Research Article / Araştırma Makalesi

Management of Incidentally Diagnosed Endometrial Cancer: A Single-Center Experience

Tesadüfen Tanı Konulan Endometrium Kanserinin Yönetimi: Tek Merkez Bir Deneyimi

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Abstract

Background: This study aimed to evaluate the clinical characteristics and treatment strategies of patients who were incidentally diagnosed with endometrial cancer following hysterectomy performed for benign indications.
Materials and Methods: In this retrospective study, data of patients who were referred to our gynecologic oncology clinic between October 15, 2023, and October 15, 2024, after being incidentally diagnosed with endometrial cancer following hysterectomy for benign reasons were reviewed. Clinical, pathological, and surgical data were obtained from hospital records, and descriptive statistics and comparative analyses were conducted using SPSS version 29.
Results: A total of 57 patients were included in the study. The mean age was 53.9 ± 8.2 years, and 57.9% of the patients were postmenopausal. The most common histological subtype was endometrioid (94.7%), and superficial myometrial invasion was present in 86.0% of the cases. Preoperative endometrial sampling had not been performed in 28.1% of the patients. While 28.1% of the patients underwent completion surgery, 71.9% were managed conservatively with close follow-up. Block revision of pathology slides was performed in 15 patients whose initial diagnoses were made at centers lacking experience in gynecologic oncology, to ensure diagnostic accuracy. Following expert pathological re-evaluation, diagnostic changes were identified in 8 of these cases (53.3%). In patients with grade 2–3 tumors, deep myometrial invasion, lymphovascular space invasion, and the need for further surgical intervention were found to be significantly more frequent ($p < 0.05$).
Conclusions: Incidentally diagnosed endometrial cancer requires a multidisciplinary and risk-adapted approach. This study highlights the value of pathology slide revision, particularly in cases initially reported by centers lacking gynecologic oncology expertise, in guiding postoperative management decisions. While conservative follow-up is safe for selected low-risk patients, timely completion surgery and adjuvant therapy are essential in high-risk cases.

Keywords: Hysterectomy, Endometrial Cancer, Incidental, Follow-Up, Management

Öz

Amaç: Bu çalışma, benign nedenlerle histerektomi uygulanan hastalarda tesadüfi olarak tanı alan endometrium kanserli olguların klinik özelliklerini ve tedavi yöntemlerini değerlendirmeyi amaçlamaktadır.
Materyal ve Metod: Bu retrospektif çalışmada, 15 Ekim 2023 – 15 Ekim 2024 tarihleri arasında benign endikasyonlarla histerektomi sonrası tesadüfen endometrium kanseri tanısı alarak jinekolojik onkoloji kliniğimize yönlendirilen hastaların verileri incelenmiştir. Klinik, patolojik ve cerrahi veriler hastane kayıtlarından elde edilmiş; tanımlayıcı istatistikler ile karşılaştırmalı analizler SPSS 29 programı kullanılarak gerçekleştirilmiştir.
Bulgular: Çalışmaya toplam 57 hasta dâhil edildi. Ortalama yaş 53,9 ± 8,2 yıl olup, hastaların %57,9'u postmenopozal dönemdeydi. En sık rastlanan histolojik alt tip %94,7 oranıyla endometrioid tip idi ve olguların %86,0'ında yüzeyel myometriyal invazyon mevcuttu. Preoperatif endometrial örnekleme hastaların %28,1'inde yapılmamıştı. Hastaların %28,1'ine tamamlayıcı cerrahi müdahale planlanırken, %71,9'u konservatif olarak yakın takip ile yönetildi. Patoloji blok revizyonu, jinekolojik onkoloji alanında deneyimi olmayan merkezlerde değerlendirilen 15 hastada, tanısal doğruluğu sağlamak amacıyla gerçekleştirilmiştir. Uzman patoloji incelemesi sonucunda bu hastaların 8'inde (%53,3) tanıda değişiklik saptanmıştır. Grade 2–3 tümörlerde derin invazyon, lenvovasküler alan invazyonu ve cerrahi gereksinimi anlamlı olarak daha yüksek bulundu ($p<0,05$).
Sonuç: Tesadüfen tanı konulan endometrium kanseri olgularında multidisipliner ve risk temelli bir yaklaşım gereklidir. Bu çalışma, özellikle jinekolojik onkoloji deneyimi olmayan merkezlerde raporlanan olgular için yapılan patoloji blok revizyonunun, tedavi kararlarını yönlendirmede önemli katkı sağladığını göstermektedir. Düşük riskli hastalarda konservatif takip güvenli bir seçenek olabilirken, yüksek riskli olgularda zamanında tamamlayıcı cerrahi ve adjuvan tedavi uygulamaları hayati önemdedir.

