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**Management and survival of elderly and very elderly patients with endometrial cancer: an age-stratified study on 1228 women from the FRANCOGYN group**

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## **Abstract**

**Introduction:** Little data exist about the clinical management and survival of elderly patients with endometrial cancer. The aim of this study was to evaluate the management of elderly and very elderly patients with endometrial cancer and the overall survival (OS) rate, disease-free survival (DFS) rate and cancer-specific survival (CSS) rate within a multicentre cohort.

**Material and methods:** Data from 1228 patients with endometrial cancer who received primary treatment between January 2001 and December 2012 were collected from a multicentre database. Clinical management, DFS, CSS and OS were analysed.

**Results:** Based on the international endometrial cancer risk classification, 36% (212/582) of women  $\leq 65$  years, 42% (220/526) of women  $>65$  years and  $\leq 80$  years and 48% (58/120) of women  $>80$  years showed high-risk endometrial cancer ( $p < 0.001$ ). Pelvic lymphadenectomy was performed in 85% (230/271) of women  $\leq 65$  years and 46% (33/71) of women  $>80$  years ( $p < 0.001$ ). Radiotherapy was performed in 27% (33/120) of very elderly and 40% (233/582) of young patients ( $p = 0.009$ ). The 3-year CSS rates were 95% (95% CI, 93-97), 90% (95% CI, 87-94) and 82% (95% CI, 73-93) for women  $\leq 65$  years,  $>65$  and  $\leq 80$  years, and  $>80$  years, respectively ( $p < 0.001$ ).

**Conclusions:** Elderly and very elderly patients with endometrial cancer showed poorer prognosis than young patients. The significant lower CSS rate in elderly patients could be due to the higher rate of high-risk endometrial cancer but also due to under-treatment. Specific guidelines for the management of elderly and very elderly patients with endometrial cancer are needed to improve their prognosis.

## Introduction

As life expectancy continues to increase, the cohort of people over age of sixty-five accounts for almost two-thirds of new cancer cases and three-fourths of cancer-related deaths<sup>1-3</sup>. Despite this trend, elderly patients have historically been under-represented in clinical trials<sup>4-7</sup>. Endometrial cancer is the most common gynaecologic malignancy in the western world, and in parallel to ageing demographics, incidence of endometrial cancer has been increasing: the average age of diagnosis is approximately 68 years<sup>8-10</sup>. It has been estimated that in the United States, more than 54,870 cases are diagnosed each year, and 10,170 deaths related to this malignancy occurred in 2015<sup>11</sup>. The standard of care for endometrial cancer remains controversial, but it mostly includes comprehensive surgical staging as recommended by the International Federation of Gynecology and Obstetrics (FIGO)<sup>12</sup>. This can involve complex procedures such as pelvic and para-aortic lymphadenectomy and omentectomy, especially for high-risk endometrial cancer<sup>12-17</sup>, and the biological aggressiveness of endometrial cancer increases with age<sup>17-19</sup>. The benefit of applying these complex procedures to elderly patients remains unclear. Indeed, scarce data exist about overall survival and specific cancer-related death in the elderly and very elderly patients. In addition, available data are biased by the different definitions of “older age” and “elderly” used<sup>20</sup>. Some authors consider older age to be over 65 years, whereas others use more strict parameters such as an age  $\geq 75$  or  $\geq 80$  years<sup>21</sup>.

The aim of this study was to evaluate the management of elderly and very elderly patients with endometrial cancer and their disease-free survival, overall survival, and cancer-specific survival rates within a large French multicentre cohort.

## **Material and methods**

### **Patients**

Data on women with histologically proven endometrial cancer who received primary surgical treatment between January 2001 and December 2013 were abstracted from seven institutions in France with maintained endometrial cancer databases (Tours University Hospital, Tenon University Hospital, Dijon Cancer Centre, Rennes University Hospital, Lille University Hospital, Reims University Hospital, Creteil University Hospital and Jean Verdier University Hospital) and from the Senti-Endo trial <sup>22</sup>. The research protocol was approved by the Institutional Review Board of the College National des Gynécologues et Obstétriciens Français (CEROG 2014-GYN-020).

