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Guideline for the Surveillance of Gynaecological Malignancies at Grace Private Gynaecological Oncology Group

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Purpose of Guideline

This guideline was devised to clarify the follow-up of gynaecological malignancies once a patient has completed primary treatment during both hospital based follow-up and on discharge to primary care.

Historically surveillance procedures have not been standardised as there is a paucity of good quality evidence to direct care. Currently hospital surveillance is primarily directed at clinical examination to detect recurrence. However it is known that clinical examination has a low detection rate in the absence of symptoms in many gynaecological malignancies and also early detection of recurrence may not impact survival outcomes [1] .

There are also costs associated with follow up for both hospital services and patients. Follow up services focussing primarily on clinical review may also not adequately address the psychological or physical sequelae that have arisen from treatment.

This guideline will outline the components of patient centred psycho-social care in addition to clinical follow up at Grace Private. Furthermore it will provide a framework for low risk patients or patients who have completed hospital base follow-up to be discharged and continue surveillance in primary care.

Stakeholders

- Gynaeoncology Cancer Survivors
- Grace Private Gynaecological Oncology Group
- General Practitioners

Surveillance By Cancer Subtype

3.1 Endometrical Cancer

Endometrial cancer is the most common gynaecological cancer treated at Grace Private.

80% of patients are endometrioid subtype, with most of these patients being low to intermediate grade malignancies and early stage at diagnosis [2] .

95% Survival in stage 1 exceeds **95%** at **5 years** and approaches **83%** overall [2] , however recurrence can occur in all stages and is most likely in patients with high grade histology. Local (pelvic) recurrence is the most common and can be curable in some patients. Most recurrences occur in the first **3 years after treatment** [3, 4].

The risk of recurrence for early stage low grade endometrial cancer is low (<5%) [2] , these patients will be discharged to primary care after an initial 6 month post treatment visit. Patients considered higher risk or those who receive adjuvant treatment will be followed up at Grace Private (in conjunction with radiation and/or medical oncology). Once hospital based follow-up (3-5 years) is completed patients will be discharged to primary care to continue follow-up with GP for a total of 10 years post diagnosis care.

Physical examination in combination with review of symptoms has resulted in rates of detection of >80% for pelvic recurrence [4-6] Therefore each review should consist careful questioning of symptoms in addition to a through speculum and pelvic examination.

Vaginal cytology is not useful to detect recurrence in the absence of symptoms [7]. Routine imaging is also not recommended in the absence of symptoms [7, 8] . Ca 125 should not be used routinely but could be used in follow-up in selected cases of patients with uterine papillary serous carcinomas [9] . CT chest/abdomen/pelvis is the preferred imaging modality if recurrence is suspected, PET/CT could be considered if available.

Further attention should be directed to assessment of psycho-social and lifestyle issues at each visit. Specific questions should be asked if appropriate regarding psychological distress, sexual dysfunction, menopausal symptoms and lymphoedema.

Appropriate referrals should then be made for on-going patient care.

Common symptoms/signs of endometrial cancer recurrence [1]

	Endometrial Cancer
Local	• Vaginal bleeding • Vaginal lesion/pain
Distant	• Abdominal/pelvic pain • Cough • Lethargy • Abdominal distension

Recommended surveillance schedule for endometrial cancer at Grace Private

Endometrial Cancer	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	5-10 Years
Stage 1A, Grade 1/2	• Single 6 month visit • Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP Care	GP Care	GP Care	GP Care
Stage 1B, Grade 1/2 (alternate with radiation oncology)	6 Monthly	Yearly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP Care
Stage 2, Grade 1/2 (alternate with radiation oncology)	6 Monthly	Yearly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP Care
Stage 3 or 4 (anv Grade) or Grade 3, serous, clear cell (any stage) (alternate with medical or radiation oncology)	4 Monthly	4 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Pap Smears	Not indicated				
Imaging	Not routinely indicated without symptoms	CT CAP or PET/CT preferred if recurrence suspected			

3.2 Borderline Ovarian Tumours

10 % to 20 % Borderline ovarian tumours (AKA low malignant potential tumours) account for **10-20%** of epithelial ovarian tumours. The average age of diagnosis is **40-60** years, but a significant proportion of these tumours can occur in young women wanting fertility preservation [10].

The risk of recurrence across all BOT is 5-8%, with ~2% of women progressing to invasive malignancy [10, 11] . Factors which may increase the risk of recurrence include advanced stage at diagnosis, ovarian cystectomy vs. unilateral or bilateral salpingo-oophorectomy, extra-ovarian disease, residual macroscopic disease, age >65 years [10-12] .

