Welcome address and Acknowledgement to country

Dr Mahilal Ratnapala

Director – Obstetrics and Gynaecology

Caboolture Hospital

Metro North Hospital and Health Service (MNHHS)

Morning session

Time	Task	Presenter
9.00 am	Welcome address	Dr Mahilal Ratnapala
9.05 am	Introduction I Housekeeping	Dr Meg Cairns
9.10 am	Cervical Screening Australia “The Renewal”	Dr Jason Stone
9.55 am	Services & referral processes	Dr Meg Cairns
10.10	Gynaecology Oncology	Dr Andrea Garrett
10.40 am	Morning Tea (30 minutes)	All
11.10 am	Urogynaecology	Dr Chris Maher
11.40 am	Case work	All
1pm	Lunch (45 minutes)	All

Afternoon session

Time	Task	Presenter
1.45 pm	Fertility	Dr Hayden Homer
2.15 pm	Breakout interactive sessions	All
3.45 pm	Questions/discussion Summary and close	All

Acknowledgements

- Metro North Hospital and Health Service
  - Caboolture Hospital
  - Redcliffe Hospital
  - Royal Brisbane and Women's Hospital
  - The Prince Charles Hospital
- Brisbane North PHN

Thank you to our sponsors

Useful resources

- MN HHS Gynaecology referral guidelines
- MN HHS Gynaecology services https://www.health.qld.gov.au/metronorth/refer/services/gynaecology/mn-gynaecology-services
- Brisbane North PHN eReferral templates http://www.brisbanenorthphn.org.au/page/health-professionals/referral-and-patient-management/Hospital+eReferral+Templates/

Useful resources

- Australian Family Physician – Female pelvic problems http://www.racgp.org.au/afp/2015/july/
- RACGP *gplearning* http://gplearning.racgp.org.au
- RACGP Clinical guidelines http://www.racgp.org.au/your-practice/guidelines/redbook/

Useful resources

- RANZCOG statements and guidelines https://www.ranzcog.edu.au/Statements-Guidelines/
- RCOG The Initial Management of Chronic Pelvic Pain https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_41.pdf
- NICE guidelines https://www.nice.org.uk/guidance/conditions-and-diseases/gynaecological-conditions

Useful resources

- True relationship & reproductive health Medical education & Clinical Training
- True health information
- Family Planning NSW Reproductive & Sexual Health resources
- Family Planning NSW Reproductive & Sexual Health publications for health professionals

Useful resources

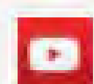
- Cancer Australia GP guides and resources
- Department of Veteran's Affairs - The impact of commonly used medicines on urinary incontinence
- NPS - Medicines that may cause or make incontinence worse
- Managing urinary incontinence in primary care

Useful resources

- http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/healthcare-providers
- http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening
- https://canceraustralia.gov.au/clinical-best-practice/gynaecological-cancers/gp-guides-and-resources

NETWORK Link

ISSUE January 2017



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Recognition for the Maternity GP Alignment Program

The Metro North Maternity GP Alignment Program was awarded Highly Commended at the recent 2016 Queensland Health Awards for Excellence.

Minister for Health and Minister for Ambulance services, Cameron Dick MP with program representatives

Brisbane North PHN

GP bulletin board - February 2017

Tear off this page to keep handy on your noticeboard.

News from General Practice Liaison Officers (GPLOs) at Brisbane North PHN and Metro North Hospital and Health Service.

Resources for GPs

GP referral guidelines, named outpatient specialist lists and other useful resources from Metro North Hospital and Health Service hospitals:

- www.health.qld.gov.au/metronorth/refer
- Central Patient Intake (outpatient referral enquiry number): 1300 364 938
- Information about Brisbane North PHN programs and services and eReferral templates:
- www.brisbanenorthphn.org.au/page/health-professionals
- named specialist lists for each public hospital can be found on your eReferral templates, go to www.brisbanenorthphn.org.au and click "Hospital eReferral templates" in the navy Quick Links box

GP education events for 2017 from Metro North Hospital and Health Service public specialists

GP gynaecology workshop – Saturday 18 February – likely Cat 1 QICPD event

GP neurology evening – Wednesday 15 March – likely Cat 2 event

GP maternity alignment program workshop – Saturday 25 March – Cat 1 QICPD points have been applied for.

See page 6 - 9 for information about these events and how to register.

Update your GP details on GP database at Queensland Health

If a GP moves practice, or works at another practice it is essential that Queensland Health is kept up-to-date.

Queensland public hospitals use a GP address book (STS - Secure Transfer Services) for the delivery of important documentation (e.g. discharge summaries and clinical letters). Queensland Health would like to update all GPs currently working at your practice as they may have old details in the address book.

Visit www.health.qld.gov.au/metronorth/refer and download the "Secure Transfer Service Address Book Update Form".

Fill in as many details on the electronic PDF as possible (you can save the PDF form on your computer so in the future you can just update information that has changed).

When finished, click on the "email form" button at the end and it will be forwarded via email to Queensland Health.

Benefits of keeping this updated include:

- ability for GPs to access pathology and radiology results with The Viewer in the future (see the January Network Link for more information on GP access to The Viewer)
- improved communication of discharge and outpatient letters and pathology results (GP Software dependent) .

Ensuring correct GP details in patient record

When a patient presents to hospital, if they do not have the correct details for your practice you may miss out on important information about their admission. Errors can occur when there are several practices with a similar name which may confuse the patient and hospital reception staff.

To ensure the correct GP name and practice name are recorded when a patient presents to hospital, consider giving your practice business card to your patients.

This helps to ensure your patient provides the correct details when they come to the hospital and ensures that information goes to the correct practice.

This is an initiative of the General Practice Liaison Officer Program

Brisbane North HealthPathways

- Developed in collaboration with hospital clinicians and local GPs

Visit: https://brisbanenorth.healthpathwayscommunity.org/
Username: Brisbane
Password: North

Health Provider Portal

- Access to patient information at QLD public hospitals
- info - www.health.qld.gov.au/hp-portal
- Pathology, radiology, operation records, discharge summaries, medication history, OPD appointments at all QLD Health facilities
- Patients can opt out- call 13Health

Cervical Screening Australia
“The Renewal”

Dr Jason Stone

Overview

- Genital HPV and current cervical screening recap
- The Renewal – basic protocols
- The Renewal – special situations
- How to take an HPV test
- Moving forward and summary

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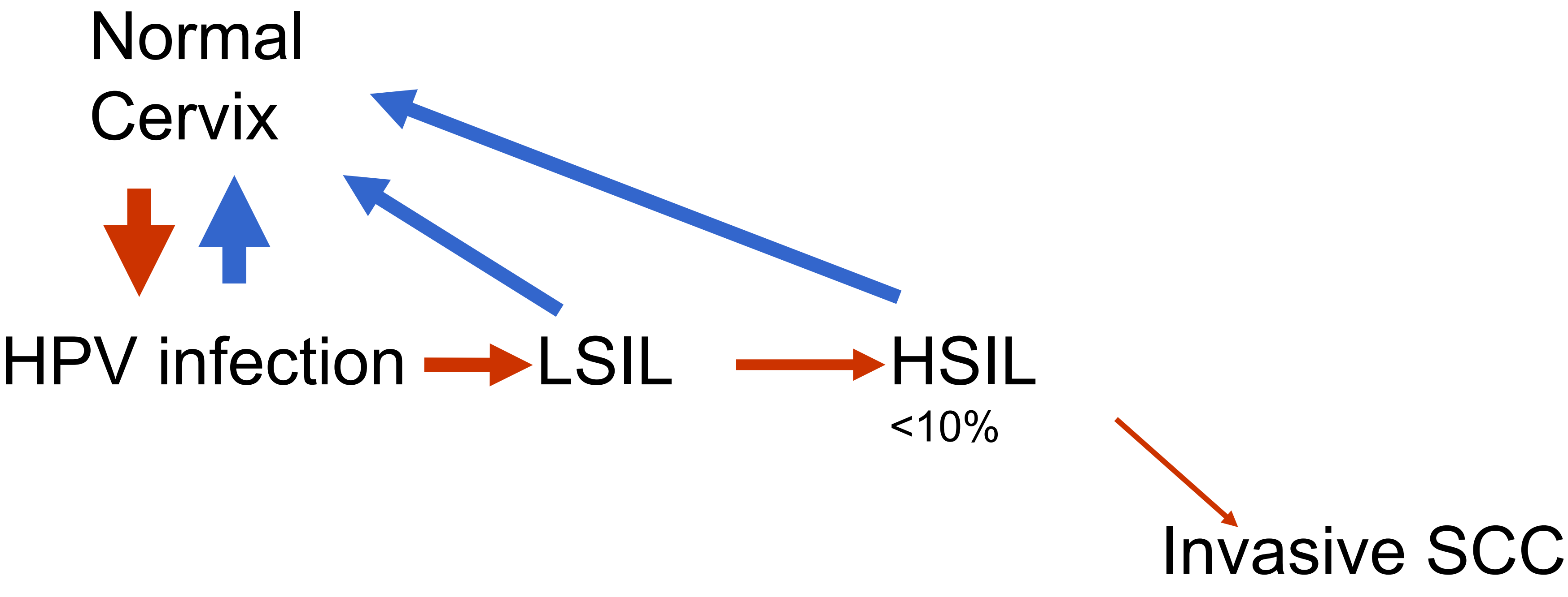
Ca cervix – Natural history



10-12 years

Genital HPV

- Most infections are before 30yrs old
- 90% of HPV resolve within 1-2 years
- Only a few women get *persistent* HPV infection
- Most serotypes are essentially harmless

- A few serotypes are regarded as **Oncogenic** HPV types
- especially Types 16 and 18
- Can lead to Squamous cancer and adenocarcinoma

- **Persistent Oncogenic HPV infection** is the key risk factor

Why test for oncogenic HPV?

