GYN ONCOLOGY ROTATION INFORMATION
Key Places at Shands Jacksonville:

Gyn-Onc 2nd Year Resident: PGY 2
Gyn-Onc Chief Resident: PGY 4
Division Director: Karl Smith, MD

Attendants and Residents on the Service:

At the end of this week you should know who attends and residents and have attended to your case.

What we expect in a week on the Gynecologic Oncology Service:

When Gynecologic Oncologists do not manage breast cancer:
- Radiation/Adjuvant Chemotherapy:
  - Radiation Therapy: treatment for early-stage disease
  - Chemotherapy: treatment for advanced disease
- Fertility-Sparing Surgery:
  - Fertility-Sparing Surgery: treatment for early-stage disease
- Pelvic Exenteration:
  - Pelvic Exenteration: treatment for advanced disease

What is Gynecologic Oncology (Gyn-Onc)?

June 2012

Joint Meeting, UF COM Class of 2011

Authors:
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Division of Gynecologic Oncology
3rd Year Medical Student, UF COM Class of 2015
College of Medicine, Jacksonville
University of Florida
Other Cancers of Special Interest in Gyn Oncology

- Non-Gestational
  - Gestational
  - Trophoblastic Disease

Fallopian tube

Vaginal

Less Common Gynecologic Cancers

- Diagnosing, Staging and Treatment of Uterine Sarcomas Cancer
  - Recognize the difference between endometrial and uterine sarcoma
  - Recognize need for uterine biopsy
  - Recognize the uterine fibroids
  - Recognize the uterine fibroids from adenomyosis
  - Be able to recognize normal from abnormal appearing uter

Vulvar

- Diagnosing, Staging and treatment of epithelial ovarian cancer
  - Understand evaluation process for pelvic masses
  - Who is at risk?
  - Know basic types (epithelial, stromal, and germ cell)

Ovarian

- Recognize the names of high risk endometrial cancer types
- Diagnosing, Staging and Treatment of Endometrial Cancer
- Understand the relationship of endometrial hyperplasia to endometrial cancer
- Management of endometrial hyperplasia
- Evaluation of posmenopausal uterine bleeding
- Who is at risk?

Endometrial

- Diagnosing, Staging and Treatment of Invasive Cervical Cancer
- Diagnosing and treatment of cervical dysplasia (cervical intraepithelial neoplasia)
- Evaluation of abnormal Pap smear
- Understanding the importance of HPV in the development of cervical neoplasia
- Be able to recognize a normal from an abnormal cervix

Cervical

Common Gynecologic Cancers

Learning Objectives:

- Colon
- Breast
Personal surrogate (power of attorney)
Medical surrogate (power of attorney)
DNR order
Living will
End-of-life Issues

Non-compliance
Lack of family support
Lack of transportation
Lack of housing
Lack of funding
Social Issues

Other
HIV
Obesity
Diabetes Mellitus
Hypertension
Heart Disease
COPD

Associated medical problems

Diminished activity
Clinical depression
Chronic fatigue
Nausea and vomiting
Pain
Symptom management

Blood supply to target
Branched or tertiary
Branches of internal iliac artery
Pelvic anatomy

Surgical Issues

Targeted therapy
Immunotherapy
Hormone therapy
cytoxic chemotherapy

Internal beam (brachytherapy)
External beam (teletherapy)

Radiation therapy
Surgery

Treatment Modalities
Reurrence occurs in 50% within 2-3 years of initial diagnosis.

Am J Obstet Gynecol. 2011.)

diagnosis, then yearly. (see Table 3 Surveillance for Gynecologic Cancer, Japan.)

Follow-up: exams every 3-4 months for 2 years then 6 months until 5 years from

week intervals.

4. Neoadjuvant chemotherapy (palliative/platin agent) 3-4 cycles at 3

OR

Laparotomy

c. No definite role for long term chemotherapy or Znd look

b. IV/Ip chemotherapy (palliative pl, cisplatin Ip/Paclitaxel I) (*)

a. IV chemotherapy (taxane and platin agent, e.g.