The majority of women with stage one disease and who have had a pelvic clearance have a very low risk of recurrence.

70 % When recurrences occur, they tend to occur late, with 70% recurring **after 5 years**

30 % and 30% after **10 years**. The main stay of salvage is surgical management [10] .

The evidence for surveillance is scanty in this group and is largely extrapolated from invasive ovarian cancers. The intensity of surveillance should be tailored to risk factors for recurrence. Routine surveillance should include clinical assessment and abdominopelvic examination.

In addition tumour markers can be used for detection of recurrence (especially if initially elevated) along with pelvic ultrasound in women who have had fertility sparing surgery. CT chest/abdomen/pelvis is the preferred imaging modality if extra-ovarian recurrence is suspected.

There is no evidence that completion surgery (hysterectomy/BSO) improves prognosis for women with BOT, but could be considered once childbearing is completed and/closer to menopause [13] .

HRT is safe and should be used if completion surgery is done prior to a menopausal age [14] .

Common symptoms/signs of borderline tumour recurrence [1]

	Borderline tumours of ovary
Local	• Pelvic nodularity/mass • Change of periods (if uterus still in situ)
Distant	• Abdominal distension • Pain (abdominal) • Weight loss • Change in bowel habits • Elevated CA 125

Recommended surveillance schedule for borderline ovarian tumours

Borderline Ovarian Tumours (BOT)	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	5-10 Years
Fertility preserving surgery	6 Monthly	Yearly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP care
Pelvic USS	6 Monthly	6 Monthly	Yearly	Yearly	Yearly
Tumour markers	6 Monthly	6 Monthly	Yearly	Yearly	Yearly
BOT with extra-ovarian disease (completion surgery or fertility sparing surgery)	6 Monthly	6 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Tumour markers	3 Monthly	6 Monthly	6 Monthly	Yearly	Yearly
Imaging	• 6 monthly Pelvic USS if residual ovary • No routine imaging if completion surgery - CT CAP preferred if recurrence suspected in this group.	6 monthly Pelvic USS if residual ovary	6 monthly Pelvic USS if residual ovary	Yearly Pelvic USS if residual ovary	Yearly Pelvic USS if residual ovary
Completion surgery	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP Care	GP Care	GP Care	GP Care

GP can refer back/when if wishes completion surgery – appropriate once patient has completed childbearing or is menopausal.

3.3 Ovarian Cancers

Epithelial Ovarian Cancer

Epithelial ovarian cancer accounts for <30% of gynaecological malignancies but is disproportionately is represented in deaths [2]. The risk of recurrence in patients with epithelial ovarian cancer is high, occurring in 25% of women with early stage disease and >80% of those with advanced stage. Median 5 year survival is 40-50%.

Patient with recurrent ovarian cancer do have options for further surgery and/or chemotherapy depending on the timing and nature of recurrence [15, 16]. Surveillance does have an important role because salvage treatments can have significant impact on on-going survival [17].

26-50% of recurrences occur in the pelvis so a thorough review of symptoms and physical (pelvic and vaginal) examination are an important part of follow up care [18].

Ca 125 is a sensitive tumour marker for recurrence and can rise months before any physical symptoms; however it is unclear that treatment prior to symptomatic recurrence improves survival [19]. The decision about whether to use Ca 125 as part of surveillance should be discussed with patients after completion of primary treatment [19].

Routine imaging in the absence of symptoms should not be performed. CT CAP or PET/CT is the preferred imaging modality if recurrence is suspected.

Further attention should be directed to assessment of psycho-social and lifestyle issues at each visit. Specific questions should be asked if appropriate regarding psychological distress (fear of living with uncertainty), sexual dysfunction, menopausal symptoms and other physical symptoms that might be a result of treatment (for example peripheral neuropathy).

Common symptoms/signs of epithelial ovarian cancer recurrence

	Epithelial Ovarian Cancers
Local	• Pelvic nodularity/mass • Change of periods (if uterus still in situ)
Distant	• Abdominal distension • Pain (abdominal) • Weight loss • Change in bowel habits • Elevated CA 125

Recommended surveillance schedule for Epithelial ovarian cancers

Epithelial ovarian cancer	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	5-10 Years
All stages (alternate with medical oncology)	3 Monthly	4 Monthly	6 Monthly	6 Monthly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Tumour marker Imaging	3 monthly Not routinely indicated without symptoms	4 monthly CT CAP or PET/CT preferred if recurrence suspecte	6 Monthly	6 Monthly	Yearly

Germ Cell And Sex Cord Stromal Tumours

Malignant germ cell tumours account for <3% of all ovarian cancers.

