Consensus Statements for the Management of Recurrent or Metastatic Endometrial Cancer (GCGS) 2026

Valerie Heong[1], Adele Wong[2], Jack Chan[3], Chay Wen Yee[3], Ieera Madan Aggarwal[2], Lim Yu Hui[2], Joseph Ng[4], Pearl Tong[4], Natalie Ngoi[4], David Tan[4], Felicia Chin[5], Julia Eng[3] and John Chia[6]

Affiliations:

1. National Healthcare Group, Tan Tock Seng Hospital (TTSH), Singapore
2. KK Women's and Children's Hospital (KKH), Singapore
3. National Cancer Centre Singapore (NCCS), Singapore
4. National University Cancer Institute, Singapore
5. Gynae Onco Partners, Singapore
6. Curie Oncology, Singapore

Background

Recurrent and metastatic endometrial cancer represents a rapidly evolving therapeutic landscape, driven by advances in molecular classification and the integration of immune checkpoint inhibitors into first-line management. In response to emerging evidence and international guideline updates, the Gynaecological Cancers Group Singapore (GCGS) convened an expert round-table discussion to contextualise contemporary data within the Singapore healthcare setting and to provide practical, consensus-based recommendations for clinicians.

Methods

A structured round-table consensus meeting was conducted on 9 February 2026, attended by 13 Board members of GCGS. Twelve members participated in formal voting. Draft statements were developed based on contemporary international guidelines and pivotal clinical trials. Each statement was discussed in plenary, refined where appropriate, and subjected to voting. Level of agreement was recorded for each statement and is reported alongside the final recommendations

---

Diagnosis, Pathology, and Molecular Stratification

Statement 1: Universal molecular classification

All patients with endometrial cancer should undergo molecular classification at diagnosis, incorporating MMR and/or MSI status, *POLE* mutation status, and p53 status based on Immunohistochemistry (IHC) or sequencing, using validated assays. Molecular classification should be integrated into routine pathology reporting to inform prognosis, guide systemic therapy selection, and support multidisciplinary decision-making.

(Vote: 100% agree)

Statement 2: Universal Lynch syndrome genetic evaluation should be performed in all patients with MMR deficiency or MSI high (MSI-H) endometrial cancer.

Patients with non-dMMR/non-MSI high with strong family history of cancer should also be referred for genetic counselling and evaluation.

Patients with tumours harbouring *MLH1* promoter methylation may be exempted from germline testing.

(Vote: 100% agree)

Statement 3: Standards for molecular pathology assessment

MMR testing should be performed by immunohistochemistry, and/or PCR for MSI testing. Routine p53 status should be assessed by immunohistochemistry. *TP53* sequencing can also be considered especially where equivocal or heterogenous p53 IHC staining patterns are observed. *POLE* testing should only recognize pathogenic exonuclease domain variants. (León-Castillo A, Britton H, McConechy MK *et al*. J Pathol 2020; 250(3):323-35. doi: 10.1002/path.5372.)

(Vote: 100% agree)

Statement 4: Specimen selection and repeat testing

Endometrial biopsy or curettage specimens are generally sufficient for molecular testing. Hysterectomy specimens can also be used for molecular testing provided there is appropriate fixation. Repeat molecular testing on a different specimen sample or recurrent tumour specimens should be considered especially in situations such as scant tissue, equivocal results, technical failure, or the presence of additional tumour components not represented in the initial specimen. Repeat testing for dynamic predictive biomarkers at recurrence such as MMR/MSI and HER2 is strongly encouraged.

(Vote: 100% agree)

Statement 5: Additional biomarker assessment

HER2 testing should be performed using standardised scoring criteria (as determined by the therapeutic agent of choice). HER2 testing should especially be considered in uterine serous carcinoma, other p53-abnormal, and other high-grade histologies. Estrogen receptor status should be assessed to inform prognosis and the potential role of endocrine therapy in advanced or recurrent disease.

(Vote: 100% agree)

Systemic Therapies

Statement 6: First-line systemic therapy for dMMR/MSI-H disease

For patients with dMMR/MSI-H recurrent or metastatic endometrial cancer, an immune checkpoint inhibitor–based approach is the standard of care in the first line setting. This can either be administered in combination with platinum-based chemotherapy followed by maintenance, or as immunotherapy alone in selected clinical contexts.

(Vote: 83% agree, 17% abstain)

Statement 7: First-line systemic therapy for non-dMMR/non-MSI disease

For patients with non-dMMR/non-MSI high recurrent or metastatic endometrial cancer, platinum-based chemotherapy remains the backbone of first-line treatment. The addition of immune checkpoint inhibitors followed by maintenance therapy should be considered.

(Vote: 92% agree, 8.3% abstain)

Statement 8: Maintenance therapy following first-line treatment

For patients who achieve disease control following first-line platinum-based chemotherapy combined with immunotherapy, continuation of immunotherapy as maintenance should be considered, provided treatment is tolerated and clinical benefit is sustained. Duration of maintenance therapy should be as per label.

Maintenance strategies should be individualised, taking into account molecular subtype, prior toxicities, patient preference, and access considerations.

In dMMR tumors there is no benefit conferred by the addition of PARP inhibitors. In non-dMMR/non-MSI-H tumours, the use of PARP inhibitors as a maintenance treatment in combination with immune checkpoint inhibitors can be considered.