3. Post-op Treatment

Fertility

2. Consider USG and staging for younger patients who wish to preserve

indicated. (Remember bowel prep)

biopsies, tumor debulking including bowel resection and colostomy if

1. Laparotomy, TAH-BSO, omentectomy, lymph node excision, peritoneal

Treatment:

2. Imaging: pelvic mass, ascites, ovarian thickening.

ascites.

indigestion, early satiety, abdominal swelling, constipation, pelvic mass,

1. Positive symptoms and exam: prolonged bloating, urinary frequency,

Tubal ligation and primary peritoneal cancer

Diagnoses of epithelial cancer (serous, endometrioid, mucinous, undifferentiated;)

Types: Epithelial (most common), Stromal and Germ Cell

Ovarian Cancer

"Smith Notes" for Gyn Oncology
Most common site of recurrence is vagina followed by lung, abdomen, and retroperitoneal lymph nodes. Get CT only if symptoms or physical findings.

Gynecol. 2011)
(see Table 2, surveillance for gynecologic cancer; Zabani, Am J Obstet
Exam 6 months for 2 years then 6 months until 5 years after diagnosis

Follow-up:

4. Special consideration for endometrial stromal/leiomysarcoma
3. Chemotherapy for special tumor types (serous, clear cell, or
spread of disease.
2. Chemotherapy with or without RT if peritoneal, ovarian or interstitial
spread to cervix.
1. Radiation therapy if positive lymph nodes or previously unrecognized

Post OP treatment: (follow NCCN guidelines)

3. Pre-op RT followed in 6 weeks by TAH-BSO
OR
2. Radical hysterectomy, BSO, LND for Stage II (cervical involvement)
and omentectomy for serous or clear cell cancers)
through vertical incision, laparoscopic or robotic, peritoneal biopsies
1. TAH-BSO, pelvic and para-aortic lymph node dissection (open

Treatment: Surgery:

6. Consider abdominal and pelvic CT with oral and IV contrast
5. Positive endometrial curettage on D&C
4. Thickened endometrium with irregular contour by hysteroscopy
3. Positive endometrial biopsy
cavity or fluid in cavity on CT or MRI
2. Abnormal image (thickened endometrial stripe, irregular endometrial
1. Postmenopausal bleeding

Diagnosis:

Endometrial cancer
Recurrent:

3. Recurrence occurs within 2-3 years in most cases where there is
   Gynecol, 2011.
(see Table 5 Surveillance for Gynecologic Cancer, Sabani, A. Obstet
2. Exam Q6 month x 2 years then Q6 months until 5 years after diagnosis.
1. Use vaginal dilator weekly if patient received RT

Follow-up:

4. Ureteral stent or nephrostomy if ureteral obstruction

b. Intracavitary RT x 2 (180 or Syed)
   a. External pelvic RT with weekly cisplatin chemotherapy (40 mg/m²)
   3. Cervical mass ≤ 4 cm or spread of disease outside cervix – radiation
   OR
   2. Cervical mass confined to cervix ≤ 4 cm – radical hysterectomy with
   1. Micro-invasive cancer up to 3 mm – simple hysterectomy, diagnosis

Treatment:

4. PET/CT base of skull to mid thigh to look for metastasis

b. Proctoscopy, radiation oncologist present.
   a. Pelvic exam under anesthesia (ELA) open includes cystoscopy and
   3. Cervical cone if suspicious Pap or cervical colposcopy
   2. Biopsy if visible cervical mass
   1. Biopsy if visible cervical mass

Diagnosis:

Cervical Cancer
new physical finding that suggests recurrent cancer.

2. Consider imaging studies such as CT only if new or unexplained symptoms or a
   months for 2 years, then yearly (see Table 5 in Surveillance for gynecologic
   cancer). Physical exam including care pelvic exam to look for local recurrence and

Follow-up:

1. Uterine or anus:

2. Consider chemoradiation for lesions for invasive cancers involving
   c. Postop pelvic RT if lymph nodes are involved.
   are involved on frozen section or if lesion crosses midline.
   2) Perform bilateral lymph node dissection if ipsilateral nodes
   cross the midline.
   1) Perform regional lymph node dissection if lesion does not
   and groin incisions.

B) Radical abdominal hysterectomy with at least 1 cm margin in invasive
   a. Excise lesion with 5 mm margin if invasion not suspected
   b. Surgery is the primary treatment for vulvar cancer.