These tumours are often unilateral and occur in younger women where fertility sparing surgery has been performed. Recurrence is relatively rare after primary treatment but can be successfully treated. It usually occurs in the first 2 years after end of primary treatment so surveillance is most intensive at this time.

Alpha-fetoprotein (AFP) can be produced by yolk sac tumours of the ovary, embryonal carcinomas, polyembryomas, and immature teratomas. Human chorionic gonadotrophin (hCG) can be produced by choriocarcinomas, embryonal carcinomas, polyembryomas and in low levels by some dysgerminomas. Lactate Dehydrogenase can be a marker for dysgerminomas.

The NCCN guidelines suggest the following schedule of visits/imaging/tumour markers for patients with germ cell tumours [20]. Patients should be carefully assessed for signs and symptoms of recurrence in addition to tumour markers and imaging.

Further attention should be directed to assessment of psycho-social and lifestyle issues at each visit. Specific questions should be asked if appropriate regarding psychological distress (fear of living with uncertainty), sexual dysfunction, menopausal symptoms and other physical symptoms that might be a result of treatment (for example peripheral neuropathy).

Recommended surveillance schedule for germ cell tumours of the ovary

Germ Cell tumours	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	>5 Years
All stages (alternate with medical oncology if chemotherapy)	2 Monthly	3 Monthly	4 Monthly	6 Monthly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Tumour marker	2 monthly	3 monthly	4 Monthly	6 Monthly	Yearly
Imaging CRX	3 monthly	4 monthly	Discontinue in absence of symptoms	Discontinue in absence of symptoms	Discontinue in absence of symptoms
MRI abdo/ pelvis (or CT abdo/pelvis)	3 monthly	4 monthly	• 6 monthly (non-dysgerminomas) • Yearly (dysgerminomas)	• 6 monthly (non-dysgerminomas) • Yearly (dysgerminomas)	Not routinely indicated without symptoms

Sex cord stromal tumours account for about 7% of ovarian malignancies. Granulosa cell tumours are the most common subtype; these commonly have elevation in serum inhibin. Recurrences tend to be late with a reported median time of 4-6 years and occur in the upper abdomen (55-70%) and pelvis (30-45%) [21]. Surveillance should consist of review of symptoms and physical examination with measurement of serum tumour markers.

Recommended surveillance schedule for sex cord stromal tumours

Sex cord stromal tumours	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	>5 Years
Early stage, low risk	6 Monthly	6 Monthly	6 Monthly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP Care
Tumour marker	6 Monthly	6 Monthly	6 Monthly	Yearly	Yearly
Imaging	Not routinely indicated without symptoms	CT CAP preferred if recurrence suspected			
High risk disease (alternate with medical oncology)	4 Monthly	6 Monthly	6 Monthly	6 Monthly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Tumour marker	4 Monthly	6 Monthly	6 Monthly	6 Monthly	Yearly
Imaging	Not routinely indicated without symptoms	CT CAP preferred if recurrence suspected			

3.4 Vulvar Cancers And Pre-Invasive Vulvar Disease

Vulvar cancer is uncommon, accounting for around 4% gynaecological malignancies.

The prognosis for patients with early stage disease is good with **>80%** 5 year survival. Lymph node status is the single most important prognostic factor [22]. Similarly local recurrence may be salvageable whilst groin or distant recurrences confer a very poor prognosis.

Most recurrences occur in the first 5 years after treatment. Long term follow-up from the GROINSS-V study showed a local recurrence rate of 27.5% at 5 years and 39.5% at 10 years following primary treatment [23]. Another study showed an overall recurrence rate of 32.7% in patients with positive lymph nodes compared to 5.1% in those with negative lymph nodes. Most recurrence in the high risk group occurred in the first 2 years, with recurrence rates (12%) after 2 years being similar in both groups [22]. Counselling patients about symptom and the need for re-presentation if concerns arise is important, as is ensuring on-going follow-up in general practice to pick up late recurrences.

Careful visual examination of the vulva and palpation of groin lymph nodes is the mainstay of post-treatment surveillance. If local recurrence is suspected, this should be confirmed with a biopsy and further management determined by the Gynaeoncology MDT. Routine imaging in an asymptomatic patient is not recommended to detect groin or distant recurrence, however if it is suspected on either clinical grounds or physical examination then imaging should be undertaken. CT CAP or PET/CT is the preferred imaging modality.

Patients with pre-invasive vulvar disease such as HPV related vulvar intra-epithelial neoplasia (aka VIN/VIN2-3/HSIL) and lichen sclerosis related vulvar dysplasia (dVIN) also require on-going surveillance. Recurrence rates after treatment range from 9 -50% and are higher in patients with positive margins [24].