1. Look for those at increased risk – "**Screening**"

2. Decide what to do with women with persistent low grade abnormalities – "**Triage**"

3. Decide when to return to routine screening after Rx for HSIL– "**Test of Cure**"

Currently, Medicare rebate ***only*** for "Test of Cure"

Current situation

- Unchanged since 2005
- Screening on conventional glass slides only
- Start after “first sex”
- Every 2 years
- Exit at 69yrs
- HPV testing for “*Test of Cure*” only

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“The Renewal”

~~1st May 2017~~

1st December 2017

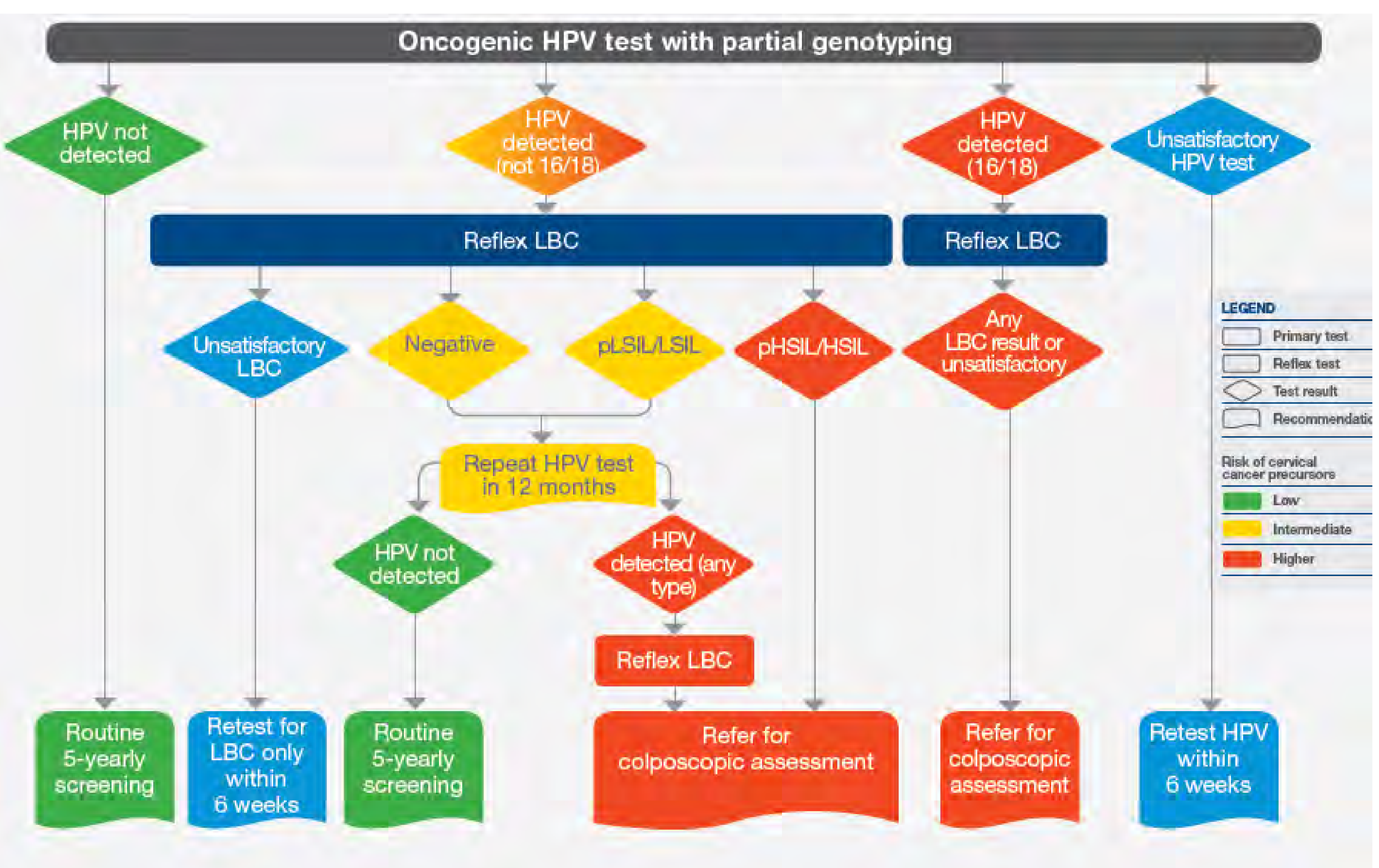
The Renewal – Key points

- Starting age 25
- 5 yearly
- Oncogenic HPV Test
- + reflex cytology if HPV Test positive

- National Register coordinating invites
- End screening age 75

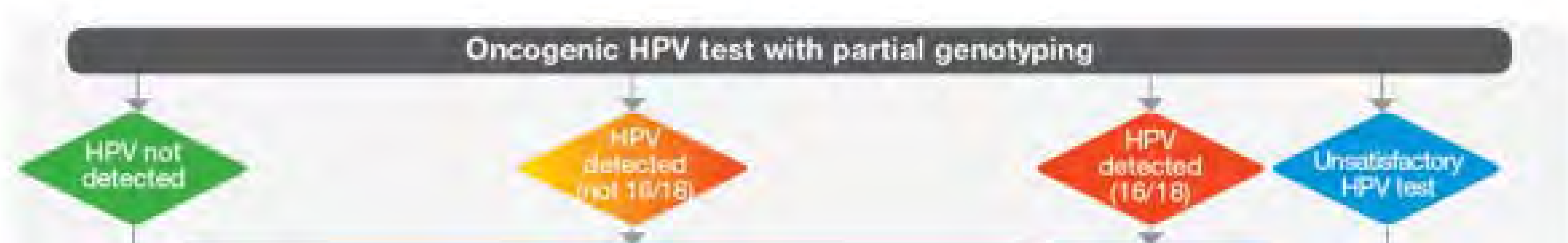
HPV test result

- Result will say:
  - Oncogenic subtype 16: *detected/not detected*
  - Oncogenic subtype 18: *detected/not detected*
  - Other twelve oncogenic subtypes: *detected/not detected*
- plus the result of any "reflex cytology" if performed
- plus the clinical recommendation

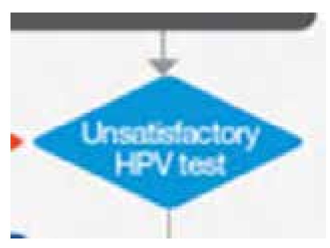

Oncogenic HPV test with partial genotyping
HPV not detected
HPV detected (not 16/18)
HPV detected (16/18)
Unsatisfactory HPV test
Reflex LBC
Reflex LBC
Unsatisfactory LBC
Negative
pLSIL/LSIL
pHSIL/HSIL
Any LBC result or unsatisfactory
Repeat HPV test in 12 months
HPV not detected
HPV detected (any type)
Reflex LBC
Routine 5-yearly screening
Retest for LBC only within 6 weeks
Routine 5-yearly screening
Refer for colposcopic assessment
Refer for colposcopic assessment
Retest HPV within 6 weeks
LEGEND
Primary test
Reflex test
Test result
Risk of cervical cancer precursors
Low
Intermediate
Higher

4 possible results of HPV test:

1. **Unsatisfactory**
2. No oncogenic HPV detected
3. **Positive** for oncogenic HPV 16/18
4. **Positive** for *other* oncogenic HPV