Anahtar Kelimeler: Histerektomi, Endometrial Kanser, İnsidental, Takip, Yönetim

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Introduction

Endometrial cancer (EC) is the most frequently diagnosed gynecological malignancy in developed countries, and its incidence continues to rise. This upward trend has been attributed to lifestyle-related factors such as obesity, changes in dietary habits, diabetes mellitus, late-onset menopause, and an aging population. In 2024, approximately 67,000 new cases and nearly 13,000 deaths associated with uterine corpus cancers were reported globally (1).

Hysterectomy is one of the most commonly performed gynecological procedures worldwide, typically indicated for benign conditions such as abnormal uterine bleeding and uterine fibroids. Incidentally diagnosed endometrial cancer refers to malignancy that is unexpectedly identified during or after a surgical procedure performed for non-malignant reasons. A review of the literature reveals a divergence in the incidence of incidentally detected endometrial cancer, which is reported to range between 0.19% and 3%. In a 2017 study, Thomas et al. (2) reported an incidence of 0.3% to 3% among cases where hysterectomy was performed for benign indications Similarly, Mahnert et al. (3), in a large-scale study involving over 370,000 patients, reported an incidence rate of 1.02%. In a cohort of 6,981 patients, Parsons et al. found an even lower rate of 0.19% (4).

Incidentally diagnosed endometrial cancer is often attributed to inadequate preoperative evaluation, the absence of endometrial biopsy prior to surgery, emergency surgeries performed without intraoperative frozen section analysis, errors in frozen section interpretation, or insufficient sampling techniques in the presence of focal lesions.

The absence of a preoperative diagnosis of malignancy may result in incomplete surgical staging and uncertainty in postoperative treatment decisions. Despite increasing clinical awareness, data regarding the incidence, risk factors, and optimal management strategies for incidentally diagnosed endometrial cancer remain limited in the current literature. Nonetheless, in most cases, the cancer is detected at an early stage. Management should be planned through a multidisciplinary approach, considering the stage of disease, histological subtype, depth of myometrial invasion, overall health status, age, and individual preferences of the patient.

This study aims to evaluate the clinical characteristics and management approaches of patients who were referred to our clinic with a postoperative diagnosis of endometrial cancer.

Materials and Methods

This retrospective cohort study was conducted by reviewing the medical records of patients referred to our gynecologic oncology clinic between October 15, 2023, and October 15, 2024, following an incidental diagnosis of endometrial cancer after undergoing hysterectomy for non-malignant indications. Data were retrieved from the institutional patient record system. No direct contact was made with the patients, and only existing clinical data were used. Maximum attention was paid to ensuring patient confidentiality throughout the study. Ethical approval was obtained from the Ethics Committee of İzmir city Hospital on 06/11/2024 (decision number: 2024/194).

In addition, block revision of pathology slides was performed in 15 patients whose initial diagnoses had been reported by centers lacking experience in gynecologic oncology and where diagnostic uncertainty was present. In these cases, histological subtype, tumor grade, depth of myometrial invasion, and the presence of lymphovascular space invasion (LVSI) were re-evaluated by a pathologist specialized in gynecologic pathology.

Descriptive statistics, including mean, standard deviation, minimum and maximum values, as well as frequencies and percentages, were used for data analysis. Pearson's Chi-square test was employed to compare categorical variables. Statistical analyses were performed using licensed SPSS version 29 software.

Results

The mean age of the patients was 53.9 ± 8.2 years, ranging from 34 to 70. The mean gravida was 3.0 ± 1.9, and the mean parity was 2.3 ± 1.6. The mean preoperative Ca125 level was 38.1 ± 84.2, and the mean preoperative endometrial thickness was 12.6 ± 6.9 mm (Table 1).