In patients with HPV related dysplasia, smoking is a major risk factor for recurrence. Smoking cessation advice should be offered to all patients. Patients with lichen sclerosis need aggressive treatment of their underlying condition. Good control of the inflammatory process reduces the risk of progression to dVIN and/or malignancy [25] .

High potency steroids should be used topically. A suggested regime is daily topical use over the vulvar skin when symptomatic flaring occurs and maintenance application of weekly topical steroid even in the absence of symptoms. The suggested ultrapotent topical steroid is clobetasone propionate 0.05% for severe/moderate disease (will require a compounding chemist prescription) or potent steroid mometasone furoate 0.1% for milder disease [26] . Further advice should be given about using non-soap cleanser, and avoiding other vulvar irritants.

Further attention should be directed to assessment of psycho-social and lifestyle issues at each visit. Specific questions should be asked if appropriate regarding psychological distress (fear of living with uncertainty), sexual dysfunction, menopausal symptoms and other physical symptoms that might be a result of treatment such as lymphoedema.

Common symptoms/signs of vulvar cancer recurrence [1]

	Cervical Vaginal
Local	• Pruritis
Distant	• Leg or groin pain • Urinary symptoms • Leg lymphedema • Weight loss • Cough

Recommended surveillance schedule for vulvar cancers and pre-invasive vulvar disease

Valvular cancers	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	>5 Years
Pre-invasive	6 Monthly	Yearly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and genital examination	GP Care
Low risk – surgical only	4 Monthly	6 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and genital examination
High risk – primary RT or adjuvant (alternate with radiation oncology)	3 Monthly	4 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and genital examination
Imaging	Not routinely indicated without symptoms	CT CAP preferred if recurrence suspected			

*Patients with recurrences during follow-up or dVIN may require longer in hospital follow-up

3.5 Cervical/Vaginal Cancer

Cervical cancers account for 1.4% of female cancer diagnoses in 2019 [27]. These cancers are almost uniformly HPV related and screen preventable. Many women presenting with cervical malignancies have not participated or only sporadically participated in the cervical screening program.

In general stage 1 disease is treated with surgery and higher stages with combined chemotherapy and radiation. Most recurrences (75%) will occur in the first 2-3 years after primary treatment (REF). In the case of patients with primary surgical treatment and local recurrence, salvage radiation treatment can be curative so early detection is important.

Routine follow-up examination has a low yield in diagnosing recurrence (26-36% of cases) [28] with symptomatic presentation being more common 46-95% [29] (see table below for symptoms). Therefore counselling of women about the signs and symptoms of possible recurrence is an important part of surveillance. Clinical assessment and physical examination are the mainstay of surveillance; examination should include a complete assessment of the genital tract susceptible to HPV infection, bimanual +/- rectal examination. Routine imaging in the absence of symptoms/signs is not recommended.

The use of HPV testing and cytology has a low yield for detection of recurrence [29, 30], but could be used annually in patients treated with surgery alone. In those women treated with primary radiation, routine cytology is not recommended as cytology can be difficult to interpret in the context of radiation, and yield is low. There is insufficient evidence to recommend HPV testing in this group [30].

Further attention should be directed to assessment of psycho-social and lifestyle issues at each visit. Specific questions should be asked if appropriate regarding psychological distress (fear of living with uncertainty), sexual dysfunction, menopausal symptoms and other physical symptoms that might be a result of treatment such as lymphoedema, bowel and bladder dysfunction.

Common symptoms/signs of cervical/vaginal cancer recurrence [1]

	Cervical Vaginal
Local	• Vaginal bleeding
Distant	• Pain (abdominal/pelvic) • Leg pain/lymphedema • Urinary symptoms • Cough • Weight loss

Recommended surveillance schedule for vulvar cancers and pre-invasive vulvar disease

Cervical/ Vaginal Cancer	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	>5 Years
Low risk – surgical only Stage 1A1	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP Care	GP Care
Stage 1A2/1B	4 Monthly	6 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Pap smear	Yearly	Yearly	Yearly	Yearly	Yearly for 10 years
High risk – primary or adjuvant ChemoRT (alternate with radiation oncology)	3 Monthly	4 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Pap smear Imaging	Not indicated Not routinely indicated without symptoms	CT CAP preferred if recurrence suspected			

3.6 Uterine Sarcomas

Uterine sarcomas are malignant mesenchymal tumours and include endometrial stroma sarcomas, undifferentiated uterine sarcoma and uterine leiomyosarcoma. In total they account for 1-2% of all uterine malignancies [31], but have a poorer prognosis. Uterine leiomyosarcoma are the most common, but have a higher recurrence risk even in early stages [32]. The most common sites of recurrence include lungs, pelvis, and liver. The use of imaging is recommended without high level evidence [33].