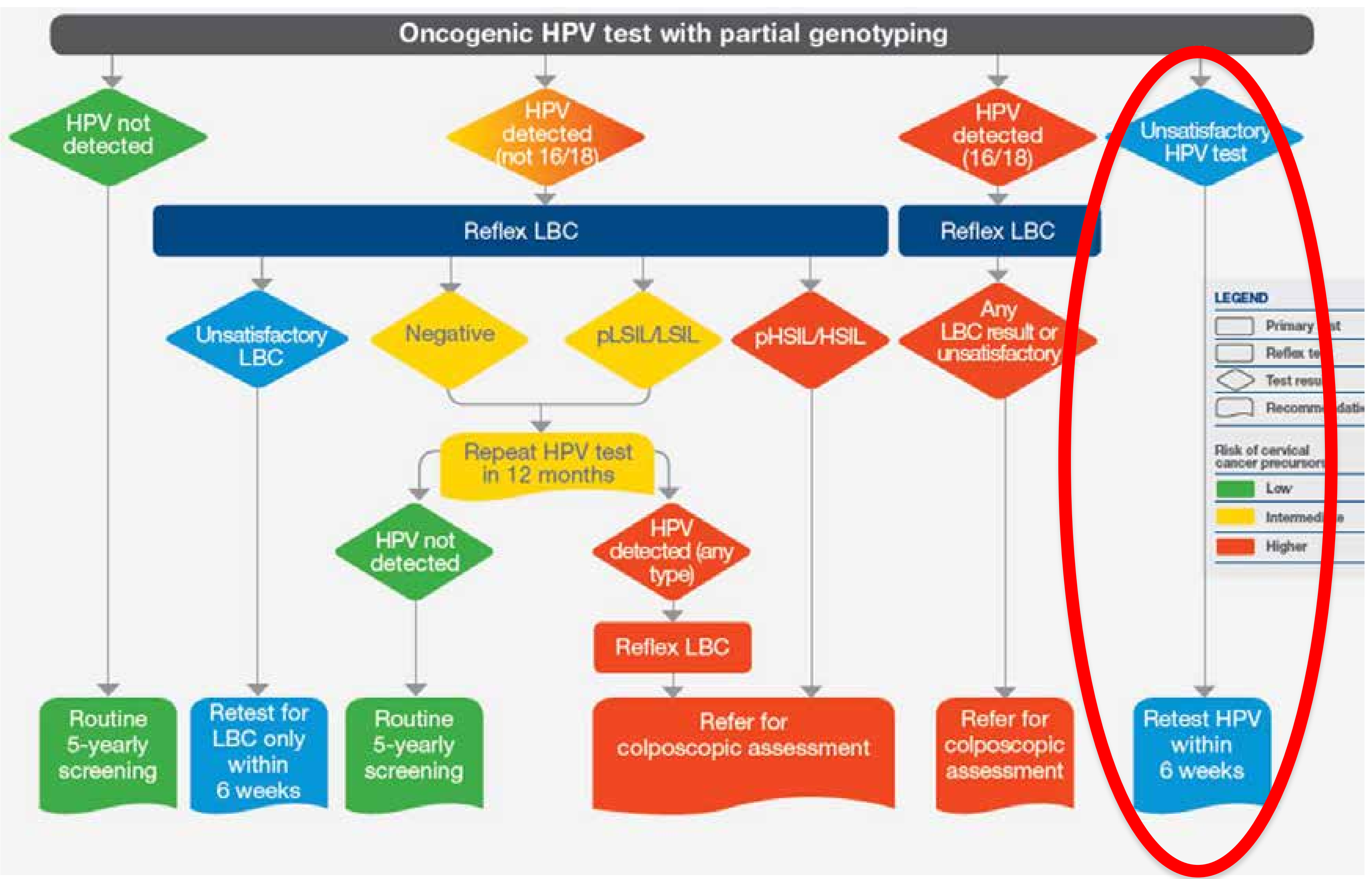


1. Unsatisfactory HPV test



- Repeat in 6 weeks
- Blood, mucus, lubricant can all inhibit DNA amplification

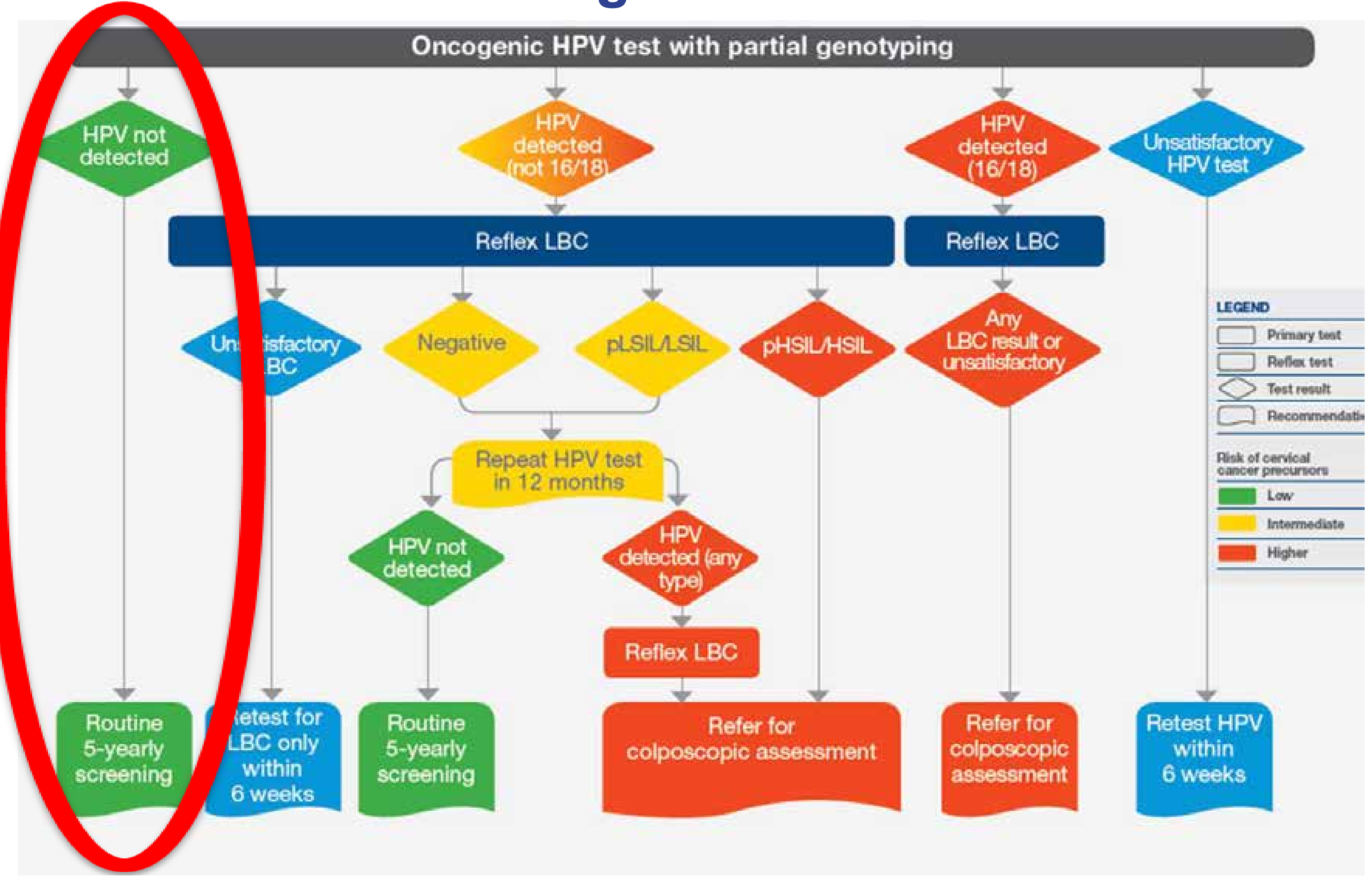
1. Unsatisfactory HPV test:



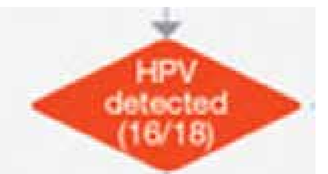
2. No oncogenic HPV detected

- Low risk for significant cervical abnormality
- Recall for screening in 5 years

2. No oncogenic HPV detected



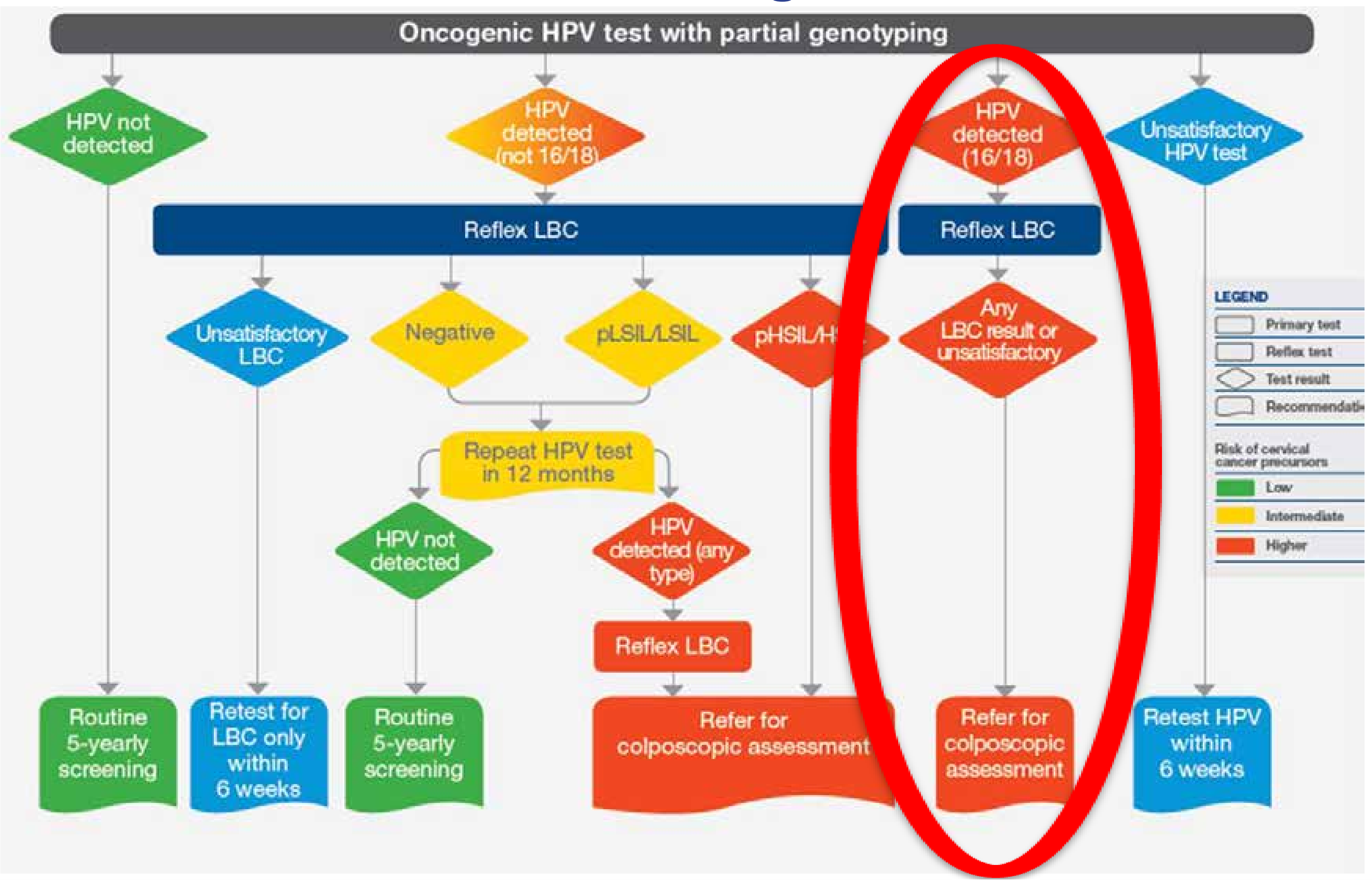
3. Positive for oncogenic HPV 16/18



- Higher risk for significant cervical abnormality
- Lab then does reflex cytology ***and***
- GP refers to colposcopy

- Remember: positive for HR HPV ≠ CIN

3. Positive for oncogenic HPV 16/18



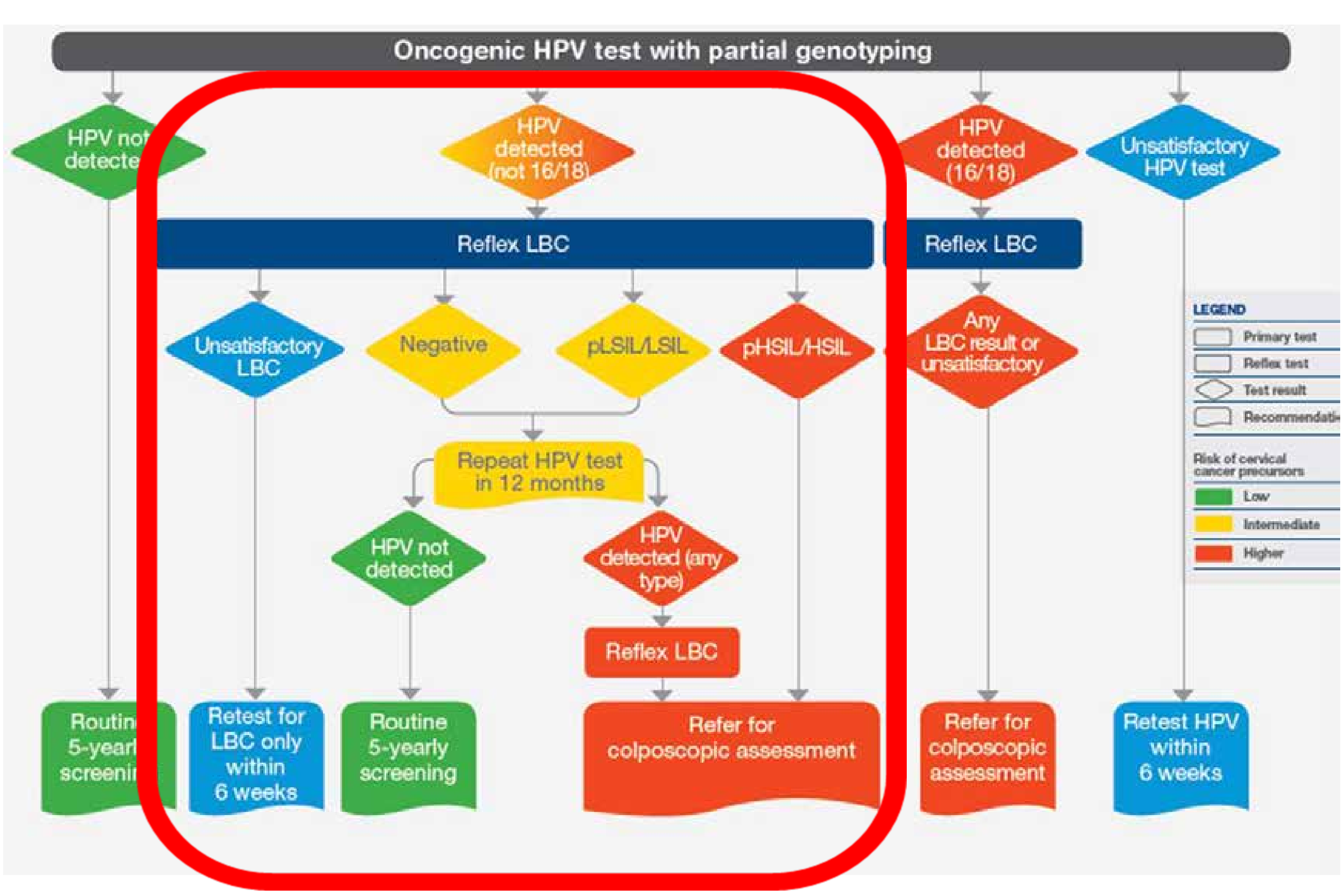
4. Positive for *other* oncogenic HPV (i.e. NOT 16/18)

HPV detected (not 16/18)

- Intermediate risk for significant cervical abnormality
- Lab then does **reflex cytology**.
- If cytology is **pHSIL or worse**:
  → colposcopy
- If cytology is **negative/pLSIL/LSIL**:
  →repeat HR HPV test in 1 year

- If repeat HR HPV test in 1 year is positive:
  → colposcopy
- If repeat HR HPV test in 1 year is negative:
  → 5 year recall

4. Positive for *other* oncogenic HPV (i.e. NOT 16/18)



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A few extras…

- **Symptomatic** (e.g. abnormal bleeding):
  → require co-test HPV *and* cytology

- Previous **endocervical AIS**:
  → annual co-test HPV *and* cytology

- **Immune deficient**:
  → recall every 3 years

A few more extras…

- 70-74 yrs, and HR HPV negative:
  → discharge

- 70-74 yrs, and HR HPV + (*any type):*
  → colposcopy & cytology

- >75 yrs and never/under screened:
  → HR HPV testing

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How to test for oncogenic HPV