Among the patients with incidentally diagnosed endometrial malignancy, 57.9% were postmenopausal. Comorbid conditions were identified in 47.4% of cases, with hypertension (31.6%) and diabetes mellitus (29.8%) being the most common. Among the 9 patients with a history of previous surgery, 2 had a prior myomectomy, and of the 4 patients with a known cancer history, 3 had breast cancer and 1 had thyroid cancer. The most frequent preoperative clinical presentations were postmenopausal bleeding (54.4%) and abnormal uterine bleeding (22.8%). Additionally, menometrorrhagia was reported in 15.8% of patients, uterine prolapse in 3.5%, chronic pelvic pain in 1.8%, and a combination of pelvic pain and menometrorrhagia in 1.8%.

Table 1. Descriptive characteristics of patients with incidental endometrial cancer after hysterectomy.

	Average	Sd	Min	Max
Age	53.9	8.2	34	70
Gravida	3.0	1.9	0	8
Parity	2.3	1.6	0	7
Preoperative Ca125	38.1	84.2	3.9	479.0
Preoperative Endometrial Thickness	12.6	6.9	1.0	34.0

Sd: Standard Deviation, Min: Minimum, Max: Maximum

Table 2. Descriptive characteristics of patients with incidental endometrial cancer after hysterectomy.

	Number	(%)
Postmenopause	33	57.9
Additional Disease	27	47.4
Hypertension	18	31.6
Diabet	17	29.8
Past Operation History	9	15.8
Past Cancer History	4	7.0
Clinical Presentation		
Chronic Pelvic Pain and Menometrorrhagia	1	1.8
Chronic Pelvic Pain	1	1.8
Uterine descent	2	3.5
Menometrorrhagia	9	15.8
Postmenopausal Bleeding	31	54.4
Abnormal Uterine Bleeding	13	22.8
Preoperative Pathology		
None	16	28.1
Endometrial Intraepithelial Neoplasia	24	42.1
Endometrial Hyperplasia	13	22.8
Endometritis	2	3.5
Endometrium in the Proliferation Phase	2	3.5
Preoperative Myoma	30	52.6
Preoperative Ovarian Pathology	12	21.1
Operation Type		
TAH+BSO	29	50.9
TLH+BSO	24	42.1
VH	4	7.0
Frozen		
Benign	14	24.6
EN	15	26.3
Malign	13	22.8
Not wanted	15	26.3
Histological Subtype		
Endometrioid	54	94.7
Serous	2	3.5
Clear Cell	1	1.8
Invasion		
Superficial Invasion	49	86.0
Deep Invasion	8	14.0
LVSI	12	21.1
Grade		
Grade 1	41	71.9
Grade 2	14	24.6
Grade 3	2	3.5
Block Revision Request	15	26.3
Decision		
Follow-up	41	71.9
Surgical	16	28.1

TAH+BSO: Total Abdominal Hysterectomy+Bilateral Salpingo-Oophorectomy; TLH&BSO: Total Laparoscopic Hysterectomy+Bilateral Salpingo-Oophorectomy; VH: Vaginal Hysterectomy; EIN: Endometrial Intraepithelial Neoplasia; LVSI: Lymphovascular Space Invasion

Regarding preoperative endometrial histopathological findings, 28.1% of patients underwent surgery without endometrial sampling, while endometrial intraepithelial neoplasia (EIN) was identified in 42.1%, and endometrial hyperplasia in 22.8%. Leiomyoma were detected in 52.6% of patients preoperatively, and adnexal pathology in 21.1% (Table 2).

When analyzing the type of surgery performed, 50.9% underwent total abdominal hysterectomy with bilateral salpingo-oophorectomy, 42.1% underwent total laparoscopic hysterectomy with bilateral salpingo-oophorectomy, and 7.0% underwent vaginal hysterectomy.

Intraoperative frozen section results revealed EIN in 26.3% of patients, benign findings in 24.6%, and malignancy in 22.8%. In 26.3% of cases, frozen section analysis was not requested.

Endometrioid histology was the most frequent subtype, seen in 94.7% of cases. Serous carcinoma was identified in 3.5%, and clear cell carcinoma in 1.8%. Superficial myometrial invasion was observed in 86.0% of patients, while deep invasion was noted in 14.0%. Lymphovascular space invasion (LVSI) was present in 21.1% of cases. While 71.9% of incidentally diagnosed patients referred to our centre were given the decision for follow-up, 28.1% were given the decision for additional surgical intervention (Table 2).