Uterine Sarcomas	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	>5 Years
All stages (alternate with medical oncology if adjuvant treatment is recommended)	3 Monthly	4 Monthly	6 Monthly	6 Monthly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Imaging	6 month post treatment CT CAP	18 month post treatment CT CAP	36 month post treatment CT CAP	Not routinely indicated without symptoms CT CAP preferred if required	Not routinely indicated without symptoms CT CAP preferred if required

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Appendix Documents

5.1 Guideline Summary Document

Endometrial Cancer	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	5-10 Years
Stage 1A, Grade 1/2	• Single 6 month visit • Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP Care	GP Care	GP Care	GP Care
Stage 1B, Grade 1/2	6 Monthly	Yearly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP Care
Stage 2, Grade 1/2	6 Monthly	Yearly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP Care
Stage 3 or 4 (anv Grade) or Grade 3, serous, clear cell (any stage) (alternate with medical or radiation oncology)	4 Monthly	4 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Pap Smears	Not indicated				
Imaging	Not routinely indicated without symptoms	CT CAP or PET/CT preferred if recurrence suspected			

Borderline Ovarian Tumours (BOT)	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	5-10 Years
Fertility preserving surgery	6 Monthly	Yearly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP care
Pelvic USS	6 Monthly	6 Monthly		Yearly	Yearly
Tumour markers	6 Monthly	6 Monthly		Yearly	Yearly
BOT with extra-ovarian disease (completion surgery or fertility sparing surgery)	6 Monthly	6 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Tumour markers **Imaging**	3 Monthly • 6 monthly Pelvic USS if residual ovary • No routine imaging if completion surgery - CT CAP preferred if recurrence suspected in this group.	6 Monthly 6 monthly Pelvic USS if residual ovary	6 Monthly 6 monthly Pelvic USS if residual ovary	Yearly Yearly Pelvic USS if residual ovary	Yearly Yearly Pelvic USS if residual ovary
Completion surgery	• No routine imaging if completion surgery. CT CAP preferred if required	GP Care	GP Care	GP Care	GP Care

Cervical/ Vaginal Cancer	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	>5 Years
Low risk – surgical only Stage 1A1	6 Monthly	6 Monthly	6 Monthly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP Care
Stage 1A2/1B	4 Monthly	6 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Pap smear	Yearly	Yearly	Yearly	Yearly	Yearly for 10 years
High risk – primary or adjuvant ChemoRT (alternate with radiation oncology)	3 Monthly	4 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Pap smear **Imaging**	Not indicated Not routinely indicated without symptoms	CT CAP preferred if recurrence suspected			

Vulva cancer	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	>5 Years
Pre-invasive	6 Monthly	Yearly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and genital examination	GP Care
Low risk – surgical only 4 monthly	4 Monthly	6 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and genital examination
High risk – primary RT or adjuvant (alternate with radiation oncology)	3 Monthly	4 Monthly	6 Monthly	Yearly	• Discharge to GP care • Annual GP visit for clinical review and genital examination
Imaging	Not routinely indicated without symptoms	CT CAP preferred if recurrence suspected			

Epithelial ovarian cancer	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	5-10 Years
All stages (alternate with medical oncology)	3 Monthly	4 Monthly	6 Monthly	6 Monthly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Tumour marker **Imaging**	3 monthly Not routinely indicated without symptoms	4 monthly CT CAP or PET/CT preferred if recurrence suspect	6 Monthly	6 Monthly	Yearly

Germ Cell tumours	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	>5 Years
All stages (alternate with medical oncology if chemotherapy)	2 Monthly	3 Monthly	4 Monthly	6 Monthly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Tumour marker	2 monthly	3 monthly	4 Monthly	6 Monthly	Yearly
Imaging CRX	3 monthly	4 monthly	• Discontinue in absence of symptoms	• Discontinue in absence of symptoms	• Discontinue in absence of symptoms
MRI abdo/ pelvis (or CT abdo/pelvis)	3 monthly	4 monthly	• 6 monthly (non-dysgerminomas) • Yearly (dysgerminomas)	• 6 monthly (non-dysgerminomas) • Yearly (dysgerminomas)	Not routinely indicated without symptoms