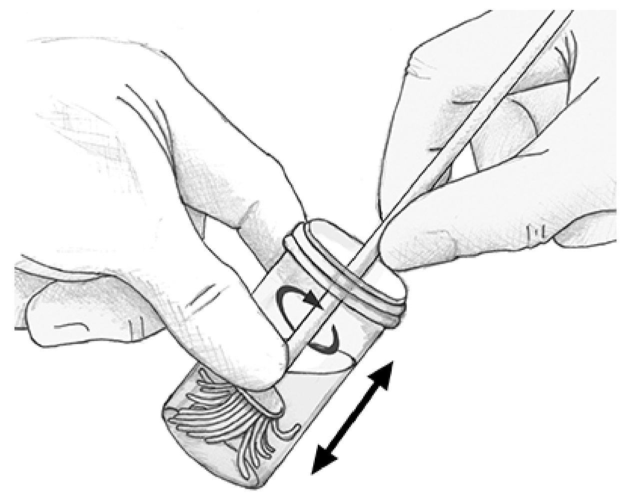
- From cervical smear only

- It is a PCR test for viral DNA
- **Not** a blood test
- **Not** a culture

- We only test for the oncogenic subtypes
- Positive test ≠ CIN of cervix

When taking the sample:

- Lab may need to also make a cytology sample from the fluid
- Therefore important to do a **proper cervical sampling** as you would do for a normal cervical smear.
- Sample **vigorously** rinsed in Thinprep vial
- NO MORE GLASS SLIDES
- AVOID LUBE



Testing for HPV

- Not for non-cervical sites
- Not for males
- Not for low-risk non-oncogenic HPV types
- Not on biopsy histology samples

Request form

- **Very important** to state if you want:
  - HPV screening test
  - or HPV and cytology co-test
  - or cytology only
- Clinical details essential for correct test by lab
- Clinical details essential for correct recommendation by lab

Request form

- Cervical Screening Test, routine
- Cervical Test, follow up of previous abnormal result
- Cervical co-test, symptomatic
- Cervical co-test, previous AIS

Self testing

- **Only** for “under-screened or never-screened
- Under medical “supervision”
- Dry flocked swab
- Only about **70% as effective**
- Therefore **not to be used for convenience only**
- Can’t do cytology from sample
- Medicare will only allow once in 7 year period

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Key points to note to minimise clinical risk!

- **Sample** cervix properly
- **Symptomatic** patients need co-test
- Previous **endocervical AIS** needs annual co-test
- Fill in **detailed** request form!

Moving forward…

Guidelines available at:

Google: "wiki cervical screening au"

- Includes:
  - Big PDF (285 pages)
  - Small PDF summary
  - Online education modules

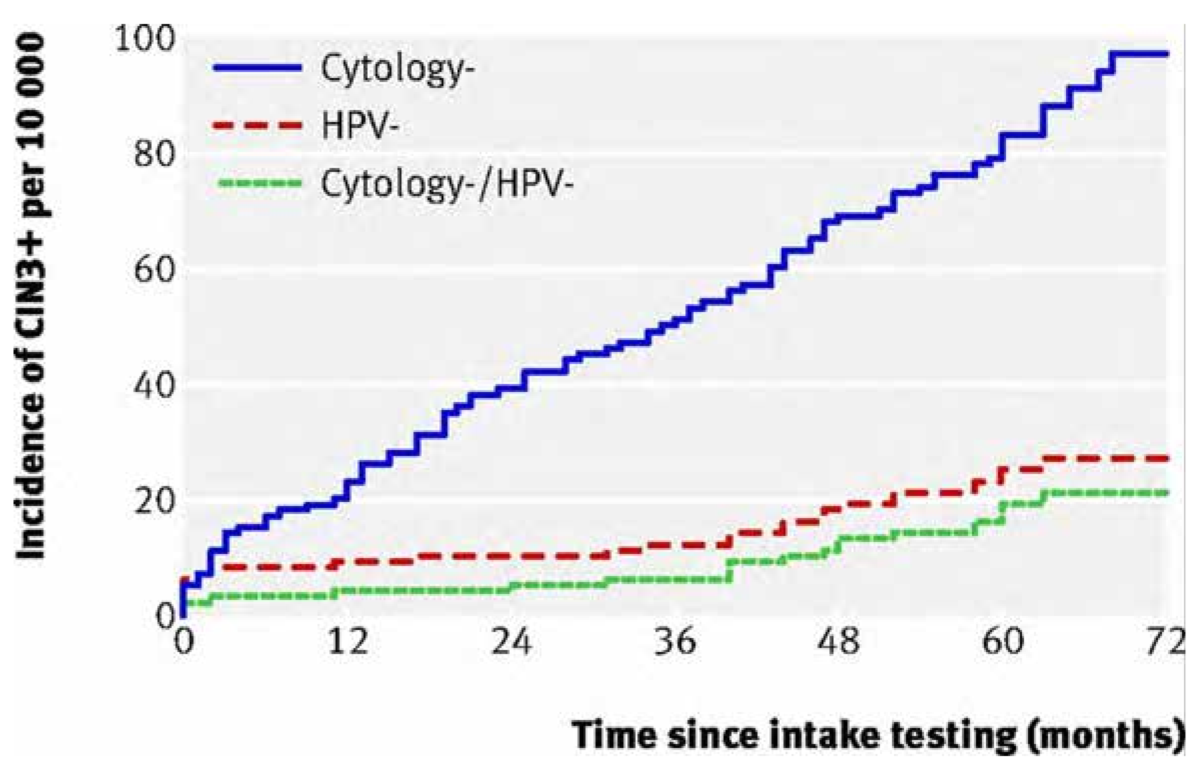
- After Dec, screening will be *by invitation* from the National Cervical Screening Register

From now to December

- HPV testing is for Test of Cure **only**
- (otherwise $40 out of pocket)

- Please use Thinprep only
- No more glass or SurePath
- NO REBATE for both slide ***and*** vial ($35 of pocket)

The evidence



Dillner J et al. BMJ. 2008
Many others

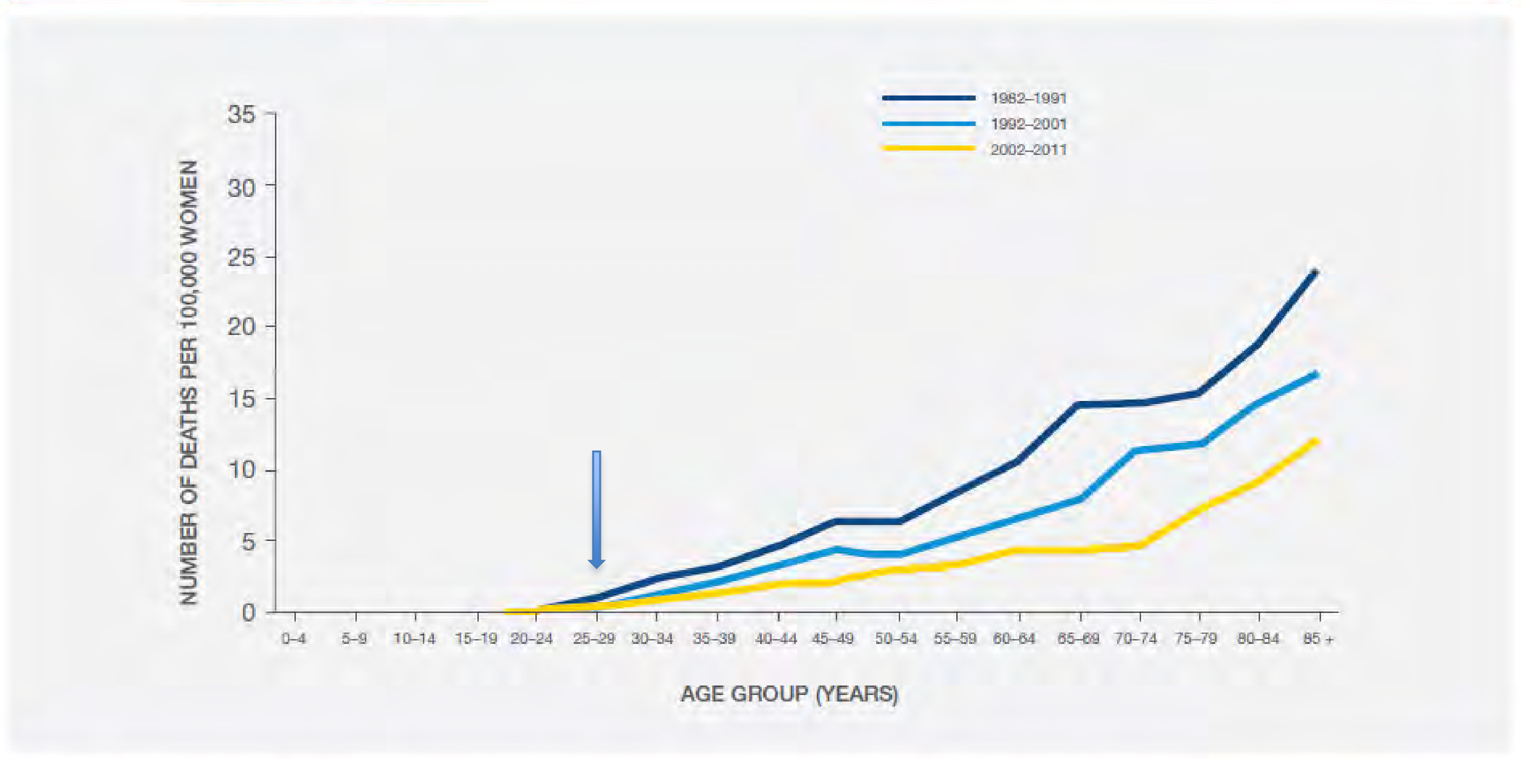
What about under 25's ? The context…

- 903 new cases cervical cancer in Australia 2016 (all ages)
- 250 deaths cervical cancer in Australia 2016 (all ages)
- i.e. cervical cancer is rare
- i.e. deaths from cervical cancer are rarer

Ref: Australia Institute Health & Welfare 2016

Mortality from ca cervix

Figure 1.5. Mortality from cervical cancer in women by 5-year age group, 1982–1991, 1992–2001, and 2002–2012



NOTE: **1.** Mortality rate is the number of deaths from cervical cancer per 100,000 women. Source: Australian Cancer Incidence and Mortality[5]

Conclusion

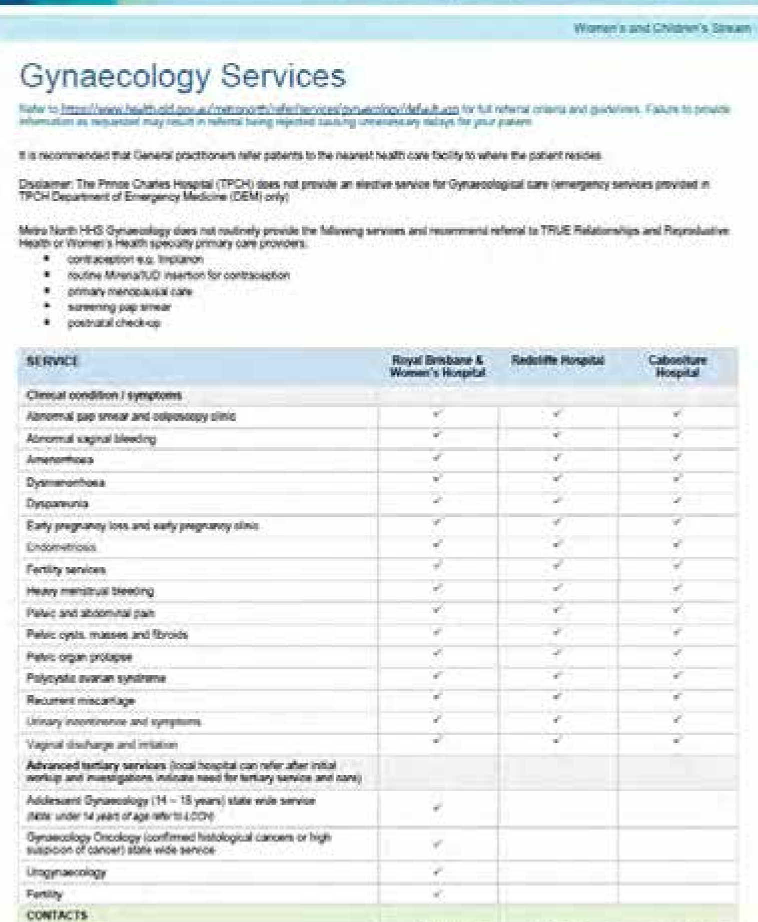
- Under 25's already have exceptionally low incidence of **carcinoma**
- Under 25's have an even lower mortality from **carcinoma**
- PLUS – they are now a *vaccinated* cohort
- So these rates will go even lower…