Among patients with Grade 1 tumors, 63.4% were postmenopausal, compared to 43.8% in Grade 2–3 cases. Although not statistically significant, the presence of preoperative leiomyoma was higher in Grade 1 patients (61%) than in those with Grade 2–3 (31.3%) ($p = 0.043$). Adnexal pathology was found in 24.4% of Grade 1 cases and in 12.5% of Grade 2–3

(p = 0.477). Endometrioid histology constituted 97.6% of Grade 1 and 87.5% of Grade 2–3 cases (p = 0.187). Superficial invasion was significantly more common in Grade 1 cases (97.6%) compared to 56.3% in Grade 2–3. Deep invasion was significantly more frequent in Grade 2–3 (43.8%) (p < 0.001). LVSI was present in 12.2% of Grade 1 cases and in 43.8% of Grade 2–3 cases (p = 0.025). The need for surgical intervention was higher in Grade 2–3 (68.8%), while 87.8% of Grade 1 cases were managed with observation (p < 0.001) (Table 3).

Although intraoperative frozen section was reported in favor of malignancy in 13 patients, staging surgery could not be performed because there was no surgeon in the center to perform gynecologic oncologic staging. Block revision was performed in 15 cases, and pathological changes were noted in 53.3% (n = 8). Following revision, Grade 3 tumors were identified in 5 cases, serous carcinoma in 2, and clear cell carcinoma in 1.

Table 3. Descriptive characteristics of patients with incidental endometrial cancer after hysterectomy.

		Grade 1		Grade 2/3		
		Number	(%)	Number	(%)	p
Menopause	+	26	63.4	7	43.8	0.177
	-	15	36.6	9	56.3	
Preoperative Leiomyoma	+	25	61.0	5	31.3	0.043
	-	16	39.0	11	68.8	
Preoperative Ovarian Pathology	+	10	24.4	2	12.5	0.477
	-	31	75.6	14	87.5	
Histological Subtype	Endometrioid	40	97.6	14	87.5	0.187
	Nonendometrioid	1	2.4	2	12.5	
Invasion	Superficial	40	97.6	9	56.3	<0.001
	Deep	1	2.4	7	43.8	
LVSI	+	5	12.2	7	43.8	0.025
	-	36	87.8	9	56.3	
Decision	Follow-up	36	87.8	5	31.3	<0.001
	Surgical	5	12.2	11	68.8	

LVSI: Lymphovascular Space Invasion.

Discussion

The management of incidentally diagnosed endometrial cancer is multifaceted and depends on numerous variables. One of the most critical clinical dilemmas following diagnosis is determining whether a second surgery is necessary for complete surgical staging and how the need for adjuvant therapy should be assessed. Treatment strategies should be planned by considering not only the extent of disease, histological subtype, and prognostic characteristics of the tumor but also the patient's age, comorbidities, general performance status, and individual

preferences. Therefore, each case should be carefully evaluated and managed through a personalized, multidisciplinary approach.

Preoperative endometrial assessment is a key step in the early detection of endometrial cancer. In our study, 28.1% of patients diagnosed with incidental endometrial cancer had not undergone endometrial sampling prior to surgery. Despite the fact that the pipelle method was the preferred technique in all 41 patients in this study, it is possible that this method may be inadequate for the detection of focal lesions. In the literature, the false-negative rate for pipelle biopsy has been reported to reach up to 10% (5). These findings suggest that either the absence of preoperative sampling or reliance on blind techniques such as pipelle may increase the risk of incidental diagnosis. Particularly in elderly patients presenting with abnormal uterine bleeding and ultrasonographic evidence of focal endometrial lesions, comprehensive evaluation including hysteroscopy-guided biopsy is recommended when pipelle sampling is inconclusive. Hysteroscopy has been shown to offer more accurate diagnosis of histologic type and tumor grade in the presence of malignancy compared to blind endometrial biopsy (5,6).

Endometrial hyperplasia and EIN are recognized as precursor lesions of endometrial carcinoma and may coexist with malignancy. According to previous studies, approximately 40% of patients with atypical endometrial hyperplasia are diagnosed with concurrent endometrial carcinoma (7,8). Clinical and radiological factors that increase the risk of concurrent malignancy include advanced age, obesity, diabetes mellitus, and endometrial thickness ≥20 mm on transvaginal ultrasonography (8). In our study, 24 patients had a preoperative diagnosis of EIN and 13 had EH, underscoring the strong association of these lesions with underlying malignancy. These findings emphasize the need for meticulous preoperative endometrial evaluation and support the recommendation for surgical procedures to be performed in centers with expertise in gynecologic oncology staging.

