GUIDELINES AND STANDARD OF CARE MANUAL FOR MANAGING GYNAECOLOGICAL CANCERS

By the

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Contents

Foreword

Genital tract cancers constitute a major public health challenge in Nigeria as a country and Africa in general. Their burden continues an exponential rise due to low levels of awareness and poor understanding of the potentials for cancer prevention by the populace. Moreover, the country lacks a strong, robust and sustainable health care system that can provide quality of care to the underprivileged group in the community due to political, religious and economic reasons. At the moment, federal and state governments allocate very little percentages of their annual budgets to health care and thus compound the problems posed by cancers. Therefore, improvement in the management of cancers in Nigeria requires refocused leadership strategies, critical thinking and investment.

Researches on prevention and management of gynaecological cancers have been in existence for many decades in Nigeria, the pioneer cancer centre being the University College Hospital, Ibadan. In the 1960s, the hospital's Obstetrics and Gynaecology department was at the forefront of research and management of gestational trophoblastic diseases, one of the few cancers that the world can boast of a complete cure. It is the pioneering work of great researchers from Ibadan in collaboration with those from Great Britain that ensured the success story of gestational trophoblastic cancers. Unfortunately, this is not the experience with other gynaecological cancers whose management continues to elude us due to a dearth of facilities required for control and prevention.

This publication on the guidelines and standard of care manual for managing gynaecological cancers by the Gynaecological Oncology Unit of the Department of Obstetrics and Gynaecology, College of Medicine, University of Ibadan/University College Hospital, Ibadan, Nigeria, is long overdue. The authors have simplified their strategies to the understanding of both junior doctors and nurses who are interested in step by step management of gynaecological cancers. With this humble beginning, it is my hope that more purposeful steps will be taken to put a stop to the disastrous consequences of gynaecological cancers in Nigeria.

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1 INTRODUCTION

Cancers are forming increasing proportions of diseases in resource constrained countries including Nigeria with important contributions to years lived with disability (YLDs) and years of life lost (YLLs). By 2020, it is predicted that new cases will increase to more than 15 million, while deaths from cancers will increase to 12 million people. Cancers affect all age groups, although they occur more in men and women above 40 years of age, a period when such people are most knowledgeable, skilled, fit or experienced in contributing to homes, communities and workforce of the society.

Gynaecological cancers consist of those of the cervix, gestational trophoblastic disease, ovaries, uterus, vagina, vulva, Fallopian tubes and pelvic peritoneum. The prevention, treatment and control of cancers are more demanding than other diseases affecting mankind in terms of needed manpower and material resources. These are compulsorily multidisciplinary given the extremely complex nature of cancers and involve the following experts: gynaecological, surgical, urological, medical, radiation, nurse and psychology oncologists, oncology histopathologists, anaesthetists, radiologists, pharmacists, palliative care specialists, public health specialists, family physicians, medical social workers, physiotherapists, occupational, music and recreational therapists and spiritual care givers. Appropriately designed care is interactively purposively given at primary, secondary and tertiary levels. It is highly desirable that **EACH AND EVERY** patient benefits from the input of almost all these specialists/carers in a timely and highly coordinated fashion to ensure optimal care.

Rationale

In 2008, approximately 72% of cancer deaths occurred in low and middle income countries, where survival rates are also much lower, largely due to delays in diagnoses of the diseases, which lead to late presentation with advanced stage diseases. Presently, there is a big gap in achieving the goal of optimal, multidisciplinary approach to prevention, management and control of gynaecological cancers in resource limited settings like in our environment.

Cancer control encompasses a package of diverse interventions aiming at reducing morbidity and mortality. Many patients receive affordable or available treatment rather than optimal treatment and those without financial capabilities are denied access to care, never reaching a centre capable of providing appropriate treatment.

The essence of this manual is to bridge part of these gaps in multidisciplinary and multicare level approach, so as to reduce the burden of gynaecological cancers, through improving communication between specialists/carers and formulating standard guidelines in the diagnosis, treatment and follow-up of gynaecological cancers.

Levels of Cancer Care

Each level of health care must have well-defined roles in the prevention, care and control of gynaecological cancers:

Primary and Secondary Health Care Levels

These are very important in prevention, early management and follow-up care through:

(A) family health education on susceptibility to, causes and courses of female reproductive tract cancers and related diseases,
(B) vaccination against human papillomavirus infection,
(C) ensuring (i) uptake and (ii) continued use of cervical screening tests while delivering patient – friendly services.

They are also very important in:

(D) the early detection of cancers through identification of symptoms and signs that may point to them. In addition, decisions are made at these levels for minimal diagnostic evaluation [such as (a) ultra-sound scanning, (b) chest radiography, (c) assay of tumour markers and (d) basic cytological or histological diagnosis].
(E) giving primary and secondary levels of palliative care at these community levels.

THERE SHOULD BE EARLY REFERRAL OF SUSPECTED CASES TO THE GYNAECOLOGICAL ONCOLOGY UNITS AT DESIGNATED TERTIARY CENTRES

Following definitive treatment, these primary and secondary centres can still participate in:

(F) the delivery of the necessary lifelong follow-up and support of cancer patients, in conjunction with the tertiary centre.

Need for Tertiary Care

The tertiary centres possess the following structures essential for optimal management of cancers:

- Availability of advanced diagnostic machinery (computerized tomography scanning, magnetic resonance imaging, positive electron tomography scanning and immunohistochemistry) and the three major modalities for cancer treatment (advanced surgery, chemotherapy and radiation therapy). Additional facilities like gene therapy will be at designated tertiary centres.
- Availability of specialized and ultraspecialized professionals in cancer management.
- Availability of advanced research capabilities.
- Training of all cadres of practitioners.
- Availability of other supportive care.

The following sections detail care at the tertiary centre, starting with the initial assessment.

2 INITIAL ASSESSMENT AT THE TERTIARY INSTITUTION

The goals of the initial assessment are:

(1) Determination of differential diagnoses through detailed history and thorough physical examination.
(2) Determination of co-morbidities.
(3) Clinical staging of the disease.
(4) Determination of the definitive diagnosis, in con-junction with laboratory oncologists, radiologists and histopathologists.
(5) Preparation for multidisciplinary assessment, treatment and follow-up. This will be done at the Multidisciplinary Board meeting where the results of tests will be discussed first before patients are dutifully counselled.

