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Article

Improvement of Cancer Care – Analysis of ESGO Quality Indicators for the Surgical Treatment of Endometrial Cancer in Slovenian and Croatia Gynaecologic Oncology Departments

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Abstract

Aim: This study aims to analyze ESGO quality indicators for the surgical treatment of endometrial cancer patients at two gynecologic oncology departments in Slovenia and Croatia, providing recommendations for improving cancer care. **Methods:** We conducted a retrospective analysis of clinical data necessary to evaluate ESGO quality indicators for surgical treatment of endometrial cancer patients from 2020 to 2022. ESGO quality indicators were calculated, and the results were discussed to formulate suggestions for enhancing cancer care. Institutional review board approval was obtained for the analysis. **Results:** The analysis reveals that the Slovenian Department for Gynecology and Breast Oncology in Maribor achieved compliance with 24 out of 26 quality indicators, while the Department of Obstetrics and Gynecology in Rijeka met 18 out of 26. The disparity may be attributed to Maribor's status as an ESGO-accredited center in training since 2014, which facilitates more rapid updates in care practices. **Conclusions:** Based on our findings and epidemiological data, we recommend several actions to enhance cancer care in both countries: (a) advance initiatives for the centralization of care (2 to 3 centers in Slovenia and 5 to 6 in Croatia), (b) implement a national system for the prospective measurement of quality indicators, and (c) pursue center accreditation and gynecologist certification in subspecialty care by international societies such as ESGO, given the small size of both countries. Our results confirm that the analysis of ESGO quality indicators is a viable method for all stakeholders involved in enhancing cancer care.

Keywords: quality indicators; improvement of cancer care; endometrial cancer

1. Introduction

Improving cancer care quality is a key mission across all healthcare levels, from individual centers to national and international societies, policymakers, and EU-level programs. It is estimated that 30-40% of patients in the general population receive treatment that is not evidence-based, with 20-25% receiving unnecessary or potentially harmful interventions (1). Establishing quality care begins with developing transparent, evidence-based guidelines, followed by creating quality indicators to assess guideline adherence through clinical audits. Ideally, meeting these indicators would be linked to center accreditation and physician certification. In gynecologic oncology, the European Society for Gynecologic Oncology (ESGO) plays a pivotal role in this process (2, 3, 4, 5). Endometrial cancer, the most common gynecologic malignancy, has an increasing incidence in developed countries due to lifestyle factors like obesity and diabetes (6, 7). ESGO, along with ESTRO

and ESP, developed comprehensive guidelines for endometrial cancer treatment, which have been downloaded over 16,500 times (8). ESGO also established quality indicators (QIs) for the surgical management of endometrial cancer (3). In July 2025 an updated ESGO-ESTRO-ESP guidelines were published, further emphasizing molecular genetic testing in endometrial cancer (9).

This study analyzes ESGO QI compliance for endometrial cancer surgery in two university-level gynecologic oncology centers—one in Slovenia and the other in Croatia. Both centers are comparable in size, volume, and historical background. The study's goal was to assess QI fulfillment and compare performance between the two centers, providing insights for improving cancer care. And, to raise awareness about the relevance of prospective evaluation of standardized and universal quality indicators, with the goal of strengthening cancer care delivery and addressing disparities in access to high-quality services. The findings of the study are intended to encourage quality improvement and should not be used punitively against physicians or institutions.

2. Methods

The study was conducted at two gynecologic oncology centers: the Department of Gynecologic and Breast Oncology, University Medical Centre Maribor, Slovenia (MB center), and the Department of Obstetrics and Gynecology, Clinical Hospital Centre Rijeka, Croatia (RI center). MB center was ESGO-accredited in 2014, while RI center, though not yet accredited, is highly motivated to apply for ESGO accreditation.

The primary endpoint was the percentage of QIs meeting their target in each center. Secondary endpoints included measuring all QIs, comparing QI results between centers, assessing data availability, and formulating recommendations for future organizational improvements.

This retrospective study gathered data for ESGO QI calculation for the surgical treatment of endometrial cancer. Both centers completed the standard ESGO accreditation table, collecting data for all consecutive endometrial cancer patients from 2020 to 2022. A personal interview at RI center was conducted by the first author to gather additional information on process QIs. QIs were calculated using published methodology, and the percentage of targets achieved was determined for each center. The study was approved by the institutional review boards of both centers, and informed consent was waived due to the retrospective, anonymized nature of the data.

3. Results

The results are presented according to the numbering and calculations of ESGO QIs as outlined in the referenced publication. Where direct calculation was not feasible (for QI 14, QI 15, and QI 18), the results are presented differently, as the form of data did not permit exact calculation. A summary of the QIs is shown in Table 1.

Table 1. Overview of ESGO quality indicators. QI-quality indicator, MIS-minimally invasive surgery, BMI-body mass index, SNB-sentinel node biopsy.