All enrolled women underwent preoperative abdomino-pelvic magnetic resonance imaging (MRI) unless contraindicated, in which case a computed tomography (CT) scan was performed. The following clinical, surgical and pathological data were collected: age; body mass index (BMI; calculated as weight in kilograms divided by the square of height in metres), surgical procedure, nodal staging and adjuvant therapy.

The patients were divided into three cohorts: 1) women  $\leq 65$  years old, 2) women  $>65$  years old and  $\leq 80$  years old, and 3) women  $>80$  years old, which were designated as young, elderly and very elderly patients, respectively.

### **Histology**

Lymph nodes (LN) were considered positive when there were macro- and/or micrometastases. Macrometastases were defined as a single focus of metastatic disease per LN, measuring more than 2 mm. Micrometastases were defined as a single focus of metastatic disease per LN, measuring between 0.2 and 2 mm <sup>23</sup>. A tumour is considered to have lymphovascular space involvement (LVSI) when tumour emboli are found within a space clearly lined by endothelial cells on a *haematoxylin* and eosin (H&E)-stained section <sup>24</sup>.

Type 1 tumours consisted of endometrioid adenocarcinomas and mixed tumours with a mucinous, villoglandular or tubular component in addition to the endometrioid component. For these tumours, histological grade was defined by the percentage of the undifferentiated component: grade 1 corresponded to an undifferentiated component less than 5%, grade 2 from 6% to 50% and grade 3 more than 50%. When nuclear atypia was present, the grade was increased by 1 point <sup>25</sup>.

Type 2 tumours were those with at least one serous, clear cell or carcinosarcoma component.

All women were classified according to the FIGO 2009 classification <sup>26</sup> after final pathological analysis.

The tumours were classified into recurrence risk groups as defined by the European Society for Medical Oncology (ESMO) / European Society of Gynaecological Oncology (ESGO) / European Society for Radiotherapy and Oncology (ESTRO) guidelines<sup>13</sup>. The four risks groups were determined as follows: low risk – stage IA, grade 1 or 2, histological type 1; intermediate risk – stage IA, grade 3 and stage IB, grade 1 or 2, histological type 1; high intermediate risk (HIR) subgroup, defined as endometrioid type 1, grade 1–2 tumours with deep ( $\geq 50\%$ ) myometrial invasion and unequivocally positive (substantial, not focal) LVSI and those with grade 3 tumours with  $< 50\%$  myometrial invasion regardless of LVSI status; and high risk – stage IB, grade 3 and, by extension, stage  $\geq$ II, histological type 1, as well as all type 2 tumours of any stage.

### **Treatment and follow-up**

According to INCa guidelines, pelvic and paraaortic lymph node surgical staging is required for HIR and high-risk groups, and pelvic lymph node surgical staging is required for intermediate-risk groups. Adjuvant therapy was administered on an individual basis at the discretion of a multidisciplinary committee, based on the INCa guidelines, and included vaginal brachytherapy (VBT) and/or external beam radiotherapy (EBRT) and/or chemotherapy (CT) and clinical follow-up [27]. Chemotherapy performed were four cycles of carboplatin and taxol. Clinical follow-up consisted of physical examinations and the use of imaging techniques according to the findings. Follow-up visits were conducted every 3 months for the first 2 years, every 6 months for the following 3 years, and once a year thereafter. Disease recurrence was diagnosed by biopsy or imaging.

### **Outcome measures**

The primary outcome measures were date of recurrence, date of death and date of cancer-related death. The secondary outcome measures were surgical staging compliance with French national guidelines [25] and surgical route (minimally invasive surgery, laparotomy and vaginal surgery).

