality of evidence: Critically LOW **Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits)**: 2 Systematic review and meta-analysis of (Non -randomized controlled cohort/follow-up study) Downgrade to evidence level 3 due to low quality. Notes: RCT and observational studies were pooled together. **Study type:** Systematic review and meta-analysis (8 retrospective studies, one post-hoc analysis of an RCT) **Databases:** Embase, MEDLINE, and Cochrane Library **Search period:** Inception until January 2022	**Population:** Patients with endometrial cancer (EC) of high-risk histology (grade 3 endometrioid adenocarcinoma, papillary serous carcinoma [PS], clear cell carcinoma [CC], and carcinosarcoma) **Intervention:** Minimally invasive surgery (MIS) **Comparison:** Open surgery (OPS)	**Primary:** Risk of recurrence and mortality rate **Secondary:** / **Results: Risk of recurrence** (MIS was performed in 886 patients and OPS in 890, 8 studies) The fixed-effects model-based meta-analysis indicated that MIS did not significantly increase the risk of recurrence (hazard ratio [HR], 0.86; 95% confidence interval [CI], 0.71–1.05; p = 0.13) when compared with OPS. The cross-study heterogeneity was low (p = 0.140; I2 = 36.2). Although publication bias was suspected in the funnel plot, no statistical difference was found in the Begg and Mazumdar rank correlation (p = 0.45) and Egger's regression intercept (p = 0.44). This pattern was also observed in the subgroup analyses based on the stage (early stage vs. all stage), histology (PS and CC), and MIS type (laparoscopy vs. robotic). **Mortality** (MIS was performed in 8830 patients and OPS in 5718, 8 studies)	9 studies were included: Fader 2012, Feuer 2014, Pant 2014, Vogel 2015, Fader 2016, Favero 2016, Koskas 2016, Monterossi 2017, Nasioudis 2020	

Inclusion Criteria: [1] included EC patients with high-risk histology (G3E, PS, CC, or CS); [2] comparison with OPS; [3] interventions included MIS (LS and RS); and 4) outcomes of recurrence or mortality rates measured as relative risks, odds ratios (ORs), or hazard ratios (HRs) with 95% confidence intervals (CIs) or availability of sufficient data for calculation **Exclusion Criteria:** Single-arm cohort studies and case reports were excluded.		Compared to OPS, MIS did not show a significant increase in mortality (HR, 0.86; 95% CI, 0.79–0.93; p < 0.001) with low cross-study heterogeneity (p = 0.106; I2 = 40.9). Publication bias was suspected in the funnel plot, but the difference was not statistically significant (Begg and Mazumdar rank correlation, p = 0.36; Egger's regression intercept, p = 0.49; classical fail-safe, N = 3) This pattern was also observed in the subgroup analyses based on the stage (early stage vs. all stage), histology (PS and CC), and MIS type (laparoscopy vs. robotic). **Author's Conclusion:** This meta-analysis of observational studies revealed that MIS did not compromise the prognosis of EC patients with high-risk histology. Well-designed randomized controlled trials could verify the results of this uncommon but deadly tumor.		

Raffone, A. et al. Laparotomic versus robotic surgery in elderly patients with endometrial cancer: A systematic review and meta-analysis. Int J Gynaecol Obstet. 157. 1-10. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 3	**Population:** Patients over the age cut-off who underwent surgery for	**Primary:** rates of overall complications associated with the surgical approach	5 studies included: Backes	

Overall confidence in the results of the review: AMSTAR II critical appraisal tool for systematic reviews: 2 critical flaws (items 7, 9), 2 non-critical flaws (items 10, 12) Overall quality of evidence: Critically Low **Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits)**: 2 Systematic review and meta-analysis of (Non - randomized controlled cohort/follow-up study) Downgrade to evidence level 3 due to low quality. Risk of bias from confounding was not assessed. Unclear, if the included studies were adjusted for confounders. Publication bias was not investigated (less than ten studies were included) **Study type:** Systematic review and meta-analysis (5 retrospective cohort studies, 7629 patients) **Databases:** MEDLINE, Google Scholar, EMBASE, Web of Sciences, Scopus, ClinicalTrial.gov, OVID, and Cochrane Library	EC. The age cut-off was 70 years for two studies,65 years for two studies, and 75 years for the remaining study **Intervention:** robotic surgery for EC (n = 1472) **Comparison:** laparotomic surgery for EC (n = 6130)	**Secondary:** rate of intra-operative complications, the rate of peri-operative complications, and the mean length of stay in hospital. **Results:** Five studies with 7629 EC patients were included. **Intraoperative and perioperative complications** Pooled RR of overall complications for robotic surgery compared with laparotomic surgery was 0.40 (95% CI 0.29–0.55, p < 0.001) with moderate heterogeneity (I2 = 76%) Pooled RR of intraoperative complications for robotic surgery compared with laparotomic surgery was 0.46 (95% CI 0.15–1.42, p = 0.18), with high heterogeneity (I 2 = 76%) Pooled RR of peri-operative complications for robotic surgery compared with laparotomic surgery for EC was 0.43 (95% CI 0.37–0.50, P < 0.001), with insignificant heterogeneity (I 2 = 14%) . At subgroup analyses, pooled RR of overall complications for robotic surgery versus laparotomic surgery was 0.34 (95% CI 0.27–0.43, P < 0.001, I 2 = 0%) in the >70 years, 0.51 (95% CI 0.37–0.71, p < 0.001, I 2 = 37%) in the >65 years, 0.20 (95% CI 0.03–1.48, p = 0.12; I 2 not applicable) in the >75 years groups. Pooled RR was 0.50 (P = 0.1) in the minor complications subgroup, and 0.42 (P =	2016, Lavoue 2014, Doo 2014, Guy 2016, Bourgin 2016	

Search period: Inception to March 2020 **Inclusion Criteria:** All peer-reviewed studies which allowed extraction of data about complications associated with laparotomic and robotic surgery for staging and treatment of elderly patients with EC were included. **Exclusion Criteria:** Studies with overlapping data with other included studies, case reports, and reviews. No restriction was applied for language.		0.002) in the major complications subgroup. **Length of stay** Pooled difference between means ± standard deviation of length of stay for robotic versus laparotomic surgery was −3.34 (95% CI −4.36 to −2.31, P < 0.001) with moderate heterogeneity (I 2 = 70%) **Author's Conclusion:** Robotics might be a viable alternative to the laparotomic approach for EC in elderly patients because it significantly decreases the risk of overall and perioperative complications (mainly major complications), and the length of stay when compared with laparotomy. The decrease in risk of overall complications is greater with increasing patient age		

Cochrane Risk of Bias Tool 1 (RCT): *2 Bewertung(en)*

Bebia, V. et al. Robot-assisted Extraperitoneal Para-aortic Lymphadenectomy Is Associated with Fewer Surgical Complications: A Post Hoc Analysis of the STELLA-2 Randomized Trial. J Minim Invasive Gynecol. 28. 2004-2012.e1. 2021

Population	Intervention / Comparison	Outcomes/Results	Methodical Notes
Evidence level: 3 **Study type:** Randomized open-label multicenter trial **Number of Patients:** 203 **Recruiting Phase:** June 2012 -	**Intervention:** extraperitoneal approach for para-aortic lymphadenectomy (n = 103) using a minimally invasive approach (either laparoscopic (n = 68) or robot-	**Primary:** Surgical complications [Time Frame: intraoperatively, within 30 days after surgery, and past 30 days after surgery up to 3 months after surgery]	**Funding Sources:** This study was funded by Instituto de Salud Carlos III (grant number: PI14/01817) and cofunded by the European

January 2019 **Inclusion Criteria:** Patients diagnosed with either initial-stage endometrial cancer (patients with tumors invading ≥50% of the myometrium, elicited by magnetic resonance imaging and/or transvaginal ultrasonography; cervical stromal involvement; grade 3 endometrial tumors; or nonendometrioid tumors) or ovarian malignancy (clinical International Federation of Gynecology and Obstetrics stage I or II) with an indication of surgical staging were eligible to participate in the study. **Exclusion Criteria:** The exclusion criteria included previous PALND, pelvic and/or aortic radiotherapy, or perioperative suspicion of advancedstage disease	assisted(n = 35)) **Comparison:** transperitoneal approach for para-aortic lymphadenectomy (n = 100) using a minimally invasive approach (either laparoscopic (n = 62) or robot-assisted (n = 38))	**Secondary:** / **Results: Surgical complications** A reduced trend in complications was observed in the extraperitoneal robot-assisted arm when considering the primary end point (X-L: 25.0%, T-L: 24.2%, X-R: 5.7%, T-R: 28.9%; p = .073). In a multivariable analysis, age (odds ratio [OR] 1.05; 95% confidence interval [CI], 1.00−1.09), body mass index (OR 1.09; 95% CI, 1.03−1.16), and waist-to-hip ratio (OR 1.66; 95% CI, 1.12−2.47) were found to independently increase the risk of PALND complications, whereas the extraperitoneal robotic approach (OR 0.13; 95% CI, 0.02−0.64) was an independent protective factor for complication occurrence. **Author's Conclusion:** Robot-assisted extraperitoneal PALND is associated with fewer surgical complications, without compromising lymph node retrieval, operative time, or length of stay. Robot-enhanced 3D visualization, surgeon ergonomics, or hemostatic precision could explain our results.	Regional Development Fund/European Social Fund. **COI:** The authors declare that they have no conflict of interest. **Randomization:** The minimally invasive approaches were not subjected to randomization. **Blinding:** Single blinded (outcome assessor was blinded) **Dropout Rate/ITT-Analysis:** All patients were analyzed. No drop-outs. **Notes:** PICO 32 Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Randomized trial) PICO 32: Cochrane risk of bias tool (Rob)-1: 1 questions(s) were considered to be unclear risk of bias; 0 question(s) were considered to be high risk of bias Overall risk of bias: Low PICO 35 and 36 Oxford Centre for Evidence-Based

			Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Randomized trial) Downgraded due to risk of bias to evidence level 3 PICO 35 and 36: Cochrane risk of bias tool (Rob)-1: 1 questions(s) were considered to be unclear risk of bias; 2 question(s) were considered to be high risk of bias Overall risk of bias: High Post-hoc analysis of the STELLA-2 trial

Reijntjes, B. et al. Recurrence and survival after laparoscopy versus laparotomy without lymphadenectomy in early-stage endometrial cancer: Long-term outcomes of a randomised trial. Gynecol Oncol. 164. 265-270. 2022

Population	Intervention / Comparison	Outcomes/Results	Methodical Notes
Evidence level: 2 **Study type:** Randomized trial **Number of Patients:** 263 **Recruiting Phase:** Between February 2007 and January 2009 **Inclusion Criteria:** Early stage endometrial cancer patients	**Intervention:** Total laparoscopic hysterectomy (TLH) without lymphadenectomy **Comparison:** Total abdominal	**Primary:** 5-year DFS (5y-DFS), calculated as the time interval from the date of hysterectomy to the date of first recurrence. Patients without disease recurrence after 5 years, who died from other causes, or who were lost to follow-up, were censored at	**Funding Sources:** There was no outside funding or technical assistance with the production of this article. **COI:** The authors declare no conflicts of interest. **Randomization:** The patients to be

(endometrioid adenocarcinoma grade 1 or 2, clinically stage I disease, negative endocervical curettage), after signed written informed consent, age 18 years and older are eligible for this trial. **Exclusion Criteria:** Exclusion criteria: other histological types than endometrioid adenocarcinoma of the endometrium, clinically advanced disease (stage II to IV), uterine size larger than conform 10 weeks gestation and cardio pulmonary contra indications for laparoscopy.	hysterectomy (TAH) without lymphadenectomy	that time. **Secondary:** 5-year OS (5y-OS), the 5-year DSS (5y-DSS), and the primary site of recurrence. The 5y-OS and the 5y-DSS were recorded as the time intervals from the date of hysterectomy to the dates of death from any cause and EC, respectively. Primary site of recurrence was classified as port-site or wound metastasis only, local recurrence only (i.e., vaginal vault), regional recurrence only (i.e., pelvic), distant metastasis only, or multiple sites. **Results:** In total, 279 women underwent a surgical procedure, of whom 263 (94%) had follow-up data. **Disease-free survival** During the 5-year follow-up period, 29 patients developed recurrence, of which 16 (9.7%) were in the TLH group and 13 (15.9%) were in the TAH group. The 5y-DFS were 90.3% in the TLH group and 84.1% in the TAH group. The aHR for EC recurrence was 0.69 (95%CI, 0.31–1.52), p = 0.19 **Overall survival** Overall, 38 patients (19 per treatment arm) died during the 5 years of follow-up, giving 5y-OS rates of 89.2% for the TLH group and 82.8% for the TAH group. The aHR for overall mortality was 0.60 (95%CI, 0.30–1.19), p = 0.06	enrolled in this trial are allocated to the TAH or TLH arm by computer randomization. For randomization, blocks of x patients are created such that balance is enforced within each block, stratified per center **Blinding:** An independent Complication Review Board of three experienced clinicians is asked to assess and judge all recorded complications and differentiate between major and minor complications, blinded to treatment arm. **Dropout Rate/ITT-Analysis:** ITT-analysis was performed. 16 patients were lost to follow-up (10 in the TLH group and 6 in the TAH group). Patients included in the current analysis were comparable to those who were lost to follow-up. **Notes: Cochrane risk of bias tool (Rob)-1:** 2 questions(s) were considered to be unclear risk of bias; 0 question(s) were considered to be high risk of bias Overall risk of bias: Low **Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits):** 2 (Randomized trial)

		Disease-specific survival Similarly, 18 patients (9 per treatment arm) died due to EC during the 5 years of follow-up, giving estimated 5y-DSS rates of 95.0% in the TLH group and 89.8% in the TAH group. The aHR for EC-specific mortality did not reach a statistically significant difference (0.62; 95%CI, 0.23–1.70), p = 0.17 At a 10% significance level, and with a non-inferiority margin of 0.20, we could reject the null hypothesis of inferiority for all three outcomes. At a 5% significance level, and at the same non-inferiority margin of 0.20, only OS was significantly non-inferior, while for the other outcomes the null hypothesis of inferiority could not be rejected **Author's Conclusion:** Disease recurrence and 5-year survival rates were comparable between the TLH and TAH groups and comparable to studies with lymphadenectomy, supporting the widespread use of TLH without lymphadenectomy as the primary treatment for early-stage, low-grade endometrial cancer	5-year Follow-up data from the Dutch TLH-TAH trial

3.16. Schlüsselfrage 36

Wie ist der Stellenwert robotergestützter operativer Verfahren beim Endometriumkarzinom im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben

Population Frauen mit EC
Intervention: Laparotomie
Comparison: Laparoskopie-Roboter-gestützte OP
Outcomes: Morbidität, Mortalität, Lebensqualität

Inhalt: *4 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Bebia, V. 2021	3	Randomized open-label multicenter trial
Kosa, S. D. 2022	3	Prospective cohort study
Liu, H. 2022	3	Systematic review and meta-analysis (29 observational studies, one RCT)
Raffone, A. 2022	3	Systematic review and meta-analysis (5 retrospective cohort studies, 7629 patients)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *2 Bewertung(en)*

Liu, H. et al. Effectiveness of robotic surgery for endometrial cancer: a systematic review and meta-analysis. Arch Gynecol Obstet. 305. 837-850. 2022				
Evidence level/Study Types	**P - I - C**	**Outcomes/Results**	**Literature References**	

Evidence level: 3 **Overall confidence in the results of the review:** AMSTAR II critical appraisal tool for systematic reviews: 5 critical flaws (items 2, 7, 9, 11, 13), 3 non-critical flaws (items 10, 12, 14) Overall quality of evidence: Critically low **Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits)**: 2 Systematic review and meta-analysis of (Non - randomized controlled cohort/follow-up study) **Downgraded to level 3 due to methodological weakness.** No quality assessment of the included studies was performed by the authors. Substantial heterogeneity was present, which was not further explored or discussed by the authors. **Study type:** Systematic review and meta-analysis (29 observational studies, one RCT) **Databases:** Embase, Cochrane library and PubMe	**Population:** Patient with EC **Intervention:** Roboter surgery **Comparison:** laparoscopic surgery (LPS) / laparotomy (LT)	**Primary:** operative time, estimated blood loss, blood transfusion, total complications, intraoperative complications, postoperative complications, hospital stay, readmission, re-operation, conversion, pelvic lymph nodes harvested (PLNH), total lymph nodes harvested (TLNH), as well as para-aortic lymph nodes harvested (PALNH). **Secondary:** **Results:** Thirty studies involving a total of 12,025 patients were eventually included in the current meta-analysis. **Operative time** There was no significant difference of operative time (WMD: 18.697, 95% CI − 2.999 to 40.393) between RS and LPS (I2 = 99.9%). Compared with LT, RS evidently increased the operative time (WMD: 29.412, 95% CI 9.239–49.586) (I2 = 100%) **Blood loss and blood transfusion** RS significantly decreased blood loss compared with LPS (WMD: − 48.406, 95% CI − 64.091 to − 32.721, I2 = 99,4%) and LT (WMD: − 173.490, 95% CI − 213.582 to − 133.397, I2 = 100%). Our analysis identified no significant difference in	30 studies (12.205 patients included): Bell 2008a, Bell 2008b, Boggess 2008a, Boggess 2008b, Cardenas-Goicoechea 2010, Chiou 2015a, Chiou 2015b, Coronado 2015a, Coronado 2015b, Corrado 2015a, Corrado 2015b, DeNardis 2008, Eklind 2015, ElSahwi 2012, Escobar 2012, Estape 2011a, Estape 2011b, Goel 2011, Fagotti 2012, Johnson 2016a, Johnson 2016b, Wook Jung 2010a, Wook Jung 2010b, Mäenpää 2016, Magrina 2008a, Magringa 2008b, Manchana 2015a, Manchana 2015b, Mok 2012, Park 2015, Pulman 2016a, Pulman 2016b, Seamon 2009, Seror 2014, Shah 2011a, Shah 2011b, Turunen 2013, Venkat 2012, Lindfors 2020, Casarin 2019, Song 2019	

Search period: Inception until June 2021 **Inclusion Criteria:** (1) they were studies of randomized controlled trials or case-control studies; (2) patients with EC were enrolled as participants; (3) patients receiving RS were allocated as the experimental group, and patients receiving LPS or LT were allocated as the control groups; (4) Chinese or English publications were available for the current study. **Exclusion Criteria:** (1) studies of duplicate articles or with repeated results; (2) studies with clear data errors; (3) systematic reviews, case reports, conference reports, theoretical research, meta-analyses, and other forms of researches or commentaries that were not designed in a randomized controlled manner; (4) studies of irrelevant outcomes; (5) studies with no control group.		blood transfusion (RR: 0.722, 95% CI 0.436–1.194, I2 0%) between RS and LPS. Compared with LT, RS was linked to markedly decreased blood transfusion (RR: 0.416, 95% CI 0.347–0.499, I2 = 19.1%). **Total complications** No significant difference was associated with the rate of total complications (RR: 0.836, 95% CI 0.648–1.080, I2 = 12%) between RS and LPS. Compared with LT, RS was linked to markedly decreased rate of total complications (RR: 0.571, 95% CI 0.521–0.625, I2 = 44.9%). **Intraoperative complications and postoperative complications** RS significantly decreased the rate of intraoperative complications compared with LPS (RR: 0.370, 95% CI 0.200–0.685, I2 = 0%) and LT (RR: 0.386, 95% CI 0.268–0.556, I2 = 38.8%). Our analysis found no significant difference when comparing postoperative complications (RR: 1.155, 95% CI 0.858–1.555, I2 = 56.2%) between RS and LPS. Compared with LT, RS was highly associated with decreased postoperative complications (RR: 0.511, 95% CI 0.366–0.713, I2 = 0%). **Length of hospital stay** RS significantly decreased the length of hospital stay in comparison of LPS (WMD:		