(Vote:100% agree)

Statement 9: Role of Lenvatinib–Pembrolizumab in recurrent/metastatic disease

For patients with non-dMMR/non-MSI-H disease who progress after platinum-based chemotherapy and have not previously received immunotherapy, the combination of Lenvatinib plus Pembrolizumab should be considered a standard systemic option, with proactive toxicity monitoring and management.

(Vote:100% agree)

Statement 10: Treatment sequencing after immunotherapy exposure

Following progression on first-line chemo-immunotherapy, subsequent treatment should be individualised, based on molecular profile, prior treatment exposure, performance status, and pace of disease. The optimal sequencing of therapies after immune checkpoint inhibition remains unclear. Clinical trial participation is encouraged for eligible patients.

(Vote:100% agree)

Statement 11: The use of Trastuzumab Deruxtecan (T-DXd) should be guided by HER2 IHC expression

In patients who have 2+ or 3+ HER2 IHC staining (by 2016 CAP/ASCO gastric criteria) should be considered for T-DXd (*Bartley AN, Washington K, Ventura CB et al. HER2 testing and clinical decision making in gastroesophageal adenocarcinoma: guideline from the College of American Pathologists, American Society for Clinical Pathology and the American Society of Clinical Oncology. Arch Pathol Lab Med 2016; 140(12):1345-1363. doi: 10.5858/arpa.2016-0331-C*)

(Vote: 92% agree, 8.3% disagree)

Carcinosarcomas with HER2 IHC (1+ and above, by gastric criteria) may be considered for T-DXd on a case-by-case basis.

(Vote: 58% agree, 25% disagree, 8.3% abstain)

Statement 12: Endocrine therapy in selected patients

Endocrine therapy should be considered in selected patients in ER positive tumours, such as those with low-grade, indolent disease, with low tumour burden.

(Vote: 100% agree)

Statement 13: Immune-related toxicity management

With increasing use of immunotherapy across disease stages, early recognition and standardised management of immune-related adverse events are essential. Institutions should adopt toxicity-management pathways aligned with international guidelines.

(Vote: 100% agree)

Surgical and Local Therapy Considerations

Statement 14: Multidisciplinary care and treatment planning

The management of recurrent or metastatic endometrial cancer should be undertaken in a specialised centre and guided by a multidisciplinary team, integrating surgical, medical, radiation oncology, pathology, radiology, and palliative care expertise.

(Vote: 100% agree)

Statement 15: Cytoreductive surgery in advanced or recurrent disease

Cytoreductive surgery may be considered in selected patients with advanced or recurrent disease when complete macroscopic resection is feasible with acceptable morbidity and quality of life. Systematic lymphadenectomy is not recommended.

(Vote: 100% agree)

Statement 16: Oligometastatic recurrent disease

Patients with oligometastatic recurrent disease should be considered for local ablative approaches, including surgery or stereotactic radiotherapy, within a multidisciplinary framework. Systemic therapy may be considered following local treatment, depending on disease biology and prior therapies.

(Vote: 100% agree)

References

These consensus statements are informed by contemporary international guidelines and pivotal clinical trials, including ESGO–ESTRO–ESP 2025 guidelines, TCGA molecular classification and its adaptations, NRG-GY018, RUBY Part 1, DUO-E, Fader's phase II trial, GARNET, KEYNOTE-158, KEYNOTE-775, DESTINY PanTumor-02 and STATICE.

Concin N, Matias-Guiu X, Cibula D *et al*. Lancet Oncol 2025; 26(8):e423-35.
Cancer Genome Atlas Research Network. Nature 2013; 497(7447): 67-73.

León-Castillo A, de Boer SM, Powell ME *et al*. J Clin Oncol 2020; 38:3388-97.
Vermij L, Jobsen JJ, León-Castillo A *et al*. Br J Cancer 2023; 128(7):1360-8.
Kommoss S, McConechy MK, Kommoss F *et al*. Ann Oncol 2018; 29:1180-8.
Eskander RN, Sill MW, Beffa L *et al*. N Engl J Med 2023; 388:2159-70.
Eskander RN, Sill MW, Beffa L *et al*. Nat Med 2025;31(5):1539-46.
Mirza MR, Chase DM, Slomovitz BM *et al*. N Engl J Med 2023; 388:2145-58.
Powell MA, Bjørge L, Willmott L *et al*. Ann Oncol 2024; 35(8):728-38.
Westin SN, Moore K, Chon HS *et al*. J Clin Oncol 2024; 42(3):283-99.
Fader AN, Roque DM, Siegel E *et al*. J Clin Oncol 2018; 36(20):2044-51.
Fader AN, Roque DM, Siegel E *et al*. Clin Cancer Res 2020; 26(15):3928-35.
Oaknin A, Gilbert L, Tinker AV *et al*. J Immunother Cancer 2022; 10(1):e003777.
O'Malley DM, Bariani GM, Cassier PA *et al*. J Clin Oncol 2022; 40(7):752-61.
Makker V, Colombo N, Herráez AC *et al*. N Engl J Med 2022; 386(5):437-48.
Makker V, Colombo N, Herráez AC *et al*. J Clin Oncol 2023; 41(16):2904-10.
Meric-Bernstam F, Makker V, Oaknin A *et al*. J Clin Oncol 2024; 42(1):47-58.
Nishikawa T, Hasegawa K, Matsumoto K *et al*. J Clin Oncol 2023;4 1(15):2789-99.