GYNECOLOGIC ONCOLOGY HANDBOOK
An Evidence-Based Clinical Guide

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An Evidence-Based Clinical Guide

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In Memoriam
Dr. Edward V. Hannigan

An amazing mentor, a consummate clinician, and a gentle soul.
non omnis moriar
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This handbook is structured to provide comprehensive care for the gynecologic cancer patient. It is directed toward clinicians at all levels of training and the chapters are tiered in this fashion. Basic diagnosis, workup, staging, and treatment are outlined first. Specific surgical and adjuvant therapies are then recommended reflecting current standards of care. Finally, the evidence-based medicine is summarized in support of recommended treatments. Thus, the medical student can have a dedicated overview, the resident can refer to directed patient care protocols, and the fellow and practicing physician can support their clinical decisions with easily accessible literature.

It has been our honor to put together this handbook for our friends and colleagues. We acknowledge the dedication it has taken from the physicians, support staff, and especially our patients, to design and participate in the trials that have advanced our knowledge of these difficult gynecologic cancers. We hope the information provided herein can continue to guide high-quality care and reflect our commitment to the subspecialty.
1. Gynecologic Oncology Referral Parameters

**Gynecologic Oncology Referral Parameters**

I. Endometrial Cancer
   A. Biopsy confirmed endometrial cancer of any grade

II. Pelvic Mass
   A. Presence of, or concern for, advanced disease:
      1. Omental caking
      2. Pleural effusion
      3. Ascites
   B. A clinically suspicious pelvic mass:
      1. Larger than 8 cm
      2. Complex
      3. Fixed
      4. Nodular
      5. Bilateral
      6. Excrescences
      7. Solid components
   C. Premenarchal girls with a pelvic mass
   D. Postmenopausal women with a suspicious mass or elevated tumor markers. Suspicious findings include: a solid mass, a simple mass greater than 8–10 cm, or a complex mass. ACOG recommends referral for a CA-125 above 35.
   E. Perimenopausal women with an ovarian mass, particularly when associated with an elevated CA-125. ACOG recommends referral for a CA-125 above 200 in pre- or peri-menopausal women.
   F. Young patients who have a pelvic mass and elevated tumor markers (CA-125, AFP, hCG, LDH)
G. A suspicious pelvic mass found in a woman with a significant family or personal history of ovarian, breast, or other cancers (one or more first-degree relatives).

III. Cervical Cancer
A. A biopsy (conization or directed) confirming invasive carcinoma
B. Women with suspicious cervical lesions should be referred but can be biopsied before referral.

IV. Vaginal Cancer
A. All women with invasive vaginal cancer
B. Depending on practitioner’s comfort level:
   1. Women with unexplained abnormal cytology after colposcopy and biopsy
   2. Women with VAIN 3 lesions (suspicious of invasion) who require treatment

V. Vulvar Cancer
A. Biopsy confirmed invasive vulvar cancer
B. Women with a suspicious vulvar lesion should be biopsied before referral. These suspicious lesions include:
   1. Nonhealing ulcers
   2. Areas of chronic pain or pruritus
   3. Areas of pigment change
   4. Grossly enlarged lesion
C. Depending on practitioner’s comfort level:
   1. Women with multifocal, complex, and/or recurrent VIN 3
   2. Women with Paget’s disease of the vulva

VI. Gestational Trophoblastic Disease
A. Referral should occur after evacuation of the molar pregnancy if there is evidence of persistent trophoblastic disease/gestational trophoblastic disease (GTD):
   1. GTD (low or high risk)
   2. Choriocarcinoma
   3. Placental site trophoblastic tumor
   If there is evidence of metastatic disease at initial diagnosis, referral should occur immediately.