		− 0.363, 95% CI − 0.619 to − 0.106, I2 = 99,7%) and LT (WMD: − 2.528, 95% CI − 3.317 to − 1.740, I2 = 100%). **Re-admission and re-operation and conversion rate** RS significantly increased the rate of readmission compared with LPS (RR: 2.623, 95% CI 1.085–6.342, I2 = 0%) while it decreased the rate of readmission compared with LT (RR: 0.586, 95% CI 0.476–0.721, I2 = 0%). No significant difference was observed when comparing the rate of re-operation (RR: 0.440, 95% CI 0.104–1.864, I2 = 61%) between RS and LPS. Compared with LT, RS significantly decreased the re-operation (RR: 0.295, 95% CI 0.120–0.727, I2 = 0%). RS significantly decreased the conversion rate compared with LPS (RR: 0.446, 95% CI 0.286–0.694, I2 = 0%). **TLNH, PLN and PALNH** The present results showed no significant difference in terms of the number of TLNH in subgroup analysis of RS versus LPS (WMD: 0.545, 95% CI − 4.813 to 5.903, I2 = 96,8%), and RS versus LT (WMD: 2.528, 95% CI − 0.667 to 5.723, I2 = 88.6%). Based on results of analysis, we identified no significant difference in the number of PLNH in subgroup analysis of RS versus LPS (WMD: 1.563, 95% CI − 0.190 to		

		3.317, I2 97,5%), and RS versus LT (WMD: 1.327, 95% CI − 0.495 to 3.150, I2 = 97,6%). There was no significant difference in terms of the number of PALNH in subgroup analysis of RS versus LPS (WMD: − 0.328, 95% CI − 2.276 to 1.621, I2 = 99,6%), and RS versus LT (WMD: 0.215, 95% CI − 3.480 to 3.910, I2 = 99,9%). **Author's Conclusion:** Considering the efects and safety profle of RS in terms of treating endometrial cancer, our study suggest that RS exerts superior outcomes than that of LPS and LT.		

Raffone, A. et al. Laparotomic versus robotic surgery in elderly patients with endometrial cancer: A systematic review and meta-analysis. Int J Gynaecol Obstet. 157. 1-10. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 3 **Overall confidence in the results of the review:** AMSTAR II critical appraisal tool for systematic reviews: 2 critical flaws (items 7, 9), 2 non-critical flaws (items 10, 12) Overall quality of evidence: Critically	**Population:** Patients over the age cut-off who underwent surgery for EC. The age cut-off was 70 years for two studies,65 years for two studies, and 75 years for the remaining study **Intervention:** robotic surgery for EC (n = 1472)	**Primary:** rates of overall complications associated with the surgical approach **Secondary:** rate of intra-operative complications, the rate of peri-operative complications, and the mean length of stay in hospital. **Results:** Five studies with 7629 EC patients	5 studies included: Backes 2016, Lavoue 2014, Doo 2014, Guy 2016, Bourgin 2016	

Low **Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits)**: 2 Systematic review and meta-analysis of (Non - randomized controlled cohort/follow-up study) Downgrade to evidence level 3 due to low quality. Risk of bias from confounding was not assessed. Unclear, if the included studies were adjusted for confounders. Publication bias was not investigated (less than ten studies were included) **Study type:** Systematic review and meta-analysis (5 retrospective cohort studies, 7629 patients) **Databases:** MEDLINE, Google Scholar, EMBASE, Web of Sciences, Scopus, ClinicalTrial.gov, OVID, and Cochrane Library **Search period:** Inception to March 2020 **Inclusion Criteria:** All peer-reviewed studies which allowed extraction of data about	**Comparison:** laparotomic surgery for EC (n = 6130)	were included. **Intraoperative and perioperative complications** Pooled RR of overall complications for robotic surgery compared with laparotomic surgery was 0.40 (95% CI 0.29–0.55, p < 0.001) with moderate heterogeneity (I2 = 76%) Pooled RR of intraoperative complications for robotic surgery compared with laparotomic surgery was 0.46 (95% CI 0.15–1.42, p = 0.18), with high heterogeneity (I 2 = 76%) Pooled RR of peri-operative complications for robotic surgery compared with laparotomic surgery for EC was 0.43 (95% CI 0.37–0.50, P < 0.001), with insignificant heterogeneity (I 2 = 14%) . At subgroup analyses, pooled RR of overall complications for robotic surgery versus laparotomic surgery was 0.34 (95% CI 0.27–0.43, P < 0.001, I 2 = 0%) in the >70 years, 0.51 (95% CI 0.37–0.71, p < 0.001, I 2 = 37%) in the >65 years, 0.20 (95% CI 0.03–1.48, p = 0.12; I 2 not applicable) in the >75 years groups. Pooled RR was 0.50 (P = 0.1) in the minor complications subgroup, and 0.42 (P = 0.002) in the major complications subgroup. **Length of stay** Pooled difference between means ± standard deviation of length of stay for robotic versus laparotomic surgery was −3.34 (95% CI −4.36 to −2.31, P < 0.001) with moderate		

complications associated with laparotomic and robotic surgery for staging and treatment of elderly patients with EC were included. **Exclusion Criteria:** Studies with overlapping data with other included studies, case reports, and reviews. No restriction was applied for language.		heterogeneity (I 2 = 70%) **Author's Conclusion:** Robotics might be a viable alternative to the laparotomic approach for EC in elderly patients because it significantly decreases the risk of overall and perioperative complications (mainly major complications), and the length of stay when compared with laparotomy. The decrease in risk of overall complications is greater with increasing patient age		

Cochrane Risk of Bias Tool 1 (RCT): *1 Bewertung(en)*

Bebia, V. et al. Robot-assisted Extraperitoneal Para-aortic Lymphadenectomy Is Associated with Fewer Surgical Complications: A Post Hoc Analysis of the STELLA-2 Randomized Trial. J Minim Invasive Gynecol. 28. 2004-2012.e1. 2021

Population	Intervention / Comparison	Outcomes/Results	Methodical Notes
Evidence level: 3 **Study type:** Randomized open-label multicenter trial **Number of Patients:** 203 **Recruiting Phase:** June 2012 - January 2019 **Inclusion Criteria:** Patients diagnosed with either initial-stage endometrial cancer (patients with tumors invading ≥50% of the myometrium, elicited by magnetic resonance imaging and/or	**Intervention:** extraperitoneal approach for para-aortic lymphadenectomy (n = 103) using a minimally invasive approach (either laparoscopic (n = 68) or robot-assisted(n = 35)) **Comparison:** transperitoneal approach for para-aortic lymphadenectomy (n = 100) using a minimally invasive approach (either	**Primary:** Surgical complications [Time Frame: intraoperatively, within 30 days after surgery, and past 30 days after surgery up to 3 months after surgery] **Secondary:** / **Results: Surgical complications** A reduced trend in complications was observed in the extraperitoneal robot-assisted arm when considering the primary end point (X-L: 25.0%, T-L: 24.2%, X-R: 5.7%, T-R: 28.9%; p =	**Funding Sources:** This study was funded by Instituto de Salud Carlos III (grant number: PI14/01817) and cofunded by the European Regional Development Fund/European Social Fund. **COI:** The authors declare that they have no conflict of interest. **Randomization:** The minimally invasive

transvaginal ultrasonography; cervical stromal involvement; grade 3 endometrial tumors; or nonendometrioid tumors) or ovarian malignancy (clinical International Federation of Gynecology and Obstetrics stage I or II) with an indication of surgical staging were eligible to participate in the study. **Exclusion Criteria:** The exclusion criteria included previous PALND, pelvic and/or aortic radiotherapy, or perioperative suspicion of advancedstage disease	laparoscopic (n = 62) or robot-assisted (n = 38))	.073). In a multivariable analysis, age (odds ratio [OR] 1.05; 95% confidence interval [CI], 1.00−1.09), body mass index (OR 1.09; 95% CI, 1.03−1.16), and waist-to-hip ratio (OR 1.66; 95% CI, 1.12−2.47) were found to independently increase the risk of PALND complications, whereas the extraperitoneal robotic approach (OR 0.13; 95% CI, 0.02−0.64) was an independent protective factor for complication occurrence. **Author's Conclusion:** Robot-assisted extraperitoneal PALND is associated with fewer surgical complications, without compromising lymph node retrieval, operative time, or length of stay. Robot-enhanced 3D visualization, surgeon ergonomics, or hemostatic precision could explain our results.	approaches were not subjected to randomization. **Blinding:** Single blinded (outcome assessor was blinded) **Dropout Rate/ITT-Analysis:** All patients were analyzed. No drop-outs. **Notes:** PICO 32 Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Randomized trial) PICO 32: Cochrane risk of bias tool (Rob)-1: 1 questions(s) were considered to be unclear risk of bias; 0 question(s) were considered to be high risk of bias Overall risk of bias: Low PICO 35 and 36 Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Randomized trial) Downgraded due to risk of bias to evidence level 3

