Overview of Gynecologic Oncology

“The Blue Book”

R. Kevin Reynolds, MD

www.med.umich.edu/obgyn/gynonc

Gyn Oncology...............................................................734-764-9106
Cancer Center Answer Line ..............................................800-865-1125
Contents

Gyn Tumors                                            Page
Breast Cancer...............................................................1
Cervical Cancer...........................................................6
Endometrial Cancer.......................................................17
Gestational Trophoblastic Neoplasia..........................24
Ovarian Cancer............................................................29
Sarcomas...........................................................................44
Vaginal Cancer...............................................................47
Vulvar Cancer...............................................................49

Associated Treatment Modalities
Nutrition, Fluid and Electrolytes.................................62
Radiation Therapy..........................................................67
Chemotherapy.................................................................71
Perioperative Management..........................................90
Tools and Equipment for the Art of Surgery................104

Appendix
GOG Toxicity Criteria....................................................119
Performance Status.........................................................123

Special thanks to William Burke, MD, for his update of the Perioperative Management chapter and to Catherine Christen, PharmD, for her careful proof reading

Favorite Quotes

"Statistics are no substitute for judgment."
Henry Clay

"A leading authority is anyone who has guessed right more than once."
Frank A. Clark

"Well done is better than well said."
Ben Franklin

"Trust me. I'm a doctor"
Donald H. Chamberlain, MD

"To err is human; to repeat the error is sometimes cause for concern."
"Good surgery is like a ballet!"
George W. Morley, MD

“Try not. Do or do not. There is no try.”
Yoda

"If your ship doesn't come in, swim out to it."
Jonathan Winters
Breast Cancer

I. Incidence: Most common cancer of women in US. 212,000 new cases in 2006, with 40,970 deaths (Jemal). Incidence increasing 1-2% annually. Average lifetime risk of developing breast cancer is 10%.

II. Epidemiology
   A. Risk factors
      1. Cumulative Likelihood of Developing Breast Cancer, By Age And Risk Factors
         | Age | 1   | 2   | 5     | Risk Factors                                                                 |
         |     | 0.5%| 1.0%| 2.5%  | 1 Menarche ≥ 14y, no breast biopsies, first birth ≤ 20y, no first degree relatives with breast cancer |
         | 20-40| 1.7%| 3.4%| 8.3%  | 2 One first degree relative with breast cancer                                |
         | 20-50| 1.7%| 3.3%| 8.1%  | first birth ≥ 30y, menarche <12y, one prior breast biopsy                       |
         | 30-50| 3.2%| 6.3%| 14.9% | 3 Two first degree relatives with breast cancer, one relative with breast cancer and one prior breast biopsy |
         | 30-60| 2.8%| 5.5%| 13.1% | Assumes well screened population                                               |
         | 40-60| 4.4%| 8.6%| 20.0% |                                                                            |
         | 40-70| 3.2%| 6.4%| 15.1% |                                                                            |
         | 50-70| 4.4%| 8.5%| 19.9% |                                                                            |
         | 50-80| 3.0%| 5.9%| 14.0% |                                                                            |
         | 60-80|     |     |       | 2. Risk of positive family history, between ages 30-70                        |
         |     |     |     |       | Mother or Sister's Lesion | Risk |
         | Premenopausal, unilateral | 7%   |
         | Postmenopausal, unilateral | 18%  |
         | Premenopausal, bilateral | 51%  |
         | Postmenopausal, bilateral | 25%  |
      3. Other risk factors: endometrial/ovarian cancer, prior radiation exposure, atypical benign breast disease (ductal or lobular hyperplasia), obesity, low parity, early menarche, high socioeconomic status
   B. Etiology. Estrogen, progesterone, prolactin implicated. Two temporal sets of etiologies:
      1. Premenopausal cancers influenced by genetic linkage, and ovarian-pituitary dysfunction. Several pedigrees exist: site specific, breast-ovary, and Lynch II family cancer syndrome. Genes BRCA-1 and BRCA-2 implicated in many familial cases
      2. Postmenopausal cancers influenced by obesity, dietary fat intake, and hormones.

III. Pathology
   A. Benign lesions
      1. Nipple discharge. Present in 75% of women. Discharge associated with: duct ectasia (green); benign intraductal papilloma and cancer (serous or bloody). Likelihood of cancer: serous discharge (6%), bloody discharge (13-20%). Evaluate suspicious discharge with ductogram and excision. Cytology rarely helpful.
      2. Fibrocystic change. Present in up to 75% of women. No longer considered an accurate diagnostic term.
      3. Cysts. Common during reproductive years. Probably develop due to estrogen. Evaluate palpable mass by FNA. If clear fluid obtained without residual mass, then repeat exam in 1 month. If bloody fluid obtained, or if mass persists, submit cytology specimen, order mammogram, and perform biopsy.

B. In-Situ Lesions
1. Ductal carcinoma in situ. Average age 55y. Represents 10-20% of new breast cancers. Often multifocal: up to 60% have residual DCIS after biopsy, 12% associated with cancer in contralateral breast, and 21-30% associated with cancer in ipsilateral breast. Lifetime breast cancer risk increased 10x. Treatment controversial. Options include excision +/- radiation, or mastectomy.
2. Lobular carcinoma in situ. Average age 45y. Usually an incidental finding (not detected on clinical or mammogram exam) in premenopausal women. Multifocal: 60-90% have residual LCIS after biopsy, 30-50% associated with LCIS in contralateral breast, and 25% associated with cancer in either breast (usually ductal). Treatment controversial. Options include bilateral mastectomy, or excision with close followup.

C. Malignant lesions
1. Ductal carcinoma
   a. Infiltrating ductal carcinoma: 80% of breast cancers (53% pure, 28% mixed ductal patterns). Arise in myoepithelial cells around duct. Marked desmoplastic response can cause skin dimple or nipple retraction. In inflammatory carcinoma, a poor-prognosis subtype, dermal lymphatics contain tumor.
   b. Comedo carcinoma: 5% of breast cancers. Predominantly intraductal tumor.
   c. Medullary carcinoma: 6% of breast cancers. Arise in ductal epithelium. Tumors bulky, soft, often necrotic. Less likely to spread than infiltrating ductal tumors. Prognosis good (85-90% 5y survival).
   e. Colloid carcinoma: < 1% of breast cancers. Bulky, gelatinous, mucin-containing tumors with relatively good prognosis.
2. Lobular carcinoma: 5% of breast cancers. Arise in acinar cells and terminal ducts. Usually multicentric.
4. Sarcoma: < 1% of breast cancers. Cystosarcoma phylloides has benign and malignant types, and is most common sarcoma of breast. Metastases rare. Treatment usually simple mastectomy.