In order to ensure complete and standardized collection of patient data the **Clinical Proforma (GO 1)** – *Appendix 1,* **MUST** be filled for all patients suspected of having gynaecological cancer, in addition to the recordings in the patient's case file. To assist in the clinical staging of each suspected case, the **International Federation of Gynaecologists and Obstetricians (FIGO) staging for each cancer is provided [FIGO Stagings (GO 2)]** – *Appendix 2.*

On account of the multisystemic nature of cancers and the available methods of treatment, the laboratory assessment of patients and their diseases entails the following as appropriate and available:

Radiology: Ultrasound scanning of the pelvis and abdomen, Computerized Axial Tomography (CAT) scanning, Magnetic Resonance Imaging (MRI) and Positive Electron Tomography (PET) scanning; Intravenous Urography (IVU); Chest Xray; and Barium studies.

Haematological: Full blood count; PT PTTK; Blood grouping and crossmatching.

Chemical Pathology: Electrolytes, urea, creatinine and uric acid; Liver function tests; Blood sugar tests; Tumour markers (Epithelial ovarian tumours – **Ca 125**, Primary GIT tumours – **CEA**, Yolk sac tumours – **alpha feto protein**, Dysgerminoma and trophoblastic diseases – **βhCG**, Granulosa cell tumour – **inhibin**).

Microbiology: As indicated.

Endoscopy: The natural orifice transluminal endoscopic surgery (N.O.T.E.S.) implies operative methodologies of 'least invasiveness' in (a) staging, (b) getting biopsy specimens and (c) performing sentinel lymph node dissection.

Other specialists are involved right from this initial assess-ment of the patient so as to render the best and appropriate service for better outcome:

- The initial assessment of the patient by the surgical/urological oncologists and the cardiothoracic surgeons will help in the preparation and determination of the extent of their involvement at surgery. Ovarian cancer surgery provides the commonest interphase between the surgical oncologist and gynaecological oncologist.
- The review by the anaesthetists helps in determining the degree of optimization needed for an early, safe and successful surgery.
- The oncology histopathologist reconciles the initial assessment of the patient with the histopathological findings following analysis of the specimen received during and after surgery.
- The palliative care specialist caters for optimal pain control; and in conjunction with the psychology oncologist and medical social worker helps address the psychological, socioeconomic, and even spiritual needs of the patient so as to improve the quality of life of the patient and prepare the relations for the enormous care required.

In conclusion, qualitative initial assessment of the patient is paramount to rendering the appropriate treatment plan for the best outcome.

The next section will discuss surgical interventions in gynaecological cancers.

3 OPERATIVE PROCEDURES

Operative procedures in gynaecological oncology range from simple ones like colposcopy and examination under anaesthesia with cervical and endometrial biopsies to more radical types such as Wertheim's hysterectomy and pelvic exenteration. Each of these procedures has its role in the holistic management of the oncologic patient, hence the need for thoroughness in doing them.

- Since 1975, multiple retrospective studies have demonstrated that the amount of residual disease after cytoreductive surgery inversely correlates with progression-free and overall survival.
- Residual disease is defined as the maximum diameter of the largest tumor mass remaining after cytoreductive surgery.
- The Gynecological Oncology Group (GOG) currently defines optimal cytoreduction as having residual tumor lesions each measuring 1cm or less in maximum diameter.

Operative Procedures in Cervical Cancers

These are examination under anaesthesia/colposcopy with cervical biopsy/excision, radical trachelectomy, extended hysterectomy and Wertheim's hysterectomy. Additionally, there may be lymphadenectomy or lymph node sampling.

Operative Procedures in Ovarian/Uterine/Endometrial/ Fallopian tube/Primary Peritoneal Cancers

They include endometrial biopsy (including hysteroscopic procedures) – in cases of suspected endometrial cancers. Laparoscopic procedures can also be done.

Other procedures include staging laparotomy, interval debulking surgery, secondary operations and second look debulking surgery.

- The utilization of peritonectomy for peritoneal surface malignancy depends on the distribution and extent of invasion of the malignancy within the peritoneal space.
- Peritoneal surface malignancy tends to involve the visceral peritoneum in greatest volume at three definite sites. These are sites where the bowel is anchored to the retroperitoneum and peristalsis results in less motion of the visceral peritoneal surface.
- Small tumor nodules are removed using electro-evaporation.

- Involvement of visceral peritoneum frequently requires resection of a portion of the stomach, small intestine, colorectum, rectosigmoid colon, ileocecal valve, antrum of the stomach and less frequently, the lesser sac, the lesser curvature of stomach and peritoneal surfaces of the liver. Upper abdominal procedures include diaphragm peritonectomy or full-thickness resection, splenectomy with or without distal pancreatectomy, cholecystectomy for gallbladder surface tumor or resection of parenchymal liver disease, porta hepatis disease or lesser sac disease in order to achieve optimal cytoreduction.
- Peritonectomies and visceral resections using the traditional scissor and knife dissection will unnecessarily disseminate a large number of tumor emboli within the abdomen.
- Lasermode electrosurgery leaves a margin of heat necrosis that is devoid of viable malignant cells.
- Electroevaporation of tumor and normal tissue at the margins of resection minimize the likelihood of persistent disease and blood loss.
- Tumors involving the diaphragm, bowel mesentery and portal triad consistently preclude optimal cyto-reduction.
- **If cytoreductive surgery is performed by physicians with training in gynaecological oncology, a survival advantage can be achieved when compared with surgery performed by general surgeons or generalist gynaecologists.**

Operative Procedures in Vulval and Vaginal Cancers

These range from colposcopy, vulval/vaginal biopsies, simple vulvectomy/vaginectomy to modified radical vulvectomy and radical vulvectomy.

Operative Procedures in Gestational Trophoblastic Diseases

These range from simple figure of eight stitches used to arrest bleeding from suburethral nodules to hysterectomy, thoracotomy and craniotomy for chemotherapy resistant tumours.

Frozen Section Diagnosis

Frozen sections are now available for diagnosis intra-operatively at the University College Hospital, Ibadan and the results can be made available in 10 minutes. However, adequate notice and proper filling of request cards are very essential.

Surgical Staging Sheet

The **Surgical staging sheet (GO 3)** – *Appendix 3* – is a specially designed form used for detailed recording of findings at surgery. This helps in the proper documentation of the stage of the disease which assists in prognosticating, training and research. It is also useful in determining and auditing further treatment for cancer patients.

In section 4, the post operative care/primary chemotherapy is discussed.

4 POST-OPERATIVE CARE OF GYNAECOLOGICAL CANCER PATIENTS–CHEMOTHERAPY

Post-operative care of the gynaecological cancer patient involves many other interventions after the primary or secondary surgery which are however specific to different cancer types. General post-operative care consists essentially of:

- General counselling on clinical status and the operative findings.
- Post-operative fluid management.
- Post-operative antibiotics, analgesics and other necessary drugs (including anticoagulants).
- Adjuvant chemotherapy.
- Adjuvant radiotherapy.
- Hormonal therapy.
- Palliative care (including parenteral nutrition).