Structural ESGO QI	Process ESGO QI	Outcome ESGO QI
a) Number of newly diagnosed cases of endometrial carcinoma treated per centre per year (QI1). b) Number of endometrial carcinoma primary	a) Surgery performed by subspecialized/dedicated gynaecologic surgeon (QI3). b) Treatment plan discussed at multidisciplinary team meeting (QI4). c) Proportion of patients undergoing complete	a) Proportion of patients with pre-operative work-up according to ESGO/ESTRO/ESP guidelines (QI6). b) Proportion of presumed FIGO stage I-II upstaged to IVB (QI7). c) Proportion of patients with non-ruptured uterus after hysterectomy (QI8).

surgeries performed per year (QI2). c) Centre participating in ongoing prospective studies (QI5).	molecular classification (QI23). d) Minimum required elements in surgical reports (QI25). e) Minimum required elements in pathology report (QI26).	d) Proportion of patients who undergone successful MIS (QI9). e) Proportion of patients with BMI>35 who undergone successful MIS (QI10). f) Proportion of conversions from MIS to laparotomy (QI11). g) Proportion of patients with intra-operative injuries (QI12). h) Proportion of infracolic omentectomy in presumed early stage serous, undifferentiated carcinoma or carcinosarcoma (QI13). i) Proportion of lymph node staging in high-intermediate, high-risk patients (QI14). j) Proportion of SNB (QI15). k) Number of SNB per surgeon per year (QI16). l) Proportion of ICG in SNB (QI17). m) Proportion of patients with site-specific LND if no SN mapping (QI18). n) Proportion of ultrastaging of SN (QI19). o) Proportion of bilateral mapping of SN (QI20). p) Proportion of macroscopic complete resection when curative intention for advanced stage (QI21). q) Proportion of macroscopic complete resection of recurrent disease in salvage surgery (QI22). r) Compliance with ESGO/ESTRO/ESP adjuvant treatment guidelines (QI24). s) Structured morbidity and mortality conference per year (QI27). t) Proportion of reoperations within 30 days (QI28). u) Structured prospective reporting of recurrences/deaths (QI29).
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Between 2020 and 2022, the centers managed 314 new endometrial cancer patients—183 in MB and 131 in RI (QI1). In both centers, over 90% of new patients and all with recurrent disease were discussed at a multidisciplinary team meeting before treatment (QI4). The few cases not presented

preoperatively involved patients initially operated on for benign conditions, where endometrial cancer was diagnosed incidentally.

In MB, patients participated in two prospective trials, TESLA-1 and EUGENIE. Additionally, in 2020, MB began the process of joining the ENGOT/CEEGOG Phase 2/3 commercial trial (Navtemadlin maintenance therapy for TP53WT advanced or recurrent endometrial cancer). No prospective trials were ongoing in RI (QI5).

Over 90% of patients in both centers underwent preoperative work-up according to ESGO/ESTRO/ESP guidelines, except those initially treated for benign conditions with an incidental cancer diagnosis (QI6).

Both centers reported over 99% of patients having the uterus removed intact, without morcellation or intraoperative rupture, with exceptions again involving benign cases (QI8).

In MB, two patients experienced intraoperative bowel injuries and one had a minor bladder injury (3/183 = 1.6%), all due to dense adhesions; one case required reoperation. No major intraoperative injuries occurred in RI over the three-year period (QI12).

In 99% of presumed early-stage cases, lymph node assessment was performed in both centers.

In MB, nearly all patients (99/101; 99%) had sentinel lymph node biopsy (SNB) performed by gynecologic oncologists (4 surgeons), with 2 cases by a new fellow under supervision. The average SNB procedures per surgeon per year was 13.5 (QI16). In RI, 86.8% (59/68) of SNB procedures were performed by gynecologic oncologists (5 surgeons), with an average of 6.3 per surgeon per year (QI16).

All identified sentinel nodes underwent ultrastaging in both centers (QI19). In MB, all patients had molecular classification per ESGO/ESTRO/ESP guidelines, with some tests (p53, MMR) done in-house and POLE outsourced through an established pathway. In RI, p53 and MMR were assessed, but POLE was not performed (QI23).

Post-surgery, all patients in both centers were discussed in multidisciplinary team meetings, with adjuvant treatment aligned with ESGO/ESTRO/ESP guidelines. The ESGO application aids clinicians in decision-making (QI24).

In MB, surgical reports are structured and uniform across all surgeons, including the items listed in QI25. In RI, reports are not structured.

In both centers, pathology reports include all items required by QI26, with structured reporting implemented during the study period. Multidisciplinary morbidity and mortality (MM) conferences are held in the event of major complications or unexpected deaths post-surgery, as mandated by hospital management, with a uniform structured report. All patients are discussed before and after surgery, as well as in recurrent/metastatic settings, though complications are not reported in a structured format (QI27).