IV. Diagnosis
A. Evaluation of a palpable mass

<table>
<thead>
<tr>
<th>Palpable mass</th>
<th>Post-menopause</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30 years old</td>
<td>&gt; 30 years old, Premenopause</td>
</tr>
<tr>
<td>Breast Ultrasound</td>
<td>Mammogram and Fine Needle Aspirate (FNA)</td>
</tr>
<tr>
<td>Cyst or Fibro-adenoma</td>
<td>Other</td>
</tr>
<tr>
<td>Observe, Biopsy if ↑</td>
<td>Simple Cyst, Resolves</td>
</tr>
<tr>
<td>Biopsy</td>
<td>Diagnostic FNA, Benign</td>
</tr>
<tr>
<td></td>
<td>FNA not Diagnostic</td>
</tr>
<tr>
<td></td>
<td>Observe, Biopsy if ↑</td>
</tr>
<tr>
<td></td>
<td>Biopsy</td>
</tr>
</tbody>
</table>

B. Screening
1. Breast examination. Most breast cancers present as palpable mass. 10-15% of cancers detectable only by clinical exam. Best to examine shortly after menses.

2. Mammography
   a. Recommended frequency (ACS): Baseline exam between 35-40y. Every other year between ages 40-50. Annually after age 50. Only 25-35% of women are currently screened following the guidelines. Ultrasound more effective for women < 35y.
   b. Efficacy: 42% of breast cancers detectable only by mammography. Regularly screened women have 30-40% less breast cancer mortality, and 25% fewer cases are advanced stage at diagnosis. False negative rate 10-15%.
   c. Technique: Breasts compressed. Radiation dose 0.1cGy. Cancers typically have irregular contour or calcifications of variable size or linear arrangement.

V. Staging

<table>
<thead>
<tr>
<th>American Joint Committee on Cancer TNM Clinical Breast Cancer Staging System, 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tx</strong></td>
</tr>
<tr>
<td><strong>T0</strong></td>
</tr>
<tr>
<td><strong>Tis</strong></td>
</tr>
<tr>
<td>DCIS</td>
</tr>
<tr>
<td>LCIS</td>
</tr>
<tr>
<td>Paget's disease if no underlying tumor present</td>
</tr>
<tr>
<td><strong>T1</strong></td>
</tr>
<tr>
<td>mic</td>
</tr>
<tr>
<td>a</td>
</tr>
<tr>
<td>b</td>
</tr>
<tr>
<td>c</td>
</tr>
<tr>
<td><strong>T2</strong></td>
</tr>
<tr>
<td><strong>T3</strong></td>
</tr>
<tr>
<td><strong>T4</strong></td>
</tr>
<tr>
<td>a</td>
</tr>
<tr>
<td>b</td>
</tr>
<tr>
<td>c</td>
</tr>
<tr>
<td>d</td>
</tr>
</tbody>
</table>

| **Nx** | Regional lymph nodes not assessable |
| **N0** | No regional lymph node involvement |
| **N1** | Metastases to movable ipsilateral axillary nodes |
| **N2** | Metastases to fixed or matted ipsilateral axillary nodes |
| a | Metastases to clinically apparent (exam or imaging) ipsilateral internal mammary nodes in the absence of axillary nodes |
| **N3** | Metastases to ipsilateral infraclavicular lymph nodes without axillary or internal mammary nodes |
| a | Metastases to ipsilateral internal mammary and ipsilateral axillary nodes |
| b | Metastases to ipsilateral supraclavicular lymph nodes |

<table>
<thead>
<tr>
<th><strong>Pathologic (pN) based on axillary dissection. If sentinel nodes done, denote with (sn) postscript</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>pNx</strong></td>
</tr>
<tr>
<td><strong>pN0</strong></td>
</tr>
<tr>
<td>ITC defined as individual tumor cells or clusters ≤ 0.2 mm detected by immunohistochemistry (IHC), molecular methods or histologic verification. Usually no evidence of proliferation or stromal reaction</td>
</tr>
<tr>
<td>pN0(i - )</td>
</tr>
<tr>
<td>pN0(i + )</td>
</tr>
<tr>
<td>pN0(mol - )</td>
</tr>
<tr>
<td>pN0(mol + )</td>
</tr>
<tr>
<td>pN1</td>
</tr>
<tr>
<td>mi</td>
</tr>
<tr>
<td>a Micrometastases in 1-3 axillary nodes</td>
</tr>
<tr>
<td>b Metastases in internal mammary nodes with microscopic disease detected by sentinel node dissection but not clinically apparent</td>
</tr>
<tr>
<td>c Metastases in axillary and internal mammary nodes with microscopic disease detected by sentinel node dissection but not clinically apparent</td>
</tr>
<tr>
<td>pN2</td>
</tr>
<tr>
<td>a Metastases in 4-9 axillary nodes with at least one tumor deposit of &gt; 2 mm</td>
</tr>
<tr>
<td>b Metastases clinically apparent internal mammary nodes in the absence of axillary node metastases</td>
</tr>
<tr>
<td>pN3</td>
</tr>
<tr>
<td>a Metastases in ≥ 10 axillary nodes with at least one tumor deposit of &gt; 2 mm, or in infraclavicular nodes</td>
</tr>
<tr>
<td>b Metastases in clinically apparent internal mammary nodes in the presence of ≥ 1 axillary node metastases; or in &gt; 3 axillary nodes with internal mammary micrometastases that are clinically inapparent</td>
</tr>
<tr>
<td>c Metastases in ipsilateral supraclavicular nodes</td>
</tr>
<tr>
<td>Mx</td>
</tr>
<tr>
<td>M0</td>
</tr>
<tr>
<td>M1</td>
</tr>
</tbody>
</table>

Note: regional lymph nodes include axillary and ipsilateral internal mammary nodes. The axillary nodes are divided into 3 groups: Level I nodes are lateral to pectoralis minor muscle, Level II nodes are between lateral and medial border of pectoralis minor (Rotter's nodes), and Level III nodes are medial to pectoralis minor including subclavicular, infraclavicular and apical nodes. Metastases to other nodes, including cervical, and contralateral internal mammary nodes are considered distant (M1).

VI. Treatment
Treatment for breast cancer is complex and rapidly evolving. Full discussion of this topic is beyond the scope of this monograph. Continually updated management guidelines can be accessed through the National Comprehensive Cancer Network at www.nccn.org
References
Breast Cancer Guidelines. www.nccn.org
Cervical Cancer

I. Incidence: Second most common cancer of women, worldwide. 12th most common cancer of women and 3rd most common gyn malignancy in USA. 9,710 cases, and 3700 deaths in 2006 in USA (Jemal)

II. Epidemiology:
A. Falling incidence 1940 to 1986. Rising since 1986 for Caucasian women
B. Table of Relative Risks (Morrow, Wright in Hoskins)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>RR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at coitarche (years)</td>
<td></td>
</tr>
<tr>
<td>&lt;16 vs &gt;19</td>
<td>16</td>
</tr>
<tr>
<td>16-19 vs &gt;19</td>
<td>3</td>
</tr>
<tr>
<td>Menarche-coitarche interval (years)</td>
<td></td>
</tr>
<tr>
<td>&lt;1 vs &gt;10</td>
<td>26</td>
</tr>
<tr>
<td>1-5 vs &gt;10</td>
<td>7</td>
</tr>
<tr>
<td>6-10 vs &gt;10</td>
<td>3</td>
</tr>
<tr>
<td>Sexual partners (# before age 20)</td>
<td></td>
</tr>
<tr>
<td>&gt;4 vs 0-1</td>
<td>4</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>3</td>
</tr>
<tr>
<td>Smoker &gt; .25 PPD, &gt;20 years vs &lt; 1 yr</td>
<td>4</td>
</tr>
<tr>
<td>HPV detectable on exam</td>
<td></td>
</tr>
<tr>
<td>Varies by HPV type</td>
<td>4-40</td>
</tr>
<tr>
<td>OCP, long term use</td>
<td>1.5-2</td>
</tr>
<tr>
<td>Deficient carotene, vitamin C (Verreault)</td>
<td>2-3</td>
</tr>
</tbody>
</table>