			PICO 35 and 36: Cochrane risk of bias tool (Rob)-1: 1 questions(s) were considered to be unclear risk of bias; 2 question(s) were considered to be high risk of bias Overall risk of bias: High Post-hoc analysis of the STELLA-2 trial

NEWCASTLE - OTTAWA Checklist: Cohort: *1 Bewertung(en)*

Kosa, S. D. et al. A prospective comparison of costs between robotics, laparoscopy, and laparotomy in endometrial cancer among women with Class III obesity or higher. J Surg Oncol. 125. 747-753. 2022

Evidence level	Methodical Notes	Patient characteristics	Interventions
Evidence level: 3 **Study type:** Prospective cohort study	**Funding sources:** Ontario Academic Health Sciences Centre Innovation Fund; University of Toronto Division of Gynecologic Oncology McArthur fund; Princess Margaret Cancer Foundation **Conflict of Interests:** None **Randomization:** /	**Total no. patients:** 103 **Recruiting Phase:** February 2012 and May 2014 **Inclusion criteria:** GOC-2 study: Patients had any type of histologically confirmed early stage cancer of the endometrium, ECOG Performance status of 0–1, and preoperative health was graded as ASA I–III, were a suitable candidate for surgery, female, 18 years of age or older, able to complete baseline questions either on their own or with assistance, and willing to comply with scheduled visits, and consented to participate	**Interventions:** robotic-assisted laparoscopy group, laparotomy and non-robotic assisted laparoscopy group **Comparison:** /

	Blinding: / **Dropout rates:** /	Of the sample of 520 patients from the GOC-2 study, 103 women with BMI of 40 or greater were included in these analyses. **Exclusion criteria:** Patients were excluded if they had major abdominal surgery or chemotherapy or radiation within 3 months before the baseline visit, evidence of diffuse peritoneal carcinomatosis by imaging or clinical exam or were unfit for surgery	
Notes:	Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 3 (Non-randomized controlled cohort/follow-up study) **Newcastle-Ottawa Scale (NOS) for cohort studies:** 7/9 stars. Secondary analysis of patients with EC with a BMI greater than or equal to 40 in the GOC-2 study **Author's conclusion:** There was no difference in overall costs between the three surgical modalities in patient with BMI ≥ 40. Given the similar costs, any form of minimally invasive surgery should be promoted in this population.		
Outcome Measures/results	**Primary** Median OR, inpatient, and overall costs across the three surgical groups **Secondary** /	**Results:** Of the sample of 520 patients from the GOC-2 study, 103 women with BMI of 40 or greater were included in these analyses of whom 22 had laparotomy, 13 had non-robotic assisted laparoscopy and 68 had robotic-assisted laparoscopy **Operating room costs** Among women with BMI greater than or equal to 40, the median OR costs were lowest at $4197.02 for laparotomy, followed by $5524.63 for non-robotic assisted laparoscopy, and highest at $7225.16 for robotic- assisted laparoscopy ($p < 0.001$, Table 2, Figure 1). In pairwise comparisons, laparotomy and non-robotic assisted laparoscopy did not have significantly different OR costs. However, the differences observed between laparotomy and robotic-assisted laparoscopy were significant ($p < 0.001$), as were the differences observed between non-robotic assisted laparoscopy and	

		robotic-assisted laparoscopy (p = 0.019). **Inpatient costs** Among women with BMI greater than or equal to 40, the median inpatient costs were highest at $5584.28 for laparotomy, followed by $3042.07 for non-robotic assisted laparoscopy, and lowest at $1794.51 for robotic-assisted laparoscopy (p < 0.001). In pairwise comparisons, the differences between robotic-assisted laparoscopy and non-robotic assisted laparoscopy were not statistically significant (p = 0.271). However, the differences between robotic-assisted laparoscopy and laparotomy (p < 0.001), as well as non-robotic assisted laparoscopy and laparotomy (p = 0.021), were statistically significant. **Overall costs** Among women with BMI greater than or equal to 40, the differences in the median overall costs were not statistically significant: $10291.50 for laparotomy, $8412.63 for non-robotic assisted laparoscopy, and $9002.48 for robotic-assisted laparoscopy (p = 0.185) **Complications** For intra- operative complications among those with a BMI greater than 40, there were no statistically significant differences (5/65 for robotic-assisted laparoscopy, 0/12 for non-robotic assisted laparoscopy, and 0/19 for Laparotomy, p = 0.63). Similarly, for perioperative complications, there were no statistically significant differences (6/65 for robotic-assisted laparoscopy vs. 1/12 for non-robotic assisted laparoscopy vs. 5/19 for laparotomy, p = 0.14).

3.17. Schlüsselfrage 39

Bei welchen Stadien bzw. histolog. Typen des Endometriumkarzinoms ist eine adjuvante externe (perkutane) Strahlentherapie in Kombination mit Brachytherapie indiziert im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben?

Population: Frauen mit EC:
- Typ I, pT1a, G1/2
- Typ I, pT1a, G3; pT1 b, G1/2
- Typ I, pT1b, G3

· Typ I, pT2 bis pTIV b, G1-3
· Typ II
Intervention: Adjuvante kombinierte Strahlentherapie (perkutan) + Brachytherapie
Comparison: nur perkutane Strahlentherapie
Outcomes: Verbesserung Lebensqualität, Kurzzeit-/ Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Inhalt: *1 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Ragab, O. M. 2022	3	Retrospective cohort study

NEWCASTLE - OTTAWA Checklist: Cohort: *1 Bewertung(en)*

Ragab, O. M. et al. Incorporation of vaginal brachytherapy to external beam radiotherapy in adjuvant therapy for high-risk early-stage cervical cancer: A comparative study. Brachytherapy. 21. 141-150. 2022

Evidence level	Methodical Notes	Patient characteristics	Interventions
Evidence level: 3 **Study type:** Retrospective cohort study	**Funding sources:** Not declared. **Conflict of Interests:** Declared. **Randomization:** - **Blinding:** - **Dropout rates:** no description	**Total no. patients:** 2470 women with high-risk early-stage cervical cancer who underwent primary hysterectomy and re- ceived adjuvant radiotherapy with EBRT during the study period **Recruiting Phase:** from 2000 to 2018. **Inclusion criteria:** Surgically treated women with American Joint Commission on Cancer (AJCC) stage T1-2 cervical cancer who had high- risk factors and received adjuvant radiotherapy with EBRT from 2000	**Interventions:** EBRT alone without VBT. **Comparison:** EBRT with VBT (EBRT-VBT).

		to 2018 were examined. Histology types were limited to squamous, adenocarcinoma, and adenosquamous carcinoma. **Exclusion criteria:** Histology types other than above, cancer stage unknown or other than above (includ- ing AJCC M1/Mx), no hysterectomy, no or unknown lym- phadenectomy, radiotherapy before or during hysterectomy, chemotherapy before hysterectomy, non–high-risk group disease, and absence of adjuvant radiotherapy with EBRT.	
Notes:	Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 3 (Non-randomized controlled cohort/follow-up study) Newcastle-Ottawa Scale (NOS) for Cohort studies / Case control studies: 8/9 stars. **Author's conclusion:** Utilization of VBT with EBRT for adjuvant radiotherapy in high-risk early- stage cervical cancer is increasing in the United States. Addition of VBT was associated with neither overall survival nor cancer-specific survival. © 2021 American Brachytherapy Society. Published by Elsevier Inc. All rights reserved		
Outcome Measures/results	**Primary** overall survival (OS), defined as the time interval between the cervical can- cer diagnosis and death from any cause (all-cause). Women without a survival event at the last followup were censored. **Secondary** Utilization of adjuvant therapy during the study period.	**Results: 5-year OS rate** 73.8% (95% CI 70.6–77.2) for the EBRT-VBT group and 77.4% (95% CI 75.3–79.6) for the EBRT alone group. The EBRT-VBT group and the EBRT alone group had comparable OS (HR 1.07, 95% CI 0.92– 1.25, p = 0.364). **Utilization of adjuvant therapy during the study period.** The utilization of VBT with EBRT gradually increased from 27.4% to 36.1% between 2000 and 2018 (p< 0.001). When examined by patient and tumor factors, a significant increase in VBT use was observed in the subgroups with nodal metastasis or both node metastasis / parametrial tumor involvement, squamous	

		tumors, aged ≥45 years, high lymph node ratio, chemotherapy use, and modified/radical hysterectomy (all, p< 0.05)

3.18. Schlüsselfrage 41

Welchen Stellenwert hat eine kombinierte Radiochemotherapie (sequenziell/simultan) im Vergleich zu anderen Verfahren (alleinige Radiatio, pelvin +/- paraaortale Bestrahlung, Abdomenganzbestrahlung, alleinige Chemotherapie) beim Endometriumkarzinom in Bezug auf Kurzzeit-/ Langzeitmorbidität, krankheitsspezifisches Gesamt-Überleben und Rezidivhäufigkeit?