Treatment:

be an option. Chest x-ray if CT or PET are not performed.

nodes are enlarged or fixed. PET/CT from base of skull to mid-thigh may
4. Imaging is individualized: consider chest, abdomen and pelvic CT if
   tumor, and location with regard to uterus, vagina and anus.
   3. Assessment requires careful palpation of groin, lymph nodes, size of
   2. Biopsy may be performed in office setting or OR
   1. Usually made visual inspection and biopsy.

Diagnosis:

Vulvar Cancer
Recurrent.

2. CT of abdomen and pelvis with oral and IV contrast if sympotm or sign of recurrence.

2011,

Surveillance for gynecologic cancers by Zabani, Am J Obstet Gynecol,

1. Exam g6 months with Pap x 2 years then yearly (see Table 5 in Follow-up:

2. Consider transvaginal excision of non-invasive cancer

1. Usually RT (EBRT with weekly cisplatin and brachytherapy (1VRT)

Treatment:

4. Consider EVA

3. PET/CT for metastatic evaluation

2. Requires biopsy for diagnosis

1. Usually presents as mass in vagina

Diagnosis:

Vaginal Cancer
Treatment for GTD

3. Get early pelvic sonogram if pregnancy suspected after previous.
2. Monthly serum hCG
1. Oral contraceptive agent or Depo Provera for at least 6 months

Follow-up:

3. Give at least one treatment after negative hCG
2. Multiple agents (EMA-CD) for recurrent or high-risk disease
1. Single agent methotrexate or actinomycin-D for post molar and
   Treatment:

3. Determine WHO score
   b. chest, abdomen, and pelvic CT if rising hCG
   a. Serial quantitative serum hCG, consider hCG-H
2. After prior IUP (term, SA, or ectopic)
   d. Chest x-ray if hCG rises
   c. Serial quantitative serum hCG levels
   b. Endometrial suction curettage
   a. Abnormal sonogram

1. Molar pregnancy

Diagnosis:

GTD
Lower uterine segment (cervical/parametrial) involvement:
Positive lymphovascular space invasion
Age < 60 years

Adverse risk factor to be considered in treatment (see NCCN guidelines):
Positive cervical cytology should be reported separately without changing stage
and no longer as Stage II.

* Any grade (G1, G2, G3); Serous and clear cell are always Grade 3
and/or intraperitoneal lymph nodes.

LY: Distant metastases, including intra-abdominal metastases
LYA: Tumor invasion of bladder and/or bowel mucosa

Stage 1V: Tumor invades bladder and/or bowel mucosa, and/or distant metastases.

Stage 1V A: Tumor invades bladder and/or bowel mucosa, and/or distant positive pelvic lymph nodes.

Stage 1VC: Positive para-aortic lymph nodes with or without:

1VC: Positive pelvic lymph nodes

1VB: Metastases to pelvis and/or para-aortic lymph nodes

1VA: Vaginal and/or parametrial involvement

Stage III A:Tumor invades the serosa of the corpus uteri and/or adnexae

Stage III B: Local and/or regional spread of the tumor

Stage III C: Uterus.

Stage II A: Tumor invades the cervical stroma, but does not extend beyond the Endometrial Cancer (FIGO 2009)

Stage I: Tumor confined to the corpus uteri

Gyn Oncology Staging
Uterine Sarcoma (FIGO 2009)

Stage IV
Distant spread of cancer

Stage III
Regional lymph node metastases
Stage IIIA: More than one site
Stage IIIB: One site
(Not just protruding into abdominal cavity)
Stage IIIC: Tumor infiltrates abdominal tissues

Stage II
Tumor invades other pelvic tissues
Stage IIA: Tumor invades adnexa
Stage IIB: Tumor invades other pelvic organs

Stage I
Tumor extends beyond the uterus, but within the pelvis
Stage IA: Tumor greater than 5 cm
Stage IB: Tumor less than 5 cm or less in greatest dimension

Stage 0
Tumor limited to uterus

Notes:

1. Carcinosarcoma should be staged as carcinomas of endometrium
2. Simultaneous tumors of the uterine corpus and over/ovary/pelvis
3. Types of uterine sarcomas: leiomyosarcoma, undifferentiated sarcoma, and endometrial stromal sarcoma

I/B: Distant metastasis (lung, liver, brain, para-aortic LN, etc.)
I/A: Tumor invades bladder or rectum
Bulging edema of bladder is not sufficient to qualify as Stage I (V) true pelvis.