### **Statistical analysis**

Descriptive parameters were expressed as the mean ( $\pm$  Standard Deviation [SD]) and median [range] when indicated. Frequencies were presented as percentages. We used Chi-square or Fisher's exact tests, as appropriate, for categorical or ordinal variables. For continuous variables, we used *t*-tests when there were two variables to compare or one-way ANOVA when there were more than 2 variables. Overall survival time was calculated in months from the date of surgery to death (related or unrelated to cancer) or date of last follow-up for surviving patients; cancer-specific survival (CSS) was calculated as time from the date of surgery to cancer-related death; and disease-free survival (DFS) was time from the date of surgery to cancer recurrence. Women who were alive and without recurrence were censored at the date of last follow-up. The Kaplan-Meier method

was used to estimate the survival distribution. Tick marks indicate censored data. The comparison test chosen to analyse survival was the log-rank test. Effects were expressed as hazard ratios (HRs) with 95% confidence intervals (CIs) as appropriate. Cox proportional hazard models included established prognostic factors: pathological type, adjuvant therapies, and nodal and LVSI status. A p-value of  $<0.05$  was considered statistically significant. Data were managed in an Excel database (Microsoft, Redmond, WA, USA) and analysed using R 3.0.2 software, which is available online.

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## **Results:**

### **Characteristics of the study population**

During the study period, 1228 women with endometrial cancer were documented as having received primary surgical treatment according to the following distribution. According to the three age groups, 582 (47%), 526 (43%) and 120 (10%) women were  $\leq 65$  years old,  $>65$  years old and  $\leq 80$  years old, and  $>80$  years old, respectively.

The median age of the women was 66.0 years (range 28–88 years), and their median BMI was 28.0 kg/m<sup>2</sup> (range 14.0–52.7). The demographic and clinicopathological characteristics of the whole cohort by age group are reported in Table 1. The rate of comorbidities, such as diabetes, high blood pressure, and previous breast cancer, was significantly higher in the older age groups.

### **Tumour characteristics**

The tumour characteristics are reported in table 2. Of note, elderly and very elderly women experienced more endometrial cancers with biological parameters indicating a poor prognosis. Indeed, 55% (58/106) of very elderly patients had a positive LVSI status *vs* 29% (148/516) of young patients ( $p < 0.001$ ). Similarly, 48% (58/120) of very elderly patients showed high-risk endometrial cancer *vs* 37% (212/582) of young patients ( $p = 0.003$ ).

### **Surgical procedures and adjuvant treatment**

The surgical procedures are described in table 3. Very elderly patients had less laparoscopic surgery than young patients: 50% (56/112) *vs* 62% (314/508), ( $p = 0.015$ ), respectively. Additionally, 59% (71/120) of very elderly women required pelvic  $\pm$  para-aortic lymphadenectomy according to French guidelines, whereas this rate was 47% (271/582) in young women ( $p = 0.011$ ). However, pelvic  $\pm$  para-aortic lymphadenectomy was performed for 46% (33/71) of very elderly patients and 85% (230/271) of young patients ( $p < 0.001$ ).

The adjuvant treatments are reported in table 3. Radiotherapy was performed in 28% (33/120) of very elderly and 40% (233/582) of young patients ( $p = 0.008$ ). Chemotherapy was performed in 4% (5/120) of very elderly and 19% (113/582) of young patients ( $p < 0.001$ ). Additionally, 50% (60/120) of very elderly and 35% (230/582) of young patients with endometrial cancer required radiotherapy according to French guidelines ( $p = 0.003$ ), but radiotherapy was performed in 55% (33/60) of very elderly women and 85% (201/230) of young patients ( $p = 0.013$ ). Among very elderly women, 40% (48/120) required chemotherapy according to French guidelines *vs* 30% (172/582) of young women with endometrial cancer ( $p = 0.044$ ), but chemotherapy was performed in 10% (5/48) of very elderly women and 56% (96/172) of young patients ( $p < 0.001$ ).



### **Survival results**

In the whole cohort, the mean time of follow-up was 34.9 ( $\pm 30.2$ ) months, respectively. In the whole population, recurrences were observed in 240 of the 1228 women (19.5%). The median and mean time of recurrence were 27 [1-386] and 37.7 ( $\pm 36.2$ ) months, respectively. In the whole population, the respective 5-year OS and DFS were 80.7% (95% CI, 77.2-84.4) and 75.7 (95% CI, 72.4-79.3%), respectively.

The survival curves are shown in figure 1. The cancer-specific survival was significantly lower in elderly and very elderly patients ( $p < 0.001$ ) (figure 1). The three-year DFS, CSS and OS rates are shown in table S1 (Supplementary data, table S1) (univariate analysis) and table 4 (multivariate analysis).