Sex cord stromal tumours	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	>5 Years
Early stage, low risk	6 Monthly	6 Monthly	6 Monthly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination	GP Care
Tumour marker	6 Monthly	6 Monthly	6 Monthly	Yearly	Yearly
Imaging	Not routinely indicated without symptoms	CT CAP preferred if recurrence suspected			
High risk disease (alternate with medical oncology)	4 Monthly	6 Monthly	6 Monthly	6 Monthly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Tumour marker	4 Monthly	6 Monthly	6 Monthly	6 Monthly	Yearly
Imaging	Not routinely indicated without symptoms	CT CAP preferred if recurrence suspected			

Uterine Sarcomas	0 -1 Years	1-2 Years	2-3 Years	3-5 Years	>5 Years
All stages (alternate with medical oncology if adjuvant treatment is recommended)	3 Monthly	4 Monthly	6 Monthly	6 Monthly	• Discharge to GP care • Annual GP visit for clinical review and pelvic examination
Imaging	6 month post treatment CT CAP	18 month post treatment CT CAP	36 month post treatment CT CAP	• Not routinely indicated without symptoms CT CAP preferred if required	• Not routinely indicated without symptoms CT CAP preferred if required

*Follow-up period commences from end of first line treatment

#GP can refer back/when if wishes completion surgery – appropriate once patient has completed childbearing or is menopausal

5.2 Cancer Specific Patient Information Sheets

Monitoring Of Endometrial Cancer With Your General Practitioner (GP)
A Guide For Grace Private Patients

Congratulations on reaching the end of your specialist follow-up! Discharge from your specialist means that the likelihood of your cancer returning is low and we feel it is safe for you to have on-going monitoring with your GP. This information leaflet is designed to help you know when to report concerning symptoms to your GP and also how often to go for routine monitoring.

How Often To See Your GP

We generally recommend you see your GP ONCE a year for a check-up specifically to address your endometrial cancer. This should be done for at least 10 years from when you were first diagnosed with endometrial cancer.

This check-up will generally include a chat with your GP about how you are and any symptoms you may have (see below). We also recommend an examination of your abdomen as well as an internal pelvic examination to look in the vagina. Routine Pap smears or scans are not recommended as they have not been shown to improve detection of cancer recurrence.

Things To Watch Out For And Report To Your GP

If you have any concerning symptoms you should see your GP urgently as these may need to be investigated with tests or scans.

- Vaginal bleeding
- Lump or pain in the vagina
- New and persistent pain in your abdominal or pelvic area
- Swelling of your abdomen
- New and persistent cough/chest pain

Your GP will refer you back to Grace Private if your tests or scans show anything of concern.
We will arrange an urgent appointment for you in this situation.

Living Well After A Diagnosis Of Cancer

A diagnosis of cancer is a life changing experience and people often have needs once treatment has ended. Maintaining a healthy BMI and regular exercise are very important.

We want you to feel supported once you are discharged from outpatient care. Depression and/or anxiety can occur and we have psychological support services available for you so please let your GP know if you feel you would benefit from this during your monitoring.

Likewise sexuality/intimacy may be different after a diagnosis of endometrial cancer and support can also be provided for with these issues. If you have had early menopause due to treatment, further monitoring of bone and cardiovascular health is very important.

Monitoring Of Ovarian Cancer With Your General Practitioner (GP)
A Guide For Grace Private Patients

Congratulations on reaching the end of your specialist follow-up! Discharge from your specialist means that the likelihood of your cancer returning is lower and we feel it is safe for you to have on-going monitoring with your GP. This information leaflet is designed to help you know when to report concerning symptoms to your GP and also how often to go for routine monitoring.

How Often To See Your GP

We generally recommend you see your GP ONCE a year for a check-up specifically to address your ovarian cancer. This should be done for at least 10 years from when you were first diagnosed with ovarian cancer.

This check-up will generally include a chat with your GP about how you are and any symptoms you may have (see below). We also recommend an examination of your abdomen as well as an internal pelvic examination to look in the vagina.

Routine Pap smears or scans are not recommended as they have not been shown to improve detection of cancer recurrence. However a yearly tumour marker blood test may be helpful – you should discuss with your GP about whether you wish to have this done.

Things To Watch Out For And Report To Your GP

If you have any concerning symptoms you should see your GP urgently as these may need to be investigated with tests or scans.

- Lump or pain in your abdominal or pelvic area
- Swelling/bloating of your abdomen
- Unexpected weight loss
- Loss of appetite
- Change in bowel habits

Your GP will refer you back to Grace Private if your tests or scans show anything of concern. We will arrange an urgent appointment for you in this situation.