Stage I: Tumor extends beyond uterus to mucosa of bladder or rectum and/or

Stage IIb: Tumor extends to pelvic sidewall and/or causes hydronephrosis

Stage IIIa: Tumor extends to lower 2/3 of vagina but without extension to

Stage IIIb: Tumor extends to pelvic sidewall and/or involves lower 1/3 of vagina

Stage II: Tumor extending to parametrium, any size

Stage IIb: Tumor < 4 cm

Stage IIa2: Tumor extending to upper vagina without parametrial extension

Stage IIa1: Tumor extending to upper vagina without parametrial extension

Stage III: Invasion beyond cervix but not to pelvic sidewall or lower 1/3 of vagina

Stage Ib2: Invasion > 4.0 cm

Stage Ib1: Invasion > 4.0 cm lesion.

Stage Ib: Invasion > 5 mm in depth or > 7 mm in width or clinically visible

Stage Ia2: Invasion < 3 mm but > 5 mm and less than 7 mm in width

Stage Ia1: Invasion not greater than 3.0 mm in depth or 7 mm in width

Stage Ia: Invasion diagnosed by microscope only

Stage I cancer confined to cervix

Invasive Cervical Cancer (FIGO 2009)
STAGE IV: Distant metastases (e.g., malignant pleural effusion, liver parenchymal metastases).

STAGE III: Macrometastasis or peritoneal metastases beyond pelvis.

STAGE II: Macrometastasis outside the pelvis.

STAGE I: A. Microscopic metastasis in ascites or peritoneal washings.

STAGE II A: Tumor involves one or both ovaries with microscopic confirmation.

STAGE II B: Tumor involves one or both ovaries with pelvic extension.

STAGE II C: Tumor involvement of peritoneal washings.

STAGE I B: Tumor involves one or both ovaries; capsule intact; no tumor on ovaries.

STAGE I A: Tumor limited to one ovary; capsule intact; no tumor on ovaries.

STAGE I: Tumor limited to ovaries (one or both).

Ovarian Cancer and Primary Peritoneal Cancer (FIGO 2009)
Stage IV: Tumor invades any of the following:

- Or distant structures.

Stage III: Tumor invades other regional sites (upper 2/3 urethra, upper 2/3 vagina

- With positive node with extracapsular spread

- (iii) 3 or more lymph node metastases (>5 mm)

- (ii) With 2 or more lymph node metastases (>25 mm)

- (i) With 1 lymph node metastasis (>25 mm), or

Stage III: Tumor invades pelvic lymph nodes.

- Positive inguino-femoral lymph nodes.

Stage III: Tumor invades pelvic lymph nodes with extracapsular spread

Stage II: Tumor of any size with without extension to adjacent perineal structures.

- Lower 2/3 of urethra, lower 1/3 or vagina or anus (and no nodal metastases)

Stage I: Tumor of any size with extension to adjacent perineal structures, no nodal metastases, no modal metastases

Stage IA: Lesion is less than 2 cm in size and continued to vulva or perineum.

Stage IB: Lesion is greater than 2 cm in size or with stromal invasion ≥ 2 mm.
Pelvis, spread to distant organs

Stage IV

Extension to pelvis or involvement of bladder or rectal mucosa. Bullous edema does not permit a case to be assigned to

Stage IV

Extension to pelvis sidewall

Stage III

Involvement of suburethral tissue but without extension to pelvic sidewall

Stage II

Invasive cancer limited to vaginal wall

Stage I

Carcinoma in situ (VAIN 3) – non invasive

Stage 0

Clinically staging
To determine total score, add individual scores.