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## Discussion

Present study highlights the occurrence of more aggressive endometrial cancer in elderly (>65 years) and very elderly (>80 years) patients when compared with younger patients<sup>27</sup>. Despite more aggressive histology (higher rate of type 2 cancer or LVSI), elderly and very elderly women had significantly less surgical staging (less lymphadenectomy) and less adjuvant radio- or chemotherapy, even when adjuvant treatment was required by guidelines according to tumour status. Data from the follow-up highlight the fact that CSS was significantly lower in elderly and very elderly women compared with their younger counterparts. Thus, this higher rate of cancer related mortality could be due to the occurrence of more aggressive endometrial cancer in elderly women but also to under-treatment. The three-year OS rate was lower than the CSS rate, indicating that death was due to cancer but also to causes other than cancer. Thus, the joint causes of death in the elderly indicate that standard treatments should be performed in some elderly patients but that the entire group of elderly patients would not benefit from this standard treatment, as some of them die from causes other than cancer. Our study emphasizes the urgent need for specific guidelines for elderly and very elderly patients with endometrial cancer.

Physicians have to consider which surgical staging to perform in elderly and very elderly women, especially for lymph node dissection associated with hysterectomy. Although minimally invasive surgery is feasible in the elderly and has shown fewer complications than laparotomy [33], major complications, grade III and IV according to the Clavien-Dindo classification [34], remain higher in patients > 70 years old<sup>17</sup>. The performance of lymph node dissection increases the surgery length and the rate of complications, particularly in the elderly<sup>28,29</sup>. Nevertheless, known lymph node status remains crucial to tailoring adjuvant treatment, especially in high-risk endometrial cancer, which occurs more frequently in the elderly<sup>30,31</sup>. Sentinel lymph node biopsy could resolve the question of node status in endometrial cancer because it addresses lymph node involvement with less morbidity<sup>22,32,33</sup>. Unfortunately, our results showed that sentinel lymph node biopsy was used less often in elderly and very elderly patients, despite their poorer prognosis endometrial cancer.

The choice of adjuvant treatment depends on the cancer prognosis but also on life expectancy, especially in elderly and very elderly patients. In the present study, as others, we showed that elderly and very elderly women received significantly less adjuvant chemo- and radiotherapy than younger patients, despite their higher rate of high-risk endometrial cancer<sup>34-36</sup>. The Post Operative Radiation Therapy in Endometrial Carcinoma (PORTEC) 1 trial showed that women over the age of 60 were threefold more likely to have a locoregional recurrence following radical surgery compared to younger patients (HR 3.90 p = 0.0017)<sup>37</sup>. The local recurrence rate in the PORTEC 1 study population was reduced from 15.5% to 6.0% with the addition of post-operative external beam

radiotherapy (EBRT). Of note, in present study, elderly had significantly less EBRT. Although, there was no significant difference in late radiation toxicity between patients aged  $\leq 64$ , 65–74 and  $\geq 75$  years old<sup>38</sup>.

One of the limitations of the present study was its retrospective nature, which led to missing data; however, the present cohort was very large, one of the most important published to date<sup>19</sup>, and the patients were managed in tertiary centers, which used well documented electronic charts. Secondly, the median follow-up for recurrence was relatively short. However, the majority of recurrences (74%; 63/85) occurred during the 2 years of follow-up. In addition, our median time of follow-up is consistent with previous studies evaluating the prognosis of endometrial cancer<sup>39,40</sup>. Thirdly, during the data collection period, there were changes in staging modalities (FIGO classification)<sup>26</sup> and in the indications for nodal staging and adjuvant therapies. For example, para-aortic lymph node dissection was not systematically recommended in France for high-risk patients before 2010. In the same way, in a recent pooled analysis of the PORTEC-1 and -2 trials on the clinical impact of LVSI, the authors report that substantial LVSI remains the strongest independent prognostic factor for pelvic regional recurrence, distant metastasis and OS<sup>15,16</sup>. Hence, for unstaged women, EBRT is recommended for unequivocally positive LVSI to reduce pelvic recurrence, by ESMO/ESGO/ESTRO<sup>41</sup>. In the same way, chemotherapy is now recommended for high-risk endometrial cancer. We noted less adjuvant treatment in elderly and very elderly, but younger counterpart did always not have optimal treatment, especially in high-risk endometrial cancer, because of these recommendation changes. Besides, during the data collection period, perception of aging changed in the oncology field, the concept of frailty was introduced to assess therapeutic morbidity risk<sup>42-44</sup>. The lower rate of lymph node dissection in the elderly and very elderly patients could have been due to a discrepancy between pre- and postoperative risk groups in whom lymph node dissection was not systematically recommended, mainly due to the associated morbidities<sup>45</sup>. Lastly, no attempt was made to replace numerical age by criteria evaluating life expectancy. Defining elderly patients based on functional status using geriatric evaluation tools might have been more discriminatory than age alone<sup>46</sup>. Some validated tools exist to predict frailty<sup>47</sup> and toxicity from chemotherapy<sup>43,44,47</sup>, but not for oncologic surgery and chronological age remains a crucial determinant of treatment decisions<sup>48,49</sup>.