Population: Frauen mit EC
Intervention: adjuvante kombinierte Radio-chemotherapie (sequenziell/simul-tan)
Comparison:
· adjuvante Strahlentherapie
· adjuvante pelvine +/- paraaortale Bestrahlung
· adjuvante Abdomenganz-bestrahlung
alleinige adjuvante Chemotherapie
Outcomes: Verbesserung Lebensqualität, Kurzzeit-/ Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspe-zifisches und Gesamtüberleben

Inhalt: *2 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Matulonis, U. A. 2022	2	phase III randomized trial
Zhang, G. 2022	2	Systematic review and meta-analysis (10 Observational studies and 1 RCT)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

Zhang, G. et al. Adjuvant chemoradiotherapy versus chemotherapy alone in stage III endometrial cancer: A systematic review and meta-analysis. J Obstet Gynaecol Res. 48. 1888-1896. 2022				
Evidence level/Study Types	**P - I - C**	**Outcomes/Results**	**Literature References**	

Evidence level: 2 **Overall confidence in the results of the review:** Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 Systematic review and meta-analysis of (Non -randomized controlled cohort/follow-up study) AMSTAR II critical appraisal tool for systematic reviews: 2 critical flaws (items 2,7), 3 non-critical flaws (items 5,6,10) Overall quality of evidence: Critically low Notes: predominantly observational studies (10) vs one RCT included. **Study type:** Systematic review and meta-analysis (10 Observational studies and 1 RCT) **Databases:** PubMed and EMBASE. **Search period:** Inception - December 19th, 2021. **Inclusion Criteria:** FIGO stage III EC and reported survival outcomes of stage III EC were enrolled, and those reporting data from subsets of stage III EC were also acceptable. Those includ- ing CRT and CT as adjuvant therapies were enrolled, whether retrospective studies or randomized control trials (RCT). Those reporting survival outcomes in terms of overall survival (OS) and RFS	**Population:** stage III EC patients. **Intervention:** Chemoradiotherapy **Comparison:** Chemotherapy	**Primary:** Overall survival and relapse-free survival **Secondary:** Subgroup analyses. **Results: Overall survival** CRT (n = 962) vs CT (n = 519), 8 studies HR 0.59 (0.49 to 0.70), I2 = 0%, Favors CRT **Relapse-free survival** CRT (n = 1061) vs CT (n = 609), 7 studies HR 0.66 (0.47 to 0.93), I2 = 69%, Favors CRT **Author's Conclusion:** CRT was associated with a better OS and RFS than CT alone in stage III EC patients.	11 studies included (1 RCT, 10 observational) Matei, Marchetti, Pichatechaiyoot, Binder, Lee, Albuquerque, Mayadev, Kahramanoglu, Weelden, Lee, Bogani.

were enrolled. OS was defined as the duration between the date of surgery and the date of death from any cause or the date of the last visit. RFS was defined as the duration between the date of surgery and the date of the first recurrence or the date of death from any cause, whichever occurred first, or the date of last visit for patients alive without recurrence. **Exclusion Criteria:** Not published in English, not full-paper available were excluded. Also, large pub- lic databases from the United States, for example, the National Cancer Data Base (NCDB) and the Surveil- lance, Epidemiology, and End Results (SEER) program, articles based upon which might cause case duplication with the more needed mono/multi-center studies, were excluded from our research.				

Cochrane Risk of Bias Tool 1 (RCT): *1 Bewertung(en)*

Matulonis, U. A. et al. Patient reported outcomes for cisplatin and radiation followed by carboplatin/paclitaxel versus carboplatin/paclitaxel for locally advanced endometrial carcinoma: An NRG oncology study. Gynecol Oncol. 164. 428-436. 2022

Population	Intervention / Comparison	Outcomes/Results	Methodical Notes
Evidence level: 2 **Study type:** phase III randomized trial **Number of Patients:** 736 women with newly diagnosed endometrial cancer stages III or IVA **Recruiting Phase:** June 29, 2009	**Intervention:** cisplatin and radiation followed by carboplatin/paclitaxel (Cis-RT+CP) **Comparison:** carboplatin/paclitaxel (CP) only	**Primary:** Patient-reported QOL during and following treatment for up to 1 year with the two treatment regimens. **Secondary:** - **Results: physical well-being (PWB) subscale score:** After starting treatment, treatment-	**Funding Sources:** Declared, governmental funding. **COI:** Declared, see article for list. **Randomization:** The two treatment regimens were

and July 28, 2014 **Inclusion Criteria:** Women who were 18 years of age or older and who had surgical stage III or IVA endometrial carcinoma according to FIGO 2009 staging criteria of any histologic subtype or had FIGO 2009 surgical stage I or II clear-cell or serous endometrial carcinoma and peritoneal washings that were positive for cancer cells. **Exclusion Criteria:** Patients with carcinosarcoma or recurrent endometrial carcinoma were excluded.		induced differences in the PWB sub-scale score varied significantly over assessment time (p-value = 0.003 for the interaction between time and treatment groups). After adjustment for patient's age and baseline score, the patients receiving Cis RT + CP reported 1.7 points lower/worse (95% CI: 0.9–2.6; adjusted p < 0.001) physical well-being at 18 weeks (end of treatment) when compared to those on CP. The treatment difference continued to be statistically significant at the 1-year post-treatment evaluation/follow- up visit (0.9 points lower on Cis-RT + CP group; 95% CI: 0.2–1.7; adjusted p = 0.035). **The functional well-being (FWB) subscale score:** Since initiating protocol treatment, the treatment differences in the FWB subscale scores varied significantly over assessment time (p- value = 0.036 for the interaction between time and treatment groups). After adjustment for patient's age and baseline score, the patients re- ceiving Cis-RT + CP reported 1.9 points lower/worse (95% CI: 1.0–2.8; adjusted p < 0.001) functional well-being at 18 weeks (end of treat- ment) as compared to those on CP. **The endometrial cancer subscale**	randomly assigned in a 1:1 ratio within permuted blocks. **Blinding:** Not blinded **Dropout Rate/ITT-Analysis:** Dropouts described, uneven per group. No mention of intention-to-treat analysis. **Notes:** Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Randomized trial) Cochrane risk of bias tool (Rob)-1: 1 questions(s) were considered to be unclear risk of bias; 1 question(s) were considered to be high risk of bias Overall risk of bias: Low Notes: Dropout rates were higher in some groups, no intention-to-treat analysis was performed.

		(ECS) score Following protocol treatment initiation, treatment differences in the ECS subscale score did not vary significantly over assessment time (p- value = 0.07 for the interaction between time and treatment groups). After adjustment for patient's age and baseline score, the patients re- ceiving Cis-RT + CP reported a non-clinically meaningful 1.0 points lower/worse (95% CI: 0.2–1.8; p = 0.011) endometrial cancer concerns. **Author's Conclusion:** ROs indicate that the chemoradiotherapy group experienced worse HRQoL and GI toxicity com- pared to patients randomized to chemotherapy alone for locally advanced endometrial cancer though based on the MID, these were not clinically meaningful differences. The GI symptom subscale was a reliable and valid scale that has value for future trials.	

3.19. Schlüsselfrage 43

Wie ist der Stellenwert der adjuvanten Chemotherapie beim Endometriumkarzinom im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben?

Population: Frauen mit EC
Intervention: adjuvante Chemotherapie
Comparison: keine adjuvante Chemotherapie
Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamtüberleben

Inhalt: *2 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Egawa-Takata, T. 2022	3	Randomized phase II study
Zhang, G. 2022	2	Systematic review and meta-analysis (10 Observational studies and 1 RCT)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

Zhang, G. et al. Adjuvant chemoradiotherapy versus chemotherapy alone in stage III endometrial cancer: A systematic review and meta-analysis. J Obstet Gynaecol Res. 48. 1888-1896. 2022				
Evidence level/Study Types	**P - I - C**	**Outcomes/Results**	**Literature References**	
Evidence level: 2 **Overall confidence in the results of the review:** Oxford Centre for Evidence-Based	**Population:** stage III EC patients. **Intervention:** Chemoradiotherapy	**Primary:** Overall survival and relapse-free survival **Secondary:** Subgroup	11 studies included (1 RCT, 10 observational) Matei, Marchetti, Pichatechaiyoot, Binder,	

Medicine 2011 Levels of Evidence (Treatment benefits): 2 Systematic review and meta-analysis of (Non -randomized controlled cohort/follow-up study) AMSTAR II critical appraisal tool for systematic reviews: 2 critical flaws (items 2,7), 3 non-critical flaws (items 5,6,10) Overall quality of evidence: Critically low Notes: predominantly observational studies (10) vs one RCT included. **Study type:** Systematic review and meta-analysis (10 Observational studies and 1 RCT) **Databases:** PubMed and EMBASE. **Search period:** Inception - December 19th, 2021. **Inclusion Criteria:** FIGO stage III EC and reported survival outcomes of stage III EC were enrolled, and those reporting data from subsets of stage III EC were also acceptable. Those includ- ing CRT and CT as adjuvant therapies were enrolled, whether retrospective studies or randomized control trials (RCT). Those reporting survival outcomes in terms of overall survival (OS) and RFS were enrolled. OS was defined as the duration between the date of surgery and the date of death from any cause or the date of the last visit. RFS was defined as the duration between the date of surgery and the date of the first recurrence or the	**Comparison:** Chemotherapy	analyses. **Results: Overall survival** CRT (n = 962) vs CT (n = 519), 8 studies HR 0.59 (0.49 to 0.70), I2 = 0%, Favors CRT **Relapse-free survival** CRT (n = 1061) vs CT (n = 609), 7 studies HR 0.66 (0.47 to 0.93), I2 = 69%, Favors CRT **Author's Conclusion:** CRT was associated with a better OS and RFS than CT alone in stage III EC patients.	Lee, Albuquerque, Mayadev, Kahramanoglu, Weelden, Lee, Bogani.	

date of death from any cause, whichever occurred first, or the date of last visit for patients alive without recurrence. **Exclusion Criteria:** Not published in English, not full-paper available were excluded. Also, large pub- lic databases from the United States, for example, the National Cancer Data Base (NCDB) and the Surveil- lance, Epidemiology, and End Results (SEER) program, articles based upon which might cause case duplication with the more needed mono/multi-center studies, were excluded from our research.				