Specific Interventions

These include tumour-specific cancer chemotherapy regimens among other issues. The selection, dosing and administration of anti-cancer agents and the management of associated toxicities are complex. Drug dose modifications, schedule and the initiation of supportive care interventions are often necessary because of expected toxicities and because of individual patient's variability, prior treatment and co-morbidities.

The pre-adjuvant chemotherapy preparation of the patient involves:

- Detailed reassessment of the clinical condition of the patient.
- Adequate investigations consisting of:
  - Full blood count and differentials.
  - Electrolytes, urea, creatinine and uric acid.
  - Liver function tests.
  - Abdominopelvic ultrasonography.
  - Chest X-ray.
  - Tumour markers.

The Goals of Chemotherapy

There are three possible goals for chemotherapy.

Cure

If possible, chemotherapy is used to cure the cancer, meaning that the cancer disappears and does not return. It often takes many years to know if a patient's cancer is actually cured.

Control

If cure is not possible, the goal may be to control the disease — to shrink any tumors and/or stop the cancer from growing and spreading. This can help the patient feel better and possibly live longer.

Palliation

When the cancer is at an advanced stage, chemotherapy drugs may be used to relieve symptoms.

Choice of Chemotherapeutic Drugs

In some cases, the best choice of doses and schedules for giving each drug are clear and most oncologists would recommend the same treatment. In other cases, less may be known about the single way to treat people with certain types and stages of cancers. In these situations different oncologists might choose different drug combinations with different schedules.

Important factors to consider in choosing drug use in chemotherapy regimens include:

- Type of cancer,
- Stage of the disease,
- Age of the patient,
- General state of health of the patient,
- Other serious co-morbidities (for example heart, liver or kidney diseases), and
- The type of cancer treatment which the patient had had in the past

An actual, specific chemotherapy regimen for epithelial ovarian cancer is shown in **GO 4** *(Appendix 4)*.

In section 5, the radiation mode of therapy will be considered.

5 PRE- AND/OR POST-OPERATIVE RADIATION THERAPY

Radiation therapy can be used in the treatment of gynaecological cancers either pre-operatively or following surgical intervention in over 60 percent of cases. All these may be concurrently with chemotherapeutic agents or without. The various modes are:

- Neoadjuvant or Adjuvant,
- Radical,
- Concurrent chemoradiation (with doxorubicin, cisplatin, paclitaxel, 5 – fluorouracil or mitomycin C according to site of tumour),
- Palliative, and
- Emergency.

Before radiotherapy, apart from clinical information, the following investigations are done:

(a) Full blood count,
(b) Electrolytes, urea, creatinine and uric acid,
(c) Liver function tests, and
(d) Radiology.
  - abdominopelvic ultrasound scan,
  - intravenous urography as indicated,
  - chest Xray,
  - computerized tomography scan or magnetic resonance imaging as needed, and
  - retroviral screening test.

Radiotherapy is given as external beam therapy, vaginal cuff brachytherapy or intracavitary therapy.

Cervical Cancer

Cervical cancer is the most successful disease treated with radiotherapy. It is usually used in advanced disease (stage IIB and above). In early stage diseases, it may be indicated in the following situations: presence of co-morbidities, elderly patients, refusal of surgery, surgeons not comfortable to operate, positive lymph node at surgery, barrel-shaped cervical cancer (more than 6cm infiltration of endometrium or bulky endometrial extension).

Prior to radiotherapy, the following information about the patient's tumour is required (in addition to identification parameters):

(1) stage of disease,
(2) histology cell type,
(3) grade of differentiation,
(4) pelvic/para-aortic lymph node status, and
(5) extent of parametrial involvement.
    - bilateral or unilateral,
    - medial 50% or more, and
(6) retroviral status.

Endometrial Cancer

Radiotherapy is especially indicated in patients with a high risk of recurrence following surgery, and it improves loco-regional control of disease in the pelvis and vagina. Prior to radiotherapy, the following information about the patient's tumour is required (in addition to identification parameters):

(1) stage of disease
(2) surgical margins
(3) lymph node status
    - pelvic/para-aortic nodes
(4) peritoneal status
    - grossly involved
    - peritoneal washing positive or negative

Uterine Sarcomas

These may respond to radiotherapy after surgery and chemotherapy.

Vulval Carcinoma

Radiotherapy is indicated when there is inguinal or palpable metastatic lymph node involvement and in lesions which are close to critical structures such as anus or perineal body.

Vaginal Carcinoma

Radiotherapy is the main mode of treatment.

Gestational Trophoblastic Tumours

Radiotherapy is indicated in cerebral metastases.

Ovarian, Fallopian Tube and Peritoneal Carcinomas

Dysgerminoma is highly radio sensitive but in residual or recurrent diseases in other varieties, radiotherapy is indicated.

In section 6, palliative and nursing care is discussed.

6 PALLIATIVE AND NURSING CARE

Palliative Care

Over three quarters of patients with gynaecological cancers are in advanced stages when cure and control are no longer possible. Such patients and their families will benefit from palliative care. This has been defined by the World Health Organization (WHO) as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other symptoms: physical, psychosocial and spiritual.

The principles of this care as they relate to gynaecological cancers are:

- Physical care. A major component of this is assessment and control of pain and other symptoms. The WHO and the World Federation of Societies of Anesthesiologists (WFSA) analgesic ladders offer a very practical approach to effective relief of pain (**see GO 6,** *Appendix 6*). The main goal is to improve the quality of life of the patient and her family.

  Care is continuous from the time of diagnosis to end-of-life period and till the patient dies. It also includes bereavement care of the relations. These aspects are:

- Psychological and psychiatric assessment and care.
- Social care that meets the needs of the patient, the family and community in a culturally sensitive manner.
- Support related to spiritual, religious and existential matters.
- Family support and bereavement plans including financial assistance.
- Effective communication (truth telling) about the nature of the diseases and available strategies for cure, control and palliation.
- Ethical issues of patient autonomy (rights of individuals to make decisions), beneficence (health care givers doing what is good in the patient's best interest), non-maleficence {doing no harm. These may include frank discussion of Do Not Resuscitate (DNR), Living Will and Euthanasia) and justice (fair treatment for all).
- Legal issues.

- Caring for carers.
- Consideration of the patient's sexual needs (especially in younger patients).
- Research to improve practice.