## **Conclusion**

Our large cohort study highlights the worse prognosis of endometrial cancer in elderly and very elderly patients when compared with their younger counterparts. Despite the significantly higher rate of high-risk endometrial cancer in the elderly, the rates of lymph node dissection and adjuvant therapy were significantly lower. The

significantly lower CSS rate in these elderly populations could have been due to their higher rate of high-risk endometrial cancer but also to under-treatment.

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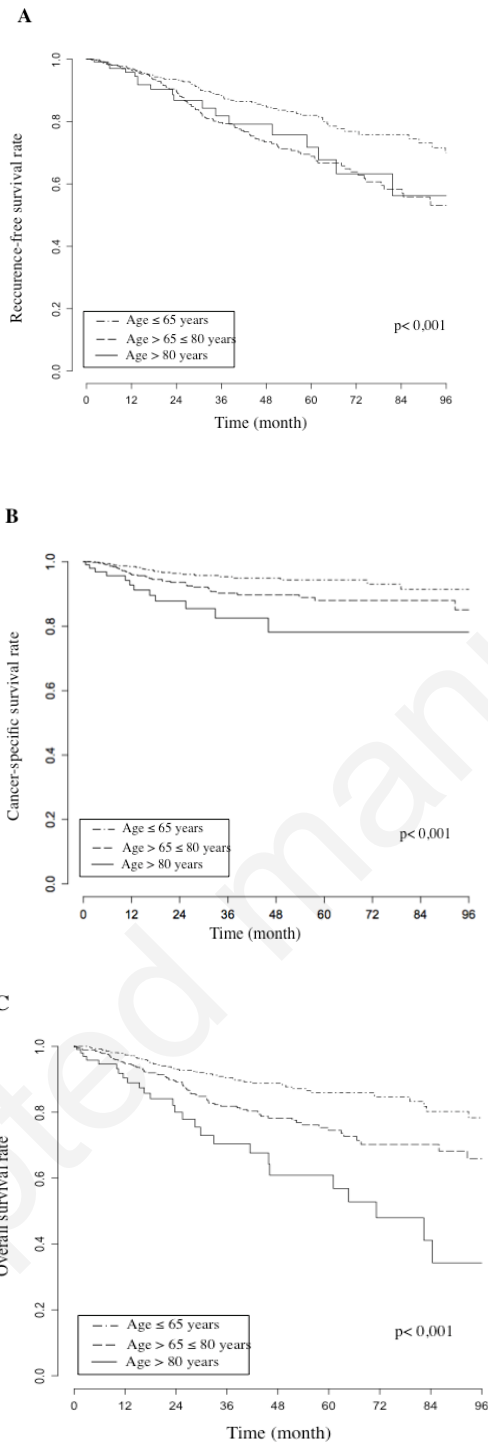
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**Figure 1: Survival curves: Disease-free survival (A), Cancer-specific survival (B), Overall survival (C)**