Increased risk: lack of screening or screening interval too long (Hartmann, Shy), immunosuppression (HIV, pharmacologic), black, poor, hi-risk male (multiple sexual partners, uncircumcised with poor hygiene)

Decreased risk: barrier contraceptives, religious social behavior

C. Etiology: cervical cancer is a sexually transmitted disease (Wright in Hoskins)
1. Human Papillomavirus (HPV) DNA detectable > 95% of squamous cervical cancers, and many adenocarcinomas (30-40%). Types 16, 18, 31, 45 (and less common types 33, 35, 39, 51, 52, 54, 55, 56, 58, 59, 66, 68) more frequently associated with malignancy than 6, 11 more often seen with condyloma. Possible co-carcinogens: nicotine, herpes
2. HPV is circular, double-strand DNA virus of about 8kb with eight open reading frames, when in its infectious state and in condyloma. Viral DNA inserts into host genome when progression to malignant phenotype occurs. HPV E6 gene codes for a protein that degrades p53 and HPV E7 gene codes for a protein which complexes with pRB, thereby releasing transcription factor E2F. The cell is immortalized.
3. Invasion is the endpoint of disease beginning as dysplasia, progressing through various stages of CIN. Incidence of progression: CIN-1 (16%), CIN-2 (30%), CIN-3 (70%). Average transit time from CIN-1 to CIN-3 is 7 years. Transit of CIN-3 to invasion ranges between 0 and 20 years.

III. Pathology, with subtypes

<table>
<thead>
<tr>
<th>Subtype</th>
<th>Prevalence</th>
<th>HPV Associated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Squamous carcinoma</td>
<td>65-85% (falling)</td>
<td>&gt;95%</td>
</tr>
<tr>
<td>Verrucous</td>
<td>rare</td>
<td></td>
</tr>
<tr>
<td>Adenocarcinoma</td>
<td>10-25% (rising)</td>
<td>Subset &gt;30%</td>
</tr>
<tr>
<td>Endocervical</td>
<td>47-69%</td>
<td></td>
</tr>
<tr>
<td>Endometrioid</td>
<td>1-17%</td>
<td></td>
</tr>
<tr>
<td>Clear cell</td>
<td>&lt;13%</td>
<td></td>
</tr>
<tr>
<td>Adenoid cystic</td>
<td>&lt;3%</td>
<td></td>
</tr>
<tr>
<td>Adenosquamous</td>
<td>5%</td>
<td>±</td>
</tr>
<tr>
<td>Glassy cell</td>
<td>rare</td>
<td></td>
</tr>
<tr>
<td>Small Cell Neuroendocrine</td>
<td>uncommon</td>
<td>unlikely</td>
</tr>
<tr>
<td>Sarcoma/lymphoma/serous</td>
<td>rare</td>
<td>unlikely</td>
</tr>
</tbody>
</table>

IV. Natural history
A. Symptoms: Postmenopausal bleeding (46%), Metrorrhagia (20%), Postcoital bleeding (10%), vaginal discharge (9%), pain (6%).
B. Spread via local invasion followed by lymphatic and vascular metastasis

V. Screening: ACS / NCCN / ASCCP consensus (Saslow)
A. When to Initiate Screening
   1. Begin 3 years after coitarche or by age 21
   2. Begin earlier if DES exposed, Hx of HPV or cervical CA, immunocompromised
   3. Do not delay onset of gyn care if screening not yet needed
B. When to discontinue screening
   1. >70y with 3 consecutive negative Paps & no CIN for 10y
   2. Hysterectomy without CIN2-3 or cancer as indication
   3. Co-morbid or life threatening illness
C. Screening interval
   1. Initial interval
      a. Every 1y conventional or
      b. Every 2y liquid cytology. Higher sensitivity than glass-slide method
   2. At >30y age may increase to
      a. Every 2-3y if 3 consecutive, satisfactory, negative Paps and no high risk factors such as CA, DES or immunocompromised
      b. Every 3y using HPV test for hi risk types with either Pap method

VI. Diagnosis of dysplasia and invasive carcinoma
A. Speculum and bimanual exam with biopsy of visible lesions
B. Cytology: false negative rate 20% for squamous CA, 40% for adeno CA
C. Colposcopy with biopsy and ECC.
   1. Flow Chart for Management of the Abnormal Pap

```
Colposcopy with biopsy and ECC

Unsatisfactory

Cone Biopsy or LEEP

Biopsy = HSIL, or persistent LSIL
  Small lesion, and low grade
  Observation only, unless persistent; or treat sparingly
  LEEP or Laser or Cone biopsy

Biopsy = invasion, Clinical staging
  FIGO stage IA-1, Invades ≤ to 3 mm
  Fertility Desired
    Yes
      Cone Biopsy
    No
      Simple hysterectomy

Satisfactory

Positive ECC

Negative ECC
```
2. Pap Triage and Indications for Colposcopy (ALTS trial, ASCCP consensus guidelines [Wright], and www.NCCN.org)
   a. ASC-US: reflex HPV test if liquid-based pap done. If HPV positive for high-risk types, then do colposcopy. If HPV negative, resume annual pap
   b. HSIL, LSIL or ASC-H: colposcopy

3. Technique of colposcopy with directed biopsy and ECC.
   a. Stain with acetic acid (3-5%). Frequently moisten mucosa.
   b. Inspect with colposcope, 15X objective; with and without green filter.
   c. Find squamocolumnar junction (SCJ). This defines "satisfactory" or "adequate" colposcopy. Most cervical cancers arise at the SCJ.
   e. Warning signs to safeguard against overlooking cancer
      i. Yellowish color, especially areas that are friable
      ii. Irregular contour (exophytic or ulcerative)
      iii. Atypical vessels
      iv. Extremely coarse mosaicism or punctation
      v. Large, complex, multiquadrant lesions