Referral processes & services - RBWH, Redcliffe, Caboolture

Gynaecology Services

- RBWH, Redcliffe and Caboolture all provide Gynaecology services
- No elective service at TPCH (emergency service provided in TPCH DEM only)
- Is your patient “ready for care”?
- Refer patients to nearest hospital

Services Directory



Metro North Hospital and Health Service

Women's and Children's Stream

Gynaecology Services

Refer to https://www.health.qld.gov.au/metronorth/refer/services/gynaecology/default.asp for full referral criteria and guidelines. Failure to provide information as requested may result in referral being rejected causing unnecessary delays for your patient.

It is recommended that General practitioners refer patients to the nearest health care facility to where the patient resides.

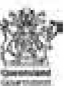
Disclaimer: The Prince Charles Hospital (TPCH) does not provide an elective service for Gynaecological care (emergency services provided in TPCH Department of Emergency Medicine (DEM) only).

Metro North HHS Gynaecology does not routinely provide the following services and recommend referral to TRUE Relationships and Reproductive Health or Women's Health specialty primary care providers.

- contraception e.g. Implanon
- routine Mirena/IUD insertion for contraception
- primary menopausal care
- screening pap smear
- postnatal check-up

SERVICE	Royal Brisbane & Women's Hospital	Redcliffe Hospital	Caboolture Hospital
Clinical condition / symptoms			
Abnormal pap smear and colposcopy clinic	✓	✓	✓
Abnormal vaginal bleeding	✓	✓	✓
Amenorrhoea	✓	✓	✓
Dysmenorrhoea	✓	✓	✓
Dyspareunia	✓	✓	✓
Early pregnancy loss and early pregnancy clinic	✓	✓	✓
Endometriosis	✓	✓	✓
Fertility services	✓	✓	✓
Heavy menstrual bleeding	✓	✓	✓
Pelvic and abdominal pain	✓	✓	✓
Pelvic cysts, masses and fibroids	✓	✓	✓
Pelvic organ prolapse	✓	✓	✓
Polycystic ovarian syndrome	✓	✓	✓
Recurrent miscarriage	✓	✓	✓
Urinary incontinence and symptoms	✓	✓	✓
Vaginal discharge and irritation	✓	✓	✓
Advanced tertiary services (local hospital can refer after initial workup and investigations indicate need for tertiary service and care)			
Adolescent Gynaecology (14 – 18 years) state wide service (Note: under 14 years of age refer to LCCH)	✓		
Gynaecology Oncology (confirmed histological cancers or high suspicion of cancer) state wide service	✓		
Urogynaecology	✓		
Fertility	✓		
CONTACTS			
Administration	3646 1783	3883 7100	5433 8955
Clinical	3646 1629	3883 7335	5433 8020

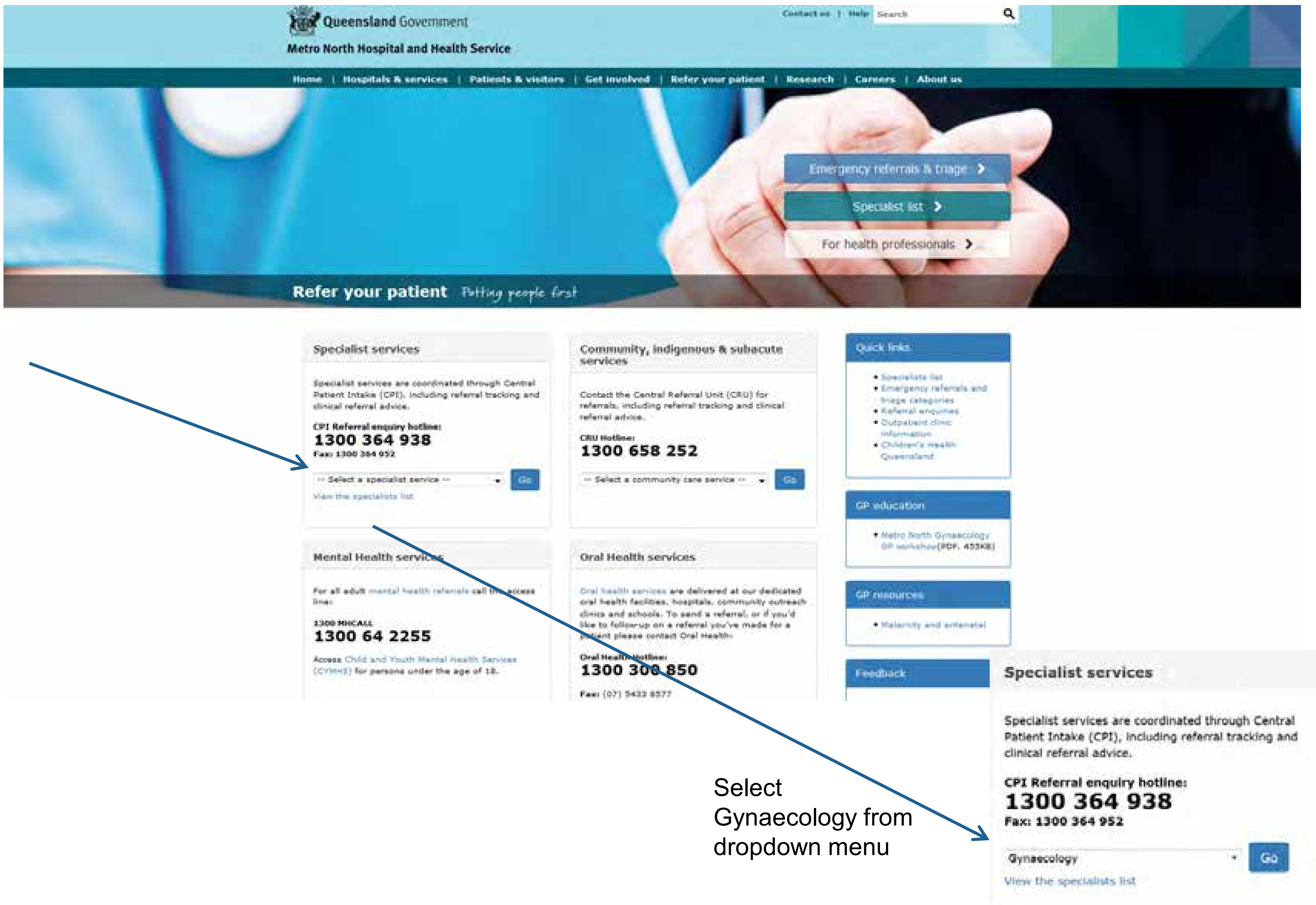
V03 Effective: March 2017 Review: March 2018



Referral Processes

- Does your patient meet minimum referral criteria?
- Please provide essential referral information for the condition
- Please attach current relevant investigation results/reports
- https://www.health.qld.gov.au/metronorth/refer

Referral process



Select Gynaecology from dropdown menu

Gynaecology

Abnormal pap smear / cervical dysplasia / abnormal cervix

Cervical polyp

Dyspareunia (deep or superficial)

Fibroids

Heavy menstrual bleeding (HMB)

Infertility/RPL/PCOS

Intermenstrual bleeding

Known or suspected endometriosis

Mirena®/progesterone releasing IUD Insertion or removal, for HMB or HRT

Ovarian cyst / pelvic mass

Pelvic floor dysfunction (e.g. prolapse and/or incontinence)

Pelvic pain/dysmenorrhea/PMS

Post-coital bleeding

Post-menopausal bleeding (vaginal bleeding more than 12 months following last menstrual period)

Primary/ secondary amenorrhoea

Vulva lesion/ lump/genital warts/ boil/ swelling/ abscess/ ulcer/ Bartholin's cyst

Gynaecology

Emergency

If any of the following are present or suspected, phone 000 to arrange immediate transfer to the emergency department or seek emergent medical advice if in a remote region.

- Ectopic pregnancy
- Ruptured haemorrhagic ovarian cyst
- Torsion of uterine appendages
- Acute/severe pelvic pain
- Significant or uncontrolled vaginal bleeding
- Severe infection
- Abscess intra pelvis or PID
- Bartholin's abscess / acute painful enlargement of a Bartholin's gland/cyst
- Acute trauma including vulva/vaginal lacerations, haematoma and/or penetrating injuries
- Post-operative complications within 6 weeks including wound infection, wound breakdown, vaginal bleeding/discharge, retained products of conception post-op, abdominal pain
- Urinary retention
- Molar pregnancy
- Inevitable and / or incomplete abortion
- Hyperemesis gravidarum
- Ascites, secondary to known underlying gynaecological oncology

Emergency referrals

All urgent cases must be discussed with the on call Registrar to obtain appropriate prioritisation and treatment. Contact through:

- RBWH switch (07) 3646 8111,
- TPCH switch (07) 3139 4000,
- Redcliffe switch (07) 3883 7777 or
- Caboolture switch (07) 5433 8888

Urgent cases accepted via phone must be accompanied with a written referral and a copy faxed immediately to the Central Patient Intake Unit: 1300 364 952.

Conditions (in-scope services)

Please note this is not an exhaustive list of all conditions for outpatient services and does not exclude consideration for referral unless specifically stipulated in the out of

Send referral

Hotline	**1300 364 938**
Fax	1300 364 952
Electronic	eReferral system
Referral template	eReferral templates
Mail	**Metro North Central Patient Intake** Aspley Community Centre 776 Zillmere Road ASPLEY QLD 4034

- Specialist list
- Outpatient clinic information
- General referral criteria
- Named referrals

Locations

- Caboolture Hospital
- Redcliffe Hospital
- Royal Brisbane and Women's Hospital

Health Pathways

Access to Health Pathways is free for clinicians in Metro North Brisbane.