Living Well After A Diagnosis Of Cancer

A diagnosis of cancer is a life changing experience and people often have needs once treatment has ended. We want you to feel supported once you are discharged from outpatient care. Depression and/or anxiety can occur and we have psychological support services available for you so please let your GP know if you feel you would benefit from this during your monitoring. Likewise sexuality/intimacy may be different after a diagnosis of ovarian cancer and support can also be provided for with these issues. If you have had early menopause due to treatment, further monitoring of bone and cardiovascular health is very important.

Monitoring Of Borderline Ovarian Tumour With Your General Practitioner (GP)
A Guide For Grace Private Health Patients

Congratulations on reaching the end of your specialist follow-up! Discharge from your specialist means that the likelihood of your borderline tumour returning is low, and we feel it is safe for you to have on-going monitoring with your GP. Monitoring is required because sometimes these tumours can come back many years from diagnosis. This information leaflet is designed to help you know when to report concerning symptoms to your GP and also how often to go for routine monitoring.

How Often To See Your GP

We generally recommend you see your GP ONCE a year for a check-up specifically to address your borderline tumour. This should be done for at least 10 years from when you were first diagnosed with a borderline tumour.

This check-up will generally include a chat with your GP about how you are and any symptoms you may have (see below). We also recommend an examination of your abdomen as well as an internal pelvic examination to look in the vagina.

Routine Pap smears or scans are not recommended if you have had both your ovaries and uterus removed as they have not been shown to improve detection of recurrent borderline tumour.

If you still have one or both ovaries inside a yearly pelvic ultrasound scan and a tumour marker blood test may be helpful to show a recurrence so you should arrange these with your GP.

Things To Watch Out For And Report To Your GP

If you have any concerning symptoms you should see your GP urgently as these may need to be investigated with tests or scans.

- Lump or pain in your abdominal or pelvic area
- Change in periods
- Swelling of your abdomen
- Change of appetite/nausea
- Unexpected weight loss
- Change in bowel habits

Your GP will refer you back to Grace Private if your tests or scans show anything of concern. We will arrange an urgent appointment for you in this situation. If you have had early menopause due to treatment, further monitoring of bone and cardiovascular health is very important.

If You Have One Or Both Ovaries Still Inside

Patients who have borderline tumours of the ovary do have a slightly higher risk of developing an ovarian cancer in the future. Some women will opt for removal of both ovaries once they have reached menopause or completed their family. Your GP can refer your back to us in the future if you wish to discuss this further.

Monitoring Of Cervical Or Vaginal Cancer With Your General Practitioner (GP)
A Guide For Grace Private Patients

Congratulations on reaching the end of your specialist follow-up! Discharge from your specialist means that the likelihood of your cancer returning is lower and we feel it is safe for you to have on-going monitoring with your GP. This information leaflet is designed to help you know when to report concerning symptoms to your GP and also how often to go for routine monitoring.

How Often To See Your GP

We generally recommend you see your GP ONCE a year for a check-up specifically to address your cervical or vaginal cancer. This should be done for at least 10 years from when you were first diagnosed with cervical or vaginal cancer.

This check-up will generally include a chat with your GP about how you are and any symptoms you may have (see below). We also recommend an examination of your abdomen as well as an internal pelvic examination to look in the vagina.

Routine scans are not recommended as they have not been shown to improve detection of cancer recurrence. A yearly Pap smear is recommended if you only had surgery as part of your treatment. If you have had radiation the Pap smear is less accurate and can be falsely abnormal.

Things To Watch Out For And Report To Your GP

If you have any concerning symptoms you should see your GP urgently as these may need to be investigated with tests or scans.

- Vaginal bleeding
- New and persistent pain in your abdominal or pelvic area
- Urinary symptoms
- Leg pain/lymphedema
- New and persistent cough/chest pain

Your GP will refer you back to Grace Private if your tests or scans show anything of concern. We will arrange an urgent appointment for you in this situation.

Living Well After A Diagnosis Of Cancer

A diagnosis of cancer is a life changing experience and people often have needs once treatment has ended. We want you to feel supported once you are discharged from outpatient care. Depression and/or anxiety can occur and we have psychological support services available for you so please let your GP know if you feel you would benefit from this during your monitoring. Likewise sexuality/intimacy may be different after a diagnosis of cervical or vaginal cancer and support can also be provided for with these issues. If you have had early menopause due to treatment, further monitoring of bone and cardiovascular health is very important.

Monitoring Of Vulvar Cancer Or Pre-Cancer With Your General Practitioner (GP) A Guide For Grace Private Patients

Congratulations on reaching the end of your specialist follow-up! Discharge from your specialist means that the likelihood of your cancer returning is low and we feel it is safe for you to have on-going monitoring with your GP. This information leaflet is designed to help you know when to report concerning symptoms to your GP and also how often to go for routine monitoring.