3. Colposcopy scoring system (Reid)
   Reid's scoring system to improve colposcopic accuracy:

<table>
<thead>
<tr>
<th></th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Margin</td>
<td>Exophytic condylomata; areas showing a micropapillary contour</td>
<td>Lesions with regular shape, showing smooth, straight edges</td>
<td>Rolled, peeling edges Any internal demarcation between areas of differing colposcopic appearance</td>
</tr>
<tr>
<td></td>
<td>Lesions with distinct edges</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feathered, scalloped edges</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lesions with angular, jagged shape</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Satellite areas and acetowhite staining distal to the original SCJ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Color</td>
<td>Shiny, snow-white color</td>
<td>Intermediate shade (shiny, but gray-white)</td>
<td>Dull reflectance with oyster-white color</td>
</tr>
<tr>
<td></td>
<td>Areas of faint, semitransparent whitening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vessels</td>
<td>Fine caliber vessels, poorly formed patterns</td>
<td>No surface vessels</td>
<td>Definite, coarse punctation or mosaic</td>
</tr>
<tr>
<td>Iodine</td>
<td>Any lesion staining mahogany brown, or mustard yellow staining by a minor lesion</td>
<td>Partial iodine staining, mottled pattern</td>
<td>Mustard yellow staining of significant lesion (score of ≥3 by first three criteria)</td>
</tr>
</tbody>
</table>

If Score 0-2: expect condyloma / CIN-I
If Score 3-5: expect CIN-II
If Score 6-8: expect CIN-III

VII. Treatment of Cervical Dysplasia. Guidelines supported by ASCCP and NCCN. In general, "treat lesions, not cytology"
A. Condyloma and CIN-I:
   1. Observation with pap smears every 6 months x 2
   2. If antecedent pap was HSIL, review cytology and consider LEEP or cone biopsy
   3. If lesion regresses on both paps, resume annual pap
   4. If lesion persists at one year or if high risk HPV types are present at one year, repeat colposcopy
B. CIN II and CIN III
   1. LEEP, or laser, or cryocautery or cone biopsy
   2. Followup with pap every 6 months x 2, then resume annual pap
3. Hysterectomy is acceptable if age, reproductive desire, and comorbidity are concordant

C. Unsatisfactory colposcopy
   If colposcopy, ECC or cytology suggest endocervical lesion, then cone biopsy. LEEP may not suffice given the difficulty in obtaining an intact endocervical canal specimen.

D. Management During Pregnancy
   2. If pap abnormal, then colposcopy with directed biopsy if HSIL or invasive carcinoma suspected. ECC contraindicated.
      a. Pap low grade SIL, colposcopic appearance concurs: pap q. 8-12 weeks and repeat colposcopy postpartum.
      b. Pap high grade SIL, and/or colposcopic appearance of high grade lesion: biopsy, then repeat colposcopy (± biopsy) q. 6-8 weeks until postpartum.
      c. Vaginal delivery indicated.
   3. Antepartum conization only for microinvasion on punch biopsy or for suspicion of invasion.

E. Treatment of vaginal dysplasia or condyloma
   1. Krebs regimen. 5% Efudex cream, 1.5 gm (one quarter applicator) intravaginally once per week for 10 weeks. Use Desitin ointment on vulva, water douche morning after Rx. Minor skin irritation common. Contraindicated during pregnancy. This is an Off Label use of the drug.
   2. Laser photoablation. Requires an anesthetic, cost higher.
   3. A few case reports support use of imiquimod cream 5% (Aldara) for treatment of vaginal or vulvar dysplasia (Diakomanolis).

VIII. General Principles of Laser Treatment for Pre-invasive Disease
   A. Clinical utility depends on use of appropriate wavelength. The CO2 laser is most applicable to ablation of condyloma, dysplasia, and carcinoma-in-situ. It is also well suited for laser conization. The 10,600 nm wavelength is absorbed by water, resulting in tissue vaporization. Absorption occurs at the surface. Thermal damage to underlying tissue is minimized.
   B. Power density must be adequate to prevent char:
      \[
      PD \ (\text{Watts/cm}^2) = \frac{Watts \times 100}{\pi \cdot r^2}, \ r=\text{spot radius (not diameter)}
      \]
   C. A colposcope is used to guide the laser. Low power Helium Neon (HeNe) laser (red beam) is used for aiming. Eye protection mandatory.

IX. Laser Treatment for Cervical Pre-invasive Disease
   A. Technique
      1. Transformation zone (T-zone) outlined using acetic acid and colposcope.
      2. Set power density to 750-1000 W/cm²; 25-30 W with spot size of 2 mm.
      3. Anesthetize cervix with 1% Lidocaine with epinephrine (0.5 mL injections around circumference of portio).
      4. Vaporize entire T-zone, one quadrant at a time, to a depth of 7 mm. This ablates gland crypts. If bleeding noted, defocus beam for hemostasis. Any char produced is removed immediately to prevent increased thermal injury.
      5. Apply Monsel's solution for hemostasis.
   B. Advantages of Laser Treatment
      1. Precise control of tissue ablation/excision.
      2. Minimal damage to adjacent normal tissue.
      3. SCJ remains at external os.
      4. More effective than cryotherapy for large lesions.
   C. Disadvantages of Laser Treatment
      1. Risk of bleeding 1-3%; risk of stenosis 1%.
2. Expensive
3. More training required than for cryocautery
4. Small but real concern of airborne transmission of viral particles
5. Destruction of large portion of cervix possible

X. General Principles of Electrosurgery for Cervical Pre-invasive Disease
   A. Radio frequency current (350 KHz-3.3 MHz) results in kinetic energy transfer to intracellular ions which vaporizes intracellular water. Avoid Faradic Effect (50 Hz-200 KHz), which stimulates muscle and nerve causing pain by using proper equipment
   B. Cutting: sine-wave RF current; coagulation: pulsed ("spark gap") RF current

XI. Loop Electrosurgical Excision Procedure (LEEP)
   A. Technique
      1. Transformation zone outlined using acetic acid and colposcope
      2. Anesthetize with 1% Lidocaine with epinephrine
      3. Choose loop to excise entire T-zone (1.5 cm x 7 mm, or 2.0 cm x 8 mm)
      4. Excise tissue in single pass, using 40 W, blend mode (use insulated speculum)
      5. Obtain ECC
      6. Cauterize base with ball electrode at 50 W, coagulation mode
      7. Apply Monsel's solution
   B. Advantages
      1. Diagnostic and therapeutic intervention, potentially with one clinic visit
      2. Histologic specimen improves diagnostic accuracy
      3. SCJ remains at external os
      4. Equipment less costly than laser
   C. Disadvantages
      1. Risk of bleeding 1-3%; risk of stenosis 1%
      2. Greater cost to patient than cryocautery
      3. Small but real concern of airborne transmission of viral particles
      4. Destruction of large portion of cervix possible

XII. General Principles of Cryosurgery for Cervical Pre-invasive Disease
   A. Rapid cooling with NO₂ forms intracellular ice which ruptures cell membranes
   B. Freeze-thaw-freeze technique results in higher success rates than single freeze

XIII. Cryocautery Procedure for Cervical Pre-invasive Disease
   A. Technique
      1. Transformation zone outlined using acetic acid and colposcope
      2. Select flat or dimpled cryo-probe (not cone tip) and apply lubricant to tip
      3. Freeze until ice ball extends 5 mm lateral to all sides of cryo-probe. Do not use time as a measure of adequacy of the freeze
      4. Allow tissue to thaw until pink and pliable
      5. Repeat step 3
   B. Advantages
      1. Inexpensive
      2. Easy to learn
   C. Disadvantages
      1. Risk of bleeding 1%; risk of stenosis 1%
      2. Heavy vaginal discharge during healing

XIV. Treatment Results for Cervical Pre-invasive Disease. Successful elimination of CIN

<table>
<thead>
<tr>
<th>Treatment</th>
<th>CIN 2 (%)</th>
<th>CIN 3 (≤ quadrants) (%)</th>
<th>CIN 3 (&gt; 2 quadrants) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cryocautery</td>
<td>80-94%</td>
<td>85%</td>
<td>60-65%</td>
</tr>
<tr>
<td>Laser</td>
<td>80-94%</td>
<td>80-94%</td>
<td>80-94%</td>
</tr>
<tr>
<td>LEEP</td>
<td>90-95%</td>
<td>82-88%</td>
<td>82-88%</td>
</tr>
<tr>
<td>Cone Biopsy</td>
<td>90-97%</td>
<td>90-97%</td>
<td>90-97%</td>
</tr>
</tbody>
</table>
A. If margin of LEEP or cone biopsy is involved with dysplasia, likelihood of successful eradication of CIN is 60%. Options include surveillance versus repeat excision.