For login details email: healthpathways@brisbanenorthphn.org.au

Login to Brisbane North Health Pathways: brisbanenorth.healthpathwayscommunity.org

Gynaecology

- Abnormal pap smear / cervical dysplasia / abnormal cervix
- Cervical polyp
- Dyspareunia (deep or superficial)
- Fibroids
- Heavy menstrual bleeding (HMB)
- **Infertility/Recurrent Pregnancy Loss (RPL)**
- Intermenstrual bleeding
- Known or suspected endometriosis
- Mirena/Progesterone Releasing IUD Insertion or Removal for Heavy Menstrual Bleeding (HMB) or Hormone Replacement Therapy (HRT)
- Ovarian cyst / pelvic mass
- Pelvic floor dysfunction (e.g. prolapse and/or incontinence)
- CPC Enhanced Guidelines V0.7 Effective: 20 June 2017 Review: 20 June 2018 Page 18 of 23 Pelvic Pain/Dysmenorrhea/Premenstrual Syndrome (PMS)
- Post-coital bleeding
- Post-menopausal bleeding (vaginal bleeding more than 12 months following last menstrual period)
- Primary/ secondary amenorrhoea

Infertility/Recurrent Pregnancy Loss (RPL)

- Minimum referral criteria
- Primary care management information
- Essential referral information
- Other essential information

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Does your patient wish to be referred?

Minimum referral criteria

Does your patient meet the minimum referral criteria?

Category 1 Appointment within 30 days is desirable	• Imminent chemotherapy required • No other Category 1 criteria. Refer to a private specialist to avoid delay.
Category 2 Appointment within 90 days is desirable	• No category 2 criteria. Refer to a private specialist to avoid delay.

Send referral

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Fax	1300 364 952
Electronic	eReferral system
Referral template	eReferral templates
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- Named referrals

Locations

- Caboolture Hospital
- Redcliffe Hospital
- Royal Brisbane and Women's Hospital

Health Pathways

Access to Health Pathways is free for clinicians in Metro North Brisbane.

For login details email:

Hospital eReferral Templates

In This Section

- Community Care
- Directories
- Health Workforce Innovations
- Mental Health Services
- Palliative Care
- Pathways Program
- Referral and Patient Management
  - **Hospital eReferral Templates**
  - Other eReferral Templates
- Service Navigator
- Team Care Coordination
- Closing the Gap
- Immunisation
- Local Positions Vacant

Hospital EReferral Templates

On this page GPs can download eReferral templates for medical practice software. Please ensure that your read the Importing Instructions (PDF - 612 KB) prior to installing these templates. If you need any assistance with these templates, please contact your Primary Care Liaison Officer.

Central Patient Intake Templates

All referrals to Metro North Hospital and Health Service Specialist Outpatient Services are processed through the Central Patient Intake (excluding Mental Health, Community, Indigenous and Subacute Services, Oral Health and Lady Cilento Children's Hospital). For more information on Central Patient Intake visit The Metro North Hospital and Health Service Refer a Patient website.

CPI eReferral templates can be downloaded below:

Metro North Hospital And Health Service EReferral Templates And Specialists Lists

RBWH - adult
MD | Best Practice | Practix | Genie | ZedMed (v4.8)

> *RBWH adult - Specialists List* (v4.8)

TPCH - adult
MD | Best Practice | Practix | Genie | ZedMed (v4.8)

Tertiary clinics - RBWH

- **Gynaecology Oncology** - confirmed histological cancers or high suspicion of cancer
- **Adolescent Gynaecology** - patients 14 - 18 years of age only; under 14 referred to LCCH
- **Vulval** - at patient's nearest hospital in first instance – tertiary referral once assessed
- **Urogynaecology** – referral from within catchment or tertiary inter-hospital

Tertiary clinics - RBWH

- **Continence Nurse Advisory Service** – internal referrals only
- **Early Pregnancy Assessment Unit (EPAU) –** service provided within speciality area of Maternal Fetal Medicine where direct scanning provided
- **Fertility** – Requirements must be met including Female and Male partner referral and investigations

Pelvic Health Clinic – Caboolture Hospital

- Referrals directed through a Physio led clinic prior to assessment by a Medical Officer
- Women assessed by Women's Health Physiotherapist

- Women treated by Physiotherapist and Continence Nurse → discharged or redirected back to see Medical Officer

Redcliffe Hospital

- Pelvic Health pathway as per Caboolture Hospital
- Relevant referrals redirected to Gynaecology Physiotherapy Screening Clinic for Continence Nurse and Physiotherapy consult

Metro North **GP Alignment Program**

GYNAECOLOGY WORKSHOP **SATURDAY 4 NOVEMBER 2017**

Skills Development Centre, Caboolture Hospital

Gynaecology Oncology

Dr Andrea Garrett

Gynaecological Oncologist

INTRODUCTION

- Lifetime risk of gynaecological cancer is 1:22
- Every year there are approximately 6073 new gynaecologic cancer cases (9.8% of all female cancers)
- Every day 12 women are diagnosed with a gynaecologic malignancy
- Every day approximately 4 women die from their disease

LIFETIME CANCER RISK

- Uterine Cancer – 3%
- Cervical Cancer – 1.6%
- Ovarian Cancer – 1.4%
- Vulval Cancer – <1%
- GTD – 1:1500 pregnancies

CASE 1

- 42 year old presents with:
  - 18/12 history of bloating and abdominal pain
  - Pain lasts for 2-3 days, occurs every 2-3 months
  - Menses 5/28, heavy on Day 1-2, painful++
  - Last 3 cycles more irregular bleeding
  - Pain with defaecation, increased frequency
  - Bladder pain at end of stream
  - Decreased appetite, some nausea
- PMHx = arthritis
- Meds = meloxicam, naprogesic
- Social = academic

CASE 1

- Differential Diagnosis??

CASE 1

- **Differential Diagnosis??**
  - Dysmenorrhoea
  - Endometriosis
  - Adenomyosis

CASE 1

- Examination
  - BMI = 23
  - Abdomen – soft, non tender, mass palpable above pubic symphysis to left of midline
  - PV and PR – tense, smooth mass, no tethering or nodularity

CASE 1

- Investigations??

CASE 1

- Investigations??
  - Blood tests
    - CA125
    - CEA
    - CA19.9
    - FBC, ELFT
  - Imaging
    - Pelvic USS
    - CT scan – chest, abdomen and pelvis

CASE 1

- Investigations??
  - Blood tests
    - ***CA125 = 140***
    - CEA = <0.5
    - ***CA19.9 = 280***
    - ***HE4 = 155***
    - ***ROMA = 58.4%***
    - FBC, ELFT
      - AST = 48
      - ***LDH = 573***

CA125

- **Benign**
  - Liver disease
  - Renal disease
  - Pleural effusion
  - Pericarditis, ascites
  - CCF
  - Lupus, sarcoid, TB
  - Colitis, diverticulosis
  - Pregnancy, Fiboids
  - Endometriosis, Menses

- **Malignant**
  - Ovarian
  - Fallopian tube
  - Primary peritoneal
  - Endometrial
  - Cervical

  - Bowel, Pancreas
  - Breast, Lung

OTHER MARKERS

- CA19.9
  - Upper GI
  - Gastric
  - Pancreas
  - Mucinous ovarian lesions
- CEA
  - *Bowel*
  - Can be expressed in ovarian mucinous tumours and breast, thyroid, lung cancers
- HE4
  - Human epididymal protein
  - Overexpressed in serous, clear cell and endometrioid cancers
  - Useful to monitor recurrent or progressive disease
  - Can be elevated in smokers, renal impairment, liver disease, age
  - May be useful to distinguish benign from malignant tumours (eg: endometriosis)

OTHER MARKERS

- **GERM CELL TUMOURS**
  - AFP
  - LDH
  - Bhcg

- **SEX CORD STROMAL TUMOURS**
  - Testosterone
  - DHEAS
  - Androstenedione
  - Inhibin

CASE 1

- Investigations??
  - Blood tests
  - Imaging
    - Pelvic USS
      - *14 x 12 x 9cm complex pelvic mass* arising from left ovary
      - Solid area may represent ovarian tissue
      - Internal homogenous components reflects blood products
      - Right ovary and uterus normal
      - *"Borderline" left ovarian mass - ?endometrioma*

RISK OF MALIGNANCY INDEX

CRITERIA	SCORING SYSTEM
Menopausal Status (A)	Pre-menopausal = 1 Post Menopausal = 3
Ultrasound Features (B) - septations - multilocular - solid areas - ascites	No Features = 0 One Feature = 1 Multiple Features = 3
Serum CA125 (C)	Absolute level
RISK OF MALIGNANCY INDEX (RMI) = A x B x C **RMI = 1 x 3 x 140 = 420**	

CASE 1

- Investigations??
  - Blood tests
  - Imaging
    - Pelvic USS
      - 14 x 12 x 9cm complex pelvic mass arising from left ovary
      - Solid area may represent ovarian tissue
      - Internal homogenous components reflects blood products
      - Right ovary and uterus normal
      - "Borderline" left ovarian mass - ?endometrioma
    - CT Scan
      - ***Multiple pulmonary metastases*** – largest 14mm
      - ***Multiple liver metastases*** – largest 16mm
      - Pelvic mass with solid and cystic areas (16-17cm) – solid area 7cm, cystic area 10cm

CASE 1

- Management plan??

CASE 1

- **Management plan??**
  - Refer to gynaecologic oncologist (RMI > 200, clinical suspicion, elevated markers)
  - Tissue diagnosis
  - Consider other investigations (colonoscopy, endoscopy)
  - Cancer treatment options

CASE 1

- **Management plan??**
  - Refer to gynaecologic oncologist (RMI > 200, clinical suspicion, elevated markers)
  - Tissue diagnosis
  - Consider other investigations (colonoscopy, gastroscopy)
  - Cancer treatment options
    - Surgical intervention
    - Chemotherapy
    - Radiation therapy
    - Hormonal therapy
    - Palliative care

CASE 1

- **MANAGEMENT PLAN 1**
  - Remove mass
  - Frozen section
  - Staging/debulking pending results
  - Not for aggressive debulking given liver and lung metastases

- **MANAGEMENT PLAN 2**
  - Tissue diagnosis with lung or liver biopsy
  - Neo-adjuvant chemotherapy
  - Interval debulking

CASE 1

- *Underwent surgery*
  - TAH, BSO, omentectomy, adhesiolysis, ureterolysis
  - Large left ovarian mass stuck to side wall, posterior uterus, left ureter
  - Rectum adherent to right ovary, uterus, POD – likely related to endometriosis
  - Right ovarian disease noted
- *Histology*
  - ***Stage IV Grade 3 endometrioid adenocarcinoma of ovary***
  - Background of endometriosis noted
- *Liver biopsy*
  - Metastatic adenocarcinoma, consistent with ovarian primary

CASE 1

- Recovered well
- Discharge plan
  - Adjuvant chemotherapy
  - BRCA testing
  - MMR gene testing
  - Referred to Choices (Cancer specific counselling)

CASE 1

- Re-presented with increasing rectal pain, elevated LFT's, elevated calcium
- Imaging reveals progressive disease with bony metastases
- Continued progression despite change in chemotherapy
- Palliative course of DXRT
- RIP 5 months after initial diagnosis

OVARIAN CANCER

- 1.4% lifetime risk
- Increased risk with increasing age
- Average age at diagnosis is 62
- 80% women present with stage III or IV disease
- Symptoms are very non-specific
  - Pain
  - Bloating
  - Altered bladder or bowel habit
  - Weight loss, decreased appetite, early satiety

RISK FACTORS

- Infertility
- Low parity
- Incessant ovulation
- Endometriosis
- HRT
- Age

- Genetic
  - BRCA 1 & 2
    - Breast and ovarian cancer risk
    - 40%, 10-20%
    - Prophylactic surgery (RRSO)
  - Lynch syndrome
    - 10% risk ovarian cancer
    - 40% risk uterine cancer
    - Prophylactic surgery (RRSO)