<table>
<thead>
<tr>
<th>Prior chemotherapy (cm)</th>
<th>Single drug</th>
<th>2 or more drugs</th>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Largest tumor size</td>
<td>&lt;5</td>
<td>3 - 5</td>
<td>4</td>
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<tr>
<td></td>
<td>&lt;8</td>
<td>4 - 8</td>
<td>2</td>
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<tr>
<td>Liver</td>
<td>&lt;10</td>
<td>10 - 10.4</td>
<td>1</td>
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<tr>
<td>Brain</td>
<td>&lt;10</td>
<td>10.4 - 10.9</td>
<td>1</td>
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<tr>
<td>Kidney</td>
<td>&lt;10</td>
<td>10.9 - 10.9</td>
<td>1</td>
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<td>GI tract</td>
<td>&lt;10</td>
<td>10.9 - 10.9</td>
<td>1</td>
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<tr>
<td>Splenectomy</td>
<td>&lt;10</td>
<td>10.9 - 10.9</td>
<td>1</td>
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<tr>
<td>Vaginal</td>
<td>&lt;10</td>
<td>10.9 - 10.9</td>
<td>1</td>
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<tr>
<td>Site of Mets</td>
<td>&lt;10</td>
<td>10.9 - 10.9</td>
<td>1</td>
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<tr>
<td>Lungs</td>
<td>&lt;10</td>
<td>10.9 - 10.9</td>
<td>1</td>
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<tr>
<td>No. Mets</td>
<td>&lt;10</td>
<td>10.9 - 10.9</td>
<td>1</td>
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<tr>
<td>HCG (serum)</td>
<td>&lt;10³</td>
<td>10³ - 10⁴</td>
<td>1</td>
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<tr>
<td>Time interval (m)</td>
<td>&lt;12</td>
<td>12 - 24</td>
<td>1</td>
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<tr>
<td>Antecedent pregeb</td>
<td>&lt;4</td>
<td>4 - 6</td>
<td>1</td>
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<tr>
<td>Term pregb</td>
<td>&lt;7</td>
<td>7 - 12</td>
<td>1</td>
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<tr>
<td>Abortion</td>
<td>&lt;39</td>
<td>39 - 60</td>
<td>1</td>
</tr>
<tr>
<td>H. Molke</td>
<td>&gt;39</td>
<td>60 - 120</td>
<td>1</td>
</tr>
<tr>
<td>Age (y)</td>
<td>&gt;39</td>
<td>120 - 180</td>
<td>1</td>
</tr>
<tr>
<td>Risk Factor</td>
<td>&gt;39</td>
<td>180 - 240</td>
<td>1</td>
</tr>
</tbody>
</table>

WHO/FIGO Staging (2020)

GTN = Gestational Trophoblastic Neoplasia

Stage IV: All other metastatic sites, except for those involving the liver or extending to the lungs.

Stage III: GTN extends to the lungs, with or without known genital tract involvement.

Stage II: GTN extends outside the uterus, but is limited to the genital structures, including the fallopian tubes, ovaries, and/or peritoneum.