XV. Followup for Cervical Pre-invasive Disease
A. Repeat Pap smear (and colposcopy at discretion of physician) every 6 months x 1 year
B. Partner should be informed about HPV and role of "safe sex"
   1. 70% will have lesions
   2. Treatment of male has no proven effect on prevention of recurrence in the female

XVI. Treatment Failures for Cervical Pre-invasive Disease
A. Reinfection of epithelium with existing latent HPV virus (not preventable)
B. Incomplete destruction of transformation zone (preventable)
C. Missed diagnosis of invasive lesion (preventable)
D. Prevention of treatment failures
   Risk of preventable treatment failure minimized by use of triage rules:

<table>
<thead>
<tr>
<th>Never ablate (cryocautery or laser) a cervical lesion unless:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All of the transformation zone is visible, and</td>
</tr>
<tr>
<td>2. Biopsies and Pap smears are consistent, and</td>
</tr>
<tr>
<td>3. Endocervical curettage is negative, and</td>
</tr>
<tr>
<td>4. There is no colposcopic or cytologic suspicion of invasion</td>
</tr>
<tr>
<td>Otherwise, excise for diagnosis (LEEP or cone biopsy)</td>
</tr>
</tbody>
</table>

XVII. Cervical Cancer Stage: determined by clinical examination.

<table>
<thead>
<tr>
<th>FIGO Staging for Cervix, Revised 1995</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0</strong> Carcinoma in situ</td>
</tr>
<tr>
<td>I Carcinoma confined to the cervix (Disregard extension to corpus)</td>
</tr>
<tr>
<td>I a 1 Measurable invasion ≤ 3 mm in depth and ≤ 7 mm in diameter</td>
</tr>
<tr>
<td>I a 2 Measurable invasion &gt; 3 and ≤ 5 mm in depth and ≤ 7 mm in diameter</td>
</tr>
<tr>
<td>I b 1 Lesion of &gt; 5 mm depth and/or &gt;7mm diameter, but ≤ 4 cm in diameter</td>
</tr>
<tr>
<td>I b 2 Lesion of &gt; 4 cm diameter</td>
</tr>
<tr>
<td>I Tumor extends beyond the cervix but not to the pelvic wall. Tumor may involve vagina, but not the lower 1/3</td>
</tr>
<tr>
<td>I I a No parametrial involvement</td>
</tr>
<tr>
<td>I I b Parametrial involvement</td>
</tr>
<tr>
<td>I I I Tumor extends to the pelvic wall, or may involve the lower 1/3 of vagina.</td>
</tr>
<tr>
<td>I I I a No extension to pelvic wall</td>
</tr>
<tr>
<td>I I I b Extension to pelvic wall. Includes hydronephrosis or non-functioning kidney</td>
</tr>
<tr>
<td>IV Spread beyond the true pelvis or involvement of bladder or rectal mucosa</td>
</tr>
<tr>
<td>IV a Spread to adjacent organs</td>
</tr>
<tr>
<td>IV b Spread to distant organs</td>
</tr>
</tbody>
</table>

A. Tests which may be used to stage include biopsy, colposcopy, IVP, CXR, cystoscopy, and sigmoidoscopy. Tests which may not be used to stage include surgery, CT or MRI scans, and lymphangiograms. All tests may be used for treatment planning
B. Cystoscopy and sigmoidoscopy usually indicated only in stage IIB, III, IV or if symptoms such as hematuria or narrowed fecal stream exist (Shingleton)

XVIII. Management of invasive cervical carcinoma
A. Microinvasion: a subset of early cancers with minimal risk of local or node metastases. See Flow Chart VI.C.1 (above) for diagnosis and clinical management
   1. Rationale for conservative treatment to preserve fertility

<table>
<thead>
<tr>
<th>SGO (FIGO IA-1)</th>
<th>FIGO IA-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histology</td>
<td>NO VSI or Confluence</td>
</tr>
<tr>
<td>Incidence of node mets</td>
<td>&lt; 1%</td>
</tr>
</tbody>
</table>
2. Adenocarcinoma is not substaged into a microinvasive category although literature supports conservative treatment in selected cases (Schorge)

B. Flow Chart for Management of Invasive (> Stage IA-1) Cervical Cancer. For microinvasive cervical cancer, see VI.C.1. (above) for flowchart.

C. Conventional radical hysterectomy is via the laparotomy approach. Newer techniques include laparoscopic radical hysterectomy, laparoscopic lymphadenectomy with Schauta (vaginal) radical hysterectomy or radical trachelectomy (Dargent, Plante, Reynolds)

D. Chemosensitization has been shown to significantly improve outcome in 5 randomized trials. Most common regimen is cisplatin 40 mg/meter\(^2\)/week (maximum dose of 70 mg/week) during RT. Other regimens include cisplatin and 5-FU. (Rose, Keys)

E. Comparison of Surgery vs Radiation (for Stage Ib/Iia tumors)

<table>
<thead>
<tr>
<th></th>
<th>Surgery</th>
<th>Radiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survival</td>
<td>91%</td>
<td>89%</td>
</tr>
<tr>
<td>Serious complications</td>
<td>Urologic Fistulae 1-2%</td>
<td>Intestinal and urinary strictures and fistulae 1.4-5.3%</td>
</tr>
<tr>
<td>Vaginal function</td>
<td>Initially shortened, lengthens with intercourse or dilator</td>
<td>Fibrosis and stenosis, especially in postmenopause. Dilator minimizes stenosis.</td>
</tr>
<tr>
<td>Ovarian function</td>
<td>Conserved</td>
<td>Destroyed</td>
</tr>
<tr>
<td>Chronic effects</td>
<td>Atonic bladder 3%</td>
<td>Radiation enteritis 6-8%</td>
</tr>
</tbody>
</table>

F. Special Cases
1. Pregnancy
   a. Stage for stage, pregnancy does not worsen survival. Delayed diagnosis is common
b. Timing of treatment controversial. Classical approach is to terminate pregnancy if gestation \(\leq 24\) weeks at diagnosis. If \(>24\) weeks, delay therapy until fetal viability. Newer studies suggest no decrease in survival with longer treatment delays (Takushi)

c. Cesarean delivery usually recommended for invasive lesions due to friability of tumor. Vaginal delivery does not worsen prognosis but tumor implants in episiotomy sites have been reported

2. Occult carcinoma: tumor not diagnosed prior to surgery

a. Treatment options include pelvic radiation, radical parametrectomy

b. If appropriate treatment not done, recurrence rate \(>75\%\)

c. Prognosis is poor if gross tumor is cut through on margins of hysterectomy

3. Barrel shaped cervix: intact cervix of \(\geq 4-6\) cm diameter (Keys, Maruyama, Paley)

a. High rate of central pelvic failure (25-40\%) after RT

b. Some advocate combined RT followed by extrafascial TAH. Reported pelvic recurrence drops from 19\% to 2\%, and extrapelvic recurrences from 16\% to 7\%.