OVARIAN CANCER

EPITHELIAL	GERM CELL TUMOURS	SEX CORD STROMAL TUMOURS	METASTATIC TUMOURS
Serous papillary	Choriocarcin oma	Granulosa cell	Bowel
Mucinous	Yolk sac	Sertoli Leydig	Stomach
Endometrioid	Endodermal Sinus	(Fibroma)	Breast
Clear Cell	Immature Teratoma		Lymphoma
	Dysgerminom a		

STAGE	DEFINITION
I IA IB IC1 IC2 IC3	**Confined to ovaries/tubes** One ovary/tube, surface not involved, washings negative Both ovaries/tubes, surface not involved, washings negative Surgical spill Capsule rupture or surface involvement Malignant washings/ascites
II IIA IIB	**Local pelvic spread or primary peritoneal cancer** Extension onto uterus, tubes or ovaries Extension onto other pelvic structures (rectum ,sigmoid, pelvic peritoneum)
III IIIA1 IIIA1(i)/IIIA1(ii) IIIA2 IIIB IIIC	**Abdominal & nodal spread** Nodal involvement (i) </= 10mm size; (ii) >10mm size Microscopic disease above the pelvic brim, with or without nodal involvement Macroscopic disease above the pelvic brim </= 2cm, with or without nodal involvement Macroscopic disease above the pelvic brim > 2cm, with or without nodal involvement
IV	**Distant metastases**

PROGNOSTIC FACTORS

- Stage
- **Residual disease**
- Chemotherapy
- Age
- Grade
- Disease volume prior to debulking
- Ascites
- Clear cell and mucinous types.
- Other – ploidy, molecular markers

MANAGEMENT OF EARLY DISEASE

- **Surgical staging**
  - Removal of pelvic mass (USO) – frozen section
  - Washings, palpate surfaces, run entire bowel
  - Hysterectomy, BSO
  - Omentectomy
  - Lymph nodes – pelvic and para-aortic
- ***30% upstaged*** – this alters treatment

- Chemotherapy given for cancers which are G3, Stage IC and above

MANAGEMENT OF ADVANCED DISEASE

- Cytoreduction or debulking
- Aim to remove all visible disease to no macroscopic residual
  - Hysterectomy, BSO
  - Omentectomy
  - Bowel resection
  - Diaphragm stripping
  - Splenectomy, appendicectomy, nodes

OPTIMAL CYTOREDUCTION

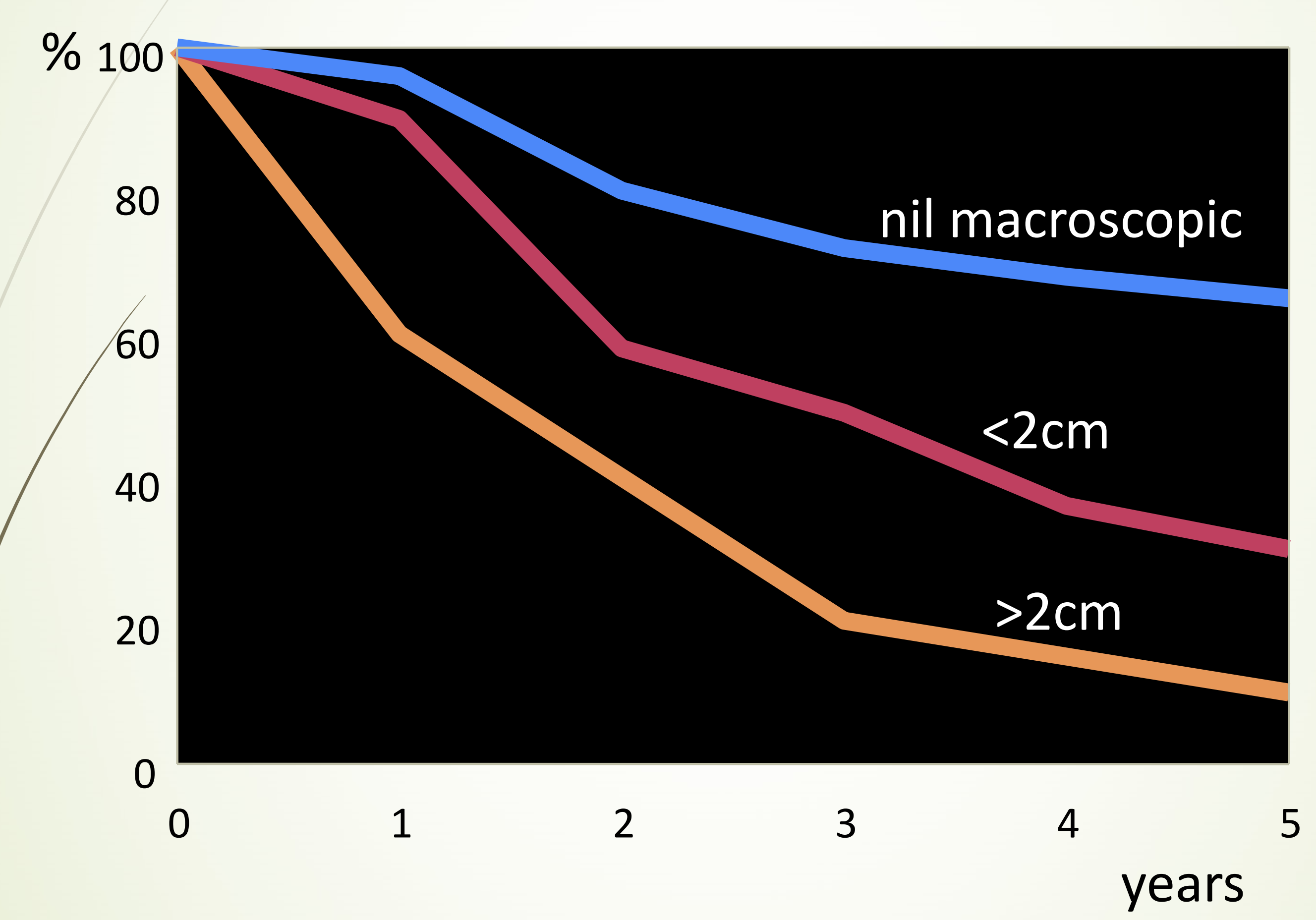
- 25% reduction in death if surgery is performed by CGO
- *Mayer et al, Gynecol Oncol 1992; 47:223-227*

SURVIVAL	CGO	General Gynae
5 years	83%	59%
DFS	76%	39%

CHEMOTHERAPY

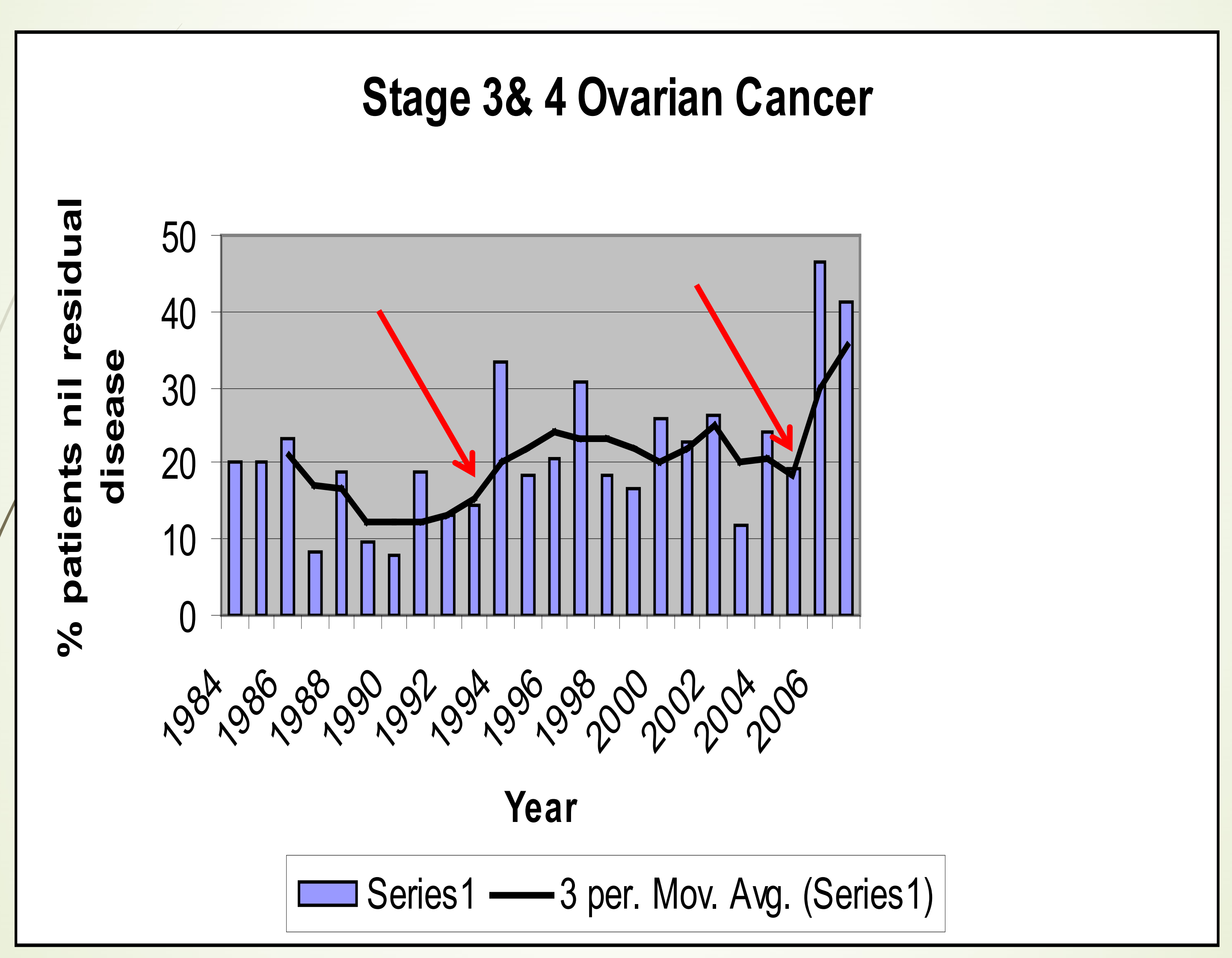
- **Neo-adjuvant**
  - 3 cycles up front, interval debulking, 3 cycles after surgery
- **Adjuvant**
  - 6 cycles after surgery
- **Administration options**
  - IV every 3 weeks
  - IV weekly
  - Intra-peritoneal