**Table 1:** Patient characteristics

Characteristics	Population n (%) N=1228	Age ≤ 65 years n (%) N = 582	65 years < Age ≤ 80 years n (%) N = 526	Age > 80 years n (%) N= 120	P value
Age (years), mean (±SD)	66 (±0.6)	57 (±0.5)	72.2 (±0.3)	83,9 (±0.6)	<0.001
BMI (kg/m <sup>2</sup> ), mean (±SD)	29.5 (±0.4)	30.30 (±0.7)	29.2 (±0.6)	26.6 (±1.0)	0.003
<b>Parity</b>					
- 0	137 (11%)	83 (14%)	37 (7%)	17 (14%)	0.002
- 1	190 (15%)	80 (14%)	89 (17%)	20 (17%)	
- ≥ 2	537 (44%)	239 (41%)	243 (46%)	55 (46%)	
- NC	364 (30%)	179 (31%)	157 (30%)	28 (23%)	
<b>Menopause</b>					
- Yes	964 (78%)	397 (68%)	526 (100%)	120 (100%)	<0.001
- No	93 (8%)	93 (16%)	0 (0%)	0 (0%)	
- NC	171 (14%)	92 (16%)	0 (0%)	0 (0%)	
<b>Arterial hypertension</b>					
- Yes	434 (35%)	151 (26%)	218 (41%)	65 (54%)	<0.001
- No	495 (40%)	278 (48%)	183 (35%)	34 (28%)	
- NC	299 (25%)	153 (26%)	125 (24%)	21 (18%)	
<b>Diabetes</b>					
- Yes	186 (15%)	87 (15%)	75 (14%)	24 (20%)	0.453
- No	891 (73%)	422 (73%)	381 (73%)	88 (73%)	
- NC	151 (12%)	73 (12%)	70 (13%)	8 (7%)	
<b>Menopausal hormone therapy</b>					
- Yes	180 (15%)	76 (13%)	99 (19%)	5 (4%)	<0.001
- No	591 (48%)	293 (50%)	231 (44%)	67 (56%)	
- NC	457 (37%)	213 (37%)	196 (37%)	48 (40%)	
<b>Beast cancer antecedent</b>					
- Yes	85 (7%)	29 (5%)	44 (8%)	12 (10%)	0.062
- No	723 (59%)	343 (59%)	306 (58%)	74 (62%)	
- NC	420 (34%)	210 (36%)	176 (34%)	34 (28%)	