4. Positive lymph vascular space involvement, positive nodes or extracervical spread detected during or after completion of radical hysterectomy (Peters)

a. If node or parametrial involvement is documented, then pelvic radiation therapy with cisplatin chemosensitization is given. If VSI positive, consider RT + chemo

b. If para-aortic nodes involved, consider scalene node biopsy and offer extended field radiation, if scalene nodes negative

5. Central pelvic recurrence

a. Patient with prior radical hysterectomy: radiation therapy to pelvis with chemosensitization.

b. Patient with prior pelvic radiation with or without prior radical hysterectomy: total pelvic exenteration. Contraindicated with lymphatic metastases, extension of disease to pelvic sidewall or distant metastasis. Removes bladder, uterus, vagina and rectum. Requires extensive reconstruction including urinary conduit (continent or non-continent), low rectal anastomosis or end colostomy, and vaginoplasty with split thickness skin graft or myocutaneous flap. Salvage rate 60-70\%, mortality rate 2\%

c. In special circumstances, patients with recurrent disease extending to the pelvic sidewall may benefit from the laterally extended endopelvic resection (LEER) procedure or intra-operative radiation to the sidewall (Höckel)

6. Distant metastatic disease cannot be considered curable with chemotherapy. Progression free intervals are in the 9-15 month range. Regimens include:

a. Cisplatin, 50-75 mg/m\(^2\), 23\% response rate

b. Ifosfamide, 1.7gm/m\(^2\)/day x 3days, with MESNA (uroprotector), 20\% of ifosfamide dose given IV 15 minutes before, 4 and 8 hours after each dose. MESNA can be given 2 and 6 hours after ifosfamide at 40\% of ifosfamide dose. Response rate 33\%

c. Other single agents reported to be active: 5-flurouracil (5-FU), paclitaxel, topotecan

d. Cisplatin and ifosfamide, 79\% response rate for tumor in non-irradiated sites, 18\% response rate for tumor in previously radiated sites. Other reported combinations include cisplatin (50 mg/m\(^2\) on day 1) with topotecan (0.75 mg/m\(^2\)/day on days 1-3); OR paclitaxel (135 mg/m\(^2\) over 24 hours on day 1) with cisplatin (50 mg/m\(^2\) on day 2)

e. Cisplatin and 5-FU, similar response rates to cisplatin and ifosfamide.

f. Participation in clinical trials is strongly encouraged
XIX. Prognostic Factors and Survival

A. Factors important to survival include: age, stage, size, VSI, grade, and node status

B. Incidence of Nodes by Stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>% Positive Pelvic Nodes</th>
<th>% Positive Para-aortic Nodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ia2</td>
<td>4.8</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Ib</td>
<td>15.9</td>
<td>2.2</td>
</tr>
<tr>
<td>IIa</td>
<td>24.5</td>
<td>11</td>
</tr>
<tr>
<td>IIb</td>
<td>31.4</td>
<td>19</td>
</tr>
<tr>
<td>III</td>
<td>44.8</td>
<td>30</td>
</tr>
<tr>
<td>IVa</td>
<td>55</td>
<td>40</td>
</tr>
</tbody>
</table>

C. Survival

<table>
<thead>
<tr>
<th>Stage</th>
<th>Nodes</th>
<th>5 Yr Survival Squamous</th>
<th>Adenocarcinoma</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Unknown</td>
<td>91%</td>
<td>60%</td>
</tr>
<tr>
<td>I</td>
<td>Negative</td>
<td>96%</td>
<td>82%</td>
</tr>
<tr>
<td>I</td>
<td>Positive</td>
<td>56%</td>
<td>28%</td>
</tr>
<tr>
<td>I</td>
<td>Positive ≤3 PLN</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>Positive &gt;3 PLN</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>Positive PAN</td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td>65%</td>
<td>47%</td>
</tr>
<tr>
<td>III</td>
<td></td>
<td>45%</td>
<td>8%</td>
</tr>
</tbody>
</table>

XX. Prevention

A. Immunization (Blumenthal, Mao, Stanley)

1. Gardasil (Merck): FDA approved in 2006, quadrivalent for HPV 6, 11, 16, 18. Phase III randomized trial (n=12,150) with injection on day 1, month 2 and month 6 showed 100% prevention of CIN 2-3 at 17 months followup if no HPV infection occurred and 97% efficacy if HPV infection occurred after immunization with 24 months followup (Villa). May be commercially available by late 2006


B. Sex education to alter high-risk behavior and age of first intercourse (Howard)

References


Reynolds RK, Burke WM. The evolving role of laparoscopic surgery for treatment of gynecologic masses and cancers. Female Patient 2004; 29: 25-32


Schoffman M, Solomon D. Findings to date from the ASCUS-LSIL triage study (ALTS). Arch Pathol Lab Med 2003; 127: 946-9


12/2006
Endometrial Carcinoma

I. Incidence: most common gyn tumor in U.S. Fourth most common cancer of women in U.S. In 2006, 41,200 new cases per year, resulting in 7,350 deaths (Jemal). Average age at onset is 58 years.

II. Epidemiology
A. Represents progression from normal to hyperplastic to atypical then invasive endometrial cells.
B. Risk factors

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>RR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight (age 50-59)</td>
<td>3</td>
</tr>
<tr>
<td>by 20-50 pounds</td>
<td></td>
</tr>
<tr>
<td>by &gt; 50 pounds</td>
<td>10</td>
</tr>
<tr>
<td>GO vs G&gt; 5</td>
<td>5</td>
</tr>
<tr>
<td>Menopause after age 52</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3</td>
</tr>
<tr>
<td>Unopposed estrogen replacement</td>
<td>6</td>
</tr>
<tr>
<td>(Includes tamoxifen)</td>
<td></td>
</tr>
<tr>
<td>Combination OCP</td>
<td>0.5</td>
</tr>
</tbody>
</table>

C. Etiology
1. Prolonged or non-cyclic estrogen stimulation (endogenous or exogenous) for Type I cancers
2. Risk of progression to cancer of endometrial hyperplasia without atypia (1-3%), with atypia (29%) (Kurman)
3. 5% of endometrial cancers arise as hereditary cancers in HNPCC families associated with mismatch repair genes MLH, MSH, PMS1, and PMS2 (Boyd)