Survival stage III ovarian carcinoma relative to post operative residual volume

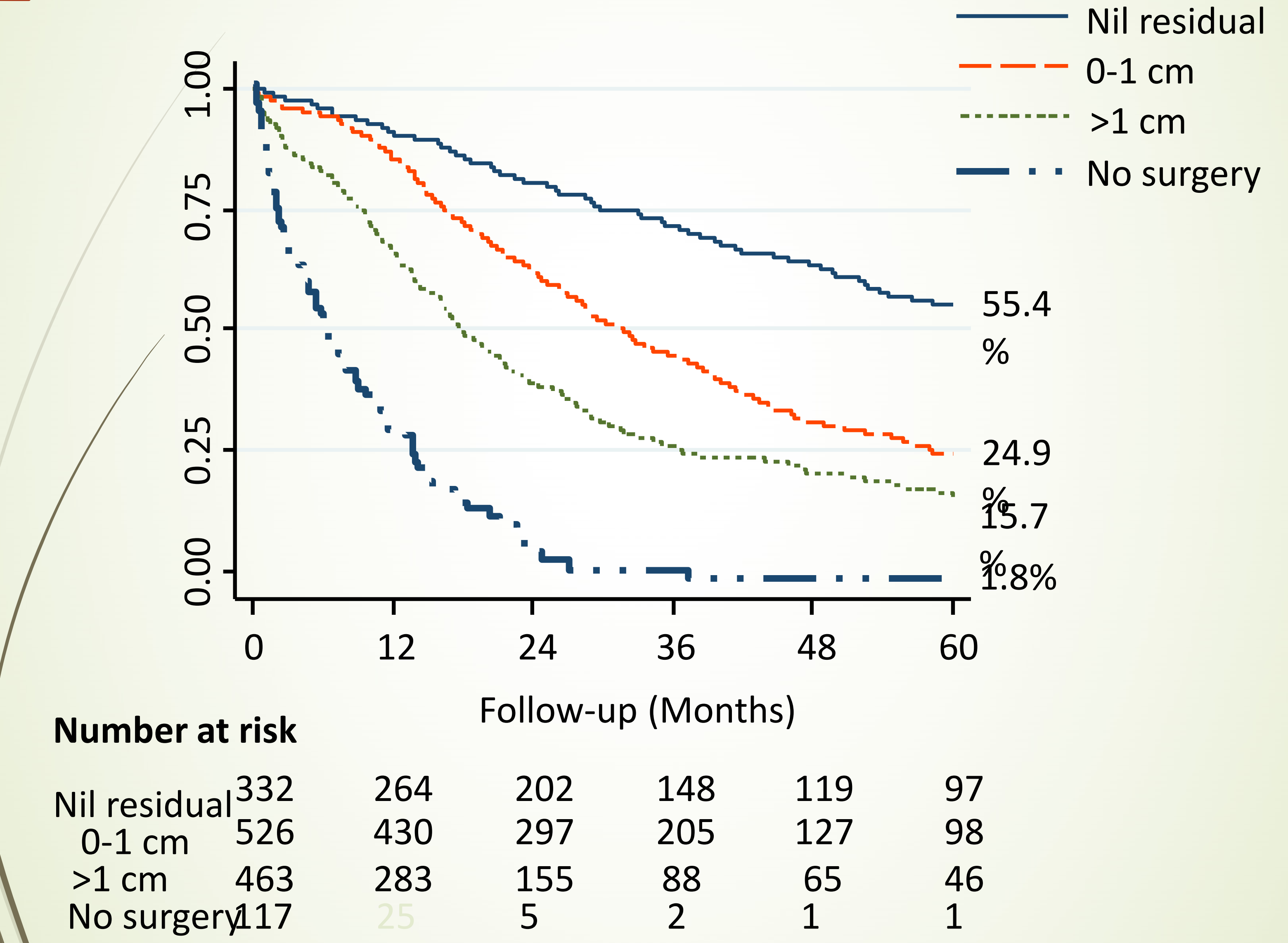


Ref: Burghardt et al, *Surg Gyn Onc 1993, 480*

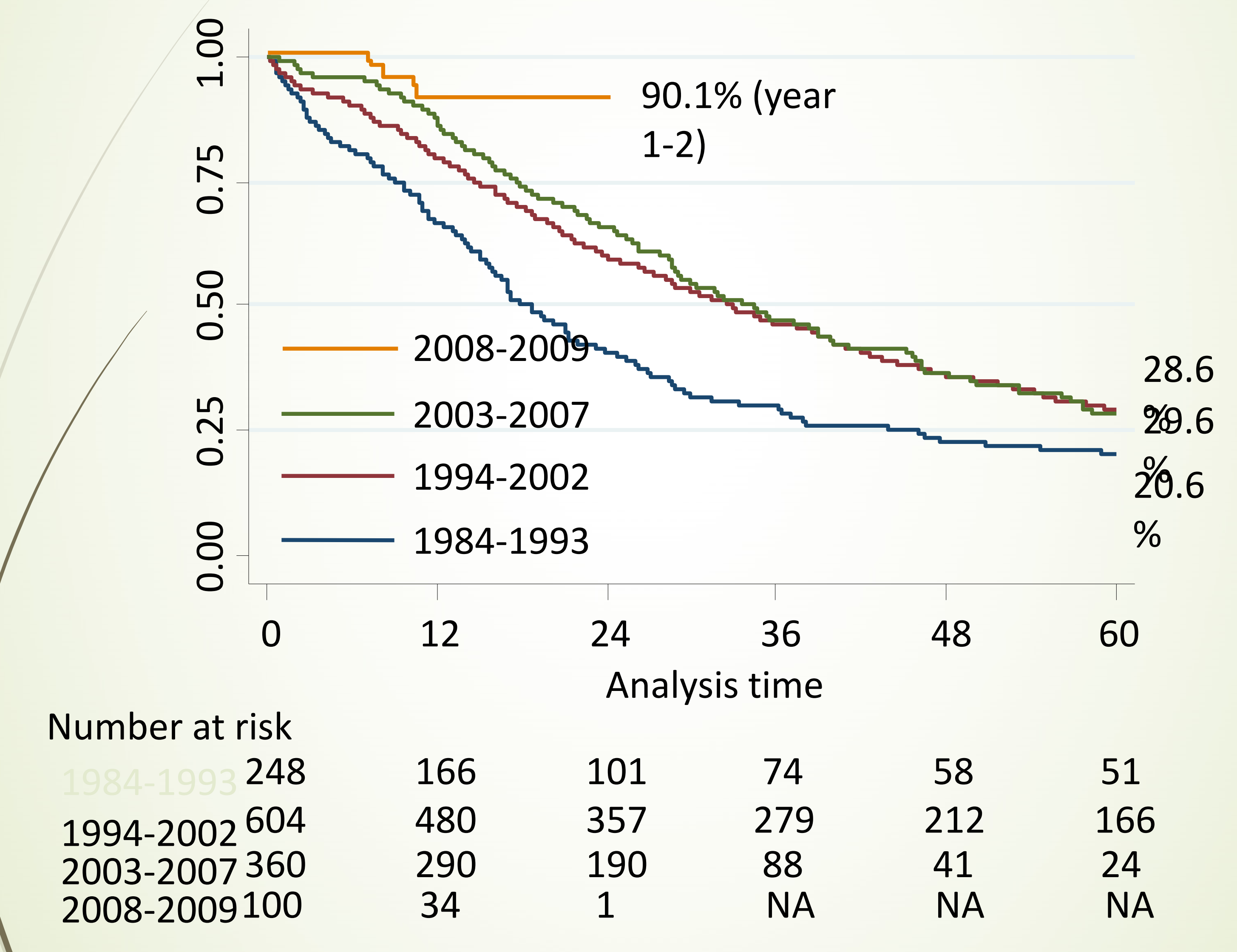
Percent nil residual disease post-debulking surgery, stages 3 and 4 at QCGC, by year



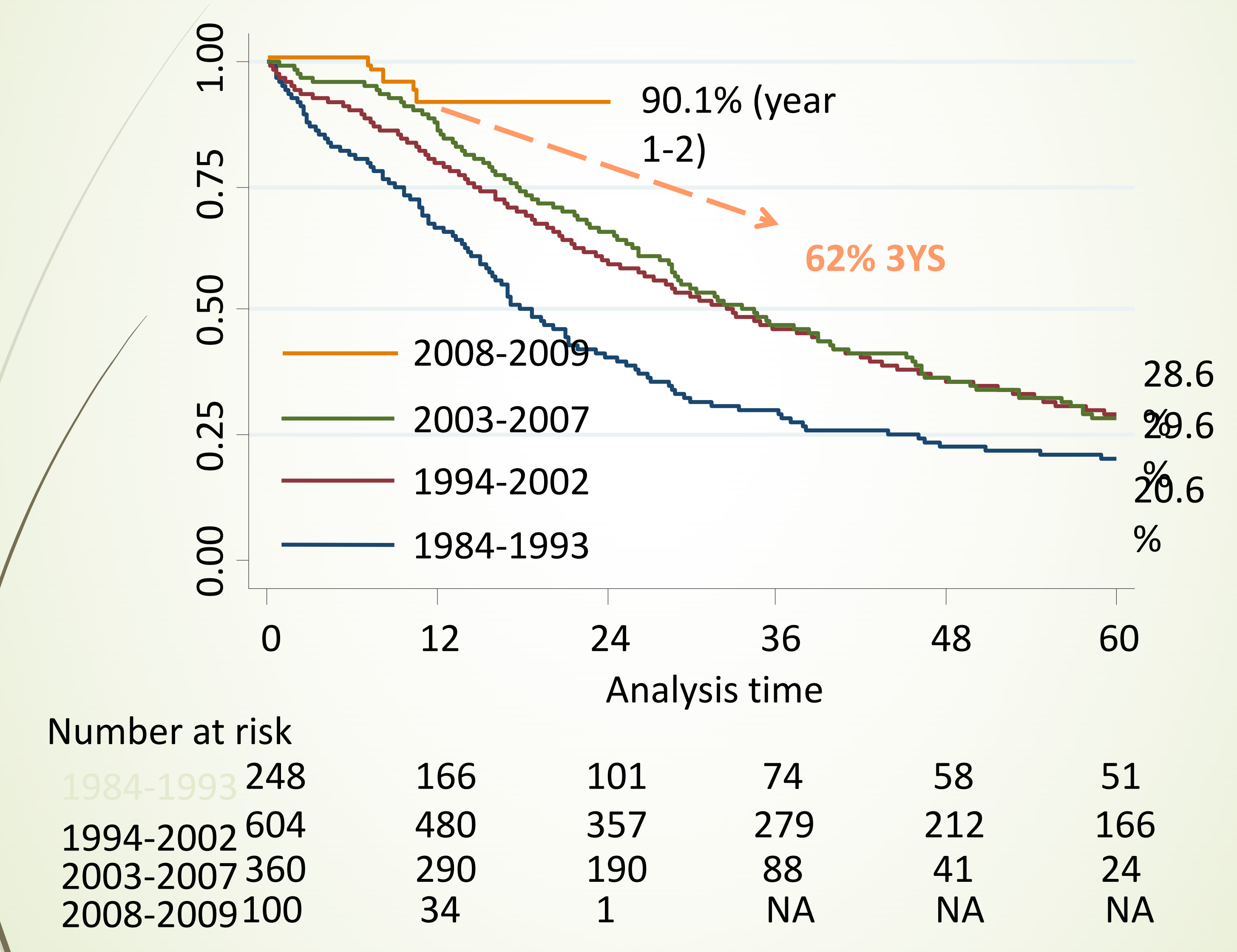
Kaplan-Meier overall survival estimates by residual disease (1984-2009, stages 3 & 4)



Kaplan-Meier overall survival estimates by time period (Stages 3 & 4)



Kaplan-Meier overall survival estimates by time period (Stages 3 & 4)



PROGNOSIS

Prognosis dependent on ability to get down to no residual disease

Overall 5YS ~ 69%

QLD data ~ 55% if **no** residual for stage III/IV disease

STAGE	PROGNOSIS (OVERALL)
I	95%
II	65%
III	15-30%
IV	10-20%

RECURRENCE

- Most common within first 2 years
- Surveillance with Hx, O/E and CA125 levels
- Asymptomatic – CA125 rise
- Symptomatic – pain, bloating, distension
- Majority are multi-focal
- Treatment
  - Secondary cyto-reduction
  - Chemotherapy

SUMMARY

- Symptoms non specific – persistence of symptoms
- CA125 is **NOT** a screening tool
- Ovarian cancer surveillance is not proven to reduce incidence or improve prognosis
- Imaging – read report and view images