In MB, a prospective database tracks all new cases, including complications and deaths. Hospital management systematically reports deaths, perioperative complications, and thromboembolic events to the department chief (QI29). Reoperations within 30 days after minimally invasive surgery were rare, with only one case (0.5%) in MB due to bowel injury. RI reported no reoperations within 30 days over the three-year period (QI28).

Both centers automatically report all recurrences and deaths to the national cancer registry, as legally required. Survival data is managed centrally by the national registries, not by the centers themselves (QI29). All other QIs are presented in Table 2.

Table 2. Results of selected quality indicator.

	MB centre (ESGO accredited in training)	RI centre	Target	Comment
All new endometrial cancer patients (three years period) (QI 1)	183	131	Optimal ≥ 90 per year Minimal: ≥ 50 per year	
No. of surgically treated patients (three years period) (QI 2)	150	122	Optimal ≥ 80 Minimal: ≥ 50	
No. of patients treated by dedicated gynaecologic oncologist (QI 3)	144/150 (96.0%)	91/122 (74.6%)	≥ 95%	
Upgrade of presumed early-stage disease to FIGO IV (QI 7)	2/135 (1.5%)	0	<5%	
Conversion to laparotomy (QI 11)	6/166 (5.2%)	4/72 (5.6%)	<10%	
Successful MIS (QI 9)	110/135 (81%)	68/106 (64.2%)	Optimal: ≥80% Minimal: 60%	
Successful MIS (QI 10)	26/31 (83.8%)	11/17 (64.7%)	>60%	
Complete resection of advanced/recurrent disease (QI 21)	12/14 primary advanced (85.7%)	5/10 primary advanced (50%) 4/6 recurrent (66.6 %)	≥75%	
Staging omentectomy (QI 13)	2/9 (22%)	5/18 (27.8%)	≥90%	Only data about final pathology are available
Using ICG for SNB (QI 17)	98/101 (97.0%);	68/68 (100%)	≥95%	Radioactive tracer used alone when technical issues with ICG equipment
Bilateral detection rate (QI 29)	80/101 (79.2%)	44/68 (64.7%)	≥75%	

Pelvic LND if unilateral detection/no mapping (QI 18)			>90%	Can not be calculated as SNB is performed also in low-risk patients where LND is not indicated if no mapping
Presumed early-stage disease and non endometrioid G1/2 disease (QI 14, QI 15)	31/31 lymph node status was done; 16/31 (51.6%) SNB 23/31 (74.2 %) LND	19/19 lymph nodes status done; 12/19 (63.2%) SNB 8/19 (42.1%) LND	>85% (QI 14) 90% (QI 15)	Can not be calculated from available data (some had both due to no mapping).

4. Discussion

The study confirmed that the MB center, ESGO-accredited in 2014, achieved a higher percentage of QI targets than the RI center (24/26; 92.3% in MB vs. 18/26; 69.2% in RI). In both centers, 3 QIs (QI 14, QI 15, QI 18) were not assessed due to a lack of data in a format suitable for calculation.

ESGO QIs for the surgical treatment of endometrial cancer are categorized into structural, process, and outcome indicators.

Structural QIs (Table 1; QI1, QI2, QI5):

MB met all three structural QIs, though its volume was at the minimum required level. Cases diagnosed at the end of December or beginning of January were allocated to either the previous or next year, but not both. RI was slightly below the targets for QI1 and QI2 and did not meet QI5, as no prospective trials were conducted.

Slovenia (2 million inhabitants) and Croatia (4 million) share a similar healthcare history, having both been part of the former Yugoslavia. Their healthcare systems are based on solidarity, with public providers delivering the majority of care. Neither country has a formal, government-led policy for the centralization of cancer care. In Croatia, all gynecologic departments can treat cancer patients, although the Ministry of Health designates "reference centers" for second opinions in gynecologic oncology. In Slovenia, while all gynecologic departments can treat endometrial cancer, centralization has been mildly encouraged by some governmental bodies, but no formal implementation strategy exists.

Epidemiological data from national cancer registries report approximately 370 new endometrial cancer cases annually in Slovenia (10) and 750 in Croatia (11). To optimize cancer care (in line with QI targets), 2 to 3 centers in Slovenia and 5 to 6 in Croatia would be ideal, ensuring no patients are treated outside these specialized centers.

Small-volume centers often face challenges in conducting prospective research due to a limited patient pool. Joining international research groups can enhance access to trials, although bureaucratic hurdles and language differences remain significant barriers. Our results and interviews indicate that ESGO accreditation may increase awareness and participation in international research networks, such as the Central and Eastern European Gynecologic Oncology Group (CEEGOG), of which MB is a member. This affiliation has allowed MB to host more prospective trials than the RI center.