Cochrane Risk of Bias Tool 1 (RCT): *1 Bewertung(en)*

Egawa-Takata, T. et al. Adjuvant Chemotherapy for Endometrial Cancer (ACE) trial: A randomized phase II study for advanced endometrial carcinoma. Cancer Sci. 113. 1693-1701. 2022

Population	Intervention / Comparison	Outcomes/Results	Methodical Notes
Evidence level: 3 **Study type:** Randomized phase II study **Number of Patients:** 101 Endometrioid cancer patients with intermediate- risk stage I and II or high-risk stage III and IV disease **Recruiting Phase:** Between 2013 and 2016 **Inclusion Criteria:** Histologically diagnosed with primary endometrial carcinoma. The patient should have	**Intervention:** six cycles of either paclitaxel-epirubicin-carboplatin (TEC) **Comparison:** , paclitaxel-anthracycline (doxorubicin)-carboplatin (TAC), dose- dense	**Primary:** Completion rate (CRate) of six cycles of treatment **Secondary:** Progression-free survival (PFS) and overall survival (OS **Results: Primary: Completion rate of six cycles of treatment:** TEC vs. TAC vs. ddTC 94% (31/33) vs. 61% (20/33) vs. 69% (24/35). **2-year PFS rate** TEC vs. TAC vs. ddTC 88%, 82%, and 89%.	**Funding Sources:** Declared, non-industrial **COI:** Declared, none **Randomization:** Randomly allocation by the data center at a 1:1:1 ratio into one of the three study arms. The minimization method, with surgical stage (I or II vs III or IV) as the adjustment factor, was used for randomization assignment. **Blinding:** Not blinded

received at least a hysterectomy, salpingo-oophorectomy, and pelvic lymphad- enectomy and there should be no residual tumor, or the residual tumor should be less than 2 cm in size. **Exclusion Criteria:** not described.	paclitaxel-carboplatin (ddTC)	**2-year survival rate** TEC vs. TAC vs. ddTC 94%, 97%, and 97%. **Author's Conclusion:** When compared to the current standard treatments for endometrial cancer, TEC is a promising candidate for a phase III trial based on its significantly superior CRate and equivalent PFS and OS.	**Dropout Rate/ITT-Analysis:** Dropout rates: 2 (paclitaxel plus epirubicin plus carboplatin) vs. 13 (paclitaxel plus doxorubicin plus carboplatin) vs. 11 (Dose-dense paclitaxel plus carboplatin). No intention-to-treat analysis was performed. **Notes:** Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Randomized trial) Cochrane risk of bias tool (Rob)-1: 0 questions(s) were considered to be unclear risk of bias; 3 question(s) were considered to be high risk of bias Overall risk of bias: High Downgrade to evidence level 3 Notes: Dropout rates were higher in some groups, no intention-to-treat analysis was performed. At least partial blinding could have been achieved.

3.20. Schlüsselfrage 48

Wie ist der Stellenwert der supportiven Mitbehandlung und Betreuung in Bezug auf Kurzzeit-/ Langzeitmorbidität, krankheitsspezifisches Gesamt-Überleben und weiteres Rezidiv?

Population: Frauen mit EC
Intervention: supportive Mitbehandlung und Betreuung
Comparison: keine supportive Mitbehandlung und Betreuung
Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberleben

Inhalt: *3 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Charatsi, D. 2022	3	Prospective observational study
D'Oria, O. 2022	2	Systematic review (8 cohort studies, one RCT)
Zamorano, A. S. 2021	2	Randomized, controlled trial

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

D'Oria, O. et al. Fractional Co2 laser for vulvo-vaginal atrophy in gynecologic cancer patients: A valid therapeutic choice? A systematic review. Eur J Obstet Gynecol Reprod Biol. 277. 84-89. 2022				
Evidence level/Study Types	**P - I - C**	**Outcomes/Results**	**Literature References**	

Evidence level: 2 **Overall confidence in the results of the review:** Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 Systematic review and meta-analysis of (Non -randomized controlled cohort/follow-up study) AMSTAR II critical appraisal tool for systematic reviews: 3 critical flaws (items 2,7,12), 4 non-critical flaws (items 5,6,8,10,14) Overall quality of evidence: Critically low Notes: predominantly observational studies (8) vs one RCT included. **Study type:** Systematic review (8 cohort studies, one RCT) **Databases:** PubMed, EMBASE, SCOPUS and Web of Science **Search period:** Inception - January 4, 2022. **Inclusion Criteria:** Lakcing description. **Exclusion Criteria:** Case-reports and non-English articles were excluded.	**Population:** Patients with vulvo-vaginal atrophy in gynecological cancer patients. **Intervention:** CO2 laser treatment. **Comparison:** Lacking description.	**Primary:** Safety, Efficacy **Secondary:** - **Results:** No quantitative results are presented in the article. The results of these studies agree that fractional CO2 laser is an effective therapy, that improves clinical symptoms of GSM and sexual life. An improvement of VAS scale score was reported in all studies. Only Quick et al. in 2020 reported a clinical improvement in urinary symp- toms, using UDI test. **Author's Conclusion:** ccording to the best evidence available, fractional CO2 laser treatment for VVA is an effective and safe therapeutic option for gynecological cancer survivors, improving sexual life and quality of life (QoL).	9 studies included: 8 cohort studies and one RCT. Pagano 2016, Pieralli 2016, Pagano 2018, Pearson 2019, Quick 2020, Hersant 2020, Angiolo 2020, Quick 2021, Siliquini 2021.	

Studies reporting incomplete data were excluded. Studies with				

Cochrane Risk of Bias Tool 1 (RCT): *1 Bewertung(en)*

Zamorano, A. S. et al. Text-message-based behavioral weight loss for endometrial cancer survivors with obesity: A randomized controlled trial. Gynecol Oncol. 162. 770-777. 2021

Population	Intervention / Comparison	Outcomes/Results	Methodical Notes
Evidence level: 2 **Study type:** Randomized, controlled trial **Number of Patients:** 80 endometrial cancer survivors. **Recruiting Phase:** between May 18 and December 31, 2017. **Inclusion Criteria:** Patients visiting a Washington University in St. Louis School of Med- icine gynecologic oncology clinic were screened to identify endometrial cancer survivors over the age of 18 years with a BMI ≥ 30 kg/m 2. To be included, patients must have completed all surgical, chemotherapy, or radiation treatment for endometrial cancer and must have had a life expectancy of at least one year with an Eastern Cooperative Oncology Group (ECOG) perfor- mance status of 0 to 2. Additionally, patients must have had access to a phone capable of receiving text messages and must not have been par- ticipating in another formal weight loss program. All eligible patients were first	**Intervention:** Technology based weigth loss intervention (Text-message-based behavioral weight loss) **Comparison:** Enhanced usual care	**Primary:** Weight loss at 6 months. **Secondary:** Weight loss at 12 months Changes in psychosocial measures. **Results: Weigth change across three time points using generalized estimating equation (GEE) model.** Weight (lbs) LSM estimate (95% CI): Text-message-based Intervention (n = 40) vs. Enhanced Usual Care (n = 40). At baseline 239.1 (225.6, 252.6) vs. 254.3 (233.5, 275.1) At month 6 237.9 (224.5, 251.3) vs. 254.7 (233.9, 275.4) Change from baseline −1.2 (−5.0, 2.7) vs. 0.3 (−2.5, 3.2) At month 12 244.0 (226.9, 261.1) vs. 245.9 (228.3, 263.6) Change from baseline 4.9 (−3.3, 13.1) vs. −8.4 (−16.8, +0.0) Weight changes were similar in the two arms P-value 0.08 **Psychosocial outcomes**	**Funding Sources:** Funding declared, governmental and medical society support. **COI:** Declared, none. **Randomization:** no extensive description. **Blinding:** non-blinded study **Dropout Rate/ITT-Analysis:** Lost to follow-up: 8 vs. 11 participants per groups **Notes:** Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 (Randomized trial) Cochrane risk of bias tool (Rob)-1:

approached at the time of a surveillance clinic visit and asked to complete a voluntary research survey. Those that indicated interest and consented completed a baseline Gynecologic Cancer Ques- tionnaire Survey, which included questions on their perception of co-morbidities that may affect weight management, such as high blood ressure, cholesterol, diabetes, depression, arthritis, and physical abili- ties. In this questionnaire, patients were also asked whether they would be interested in participating in a formal weight loss support pro- gram. Those who answered “yes” were then offered the opportunity to enroll in the randomized controlled trial. Patients were enrolled and assigned to an intervention by a research coordinator. **Exclusion Criteria:** -		At baseline, there were no differences in quality of life scores or activity levels between those in the text-message-based intervention and those in enhanced usual care. At baseline, 26% reported no walking, 49% reported no moderate physical activity, and 65% reported no vigorous physical activity at all within the last seven days . Between baseline and six months, those in the text-message-based intervention had a greater increase in moderate activity than those in enhanced usual care. At baseline and six months, there were no differences between groups in mean Cancer- Related Body Image scores, PHQ-9 scores, or Multidimensional Body Self Relations Questionnaire-Appearance Subscales scores. **Author's Conclusion:** This text-message-based intervention did not increase weight loss among endometrial cancer survivors with obesity, nor did participation in the trial. Other weight management interventions should be pro- moted to increase weight loss.	2 questions(s) were considered to be unclear risk of bias; 0 question(s) were considered to be high risk of bias Overall risk of bias: Low

NEWCASTLE - OTTAWA Checklist: Cohort: *1 Bewertung(en)*

Charatsi, D. et al. Vaginal dilator use to promote sexual wellbeing after radiotherapy in gynecological cancer survivors. Medicine (Baltimore). 101. e28705. 2022			
Evidence level	**Methodical Notes**	**Patient characteristics**	**Interventions**
Evidence level: 3 **Study type:** Prospective observational study	**Funding sources:** The authors have no funding and conflicts of interests to disclose. **Conflict of Interests:** see funding sources. **Randomization:** - **Blinding:** - **Dropout rates:** 11 were lost to follow-up due to metastasis or other health problems, nonadherence to VD instructions, or family reasons.	**Total no. patients:** 53 patients with endometrial or cervical cancer who underwent Pelvic EBRT and/or intravaginal BT as definitive or adjuvant therapy ± chemotherapy. **Recruiting Phase:** From November 2017 to October 2019 **Inclusion criteria:** 1. women aged 18 to 85 years at the time of treatment, 2. histologically proven endometrial or cervical cancer, 3. pelvic EBRT and/or intravaginal BT as definitive or adjuvant therapy ± chemotherapy, 4. initial post-RT VS grading ≥2 according to the Common Terminology Criteria for Adverse Events 5. written informed consent, and 6. residing near the treatment site (Central Greece) **Exclusion criteria:** 1. patients previously treated for all stages (I–IV) of pelvic malignancy (except for treated non-melanoma skin cancer)	**Interventions:** Treatment of vaginal stenosis (VS) with vaginal dilators (VD) **Comparison:** no control group.