Nursing Care

The oncology nurse has diverse and unique roles to play, in conjunction with other specialists, in managing patients with gynaecological cancers. These roles involve:

- Assessment of symptoms associated with gynaecological cancers, including their impact on the patient, her family and close associates.
- Assessment of the patient and her family's expectations and goals of management of the disease.
- Understanding and providing emerging nursing management strategies at all stages (pre-therapy, during therapy, post-therapy and during lifelong follow-up) for patients undergoing surgery, radiation, and chemotherapy.
- Providing supportive care to ensure that patient and her family understand the disease and its management. The nurse strives to reduce their anxiety by using non-pharmacologic and/or pharmacologic methods and encourages both to take active part in the management of the disease.
- Administering cancer treatment.
- Assisting patients and their families to adjust and adapt to life with cancer. Among these are included lifestyle changes (including weight control, exercise, rest, sleep and resumption of normal activities) and family adjustments. Gynaecological tract cancers and their treatment affect sexuality, sexual capabilities and attainment of sexual pleasure. Therefore, the patients may require intense education and support in their desire and ability to achieve sexual pleasure. The **BETTER** model can be used in managing this problem:

  B - Bring up sexuality issue.
  E - Explain sexuality as an important Quality of Life issue.
  T - Tell patients that you can assist in providing resources.
  T - Timing: discuss and provide information when patient/families desire it.
  E - Educate patient/families about potential sexual changes and reproductive issues.
  R - Record discussions, assessments, interventions and outcomes.

- Preventing and managing the problems caused by cancer and its treatment. One of the most important among these problems is infection, especially when invasive catheters or infusion lines are in place. A very effective method of preventing infection is through barrier nursing.
- Helping to institute appropriate family planning techniques as needed.
- Ensuring adequate nutrition through nasogastric tube feeding and parenteral (intravenous) feeding when recurrent, severe episodes of nausea, vomiting, abdominal pain, abdominal distension, and constipation may suggest intestinal obstruction.

In section 7, follow-up of the patients is considered.

7 FOLLOW-UP

All patients who have completed their treatment for gynaecological cancers should be followed up for life. Prior to discharge, they should be appropriately counselled and informed of the follow-up programme specific to their disease.

A pamphlet containing information about the clinic days and contact numbers of the Gynaecological Oncology Unit members will be given to them. They will be encouraged to keep in touch and report to the clinic and emergency unit should any problem arise.

Patients may be referred to primary and secondary health centres especially where their place of abode is distant from the teaching hospital. In **GO 7**, *Appendix 7* is the table of follow-up schedules for gynaecological cancer patients.

Appendix 1

Clinical Proforma (GO 1)

Date of first contact: **Name and signature of doctor:**

IDENTIFICATION						
Name, Address of patient/next of kin:			**Hospital number:**			
			Telephone number:			
Date of birth:	**Age last birthday (yrs):**		**Marital status:**		**Occupation:**	
Educational qualification:		**Religion:**		**Tribe:**	**Husband's occupation:**	
Husband's educational qualification:		**Next of kin (if different from husband):**			**Relationship:**	
Addresses (including that of next of kin, if applicable):					**Phone number/s:**	
Source of referral:					**Level of care:**	
GYNAECOLOGICAL HISTORY						
Menarche:	**Flow (days):**	**Cycle length (days):**		**Regularity:**		
Dysmenorrhoea (type and drugs used, if positive):				**Menorrhagia:**		
Parity: **Deliveries**						

	1	2	3	4	5	6
Year of delivery						
Gestational age at delivery (weeks)						
Mode of delivery*						
Sex/es of baby						
Length of breastfeeding (months)						

*Vaginal (**VD**), Caeserean section (**CS**), Forceps (**FP**), Vacuum extraction (**VE**),

Abortions

	1	2	3	4	5	6
Year						
Pregnancy confirmed*						
Gestational age at termination						
Type**						
Termination type[+] (+ number of times)						
Histological confirmation						

*Urine pregnancy test **(UPT)**, Ultrasound **(USS)**. **Spontaneous **(SP)**, Voluntary termination **(VT)**				
⁺Medical **M (drugs)**, Surgical **S** (Dilatation and curettage, Manual Vacuum Aspiration, Abdominal)				
Contraception:				
	1	**2**	**3**	**4**
Type				
Year started				
Duration of use				
Last normal menstrual period:	**Past menstrual period 1:**		**Past menstrual period 2:**	

PRESENTING COMPLAINTS AND DURATION	
1	
2	
3	
4	
SYSTEMIC REVIEW	
1. Cardiovascular	
2. Haematological	
3. Respiratory	
4. Gastrointestinal	
5. Genitourinary	
6. Central nervous system	
7. Dermatological	
8. Musculoskeletal	
9. Ophthalmological	
10. Otorhinolaryngological	

FAMILY HISTORY					
Disease	**Type of relation**	**Disease**	**Type of relation**	**Disease**	**Type of relation**
1.Hypertension		**2. Diabetes mellitus**		**3. Genital cancer (type)**	
4. Breast cancer		**5. Other cancers**		**Others**	

MEDICAL AND SURGICAL HISTORY	
1	
2	
3	
4	
DRUG HISTORY AND ALLERGIES	
Drugs used presently:	

Allergies:				
SEXUAL HISTORY				
Coitarche:		**Age at first delivery:**		**Number of sexual partners:**
Sexually transmitted diseases:				
Year:	**Type:**	**Lesion:**	**Treatment:**	**Contact tracing:**
SOCIAL HISTORY				
Smoking (state number and frequency)		**Alcohol (state type, amount and frequency)**		**Controlled drugs (state type, amount and frequency)**
EXAMINATION				
GENERAL CONDITION:				
Height (m):	**Weight (kg):**	**BMI (kg/m^2)**	**Body surface area(m^2)**	
Thyroid:	**Breasts (discharge, mass. State side):**			
Peripheral lymphadenopathy (State location and the characteristics):				
Pedal and other oedema:				
RESPIRATORY SYSTEM:				
Excursions per min:	**Right lung field:**	**Left lung field:**		
CARDIOVASCULAR SYSTEM:				
Pulse rate:	**Blood pressure:**	**Heart sounds:**		
ABDOMEN:				
Inspection:				
Liver:		**Spleen:**		
Right kidney:		**Left kidney:**		
Uterus:		**Ascites, tenderness and other masses;**		
PELVIC EXAMINATION:				
Vulva:		**Vagina:**		
Cervix (including excitation tenderness):		**Uterus:**		
Right adnexa (including tenderness):		**Left adnexa (including tenderness):**		
Pelvic side wall:		**Pouch of Douglas:**		
Discharge:		**Bleeding:**		