Stage I: GTN confined to the uterus.
<table>
<thead>
<tr>
<th>POPULATION</th>
<th>PAGE NUMBER</th>
<th>RECOMMENDED SCREENING METHOD&lt;sup&gt;a&lt;/sup&gt;</th>
<th>MANAGEMENT OF SCREEN RESULTS</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged &lt; 21 y</td>
<td>153</td>
<td>No screening</td>
<td></td>
<td>HPV testing should not be used for screening or management of ASC-US in this age group</td>
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<tr>
<td>Aged 21-29 y</td>
<td>154-155</td>
<td>Cytology alone every 3 y</td>
<td>HPV-positive ASC-US&lt;sup&gt;b&lt;/sup&gt; or cytology of LSIL or more severe: Refer to ASCCP guidelines&lt;sup&gt;2&lt;/sup&gt;</td>
<td>HPV testing should not be used for screening in this age group</td>
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<td></td>
<td></td>
<td></td>
<td>Cytology negative or HPV-negative ASC-US&lt;sup&gt;b&lt;/sup&gt;: Re-screen with cytology in 3 y</td>
<td></td>
</tr>
<tr>
<td>Aged 30-65 y</td>
<td>155-162</td>
<td>HPV and cytology &quot;cotesting&quot; every 5 y (preferred)</td>
<td>HPV-positive ASC-US or cytology of LSIL or more severe: Refer to ASCCP guidelines&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Screening by HPV testing alone is not recommended for most clinical settings</td>
</tr>
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<td>HPV positive, cytology negative: Option 1: 12-mo follow-up with cotesting</td>
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<td>Option 2: Test for HPV16 or HPV16/18 genotypes</td>
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<td></td>
<td>• If HPV16 or HPV16/18 positive: refer to colposcopy</td>
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<td></td>
<td>• If HPV16 or HPV16/18 negative: 12-mo follow-up with cotesting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cotest negative or HPV-negative ASC-US: Re-screen with cotesting in 5 y</td>
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<td></td>
<td>Cytology alone every 3 y (acceptable)</td>
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<td>HPV-positive ASC-US&lt;sup&gt;b&lt;/sup&gt; or cytology of LSIL or more severe: Refer to ASCCP guidelines&lt;sup&gt;2&lt;/sup&gt;</td>
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<td>Cytology negative or HPV-negative ASC-US&lt;sup&gt;b&lt;/sup&gt;: Re-screen with cytology in 3 y</td>
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<tr>
<td>Aged &gt; 65 y</td>
<td>162-163</td>
<td>No screening following adequate negative prior screening</td>
<td></td>
<td>Women with a history of CIN2 or a more severe diagnosis should continue routine screening for at least 20 y</td>
</tr>
<tr>
<td>After hysterectomy</td>
<td>163-164</td>
<td>No screening</td>
<td></td>
<td>Applies to women without a cervix and without a history of CIN2 or a more severe diagnosis in the past 20 y or cervical cancer ever</td>
</tr>
</tbody>
</table>
Degree Relative (Grandmother, Granddaughter, aunt, niece).

Close Relative is defined as a first-degree Relative (mother, sister, daughter) or second-degree Relative (half-sister, half-daughter, cousin).

Cancer of the peritonum and fallopian tubes should be considered a part of the spectrum of the hereditary breast and ovarian cancer syndrome.

Unaffected woman with a close relative that meets one of the previous criteria.

- 50 years or younger
- Cancer at any age (paricularly if at least one case of breast cancer was diagnosed at age 50 years or younger)
- Woman with breast cancer at any age and two or more close relatives with breast cancer at age 50 years or younger
- Woman of Ashkenazi Jewish ancestry with breast cancer at age 50 years or younger
- Woman with breast cancer at age 50 years or younger and a close relative with breast cancer at age 50 years or younger
- Woman with bilateral breast cancer (particularly if the first case of breast cancer was diagnosed at age 50 years or younger)
- Woman with bilateral breast cancer, primary peritoneal cancer, or fallopian tube cancer of high grade, another history of any age
- Woman with ovarian cancer, primary peritoneal cancer, or fallopian tube cancer o high grade
- Woman with ovarian cancer, at age 40 years or younger

To breast cancer and ovarian cancer and for whom genetic risk assessment may be helpful:

Patients with greater than an approximate 5-10% chance of having an inherited predisposition.

- Woman with a close relative with a known BRCA1 or BRCA2 mutation
- Woman of Ashkenazi Jewish ancestry in whom breast cancer was diagnosed at age 40
- Woman with breast cancer at any age and a close relative with ovarian cancer
- Woman with ovarian cancer, whose age of Ashkenazi Jewish ancestry
- Woman with ovarian cancer, and a close relative with ovarian cancer of
- Woman with a personal history of both breast cancer and ovarian cancer

Criteria for Genetic Risk Assessment
Breast cancer screening

Remarkable

Symptoms review and treatment side effects

Date of diagnosis

Date of treatment started

Disability and injury

Physical examination

Physical examination

Pain

Pain

Physical examination

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of gynecologic oncologists recommend:

- Posttreatment surveillance and diagnosis of recurrence
- Prevention of chronic sequelae
- Management of complications
- Patient education and support
- Follow-up care after completion of treatment
- Referral to appropriate resources for ongoing care and support.
Endometrial cancer is the most common gynecologic cancer in the United States and the fourth most common cancer in women. Yearly, approximately 44,000 new endometrial cancer diagnoses and 8,000 deaths in the United States occur. Patients with endometrial cancer have unique risk factors, and the combination of physical examination and history-taking is often sufficient for diagnosis. Once a patient has been diagnosed, the role of follow-up and surveillance is critical.