		2. prior pelvic irradiation, 3. stage IV disease, 4. inability to fill out questionnaires due to language or cognitive barriers (e.g., dementia), 5. physical handicaps that would prohibit patients from full participation in the study (e.g., significant hearing deficit), and 6. refusal or inability to provide written informed consent.	
Notes:	Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Prognosis): 3 (Non-randomized controlled cohort/follow-up study*) Newcastle-Ottawa Scale (NOS) for cohort studies: 7/9 stars. **Author's conclusion:** Endometrial and cervical cancer survivors are encouraged to use VD to treat VS and for sexual rehabilitation after RT. This study recommends starting vaginal dilation no more than 3 months after treatment at least 2 to 3 times a week for 10 to 15 minutes over 12 months. However, larger, well-designed randomized clinical trials should be conducted to develop specific guidelines for VD use and efficacy in VS and sexual sexual quality of life after RT.		
Outcome Measures/results	**Primary** Treatment for RT-induced VS VD therapy on sexual QoL. **Secondary** -	**Results: Vaginal stenosis** 65.8% of the patients with initial grade 2 VS showed a final VS of grade 1, while all patients with initial grade 3 showed a final grade 2 VS after 12 months of VD use. **Vaginal dilation and sexual life before vs after treatment with VD:** <u>Vaginal dryness</u> “not at all” 3.8%, 19.6%, 72.3%, and 95.7% before the start of VD use and at 3, 6, and 12 months of VD use, respectively (P value = .000), “quite a bit” before 61.5% vs. 17.4% at 3 months of dilation and 0% at 6 and 12 months (P = .000). <u>Pain during intercourse</u> 89.1% of patients did not experience pain during intercourse after 12 vs. 11.5% before (P = .000).	

		"A little" pain was felt by 61.5% of participants before vs. 10.9% after 12 months of dilation (P = .000). <u>Bleeding:</u> No patient had bleeding during intercourse at 12 months, with 84.6% having answered no bleeding before (P = .015). <u>Satisfaction after 12 months VD</u> 47.17% rated 5 out of 7 and only 3.77% gave a score of 3 out of 7.

3.21. Schlüsselfrage 52

Kann bei an Endometriumkarzinom erkrankten Patientinnen mit Trockenheit der Vagina diese durch die Applikation von inerten Gleitgelen oder Cremes oder vaginaler Lasertherapie vermindert werden, so dass sich die Lebensqualität verbessert in Bezug auf sexuelle Funktionsstörungen und vaginale Beschwerden?

Population: an EC erkrankte Patientinnen mit Trockenheit der Vagina
Intervention:
· Applikation von inerten Gleitgelen oder Cremes
· Anwendung vaginaler Lasertherapie
Comparison:
· keine Applikation von inerten Gleitgelen oder Cremes
· keine vaginale Lasertherapie
Outcomes: Verbesserung der Lebensqualität in Bezug auf sexuelle Funktions-störungen und vaginale Beschwerden

Inhalt: *2 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Charatsi, D. 2022	3	Prospective observational study
D'Oria, O. 2022	2	Systematic review (8 cohort studies, one RCT)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

D'Oria, O. et al. Fractional Co2 laser for vulvo-vaginal atrophy in gynecologic cancer patients: A valid therapeutic choice? A systematic review. Eur J Obstet Gynecol Reprod Biol. 277. 84-89. 2022				
Evidence level/Study Types	**P - I - C**	**Outcomes/Results**	**Literature References**	

Evidence level: 2 **Overall confidence in the results of the review:** Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Treatment benefits): 2 Systematic review and meta-analysis of (Non -randomized controlled cohort/follow-up study) AMSTAR II critical appraisal tool for systematic reviews: 3 critical flaws (items 2,7,12), 4 non-critical flaws (items 5,6,8,10,14) Overall quality of evidence: Critically low Notes: predominantly observational studies (8) vs one RCT included. **Study type:** Systematic review (8 cohort studies, one RCT) **Databases:** PubMed, EMBASE, SCOPUS and Web of Science **Search period:** Inception - January 4, 2022. **Inclusion Criteria:** Lakcing description. **Exclusion Criteria:** Case-reports and non-English articles were excluded.	**Population:** Patients with vulvo-vaginal atrophy in gynecological cancer patients. **Intervention:** CO2 laser treatment. **Comparison:** Lacking description.	**Primary:** Safety, Efficacy **Secondary:** - **Results:** No quantitative results are presented in the article. The results of these studies agree that fractional CO2 laser is an effective therapy, that improves clinical symptoms of GSM and sexual life. An improvement of VAS scale score was reported in all studies. Only Quick et al. in 2020 reported a clinical improvement in urinary symp- toms, using UDI test. **Author's Conclusion:** ccording to the best evidence available, fractional CO2 laser treatment for VVA is an effective and safe therapeutic option for gynecological cancer survivors, improving sexual life and quality of life (QoL).	9 studies included: 8 cohort studies and one RCT. Pagano 2016, Pieralli 2016, Pagano 2018, Pearson 2019, Quick 2020, Hersant 2020, Angiolo 2020, Quick 2021, Siliquini 2021.	

Studies reporting incomplete data were excluded. Studies with				

NEWCASTLE - OTTAWA Checklist: Cohort: *1 Bewertung(en)*

Charatsi, D. et al. Vaginal dilator use to promote sexual wellbeing after radiotherapy in gynecological cancer survivors. Medicine (Baltimore). 101. e28705. 2022

Evidence level	Methodical Notes	Patient characteristics	Interventions
Evidence level: 3 **Study type:** Prospective observational study	**Funding sources:** The authors have no funding and conflicts of interests to disclose. **Conflict of Interests:** see funding sources. **Randomization:** - **Blinding:** - **Dropout rates:** 11 were lost to follow-up due to metastasis or other health problems, nonadherence to VD instructions, or family reasons.	**Total no. patients:** 53 patients with endometrial or cervical cancer who underwent Pelvic EBRT and/or intravaginal BT as definitive or adjuvant therapy ± chemotherapy. **Recruiting Phase:** From November 2017 to October 2019 **Inclusion criteria:** 1. women aged 18 to 85 years at the time of treatment, 2. histologically proven endometrial or cervical cancer, 3. pelvic EBRT and/or intravaginal BT as definitive or adjuvant therapy ± chemotherapy, 4. initial post-RT VS grading ≥2 according to the Common Terminology Criteria for Adverse Events 5. written informed consent, and 6. residing near the treatment site (Central Greece)	**Interventions:** Treatment of vaginal stenosis (VS) with vaginal dilators (VD) **Comparison:** no control group.

		Exclusion criteria: 1. patients previously treated for all stages (I–IV) of pelvic malignancy (except for treated non-melanoma skin cancer) 2. prior pelvic irradiation, 3. stage IV disease, 4. inability to fill out questionnaires due to language or cognitive barriers (e.g., dementia), 5. physical handicaps that would prohibit patients from full participation in the study (e.g., significant hearing deficit), and 6. refusal or inability to provide written informed consent.	
Notes:	Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Prognosis): 3 (Non-randomized controlled cohort/follow-up study*) Newcastle-Ottawa Scale (NOS) for cohort studies: 7/9 stars. **Author's conclusion:** Endometrial and cervical cancer survivors are encouraged to use VD to treat VS and for sexual rehabilitation after RT. This study recommends starting vaginal dilation no more than 3 months after treatment at least 2 to 3 times a week for 10 to 15 minutes over 12 months. However, larger, well-designed randomized clinical trials should be conducted to develop specific guidelines for VD use and efficacy in VS and sexual sexual quality of life after RT.		
Outcome Measures/results	**Primary** Treatment for RT-induced VS VD therapy on sexual QoL. **Secondary** -	**Results: Vaginal stenosis** 65.8% of the patients with initial grade 2 VS showed a final VS of grade 1, while all patients with initial grade 3 showed a final grade 2 VS after 12 months of VD use. **Vaginal dilation and sexual life before vs after treatment with VD:** <u>Vaginal dryness</u> “not at all” 3.8%, 19.6%, 72.3%, and 95.7% before the start of VD use and at 3, 6, and 12 months of VD use, respectively (P value = .000), “quite a bit” before 61.5% vs. 17.4% at 3 months of dilation and 0% at 6 and 12	

		months (P = .000). Pain during intercourse 89.1% of patients did not experience pain during intercourse after 12 vs. 11.5% before (P = .000). “A little” pain was felt by 61.5% of participants before vs. 10.9% after 12 months of dilation (P = .000). Bleeding: No patient had bleeding during intercourse at 12 months, with 84.6% having answered no bleeding before (P = .015). Satisfaction after 12 months VD 47.17% rated 5 out of 7 and only 3.77% gave a score of 3 out of 7.