III. Screening
No test or procedure has been identified as a cost-effective method to screen for endometrial cancer. ACOG does not recommend screening

IV. Diagnosis
A. Symptoms: 90% present with postmenopausal bleeding (PMB) or abnormal discharge
1. Common etiologies of PMB: hormone replacement therapy (27%), endometrial carcinoma (13-16%), cervical carcinoma (1-4%), atrophy (10%), polyps (7-23%), cervicitis (6-14%). No pathology (20-23%).
2. Likelihood that PMB is associated with endometrial cancer is a function of age:

   ![Graph showing the likelihood of PMB associated with endometrial cancer]

   - <50: <5% (baseline)
   - 50-59: <10%
   - 60-69: <20%
   - 70-79: <30%
   - >80: >40%

B. Pap test very low sensitivity, but necessary to rule out cervical cancer as a cause of postmenopausal bleeding
C. Endometrial biopsy 90-97.5% sensitive (Stovall)
D. Fractional curettage ± hysteroscopy is diagnostic gold standard
E. Vaginal U/S for endometrial thickness. Cancer rare if stripe <4 mm (Varner)
F. Preoperative CXR
G. Preop CA-125: accurate predictor of extra-uterine disease and survival (Sood)

V. Pathology

<table>
<thead>
<tr>
<th>Endometrioid</th>
<th>75-85%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Squamous differentiation</td>
<td>common</td>
</tr>
<tr>
<td>Papillary (Villoglandular)</td>
<td>rare</td>
</tr>
<tr>
<td>Secretory</td>
<td>rare</td>
</tr>
<tr>
<td>Uterine Papillary Serous Tumor (UPST)</td>
<td>5-7%</td>
</tr>
<tr>
<td>Clear Cell Carcinoma</td>
<td>4%</td>
</tr>
<tr>
<td>Mucinous</td>
<td>Rare</td>
</tr>
<tr>
<td>Squamous</td>
<td>Rare</td>
</tr>
</tbody>
</table>

Type I refers to well differentiated tumors arising from estrogen stimulation
Type II refers to poorly differentiated or non-endometrioid histology and is associated with poorer prognosis (Boyd)

VI. Prognostic Factors
A. Recurrence rate without extrauterine mets (7%), with extrauterine mets (43%)
B. Incidence of adnexal metastases by grade and depth of invasion in clinical stage I:
   Grade 1 (2.5%), 2 (3.5%), 3 (13%); Depth 0 (4%), ≤1/3 (1.5%), ≤2/3 (9%), >2/3 (10%).
C. Histologic type: prognosis poor with papillary serous and clear cell types.
D. Estrogen/Progesterone receptors: present in 80% of grade 1, and 30% of grade 3 tumors.
E. Incidence of Node Metastases
1. When complete surgical staging has not been done (Boronow)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Pelvic Node Mets</th>
<th>Paraaortic Node Mets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Grade 2</td>
<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>Grade 3</td>
<td>18%</td>
<td>11%</td>
</tr>
<tr>
<td>No invasion</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Invades inner third</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Invades middle third</td>
<td>6%</td>
<td>1%</td>
</tr>
<tr>
<td>Invades outer third</td>
<td>25%</td>
<td>17%</td>
</tr>
<tr>
<td>Invades lower uterine segment</td>
<td>16%</td>
<td>14%</td>
</tr>
<tr>
<td>Vascular space involvement</td>
<td>27%</td>
<td>19%</td>
</tr>
<tr>
<td>Positive peritoneal cytology</td>
<td>25%</td>
<td>19%</td>
</tr>
<tr>
<td>Adnexal metastasis</td>
<td>32%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Pelvic / Paraaortic Node Mets by Depth of Invasion and Grade

<table>
<thead>
<tr>
<th></th>
<th>≤ 1/3</th>
<th>≤ 2/3</th>
<th>&gt; 2/3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 2</td>
<td>3/0%</td>
<td>33/17%</td>
<td>20/20%</td>
</tr>
<tr>
<td>Grade 3</td>
<td>24/33%</td>
<td>25/0%</td>
<td>42/25%</td>
</tr>
</tbody>
</table>

2. Incidence of positive pelvic nodes in Stage II 36%.
VII. Staging is surgical:

<table>
<thead>
<tr>
<th>FIGO Staging for Endometrium (Revised 1989)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
</tr>
<tr>
<td>I a</td>
</tr>
<tr>
<td>I b</td>
</tr>
<tr>
<td>I c</td>
</tr>
<tr>
<td>II a</td>
</tr>
<tr>
<td>II b</td>
</tr>
<tr>
<td>II c</td>
</tr>
<tr>
<td>III b</td>
</tr>
<tr>
<td>III c</td>
</tr>
<tr>
<td>IV a</td>
</tr>
<tr>
<td>IV b</td>
</tr>
</tbody>
</table>

| Grade 1 | ≤5% of nonsquamous solid growth pattern |
| Grade 2 | 6-50% of nonsquamous solid growth pattern |
| Grade 3 | >50% of nonsquamous solid growth pattern |

VIII. Treatment based on initial clinical presentation

A. If medically operable, clinical stage I: total hysterectomy with bilateral salpingo-oophorectomy (TH/BSO), pelvic and para-aortic lymphadenectomy, peritoneal cytology
   1. Abdominal hysterectomy has historically been the standard approach for treatment of endometrial cancer
   2. Laparoscopic hysterectomy
      a. A number of studies have shown similar staging efficacy and complication rates for laparoscopic vs. abdominal approach (review by Kueck).
      b. Small prospective randomized trials show equivalent survival outcome (review by Kueck).
      c. Definitive, large, randomized trial (GOG LAP-2) has not yet reported survival outcomes comparing laparoscopy vs laparotomy
   3. Role of lymphadenectomy
      a. Surgery without lymphadenectomy will miss metastatic disease in 29% (Ben-Shachar, Yenen) and upstaging or upgrading occurs in 67% of fully staged patients compared to those in whom frozen section is relied upon to determine need for staging (Frumovitz)
      b. Therapeutic value of lymphadenectomy is debated, with a number of studies suggesting survival benefit (Chan, Cragun, Creutzberg, Kilgore, Trimble) and a number of studies showing no benefit (Ceccaroni, Kitchener, Vizza). There have been no sizable, prospective, randomized trials to date.
   4. Panniculectomy: may improve exposure for the obese patient. Shown to increase number of nodes recovered and ability to complete surgical staging (Wright)

B. If poor candidate for complete staging procedure, clinical Stage I, Grade 1-2: vaginal hysterectomy with bilateral salpingo-oophorectomy

C. In young patients desiring to retain fertility with clinical stage I grade 1 disease: treat with curettage followed by progestin therapy (megestrol acetate 80 mg po bid for 3 months) followed by repeat biopsy or curettage. Small series show excellent outcomes, but careful informed consent necessary for non-standard therapy (Farhi)