Another crucial step in the management of patients with incidentally diagnosed endometrial cancer is the reevaluation of surgical specimens. When such a diagnosis is established, it is strongly recommended that the hysterectomy ± salpingo-oophorectomy specimens be re-examined at a center with expertise in gynecologic oncology pathology. During this process, a detailed pathological report should be requested, including confirmation of the diagnosis, histologic subtype, tumor grade, localization, depth of myometrial invasion, cervical involvement, tumor size, lymphovascular

space invasion (LVSI), and adnexal involvement.

In our study, pathological slide revision was performed in 15 patients, and significant changes were observed in 53.3% (n = 8). Following a thorough review of the relevant data, the tumour grade was re-evaluated and re-classified as Grade 3 in five patients. In addition, the serous carcinoma subtype was defined in two patients, and the clear cell carcinoma subtype was identified in one patient. These findings highlight the diagnostic and therapeutic importance of reviewing surgical specimens in patients with incidentally diagnosed endometrial cancer.

When surgery is performed at an external center, obtaining detailed intraoperative findings from the primary surgeon is essential for treatment planning. For example, in cases where supracervical hysterectomy has been performed or bilateral salpingo-oophorectomy was not carried out, the risk of cervical or synchronous ovarian involvement may pose significant clinical uncertainties. Completion staging surgery in such cases may help prevent unnecessary pelvic radiation. However, it is also associated with increased surgical morbidity. Therefore, individualized patient management through a multidisciplinary approach is of utmost importance.

For low-risk patients (Grade 1, endometrioid subtype, <50% myometrial invasion, LVSI-negative, tumor diameter <2 cm), current guidelines suggest that follow-up without staging surgery may be a safe alternative. Indeed, in this patient group, the risk of extrauterine disease is reported to be below 1%, with 5-year disease-free survival rates ranging between 95% and 99% (3,10). Especially in elderly or comorbid patients with high surgical risk, the morbidity of staging procedures may outweigh the potential survival benefit.

In contrast, for patients with Grade 2–3 tumors, serous or clear cell histological subtypes, positive LVSI, or deep myometrial invasion, it may be challenging to plan adjuvant treatment without comprehensive surgical staging. In such cases, lymph node evaluation, omentectomy, and peritoneal cytology are important not only for prognostic assessment but also for guiding further treatment.

The management of ovaries should be tailored based on the patient's age, histologic subtype, disease stage, presence of LVSI, and fertility expectations. In premenopausal patients who desire fertility preservation and have low-stage (Stage IA), low-grade (Grade 1–2), endometrioid-type tumors with <50% myometrial invasion and negative LVSI, ovarian preservation may be considered a safe option. However, in cases involving non-endometrioid histologic subtypes such as serous or clear cell carcinoma, high-grade tumors, positive LVSI, or suspected Lynch syndrome, bilateral salpingo-oophorectomy is generally recommended (10). In postmenopausal women, the risk of synchronous ovarian malignancy or metastatic involvement is higher; thus, oophorectomy is accepted as the standard approach.

In our study, three patients who underwent vaginal hysterectomy due to uterine prolapse did not undergo oophorectomy. All of these patients were premenopausal. Their final pathology revealed endometrioid histology, superficial myometrial invasion, and negative LVSI. After thorough counseling and obtaining written informed consent, the patients opted to preserve their ovaries based on oncologic suitability and personal preference. These patients were monitored with a follow-up schedule similar to that recommended for high-risk cases.

In patients diagnosed with incidental endometrial cancer, postoperative imaging plays a critical role in assessing disease spread, evaluating the need for adjuvant therapy, and determining whether completion surgery is necessary. This is particularly important when preoperative staging has not been performed or when the initial surgery was conducted at an external facility, warranting a systematic imaging approach.

As a first step, contrast-enhanced thoracoabdominal-pelvic computed tomography (CT) is preferred for evaluating distant metastases (particularly pulmonary) and assessing pelvic and para-aortic lymph node size (9). Pelvic magnetic resonance imaging (MRI) offers higher sensitivity than CT in detecting local disease extension, including cervical and parametrial involvement (11). Additionally, in the presence of suspicious postoperative findings such as vaginal bleeding, pelvic mass, or elevated tumor markers, MRI can aid in assessing residual disease or recurrence (12).