3.22. Schlüsselfrage 54

Kann bei an Endometriumkarzinom erkrankten Patientinnen, die behandelt wurden mittels Strahlentherapie, welche die Vaginalregion einbezogen hat, eine mechanische Dilatation mittels Vaginaldilatatoren oder Tampons mit inerten Cremes ab vier bis sechs Wochen postoperativ eine Vaginalstenose verhindern, so dass die Lebensqualität erhalten bleibt in Bezug auf sexuelle Funktionsstörungen und vaginale Beschwerden?

Population EC-Patientinnen 4-6 Wochen postoperativ und im Zustand nach Radiatio der Vaginalregion
Intervention: mechanische Dilatation mittels Vaginaldilatatoren oder Tampons mit inerten Cremes
Comparison: keine mechanische Dilatation
Outcomes: Verbesserung Lebensqualität, Kurzzeit-/Langzeit-morbidität, Rezidivhäufigkeit, krankheits-spezifisches und Gesamtüberlebe

Inhalt: *1 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Charatsi, D. 2022	3	Prospective observational study

NEWCASTLE - OTTAWA Checklist: Cohort: *1 Bewertung(en)*

Charatsi, D. et al. Vaginal dilator use to promote sexual wellbeing after radiotherapy in gynecological cancer survivors. Medicine (Baltimore). 101. e28705. 2022

Evidence level	Methodical Notes	Patient characteristics	Interventions
Evidence level: 3 **Study type:** Prospective observational study	**Funding sources:** The authors have no funding and conflicts of interests to disclose. **Conflict of Interests:** see funding sources.	**Total no. patients:** 53 patients with endometrial or cervical cancer who underwent Pelvic EBRT and/or intravaginal BT as definitive or adjuvant therapy ± chemotherapy.	**Interventions:** Treatment of vaginal stenosis (VS) with vaginal dilators (VD) **Comparison:** no control group.

	Randomization: - **Blinding:** - **Dropout rates:** 11 were lost to follow-up due to metastasis or other health problems, nonadherence to VD instructions, or family reasons.	**Recruiting Phase:** From November 2017 to October 2019 **Inclusion criteria:** 1. women aged 18 to 85 years at the time of treatment, 2. histologically proven endometrial or cervical cancer, 3. pelvic EBRT and/or intravaginal BT as definitive or adjuvant therapy ± chemotherapy, 4. initial post-RT VS grading ≥2 according to the Common Terminology Criteria for Adverse Events 5. written informed consent, and 6. residing near the treatment site (Central Greece) **Exclusion criteria:** 1. patients previously treated for all stages (I–IV) of pelvic malignancy (except for treated non-melanoma skin cancer) 2. prior pelvic irradiation, 3. stage IV disease, 4. inability to fill out questionnaires due to language or cognitive barriers (e.g., dementia), 5. physical handicaps that would prohibit patients from full participation in the study (e.g., significant hearing deficit), and 6. refusal or inability to provide written informed consent.	

Notes:	Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Prognosis): 3 (Non-randomized controlled cohort/follow-up study*) Newcastle-Ottawa Scale (NOS) for cohort studies: 7/9 stars. **Author's conclusion:** Endometrial and cervical cancer survivors are encouraged to use VD to treat VS and for sexual rehabilitation after RT. This study recommends starting vaginal dilation no more than 3 months after treatment at least 2 to 3 times a week for 10 to 15 minutes over 12 months. However, larger, well-designed randomized clinical trials should be conducted to develop specific guidelines for VD use and efficacy in VS and sexual sexual quality of life after RT.	
Outcome Measures/results	**Primary** Treatment for RT-induced VS VD therapy on sexual QoL. **Secondary** -	**Results: Vaginal stenosis** 65.8% of the patients with initial grade 2 VS showed a final VS of grade 1, while all patients with initial grade 3 showed a final grade 2 VS after 12 months of VD use. **Vaginal dilation and sexual life before vs after treatment with VD:** <u>Vaginal dryness</u> "not at all" 3.8%, 19.6%, 72.3%, and 95.7% before the start of VD use and at 3, 6, and 12 months of VD use, respectively (P value = .000), "quite a bit" before 61.5% vs. 17.4% at 3 months of dilation and 0% at 6 and 12 months (P = .000). <u>Pain during intercourse</u> 89.1% of patients did not experience pain during intercourse after 12 vs. 11.5% before (P = .000). "A little" pain was felt by 61.5% of participants before vs. 10.9% after 12 months of dilation (P = .000). <u>Bleeding:</u> No patient had bleeding during intercourse at 12 months, with 84.6% having answered no bleeding before (P = .015). <u>Satisfaction after 12 months VD</u> 47.17% rated 5 out of 7 and only 3.77% gave a score of 3 out of 7.

3.23. Schlüsselfrage 57

Ist beim frühen Endometriumkarzinom (Typ 1, G1, G2, pT1a) die Sentinel-Node-Entfernung prognostisch relevanter UND prädiktiver als der Verzicht auf ein solches chirurgisches Staging im Hinblick auf Lebensqualität, Kurzzeit-/Langzeitmorbidität, Rezidivhäufigkeit, krankheitsspezifisches und Gesamt-Überleben?

Population: Frauen mit frühem EC,Typ 1, G1, G2, pT1a
Intervention: Sentinel-Lymphknotenbiopsie (SLN)
Comparison: keine Sentinel-Lymphknotenbiopsie (SLN)
Outcomes: Morbidität, Lebensqualität, Rezidivhäufigkeit, krankheits-spezifisches Überleben, Gesamtüberleben

Inhalt: *1 Literaturstellen*

Literaturstelle	Evidenzlevel	Studientyp
Burg, L. C. 2022	2	Systematic review and meta-analysis (13 observational studies, 1 RCT)

OXFORD (2011) - AMSTAR 2: Systematic Reviews: *1 Bewertung(en)*

Burg, L. C. et al. The added value of SLN mapping with indocyanine green in low- and intermediate-risk endometrial cancer management: a systematic review and meta-analysis. J Gynecol Oncol. 33. e66. 2022

Evidence level/Study Types	P - I - C	Outcomes/Results	Literature References	
Evidence level: 2 **Overall confidence in the results of the review:** Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (Screening): 2 Systematic	**Population:** Early stage, low- and intermediate-risk endometrial cancer (endometrioid histology, histological grade 1 and 2	**Primary:** SLN detection rate in presumed early stage, low- and intermediate-risk endometrial cancers, the incidence of SLN metastases, negative predictive value of SLN mapping performed with indocyanine green (ICG).	14 studies: Backes 2019, Bogani 2020, Buda 2016, Clinton 2017, Cusimano 2021, Diniz 2021, Ditto 2020, Holloway 2016,	

review and meta-analysis of (Non - randomized controlled cohort/follow-up study) AMSTAR II critical appraisal tool for systematic reviews: 2 critical flaws (items 2,7), 4 non-critical flaws (items 5,6,10,14) Overall quality of evidence: Critically low Notes: predominantly observational studies (13) vs one RCTs included. **Study type:** Systematic review and meta-analysis (13 observational studies, 1 RCT) **Databases:** PubMed, Embase, Web of Science, the Cochrane Library and ClinicalTrials.gov **Search period:** no filter on year of publication was set **Inclusion Criteria:** A) early stage, low- and intermediate-risk endometrial cancer (endometrioid histology, histological grade 1 and 2); B) cervical injection with ICG; C) a minimal number of twenty included patients per study. To assess the diagnostic value of SLN	**Intervention:** Cervical injection with ICG for detection of SLN metastasis **Comparison:** -	**Secondary:** - **Results:** **SLN detection rate:** 86.0% to 100% with a pooled average of 95.6% (95% CI=92.4%–97.9%) **Prediction interval** from 81.1% to 100% **The pooled average of no SLN detection** at all is therefore 4.4% **Bilateral detection rate of SLN mapping** ranged from 52.1% to 95.2%, with a pooled average of 76.5% (95% CI=68.1%–84.0%) and a prediction interval from 43.0% to 97.6%. **Unilateral detection rate of SLN mapping** ranged from 4.4% to 34.8%, with a pooled average of 18.2% (95% CI=12.2%–25.1%) and a prediction interval from 1.8% to 4.6% **Estimated pooled incidence of SLN metastases in studies including grade 1 and 2 endometrial cancer patients** was 9.6% (95% CI=5.1%–15.2%), with a range from 3.1% to 24.0% and a prediction interval from 0.7% to 26.7% **In studies including grade 1, 2, and 3 endometrial cancer patients**, the estimated pooled incidence of SLN metastases was 11.8% (95% CI=8.1%–16.1%), with a range from 3.1% to 29.4% and a prediction interval from 1.7% to 29.1%. **estimated pooled negative predictive value in studies including only in grade 1 and 2** endometrial cancer patients was 100% (95% CI=98.8%–100%), but the prediction interval	Papdia 2016, Rossi 2017, Stephens 2020, Taskin 2020, Xue 2021, Ye 2019.	

mapping, D) a subsequent (pelvic) lymph node dissection was an additional eligibility criterion **Exclusion Criteria:** Reviews and case reports were excluded.		shows that in a future setting the true negative rate may be as low as 89.9%. **The estimated pooled negative predictive value in studies including grade 1, 2, and 3 endometrial cancer patients** was 99.2% (95% CI=97.9%–99.9%), with a range from 96.9% to 100% across studies. The prediction interval shows that in a future setting the true negative rate may be as low as 94.9%. **Author's Conclusion:** SLN mapping with ICG is feasible with a high detection rate and negative predictive value in low- and intermediate-risk endometrial cancers. Given the incidence of SLN metastases is approximately 10% in those patients, SLN mapping may lead to stage shifting with potential therapeutic consequences. Given the high negative predictive value with SLN mapping, routine lymphadenectomy should be omitted in low- and intermediate- risk endometrial cancer		

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