Appendix 2

Clinico-pathological Staging of Gynaecological Cancers (GO 2)
Cervical Cancer

Modified FIGO Staging

FIGO Stage	
I	**The carcinoma is strictly confined to the cervix (extension to the corpus should be disregarded)**
IA	Invasive cancer identified only microscopically. All gross lesions, even with superficial invasion, are stage IB cancers. Invasion is limited to measured stromal invasion with a maximum depth of 5mm and a width no greater than 7mm
IA1	Measured invasion of stroma ≤ 3mm in depth and ≤ 7mm in width
IA2	Measured invasion of stroma > 3mm and ≤ 5mm in depth and ≤ 7mm in width
IB	Clinical lesions confined to the cervix or preclinical lesions larger than stage IA
IB1	Clinical lesions ≤ 4cm
IB2	Clinical lesions > 4cm
II	**The carcinoma extends beyond the cervix but has not extended onto the pelvic wall. Involves the vagina but does not extend as far as the lower third of the vagina**
IIA	No obvious parametrial involvement
IIB	Obvious parametrial involvement
III	**The carcinoma has extended onto the pelvic wall. On rectal examination, there is no cancer – free space between the tumour and the pelvic wall. The tumour involves the lower third of the vagina. All cases with hydronephrosis or a non-functioning kidney should be included unless they are known to result from another cause**
IIIA	No extension onto the pelvic wall but involvement of the lower third of the vagina
IIIB	Extension onto the pelvic wall or hydronephrosis or non-functioning kidney
IV	**The carcinoma has extended beyond the true pelvis or has clinically involved the mucosa of the bladder or rectum**
IVA	Spread to adjacent organs
IVB	Spread to distant organs

Endometrial Cancer

Staging for Corpus Uteri Carcinoma

Each Staging Category is subdivided into Histologic Grade 1, 2, or 3

FIGO Stage	
I	**Tumour limited to endometrium**
IA	Tumour confined to corpus uteri
IB	Tumour invades up to or less than one – half of the myometrium
IC	Tumour invades to more than one half of the myometrium
II	**Tumour invades cervix, but does not extend beyond uterus**
IIA	Endocervical glandular involvement only
IIB	Cervical stromal invasion
III	**Local and/or regional spread as specified in T3a, T3b, N1, and FIGO IIIA, IIIB, and IIIC below**
IIIA	Tumour involves serosa and/or adnexa (direct extension or metastasis) and/or cancer cells in ascites or peritoneal washings
IIIB	Vaginal involvement (direct extension or metastasis)
IIIC	Metastasis to the pelvic and/or para – aortic lymph nodes
IV	
IVA	Tumour invades bladder mucosa and/or bowel mucosa
IVB	Distant metastasis excluding metastasis to vagina, pelvic serosa, or adnexa; including metastasis to intraabdominal lymph nodes other than para – aortic and/ or inguinal lymph nodes

Fallopian Tube Cancer

FIGO Stage	
I	**Growth limited to the fallopian tubes**
IA	Growth limited to one tube with extension into the submucosa and/or muscularis but not penetrating the serosal surface, no ascites
IB	Growth limited to both tubes with extension into the submucosa and/or muscularis but not penetrating the serosal surfaces, no ascites
IC	Tumour either stage IA or IB with tumour extension through or onto the tubal serosa or with ascites present containing malignant cells or with positive washings
II	**Growth involving one or both fallopian tubes with pelvic extension**
IIA	Extension and/or metastasis to the uterus and/or ovaries
IIB	Extension to other pelvic tissues
IIC	Tumour either stage IIA or IIB and with ascites present containing malignant cells or with positive peritoneal washings
III	**Tumour involving one or both fallopian tubes with peritoneal implants outside of the pelvis and/or retroperitoneal or inguinal nodes. Superficial liver metastases equals stage III. Tumour seems limited to the true pelvis with negative nodes but with histologically proven malignant extension to the small bowel or omentum**
IIIA	Tumour grossly limited to the true pelvis with negative nodes but with histologically confirmed microscopic seeding of abdominal peritoneal surfaces
IIIB	Tumour involving one or both tubes with histologically confirmed implants of abdominal peritoneal surfaces, none exceeding 2cm in diameter. Lymph nodes negative
IIIC	Abdominal implants greater than 2cm in diameter and/or positive retroperitoneal or inguinal nodes
IV	**Growth invading one or both fallopian tubes with distant metastases. If pleural effusion is present, there must be positive cytology to be stage IV. Parenchymal liver metastases equals stage IV**

Appendix 2

DIAGNOSTIC CRITERIA FOR CARCINOMA OF THE FALLOPIAN TUBE	
1.	Grossly: The main tumour is in the tube and arises from the endosalpinx
2.	Histologically: The pattern reproduces the epithelium of tubal mucosa (papillary pattern)
3.	Transition from benign to malignant tubal epithelium should be demonstrated
4.	The ovaries and endometrium are normal or have a much smaller tumour volume than that of the tube

HISTOPATHOLOGY: DEGREE OF DIFFERENTIATION	
G1	5% or less of a nonsquamous or nonmorular solid growth pattern
G2	6% to 50% of a nonsquamous or nonmorular solid growth pattern
G3	More than 50% of a nonsquamous or nonmorular solid growth pattern

Gestational Trophoblastic Tumours
Scoring System Based on Prognostic Factors

S/No	Score				
		0	1	2	4
1.	Age (years)	< 39	>39		
2.	Antecedent pregnancy	Mole	Abortion	Term	
3.	Interval (months between end of antecedent pregnancy and start of chemotherapy)	< 4	4 – 6	7 – 12	
4.	hCG (IU / L)	$< 10^3$	$10^3 – 10^4$	$10^4 – 10^5$	
5.	ABO groups (female x male)		O x A A x O	B AB	
6.	Largest tumour, including uterine tumour		3 – 5cm	5cm	
7.	Site of metastases		Spleen, kidney	Gastrointestinal tract, liver	Brain
8.	Number of metastases identified		1 – 4	4 – 8	> 8
9.	Prior chemotherapy			Single drug	2 or more