Process QIs (Table 1; QI 3, QI 4, QI 23, QI 25, QI 26):

All listed QIs are met in MB. In RI, QI 4 (multidisciplinary tumor board discussions) and QI 26 (pathologic report requirements) are fully met; however, about 25% of patients are treated by general gynecologists (QI 3), the surgical report is unstructured (QI 25), and POLE is unavailable (QI 23).

In Croatia, subspecialty training in gynecologic oncology is established but not mandatory for treating cancer patients. Conversely, Slovenia lacks a formal gynecologic oncology subspecialty program, with only one individual having completed ESGO subspecialty training—currently employed at the MB center. The MB center's organization, with a dedicated gynecologic oncology department, facilitates subspecialization through practice and experience in line with ESGO curriculum. All gynecologists at MB dedicate over 80% of their time to gynecologic patients. Both countries could benefit from making international subspecialty training and licensing mandatory for treating gynecologic cancer patients, as evidence suggests that a surgeon's subspecialty background positively impacts oncologic outcomes (12).

Our results indicate that both centers recognize the importance of multidisciplinary treatment planning and have integrated it into their daily practice. Decisions made during multidisciplinary team meetings are more likely to align with evidence-based guidelines than those made by individual physicians (13, 14, 15). Centralization of care allows access to various specialists and necessary equipment in one location. As both centers are part of university hospitals, they benefit from the availability of specialists and organized multidisciplinary team meetings, further supporting the case for centralization in both countries.

Molecular markers for endometrial cancer are rapidly emerging as diagnostic tools that significantly influence treatment modalities (2, 9, 16). POLE is one such marker, though its laboratory performance requirements and costs limit its availability. Our analysis based on ESGO QIs can assist departments in advocating for the availability of POLE, whether within or outside their institutions, to hospital management and insurance companies.

Outcome ESGO QI (Table 1; QI 6-22, QI 24, QI 27, QI 28, QI 29)

Both centers have implemented modern management practices for patients with endometrial cancer, though some QIs do not meet target values. The RI center has yet to fully adopt the requirement for subspecialists to perform surgeries on all patients, contributing to a low number of sentinel node biopsies (SNBs) per surgeon annually and resulting in failure to meet the target for bilateral mapping. In contrast, while the MB center has achieved the bilateral mapping target, it has not reached the recommended number of SNBs performed by a single surgeon (Table 2).

Being situated in a small country leads to smaller centers, even at the university level. Centers must balance the number of new patients per surgeon with the constant availability of surgeons, who may need to take holidays, attend educational events, or manage sick leave. Consequently, the MB center likely has an optimal number of surgeons, whereas the RI center may benefit from having one fewer. Both centers address the lower patient volume per surgeon by assigning two dedicated surgeons to most surgeries. Centralizing care within a limited number of centers would enhance patient numbers and care quality.

Our analysis revealed that while both centers have access to all necessary data, it is not organized in a way that allows for automatic calculation of QIs (QI 14, QI 15, QI 18). These indicators relate to the estimation of the sentinel node biopsy (SNB) algorithms used by the centers. According to guidelines, surgical assessment of lymph nodes is not required for low-risk endometrial cancer patients, although SNB can be performed. For high and intermediate-high risk patients, surgical lymph node assessment is recommended, and SNB is an acceptable method (2, 9). If the sentinel node is not detected, a site-specific lymphadenectomy should be conducted.

Both centers utilize the Mark-Sloan-Kettering Cancer Center algorithm (17), leading us to suspect that QIs 14, 15, and 18 are being met, even though the data format does not permit direct calculation.

Prospective collection and analysis of perioperative complications, along with proper documentation, are essential for quality control. Currently, neither country has established national

quality control programs to systematically collect indicators such as complications, readmissions, and reoperations. Both departments monitor their patients and maintain prospective databases, and they have guidelines from hospital management for reporting multidisciplinary team meetings. However, the implementation of objective tools for assessing and analyzing perioperative complications, such as the Clavien-Dindo classification (18), is recommended for both centers.

Both centers recognize that published ESGO QIs are valuable for performance assessment and serve as practical guides for future organizational changes. These indicators provide an objective tool for engaging with hospital management and national policy bodies.

5. Conclusions

Our results demonstrate that the included ESGO-accredited center exhibited superior compliance with ESGO quality indicators for endometrial cancer treatment compared to a similarly positioned center in the healthcare system. The prospective collection and analysis of quality indicators enable centers to perform objective self-assessments, inform future organizational planning, and support national policies aimed at improving cancer care. This analysis confirms the feasibility of using ESGO quality indicators as a method for all stakeholders to enhance cancer care. Furthermore, establishing EU-based international prospective databases with standardized data collection for automatic quality indicator calculation would serve as a valuable tool for implementing guidelines, harmonizing cancer care, and reducing disparities in access to high-quality care.

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