BMI: body mass index; NC: not communicated; SD: Standard Deviation

NC: not communicated



**Table 2:** Tumour characteristics

Characteristics	Population n (%) N=1228	Age ≤ 65 years n (%) N = 582	65 years < Age ≤ 80 years n (%) N = 526	Age > 80 years n (%) N= 120	P value
<b>Tumour size</b>					
- < 3,5 cm	404 (33%)	199 (34%)	173 (33%)	32 (26%)	
- ≥ 3,5 cm	383 (31%)	172 (30%)	168 (32%)	43 (36%)	
- NC	441 (36%)	211 (36%)	185 (35%)	45 (38%)	NS
<b>Myometrial invasion</b>					
- < 50%	607 (49%)	324 (56%)	233 (44%)	50 (42%)	
- ≥ 50%	500 (41%)	199 (34%)	243 (46%)	58 (48%)	
- NC	121 (10%)	59 (10%)	50 (10%)	12 (10%)	<0.001
<b>Histology</b>					
- Endometrioid	946 (77%)	476 (81%)	383 (73%)	87 (73%)	
- Serous	92 (8%)	35 (6%)	50 (10%)	7 (6%)	
- Clear cells	66 (5%)	28 (5%)	34 (6%)	4 (3%)	
- Other *	106 (9%)	34 (6%)	55 (10%)	17 (14%)	
- NC	18 (1%)	9 (2%)	4 (1%)	5 (4%)	0.001
<b>Histological type</b>					
- Type 1	981 (80%)	488 (84%)	403 (77%)	90 (75%)	
- Type 2	222 (18%)	83 (14%)	115 (22%)	24 (20%)	
- Other**	7 (1%)	2 (0%)	4 (0,5%)	1 (1%)	
- NC	18 (1%)	9 (2%)	4 (0,5%)	5 (4%)	0.003
<b>Histological grade</b>					
- 1	529 (43%)	277 (48%)	206 (39%)	46 (38%)	
- 2	344 (28%)	156 (27%)	154 (29%)	34 (29%)	
- 3	322 (26%)	134 (23%)	152 (29%)	36 (30%)	
- NC	33 (3%)	15 (2%)	14 (3%)	4 (3%)	0.037
<b>Lymphovascular space involvement</b>					
- Yes	360 (29%)	148 (26%)	172 (33%)	40 (33%)	
- No	743 (61%)	368 (63%)	309 (59%)	66 (55%)	
- NC	125 (10%)	66 (11%)	45 (8%)	14 (12%)	0.029
<b>Pelvic lymph node metastasis</b>					
- Yes	93 (10%)	47 (10%)	43 (10%)	3 (5%)	
- No	552 (57%)	278 (58%)	244 (59%)	30 (49%)	
- NC	316 (33%)	157 (32%)	131 (31%)	28 (46%)	NS
<b>Para-aortic lymph node metastasis</b>					
- Yes	34 (26%)	20 (25%)	13 (28%)	1 (33%)	
- No	81 (63%)	51 (64%)	29 (63%)	1 (33%)	
- NC	14 (11%)	9 (11%)	4 (9%)	1 (33%)	NS
<b>FIGO stage</b>					
- I	856 (70%)	413 (71%)	361 (69%)	82 (68%)	
- II	99 (8%)	40 (7%)	45 (9%)	14 (12%)	
- III	243 (20%)	115 (20%)	107 (20%)	21 (18%)	
- IV	30 (2%)	14 (2%)	13 (2%)	3 (2%)	NS
<b>ESMO/ESGO/ESTRO risk groups</b>					
- Low risk	399 (33%)	225 (39%)	142 (27%)	35 (29%)	
- Intermediate risk	155 (13%)	63 (11%)	80 (15%)	12 (10%)	
- High-intermediate risk	120 (10%)	54 (9%)	56 (11%)	10 (8%)	
- High risk	495 (40%)	215 (37%)	222 (42%)	58 (48%)	
- Advanced/metastatic	30 (2%)	14 (2%)	13 (2,5%)	3 (2%)	
- NC	29 (2%)	11 (2%)	13 (2,5%)	5 (4%)	0.003

\* mucinous, carcinosarcoma or undifferentiated, sex cord-stromal tumour, choriocarcinoma \*\* sex cord-stromal tumour, choriocarcinoma

NC: not communicated; NS: not significant

**Table 3:** Surgical characteristics and adjuvant treatment

Characteristics	Population n (%) N=1228	Age ≤ 65 years n (%) N = 582	65 years < Age ≤ 80 years n (%) N = 526	Age > 80 years n (%) N= 120	P value
<b>Surgical approach:</b>					
- Laparoscopy	632 (52%)	314 (54%)	262 (50%)	56 (46%)	
- Laparotomy	407 (33%)	183 (31%)	180 (34%)	44 (37%)	
- Vaginal approach	40 (3%)	11 (2%)	6 (1%)	12 (10%)	
- NC	149 (12%)	74 (13%)	78 (15%)	8 (7%)	0,002
<b>Sentinel lymph node</b>					
- Yes	304 (25%)	153 (26%)	137 (26%)	14 (12%)	
- No	626 (51%)	279 (48%)	273 (52%)	74 (62%)	
- NC	298 (24%)	150 (26%)	116 (22%)	32 (26%)	0,002
<b>Pelvic lymphadenectomy</b>					
- Yes	961 (78%)	482 (83%)	418 (79%)	61 (51%)	
- No	267 (22%)	100 (17%)	108 (21%)	59 (49%)	<0,001
<b>Para-aortic lymphadenectomy</b>					
- Yes	129 (11%)	80 (14%)	46 (9%)	3 (2%)	
- No	1099 (89%)	502 (86%)	480 (91%)	117 (98%)	<0,001
<b>No. pelvic node removed, mean (95% CI)</b>	11,5 (±0,4)	12,2 (±1,2)	11,2 (±1,6)	7,5 (±2,5)	0,045
<b>No. para-aortic node removed, mean (95% CI)</b>	13,9 (±1,5)	14,3 (±2,0)	13,1 (±2,4)	16 (±14,7)	NS
<b>Indicated pelvic lymphadenectomy*</b>	615 (50%)	271 (47%)	273 (52%)	71 (59%)	0,023
- Performed	481 (78%)	230 (85%)	218 (80%)	33 (46%)	
- Not performed	134 (22%)	41 (15%)	55 (20%)	38 (54%)	<0,001
<b>Indicated para-aortic lymphadenectomy*</b>	615 (50%)	271 (47%)	273 (52%)	71 (59%)	0,023
- Performed	116 (19%)	71 (26%)	42 (15%)	3 (4%)	
- Not performed	499 (81%)	200 (74%)	231 (85%)	68 (96%)	<0,001
<b>No adjuvant treatment</b>	385 (31%)	187 (32%)	143 (27%)	55 (46%)	<0,001
<b>Indicated EBRT*</b>	475 (39%)	201 (35%)	214 (41%)	60 (50%)	0,003
- Performed	117 (25%)	48 (24%)	44 (21%)	25 (42%)	
- Not performed	358 (75%)	153 (76%)	170 (79%)	35 (48%)	0,003
<b>Indicated chemotherapy*</b>	401 (33%)	172 (30%)	181 (34%)	48 (40%)	0,044
- Performed	173 (43%)	96 (56%)	72 (40%)	5 (10%)	
- Not performed	228 (47%)	76 (44%)	109 (60%)	43 (90%)	<0,001
<b>Indicated brachytherapy*</b>	384 (31%)	168 (29%)	184 (35%)	32 (27%)	0,05
- Performed	256 (67%)	113 (67%)	126 (68%)	17 (53%)	
- Not performed	128 (33%)	55 (33%)	58 (32%)	15 (47%)	NS