Total score:
< 4 = low risk
5 – 7 = intermediate risk
> 8 = high risk

Ovarian Cancer

FIGO Stage	
I	**Growth limited to the ovaries**
IA	Growth limited to the ovary; no ascites. No tumour on the external surface; capsule intact.
IB	Growth limited to both ovaries; no ascites. No tumour on the external surfaces; capsule intact.
IC	Tumour either stage IA or IB but with tumour on the surface of one or both ovaries; or with capsule ruptured; or with ascites present containing malignant cells or with positive peritoneal washings.
II	**Growth involving one or both ovaries with pelvic extension**
IIA	Extension and/or metastases to the uterus and/or tubes.
IIB	Extension to other pelvic tissues.
IIC	Tumour either stage IIA or IIB with tumour on the surface of one or both ovaries; or with capsule(s) ruptured; or with ascites present containing malignant cells or with positive peritoneal washings.
III	**Tumour involving one or both ovaries and/or positive retroperitoneal or inguinal nodes** **Superficial liver metastases equals stage III. Tumour is limited to the true pelvis, but with histologically proven malignant extension to small bowel or omentum**
IIIA	Tumour grossly limited to the true pelvis with negative nodes but with histologically confirmed implants of abdominal peritoneal surfaces, none exceeding 2cm in diameter. Nodes negative.
IIIB	Tumour of one or both ovaries with histologically confirmed implants of abdominal peritoneal surfaces, none exceeding 2cm in diameter. Nodes negative.
IIIC	Abdominal implants more than 2cm in diameter and/or positive retroperitoneal or inguinal nodes.
IV	**Growth involving one or both ovaries with distant metastasis. If pleural effusion is present, there must be positive cytologic test results to allot a case to stage IV. Parenchymal liver metastasis equals stage IV.**
These categories are based on findings at clinical examination and/or surgical exploration. The histologic characteristics are to be considered in the staging, as are results of cytologic testing as far as effusions are concerned. It is desirable that a biopsy be performed on suspicious areas outside the pelvis. In order to evaluate the impact on prognosis of the different criteria for allotting cases to stage IC or IIC, it would be of value to know if rupture of the capsule was (1) spontaneous or (2) caused by the surgeon, and if the source of malignant cells detected was (1) peritoneal washings or (2) ascites.	

Vaginal Cancer

FIGO Staging Classification for Vaginal Carcinoma

FIGO Stage	
I	**Carcinoma limited to vaginal wall**
II	**Carcinoma involves subvaginal tissue but has not extended to pelvic wall**
III	**Carcinoma extends to pelvic wall**
IV	**Carcinoma extends beyond true pelvis or involves mucosa of bladder or rectum**

Vulval Cancer

TNM Classification and Staging of Vulval Carcinoma

TNM – tumour, node, metastasis

TNM CLASSIFICATION	
T	**Primary tumour**
T1	Tumour confined to the vulva and/or perineum; 2cm or less in diameter
T2	Tumour confined to the vulva and/or perineum; more than 2cm in diameter
T3	Tumour of any size with adjacent spread to the urethra, vagina, or anus
T4	Tumour of any size infiltrating the bladder mucosa, the rectal mucosa, or both, including the upper part of the urethral mucosa, or fixed to the anus
N	**Regional lymph nodes**
N0	No nodes palpable
N1	Unilateral regional lymph node metastases
N2	Bilateral regional lymph node metastases
M	**Distant metastases**
M	Distant metastases
M0	No clinical metastases
M1	Distant metastases (including pelvic lymph node metastases

Appendix 2

FIGO Staging (1988)		
I		
	T1N0M0	Tumour confined to the vulva and/or perineum; 2cm or less in greatest dimension. No nodal metastasis
II		
	T2N0	Tumour confined to the vulva and/or perineum; more than 2cm in greatest dimension. No nodal metastasis
III		
	T3N0M0 T1N1M0 T2N1M0 T3N1M0	Tumour of any size with (1) adjacent spread to the lower urethra and/or the vagina and/or the anus and/or (2) unilateral regional lymph node metastasis
IV		
IVA	T1N2M0 T2N2M0 T3N2M0 T3N2M0 T4, any N, M0	Tumour invades any of the following: upper urethra, bladder mucosa, rectal mucosa, pelvic bone, and/or bilateral regional node metastasis
IVB	Any T, any N, M1	Any distant metastasis including pelvic lymph nodes

CLASSIFICATION OF MELANOMAS OF THE VULVA			
CLARK LEVEL	I	Intraepithelial	
	II	Extension to papillary dermes	
	III	Filling the dermal papillae	
	IV	Invasion of collagen in reticular dermis	
	V	Extension into subcutaneous fat	
BRESLOW DEPTH OF INVASION		I	< 0.75mm from skin surface
		II	0.76 – 1.4mm from skin surface
		III	> 1.5mm from skin surface

Appendix 3

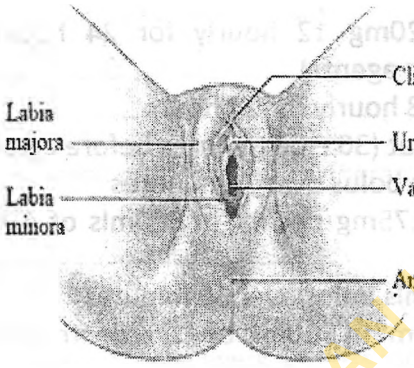
Surgical Staging Sheet for Operations for Gynaecological Cancers (GO 3)

Patient's name:			
Date:	**Hospital number:**	**Age (years):**	
Abdominal incision type:	**Low transverse**	**Midline**	**Paramedian**
Cytology:		**Fresh frozen histology:**	
GROSS FINDINGS			
Uterus:			
Fallopian tube (right):		**Fallopian tube (left):**	
Ovary (right):		**Ovary (left):**	
Stomach:			
Omentum:			
Intestines:			
Colon/Rectum:			
Liver:			
Gall bladder:			
Spleen:			
Pancreas:			
Diaphragm:			

Appendix 3

Kidney (right):	**Kidney (left):**
Ureter (right):	**Ureter (left):**
Bladder:	
Lymph nodes:	
1. External iliac –	**2. Internal iliac –**
3. Obturator –	**4. Common iliac –**
5. Para – aortic –	
Ascites:	
Pouch of Douglas:	
Peritoneal surfaces:	
Peritoneal washings:	

Appendix 3

Description of operation performed:		
FOR VULVAL CANCERS 		
Lead Surgeon/s:	**Consultant/s-**	**Senior registrar/s-**
Assistant surgeons:	**Senior registrar /s-**	**Registrar/s -**
Name and signature of recorder:		**Date:**
Designation:		

Appendix 4

Full Schedule of Chemotherapy for Epithelial Ovarian Cancer (GO 4)

Each dose is given every 3 weeks

1. IV Dexamethasone 20mg 12 hourly for 24 hours (6 – 12 hours before commencing cytotoxic agents)
2. IV Ondasetrone 8mg 8 hourly for 24 hours
3. IV Ranitidine 50 mg stat (30 – 60 minutes before cytotoxic agents)
4. IV Normal saline I litre bolus over 30 minutes
5. IV Paclitaxel 135 to 175mg per m^2 in 500mls of 4.3% dextrose saline over 6 hours
6. IV Normal saline 500mls bolus over 30 minutes
7. IV Cisplatin 75mg per m^2 in 500mls of 4.3% dextrose saline over 3 hours, or *IV Carboplatin
8. IV Normal saline 500mls bolus over 30 minutes

*IV Carboplatin over 15 to 60 minutes -
Use Calvert's formula:
Carboplatin dose (mg) = {target area under the curve (AUC)} X {glomerular filtration rate (GFR) + 25}.
AUC range is 4 – 6.