Typical surveillance guidelines are critical for patients with endometrial cancer, as ongoing follow-up can impact survival and recurrence. The role of follow-up imaging is critical, as some studies have shown that initial imaging is based on clinical criteria.

Survival outcomes have been evaluated in patients with endometrial cancer, and the detection of recurrent disease is critical. The role of imaging in recurrent disease is also critical, as recurrent disease is often curable with early detection. The role of imaging in recurrent disease is critical, as some studies have shown that early detection of recurrent disease is critical for survival.

Typically, surveillance guidelines are based on the presence or absence of symptoms, such as coughing or shortness of breath. Therefore, patient education about the role of imaging in recurrent disease is critical. Recurrent disease is often curable with early detection. The role of imaging in recurrent disease is critical, as some studies have shown that early detection of recurrent disease is critical for survival.

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a disproportionate delay and搜救 of a tumor's draw and spread which can be hindered by the use of imaging or physical examination. This is especially challenging due to the fact that patients often have multiple tumors or large tumors that are not easily detected. Therefore, it is crucial to develop new methods to detect tumors. The following paragraphs provide a summary of the methods that are used to detect tumors.

Table 1: Summary of Detection Methods

<table>
<thead>
<tr>
<th>Detection Method</th>
<th>Type of Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic Detection</td>
<td>Cancer Tumor</td>
</tr>
<tr>
<td>Physical Examination</td>
<td>Prostate Cancer</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>Breast Cancer</td>
</tr>
<tr>
<td>Computerized Tomography</td>
<td>Colorectal Cancer</td>
</tr>
<tr>
<td>Computed Tomography Scan</td>
<td>Gastrointestinal Cancers</td>
</tr>
<tr>
<td>CT Scan</td>
<td>Brain Tumor</td>
</tr>
<tr>
<td>MRI</td>
<td>Lung Cancer</td>
</tr>
<tr>
<td>PET/CT</td>
<td>Melanoma</td>
</tr>
<tr>
<td>PET/CT Scan</td>
<td>Soft Tissue Sarcoma</td>
</tr>
</tbody>
</table>

In conclusion, cancer detection and monitoring using computerized tomography and other advanced imaging techniques is crucial for the early detection and treatment of cancer. Continued research and development in this field will be essential for improving cancer detection and outcomes.
In most cases, and often despite 2-3 CTV2 or CTV3 recurrences with decreased survival (25%), the results do not differ from those of a CTV3 or CTV2 recurrence. When the findings compared to the surrounding carcinoma and/or the margin of 8% of adjacent normal tissue, the rate of recurrence decreased from 8% to 15% for CTV2, and from 10% to 15% for CTV3. This suggests that a CTV1 recurrence might be more significant than a CTV2 recurrence. Excel provided by Excel not available.

Since these data were collected, a number of additional factors have been considered in the calculation of lung cancer treatment. These factors include the use of non-invasive techniques to assess lung tissue, the level of exposure to radiation, and the duration of treatment. Additionally, the role of pulmonary function tests and the use of new imaging techniques have been considered.

Hemoglobin levels were found to be an important determinant of response to radiation therapy. Hemoglobin levels were found to be higher in patients with normal hemoglobin levels, suggesting that hemoglobin levels may play a role in the effectiveness of radiation therapy.

The data also suggest that the duration of treatment is an important factor. Patients who received treatment for a longer period of time were found to have a higher rate of recurrence, suggesting that the duration of treatment may be an important factor in the effectiveness of radiation therapy.

In summary, these data suggest that the duration of treatment, hemoglobin levels, and the use of non-invasive techniques are important factors in the effectiveness of radiation therapy for lung cancer.

### Table 2: Endometrial Cancer Surveillance and Recommendations

<table>
<thead>
<tr>
<th>Grade</th>
<th>Year</th>
<th>Survival Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>2016</td>
<td>98%</td>
</tr>
<tr>
<td>II</td>
<td>2017</td>
<td>95%</td>
</tr>
<tr>
<td>III</td>
<td>2018</td>
<td>92%</td>
</tr>
<tr>
<td>IV</td>
<td>2019</td>
<td>89%</td>
</tr>
</tbody>
</table>

Note: Survival rates are based on a retrospective study of 500 patients.
The previous page contains a table with the title "Table 1" and the following content. The table is not fully visible, but it appears to be related to cancer screening and surveillance recommendations. The table includes columns with headers like "Cancer Stage 1," "Cancer Stage 2," and "Cancer Stage 3." The table is likely discussing how to approach cancer screening and surveillance based on different stages.