Positron emission tomography/computed tomography (PET/CT) may be useful in identifying metabolically active lymph nodes and distant metastases. However, its routine use is not recommended in early-stage cases and is instead reserved for high-risk patients (e.g., those with positive LVSI, high tumor grade, or radiologically suspicious lesions) (12). The sensitivity and specificity of PET/CT for detecting lymph node metastases have been reported as %63 and %94.7 respectively. Due to the risk of false negatives, direct surgical staging may be a more reliable approach for guiding adjuvant treatment in high-risk cases (13).

One of the most important clinical dilemmas in the management of incidentally diagnosed endometrial cancer is determining the optimal timing for completion staging surgery. When reoperation is indicated following oncologic surgery, the timing should consider both oncologic factors and the biological phases of wound healing. During the proliferative phase of wound healing, particularly between day 21 and week 6 postoperatively, collagen breakdown and remodeling predominate (14). During this period, collagen fibrils are disorganized, and the surgical site remains mechanically vulnerable. Therefore, early reintervention carries increased risks of wound dehiscence, herniation, and infection.

In our study, 16 patients underwent completion surgery, which included bilateral pelvic lymphadenectomy, para-aortic lymphadenectomy, and omentectomy. For patients managed conservatively in the low-risk group, follow-up was planned every 6 months for the first 2 years, consisting of physical examination and symptom review. For those whose ovaries were preserved, follow-up also included abdominal

CT every 6 months for 2 years, in line with protocols for higher-stage disease.

Decision-making in these patients must be individualized and discussed within a multidisciplinary tumor board. Moreover, in cases where complete staging cannot be performed but adjuvant therapy is considered, treatment protocols must be structured with acknowledgment of this staging uncertainty.

Surgical morbidity increases significantly in elderly patients. The literature highlights the adverse effects of pelvic lymphadenectomy and complete staging surgery on quality of life and functional status, particularly in individuals aged 75 years and older (15,16). Therefore, for low-risk elderly patients, close follow-up without surgical staging may be a preferable and safer approach.

In patients with significant comorbidities, such as diabetes mellitus, heart failure or chronic obstructive pulmonary disease, the potential risks of additional morbidity from further surgical procedures should be meticulously evaluated. In this particular subgroup, the administration of adjuvant therapy may be considered with greater frequency. In particular, when high-risk features such as deep myometrial invasion, LVSI, or high-grade tumors are present, radiation-based treatment strategies may serve as appropriate alternatives to surgery (10).

The diagnosis of incidental endometrial cancer, often discovered following surgery performed for presumed benign conditions, carries significant psychological implications. Patients who receive an unexpected cancer diagnosis after hysterectomy frequently experience anxiety, loss of trust, anger, and guilt. Furthermore, they are often left with emotionally distressing questions such as, “Was the surgery incomplete?” or “Has the cancer already spread?”, which can intensify uncertainty and distress about subsequent treatment decisions.

In particular, for patients who require additional surgery or adjuvant treatment, the process of conveying information must be managed with great sensitivity, and shared decision-making should be actively supported. Providing psychosocial support in the postoperative period can positively influence both treatment compliance and overall quality of life. A psycho-oncology specialist or clinical psychologist, integrated within the multidisciplinary team, should be available to offer timely and ongoing support during the post-diagnosis period (17).

From the moment of diagnosis, patients should receive clear and structured communication, both verbally and in writing. Topics such as the necessity for completion surgery, the rationale for adjuvant therapy, and potential follow-up plans should be explained transparently and comprehensively. This approach not only strengthens the patient and physician relationship but also helps to reduce anxiety (18).

Incidentally diagnosed endometrial cancer presents unique diagnostic and therapeutic challenges that require a multidisciplinary and risk-adapted approach. Our findings indicate that conservative follow-up is safe in selected low-risk patients, whereas completion staging and individualized adjuvant therapy are essential in high-risk cases. The study underscores the importance of pathology slide revision and expert imaging in enhancing postoperative decision-making. By presenting real-world data on surgical reconsideration, pathological reassessment, and adjuvant strategies, our study offers valuable insight into the management of these patients. Despite its retrospective and single-center nature, the findings carry practical relevance for optimizing personalized care.

Ethical Approval: *This study was designed in accordance with the Helsinki Declaration and approved by Ethics Committee of İzmir City Hospital. (Study ethics committee number: 2024/194; date 06/11/2024). Purpose and methods of the study were explained to patients, and they provided written informed consent.*

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