Appendix 4

Suggested Drug Regimes

Cervical Cancer

Locally Advanced Cervical Cancer	
First-Line Therapy with Radiotherapy (Chemoradiation)	
Cisplatin	
Cisplatin and 5-FU	
Cisplatin and 5-FU and hydroxyurea	
Cisplatin and gemcitabine and radiotherapy and brachytherapy	Induction therapy Repeat every 3 weeks for 2 cycles.
Metastatic or Recurrent Cervical Cancer	
First-Line Combination Therapy	
Paclitaxel and cisplatin	Repeat cycle every 3 weeks for 6 cycles.
Carboplatin and paclitaxel	Repeat cycle every 3 weeks for 6–9 cycles or until disease progression or unacceptable toxicity.
Cisplatin and topotecan	Repeat cycle every 3 weeks.
Cisplatin and gemcitabine	Repeat cycle every 4 weeks.
First-Line Monotherapy	
Cisplatin (preferred as a single agent)	Repeat cycle every 3 weeks for a total of 6 cycles. Most patients who develop metastatic cervical cancer have received concurrent cisplatin/radiotherapy as primary treatment and may no longer be sensitive to single-agent platinum therapy.
Second-Line Therapy	
Bevacizumab	Repeat cycle every 3 weeks.
Docetaxel Gemcitabine	Repeat cycle every 3 weeks. Repeat cycle every 4 weeks.

Appendix 4

Ovarian Cancer Chemotherapy

Principle of therapy: All regimens involving primary chemotherapy/primary adjuvant therapy include intravenous (IV) and intraperitoneal (IP) options, and may be used for epithelial ovarian, primary peritoneal, and Fallopian tube cancers.	
Regimen	**Dosing**
Intravenous First-Line Primary Chemotherapy/Primary Adjuvant Therapy (Stages II–IV).	
Paclitaxel and carboplatin	Repeat every 3 weeks for 6 cycles.
Docetaxel and carboplatin	Repeat every 3 weeks for 6 cycles.
Dose-dense paclitaxel and carboplatin	Repeat every 3 weeks for 6 cycles.
Intraperitoneal First-Line Therapy for Advanced Disease	
Paclitaxel and cisplatin	Repeat every 3 weeks for 6 cycles.
Germ cell tumours	
Bleomycin	Bolus per week
Etoposide	Days 1 – 5
Cisplatin	Days 1 – 5. Given every 3 weeks for 3 – 4 cycles

Endometrial Cancer Regimen

Regimen	**Dosing**
Chemotherapy Regimens and other Treatment Regimens	
Cisplatin and doxorubicin (for adjuvant use)	Repeat cycle every 3 weeks; maximum 6 cycles.
Cisplatin and doxorubicin (for advanced disease use)	Repeat cycle every 3 weeks for max 7 cycles. Maximum BSA of 2.0 to be used for calculations.
Cisplatin and doxorubicin and paclitaxel	Repeat cycle every 3 weeks for max 7 cycles. Maximum BSA of 2.0 to be used for calculations.
Ifosfamide and paclitaxel	Repeat cycle every 3 weeks for 8 cycles.
Carboplatin and paclitaxel	Repeat cycle every 3 weeks.
CIM (cisplatin and ifosfamide and mesna) for carcinosarcoma	Repeat cycle every 3 weeks for 3 cycles.

Appendix 4

Ovarian Cancer contd.

Bevacizumab (Category 2B)	Repeat cycle every 3 weeks until disease progression or toxicity occurs. May be considered for use in patients who have progressed on prior cytotoxic chemotherapy.
Hormonal Regimens (for Endometrioid Histologies Only)	
Tamoxifen	
Medroxyprogesterone acetate (MPA)	
Tamoxifen and medroxyprogesterone acetate	Repeat cycle every 3 weeks. Combination is associated with grade 4 thromboembolic events in a few patients

Uterine Sarcoma

Regimen	**Dosing**
Chemotherapy	
Doxorubicin	Repeat cycle every 31 days OR dosed every 3 weeks.
Gemcitabine and docetaxel and granulocyte-colony-stimulating factor (G-CSF)	Repeat cycle every 3 weeks until disease progression or toxicity occurs. NOTE: Patients with prior pelvic irradiation to receive Gemcitabine and Docetaxel.
Gemcitabine	Repeat cycle every 4 weeks.
Hormone Therapy (Endometrial Stromal Sarcoma only)	
Medroxyprogesterone acetate and Megestrol acetate	

Appendix 4

Gestational Trophoblastic Disease

Regimen	**Dosing**
Single agent	
Methotrexate – Folinic acid	Alternated between Days 1 – 8. Given according to βhCG levels
5 – day Methotrexate	
Pulse Methotrexate	
5 – day Actinomycin D	
Pulse Actinomycin D	
Combination chemotherapy	
MAC regime Methotrexate Actinomycin D Cyclophosphamide	 Days 1, 3, 5, 7. Folinic acid on Days 2, 4, 6, 8. Days 1 – 5 Days 1 – 5
EMACO Day 1: Etoposide, Actinomycin D, Methotrexate Day 2: Etoposide, Actinomycin D, Folinic acid Day 8: Cyclophosphamide and Vincristine	At 2 to 3 weeks
EMACE Day 1: Etoposide, Actinomycin D, Methotrexate Day 2: Etoposide, Actinomycin D, Folinic acid Day 8: Cisplatin, Etoposide	

Graphical representation of each course of chemotherapy is achieved with the use of the **cancer chemotherapy chart – GO 5** *(Appendix 5)*.

Appendix 5

CANCER CHEMOTHERAPY CHART GO 5

NAME:	WARD:	HOSP. No:	DATE:	COURSE:
DIAGNOSIS:			STAGE / SCORE:	

DRUGS:	D1	D2	D3	D4	D5	D6	D7	D8	D9	D10	D11
1.											
2.											
3.											
4.											
5.											
6.											