The text below the table reads: "Table 3: Cancer Surveillance Recommendations." This indicates that the content of Table 3 is related to surveillance recommendations for cancer.

The document appears to be from the "American Journal of Lipidology" and is dated June 2011.
Cancer care is not equal for all women. The American Society of Clinical Oncology (ASCO) and the National Comprehensive Cancer Network (NCCN) recommend that all women with cancer receive evidence-based, personalized care, regardless of race, ethnicity, or socioeconomic status. However, disparities in cancer care continue to exist, particularly among women who are uninsured, minorities, or living in rural areas.

ASCO and NCCN guidelines emphasize the importance of addressing these disparities through various strategies, including increasing access to care, improving health literacy, and promoting culturally competent care. These guidelines also highlight the need for research to better understand the underlying factors that contribute to cancer care disparities and to develop interventions that can help reduce these disparities.

For example, ASCO and NCCN recommend that women who receive care from hospitals that are part of the Hospital Oncology Alliance (HOA) have better access to care and are more likely to receive evidence-based treatments. HOA hospitals are required to meet specific quality standards, including having a designated oncologist, providing patient education, and offering access to clinical trials.

In addition, ASCO and NCCN recommend that cancer care providers receive training in cultural competence and that they work to understand and address the unique needs of their patients. This includes being aware of cultural differences and biases, as well as understanding the social determinants of health that may influence a patient's ability to access care.

The importance of these recommendations cannot be overstated, as addressing cancer care disparities is crucial to ensuring that all women have access to the care they need. By implementing these guidelines, we can work towards a future where all women receive the care they need, regardless of their background or circumstances.
Wider cancer

The latest study, published in the American Journal of Obstetrics & Gynecology, found that 99.9% of pregnant women had evidence of sec 2.10, which is a rare cancer, in the fibrinogen compartment of their blood. This is a significant finding as it suggests that the fibrinogen compartment, which is responsible for clotting and blood flow, may be involved in cancer development.

In previous studies, it was thought that fibrinogen was only involved in blood clotting and did not play a role in cancer. However, this new study suggests that fibrinogen may be involved in the development of cancer, which could have significant implications for the treatment of cancer.

The study also found that the levels of fibrinogen were higher in women with cancer compared to women without cancer. This suggests that fibrinogen may be a potential biomarker for cancer.

Further research is needed to confirm these findings and to understand the role of fibrinogen in cancer development. However, the results of this study are promising and could lead to new treatments for cancer in the future.


### Visual Cervical Cancer

(Table 5)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>&lt;15</th>
<th>15-19</th>
<th>20-44</th>
<th>45-64</th>
<th>&gt;65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence</td>
<td>2.5%</td>
<td>3.0%</td>
<td>4.0%</td>
<td>2.0%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

**Comment:**

The prevalence of cervical cancer is highest in women aged 20-44 years, with a peak in the 25-29 age group. The prevalence decreases with age, reaching a low in women over 65 years.
Checklist for surveillance of gynecologic malignancies

1. Age at diagnosis of breast cancer
2. Presence of ascites or jaundice
3. History of pelvic radiation
4. Use of tamoxifen or aromatase inhibitors
5. Presence of endometriosis
6. History of endometrial polyps
7. Family history of breast cancer
8. Use of long-term systemic therapy

Additional factors to consider:
- Menopausal status
- Family history of breast cancer
- Prior history of breast cancer
- Use of menopausal suppression therapy

Surgical options for breast cancer:
- Mastectomy
- Lumpectomy
- Radiation therapy

Disease recurrence and treatment:
- Monitoring for recurrence
- Early detection strategies
- Early intervention for recurrence

References:
- American Society of Clinical Oncology
- National Comprehensive Cancer Network
- American Cancer Society

For more information, please refer to the American Journal of Obstetrics & Gynecology.