\* According to 2010 French guidelines

NC: not communicated; NS: not significant; EBRT: External beam radiotherapy.

**Table 4:** Three-year disease-free survival, cancer-specific survival and overall survival rates (multivariate analysis)

	<b>Disease-free survival</b> <b>HR (95% CI)</b>	<i>P</i>	<b>Cancer-specific survival</b> <b>HR (95% CI)</b>	<i>P</i>	<b>Overall survival</b> <b>HR (95% CI)</b>	<i>P</i>
<b><u>Age</u></b>						
- ≤ 65 years (ref)	1		1		1	
- 65 years < age ≤ 80 years	1.60 (1.15-2.2)	0.005	1.31 (0.68-2.52)	0.415	1.60 (1.04-2.45)	0.031
- > 80 years	1.93 (0.91-4.12)	0.088	2.76 (0.77-9.82)	0.118	3.22 (1.49-6.93)	0.003
<b><u>Adjuvant treatment</u></b>						
<b>Adjuvant treatment</b>						
- No (ref)	1		1		1	
- Yes	0.69 (0.35-1.35)	0.28	0.45 (0.10-1.94)	0.284	0.77 (0.34-1.79)	0.549
<b>External beam radiotherapy</b>						
- No (ref)	1		1		1	
- Yes	1.51 (0.99-2.31)	0.057	1.06 (0.49-2.27)	0.882	1.15 (0.70-1.89)	0.574
<b>Chemotherapy</b>						
- No (ref)	1		1		1	
- Yes	1.87 (1.26-2.77)	0.002	2.21 (1.01-4.81)	0.046	2.63 (1.59-4.37)	<0.001
<b>Vaginal brachytherapy</b>						
- No (ref)	1		1		1	
- Yes	0.61 (0.42-0.89)	0.011	0.80 (0.42-1.82)	0.537	0.78 (0.48-1.26)	0.307
<b><u>Lymphovascular space involvement</u></b>						
- No (ref)	1		1		1	
- Yes	2.02 (1.39-2.92)	<0.001	4.39 (2.02-9.52)	<0.00	3.03 (1.89-4.85)	<0.001
<b><u>Lymph node metastasis</u></b>						
- No (ref)	1		1		1	
- Yes	1.26 (0.84-1.89)	0.256	1.24 (0.58-2.65)	0.618	1.15 (0.69-1.94)	0.585
- Node status unknown (Lymphadenectomy not performed)	1.00 (0.59-1.71)	0.990	0 (0-0)	0.995	1.50 (0.81-2.76)	0.194