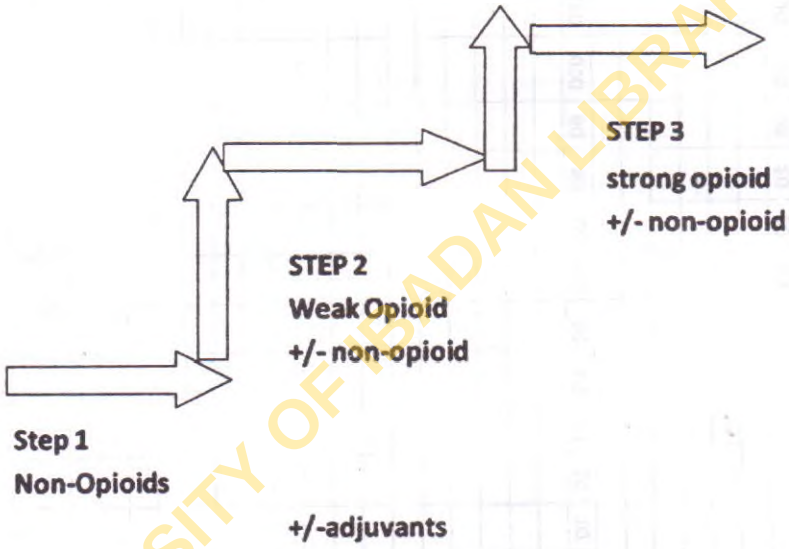
LIVER FUNCTION TESTS	D0	D1	D2	D3	D4	D5	D6	D7	D8	D9	D10	D11	D12	D13	D14	D15	D16
BILIRUBIN (Total and Conjugated)																	
ALKALINE PHOSPHATASE																	
AST																	
ALT																	
ALBUMIN/GLOBULIN. TOTAL																	
ELECTROLYTES AND UREA																	
Na^+																	
K^+																	
Cl^-																	
HCO_3^-																	
UREA																	
URIC ACID																	
CREATININE																	
FULL BLOOD COUNT																	
PACKED CELL VOLUME																	
WHITE BLOOD CELL COUNT																	
PLATELETS																	
ULTRASONOGRAPHY																	
CHEST X – RAY																	
TUMOUR MARKERS																	
URINE PREGNANCY TEST																	

Appendix 6. GO 6.

World Health Organization (WHO) and WFSA Analgesic Ladders

Guidelines:

- Administer drugs by mouth
- Administer by the clock
- For the individual
- Attention to details
-



Adjuvants include sedatives, anxiolytics, anti - depressants

WFSA Analgesic Ladder

Parenteral opioids for severe pain +/- local anaesthetic techniques	Oral opioids for mild to moderate pain +/- non-opioid analgesics	Non – opioid analgesics

Decreasing pain

Appendix 7

Follow-up Schedules (GO 7)

Ovarian Cancer

Tumour Type	Frequency
Germ cell tumours	Year 1: monthly visits Years 2 – 3: monthly visits Years 3 – 4: monthly visits Years 4/5 –6: monthly visits Beyond 5 years: continue yearly visits and discharge at 10 years.
Epithelial cancers	Years 1 – 3: monthly visits Years 2 – 4: monthly visits Years 3 – 6: monthly visits Years 4/5: annually Beyond 5 years: continue yearly visits and discharge at 10 years.
Ovarian Sex Cord Stromal Tumours	Year 1: monthly visits Year 2: 3 monthly visits Years 3 – 4: monthly visits Years 4/5 – 6: monthly visits Beyond 5 years: continue yearly visits and discharge at 10 years.
Components of the follow-up	Year 1 – tumour markers – AFP, hCG, Ca-125 monthly; pelvic imaging with ultrasound scanning 4-monthly. Year 2 – tumour markers 3 monthly; pelvic imaging 6-monthly. Year 3 – tumour markers 4 monthly; pelvic imaging yearly Year 4/5 – yearly ultrasound scanning every visit
Responsibility of Care	Consultant-led Gynaecological Oncology Unit or Centre.

Cervical Cancers

Tumour Type	Frequency
Cervical cancers	Year 1: 3 monthly visits Year 2: 4 monthly visits Years 3 – 5: 6 monthly visits Beyond 5 years: Consider for discharge.
Components of the follow-up	At each visit, a brief history, general physical examination as well as pelvic examination is desirable where feasible. Years 1 - 5: pelvic imaging with ultrasound scanning and cytologic screening yearly
Responsibility of Care	Consultant-led Gynaecological Oncology Unit or Centre.

Endometrial Cancers/Fallopian Tube Cancers

Tumour Type	Frequency
Endometrial/Fallopian Tube cancers	Year 1: monthly visits Years 2 – 3: monthly visits Years 3 – 4: monthly visits Years 4/5 – 6: monthly visits Beyond 5 years: continue yearly visits and discharge at 10 years.
Components of the follow-up	At each visit, a brief history, general physical examination as well as pelvic examination is desirable where feasible. Year 1: pelvic imaging with ultrasound scanning monthly Year 2: pelvic imaging with ultrasound scanning 3 - monthly Year 3: pelvic imaging with ultrasound scanning 4 - monthly Years 4/5: yearly pelvic imaging with ultrasound scanning
Responsibility of Care	Consultant-led Gynaecological Oncology Unit or Centre.

Appendix 7

Vulval and Vaginal Cancers

Tumour Type	Frequency
Vulval and Vaginal cancers	Year 1: 3 monthly visits Years 2 – 3: monthly visits Years 3 – 6: monthly visits Years 4/5 – 6: monthly visits Beyond 5 years: Consider for discharge.
Components of the follow-up	At each visit, a brief history, general physical examination as well as pelvic examination is desirable where feasible. Year 1: pelvic imaging with ultrasound scanning 6 monthly Year 2: pelvic imaging with ultrasound scanning 6 monthly Year 3: pelvic imaging with ultrasound scanning yearly Years 4/5: pelvic imaging with ultrasound scanning yearly
Responsibility of Care	Consultant-led Gynaecological Oncology Unit or Centre.

Appendix 7

Gestational Trophoblastic Diseases

Tumour Type	Frequency
Hydatidiform - mole (Complete or Partial), Placental Site Trophoblastic Tumour, Invasive mole, Choriocarcinoma	Years 1 – 2: weekly visits in first 2 months then monthly for next 10 months. Year 2: once every 2 months. Years 3, 4 & 5: 6 monthly Yearly visits for life.
Components of the follow-up	Year 1: At each visit, ensure tumour marker hCG, pelvic examination, ultrasound scanning of the pelvis. Year 2: At each visit, ensure tumour marker hCG, pelvic examination, ultrasound scanning of the pelvis. Years 3, 4 & 5: At each visit, ensure tumour marker hCG; ultrasound scanning of the pelvis yearly. NB: Patient to have chest Xray at 6 weeks and at 3 months after treatment; thereafter 6 monthly for another 1year and if all are normal then discontinue.
Responsibility of Care	Consultant-led Gynaecological Oncology Unit or Centre.

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