How Often To See Your GP

We generally recommend you see your GP ONCE a year for a check-up specifically to address your vulvar cancer or pre-cancer. This should be done for at least 10 years from when you were first diagnosed with vulvar cancer or pre-cancer.

This check-up will generally include a chat with your GP about how you are and any symptoms you may have (see below). We also recommend an examination of your abdomen and groin lymph nodes as well as a check of the vulva.

Routine scans are not recommended as they have not been shown to improve detection of cancer recurrence. You should have regular Pap smear if you still have a cervix.

Things To Watch Out For And Report To Your GP

If you have any concerning symptoms you should see your GP urgently:

- Bleeding
- New lump or pain in the vulva
- Vulval itching
- Leg/groin pain or swelling
- Unexpected weight loss
- New and persistent cough/chest pain

Your GP will refer you back to Grace Private if there are concerns and we will arrange an urgent appointment for you in this situation.

Living Well After A Diagnosis Of Cancer

A diagnosis of cancer is a life changing experience and people often have needs once treatment has ended. We want you to feel supported once you are discharged from outpatient care. Depression and/or anxiety can occur and we have psychological support services available for you so please let your GP know if you feel you would benefit from this during your monitoring. Likewise sexuality/intimacy may be different after a diagnosis and treatment of vulvar cancer or pre-cancer and support can also be provided for with these issues. If you have had early menopause due to treatment, further monitoring of bone and cardiovascular health is very important.

5.3 GP Information Sheet

Grace Private Recommendations For Surveillance Of Gynaecological Cancers In General Practice

Your patient has been discharged from specialist follow up. Current international guidelines recommend a total of 10 years of clinical follow up for most patients with gynaecological malignancies (Salani et al 2017).

Common symptoms/signs associated with gynaecological cancer recurrence (Salani et al 2017)

	Endometrial	Ovarian/borderline tumours of ovary	Cervical/Vaginal	Vulvar
Local	• Vaginal bleeding • Vaginal lesion/pain	• Pelvic nodularity/mass • Change of periods (if uterus still in situ)	• Vaginal bleeding	• New lesion/mass/ulcer • Pruritis
Distant	• Abdominal/pelvic pain • Cough • Lethargy • Abdominal distension	• Abdominal distension • Pain (abdominal) • Weight loss • Change in bowel habits • Elevated CA 125	• Pain (abdominal/pelvic) • Leg pain/lymphedema • Urinary symptoms • Cough • Weight loss	• Leg or groin pain • Urinary symptoms • Leg lymphedema • Weight loss • Cough

Grace Private Recommendations for routine follow-up and investigation of Gynaecological cancer patients in the absence of symptoms/signs (Grace Private Gynaeoncology Group Guideline)

	Endometrial	Ovarian	Cervical/ Vaginal	Vulva	Vulva dysplasia	Borderline tumours of the ovary
Clinical assessment	Annual assessment and vaginal examination for 10 years post end of treatment	Annual assessment and vaginal examination for 10 years post end of treatment	Annual assessment and vaginal examination for 10 years post end of treatment	Annual assessment and vulvar examination for 10 years post end of treatment	Annual assessment and vulvar examination for 10 years post end of treatment	Annual assessment and vulvar examination for 10 years post end of treatment
Smear	nil	nil	Annual smear in patients treated with surgery alone Avoid in post pelvic Radiation as difficult to accurately interpret	Continue normal screening if cervix in situ	Continue normal screening if cervix in situ	Continue normal screening if cervix in situ
Tumour markers	nil	Annual tumour marker if patient wishes to have testing	nil	nil	nil	Annual tumour marker if residual ovary(s) or extra-ovarian disease at diagnosis
Imaging	nil	nil	nil	nil	nil	Annual Pelvic USS only if residual ovary(s)
Misc.			Smoking cessation in HPV related disease	Smoking cessation in HPV related disease		Could refer back to Gynaecological Oncology services if wishes completion surgery once family complete or menopausal

Please refer back any patient with concerning symptoms after appropriate investigations. If you wish to contact our service urgently, then options include phoning Grace Private on **(07) 55947632** or emailing our nurses at **nurse@graceprivate.com.au** or admin team at **reception@graceprivate.com.au.**

Our specialists are happy to take phone calls from our referring doctors. If our practice is closed, we can be phoned via Gold Coast Private Hospital switchboard on **(07) 55300300.**

5.4 Acknowledgments

This guideline was first produced and adopted by the Gynaeoncology team at Mater Health service Brisbane in 2020.

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