D. If medically inoperable: pelvic radiation therapy with brachytherapy application(s)

E. Clinical Stage II: pelvic radiation therapy (Pelvic RT and brachytherapy) followed by TAH/BSO and para-aortic lymphadenectomy, or radical hysterectomy/BSO and nodes
F. Suspected metastatic disease in peritoneal cavity or nodes: Pre-op imaging with CT or MRI, then TH/BSO, pelvic and para-aortic lymphadenectomy, peritoneal cytology, omentectomy, debulking (Bristow, Mariani)

G. Suspected metastatic disease in vagina, parametrium, bladder or rectum: Pre-op imaging with CT or MRI, then RT +/- surgery or chemotherapy

H. Suspected distant metastases: Pre-op imaging with CT or MRI, then multimodal therapy with chemotherapy +/- RT or surgery

IX. Adjuvant therapy for surgically staged disease

A. Stage I disease

<table>
<thead>
<tr>
<th>Postoperative Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Risk</strong></td>
</tr>
<tr>
<td>Stage IA G1 or G2, or</td>
</tr>
<tr>
<td>Stage IB G1 or G2, or</td>
</tr>
<tr>
<td>Stage IA G3, and</td>
</tr>
<tr>
<td>No adverse risk factors*</td>
</tr>
<tr>
<td>No further treatment</td>
</tr>
<tr>
<td><strong>Intermediate Risk</strong></td>
</tr>
<tr>
<td>Stage IC G1 or G2, or</td>
</tr>
<tr>
<td>Stage IB G3, and</td>
</tr>
<tr>
<td>No adverse risk factors*</td>
</tr>
<tr>
<td>No further treatment vs. Pelvic RT or vaginal brachytherapy**</td>
</tr>
<tr>
<td><strong>High Risk</strong></td>
</tr>
<tr>
<td>Stage IB G3 or</td>
</tr>
<tr>
<td>Stage IC G1 or G2 with</td>
</tr>
<tr>
<td>adverse risk factors*, or</td>
</tr>
<tr>
<td>Stage IC G3 (any)</td>
</tr>
<tr>
<td>Pelvic RT</td>
</tr>
</tbody>
</table>

1. Adverse risk factors (*) defined as age >60, lymph vascular space involvement (LVSI), tumor size, lower uterine segment involvement
2. Randomized trials (**) show reduced pelvic recurrences with pelvic radiotherapy but no improvement in overall survival (Keys: GOG 99, Creutzberg: PORTEC-1).

B. Stage II

1. Stage IIA grade 1-2: observe or vaginal brachytherapy
2. Stage IIA grade 3 or all stage IIB: vaginal brachytherapy +/- pelvic RT
3. If initial Tx was radical hysterectomy without extraperitoneal spread, then no RT

C. Stage III:

1. Stage IIIA
   a. Positive washings with no other evidence of metastatic disease. Prognostic significance debated with some studies showing no impact on survival (Grimshaw, Kasamatsu) and some showing poor outcome (Creasman)
   b. Adnexal or uterine serosal involvement: treated with chemotherapy +/- tumor directed RT (NCCN)
2. Stage IIIB: tumor directed RT +/- chemotherapy
3. Stage IIIC: chemotherapy better (50% vs. 38% disease free survival at 5 years) based on randomized trial comparing whole abdominal RT vs. cisplatin and doxorubicin chemotherapy (Randall)
4. Treatment individualized. May include surgery, and/or tumor directed RT

D. Stage IV: Treatment individualized.

1. Chemotherapy
   a. Cisplatin 50 mg/m² day 1, doxorubicin 45 mg/m² day 1 and paclitaxel 165 mg/m² day 2 with cytokine support days 3-12 repeated every 3 weeks. Regimen has highest response rates 57% vs. 34% for cisplatin 50 mg/m² and doxorubicin 60 mg/m². Average progression free survival is 5 to 8 months (Fleming)
   b. Doxorubicin (Adriamycin), 60-75 mg/m² IV q3weeks (maximum cumulative dose 450 mg/m²), is the most active single-agent drug. Response rate is 37%
2. Tumor directed RT may be useful to palliate bleeding or pain.
3. For estrogen-progesterone receptor positive tumors, or metastatic grade 1-2 tumors, hormonal therapy with megestrol acetate, 80 mg po bid and / or tamoxifen 10-20 mg po bid, sometimes useful

E. There is no demonstrated benefit of adjuvant chemotherapy or hormonal therapy (Morrow)

F. Uterine papillary serous tumors (UPST)
   1. Clinical stage underestimates extent of disease in 50%.
   2. Patients with surgical stage I recur in 50-60%. Recur in upper abdomen 67%.
      Natural history resembles ovarian tumors.
   3. Adjuvant therapy using combination chemotherapy with or without pelvic RT favored in phase II trials. No sizable phase III studies available. Best regimens reported include carboplatin and paclitaxel alone (Dietrich) or in combination with RT (Bancher-Todesca, Kelly, Turner)

G. Incompletely staged disease. If uterine disease is myoinvasive or grade is 2-3, then either complete staging surgically or image and base adjuvant therapy on best assessment of disease extent.

X. Survival
   A. Endometrioid Histology

<table>
<thead>
<tr>
<th>Stage</th>
<th>Grade 1</th>
<th>5 Yr Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Grade 1</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td>Grade 2</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>Grade 3</td>
<td>75%</td>
</tr>
<tr>
<td>II</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>9%</td>
<td></td>
</tr>
</tbody>
</table>

B. Uterine Papillary Serous Histology

<table>
<thead>
<tr>
<th>Stage</th>
<th>5 Yr Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-II</td>
<td>45%</td>
</tr>
<tr>
<td>III-IV</td>
<td>11%</td>
</tr>
</tbody>
</table>

XI. References


Grimshaw RN, Tubber C, Fraser RC, Tompkins MG, Jeffrey JF. Prognostic value of peritoneal cytology in endometrial carcinoma. Gyn Oncol 1990; 36:97-100


12/2006
Gestational Trophoblastic Neoplasia

I. Trophoblastic neoplasms are essentially tumors of the placenta. The disease can be divided into a non-invasive group of tumors consisting of complete and partial moles, and an invasive group of tumors including invasive mole, choriocarcinoma and placental site trophoblastic tumor.

II. Incidence of hydatidiform molar pregnancies (Non-invasive disease)
   A. Population based studies 1:522 (Japan) to 1:1560 (Sweden)
   B. Hospital based studies 1:85 (Indonesia) to 1:1724 (USA)
   C. In elective abortions in US 1:600 and 1:1500 pregnancies in US

III. Epidemiology of hydatidiform moles

<table>
<thead>
<tr>
<th>Table of Relative Risks</th>
<th>RR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Molar Pregnancy</td>
<td>10-40</td>
</tr>
<tr>
<td>Maternal age &lt;20</td>
<td>1.5</td>
</tr>
<tr>
<td>Maternal age &gt;40</td>
<td>5.2</td>
</tr>
<tr>
<td>Prior Spontaneous Abortion</td>
<td>1.9-3.3</td>
</tr>
<tr>
<td>Vitamin A, above median</td>
<td>0.6</td>
</tr>
<tr>
<td>Parity &gt;1</td>
<td>0.4</td>
</tr>
</tbody>
</table>

IV. Pathology of hydatidiform moles
   A. Complete: Arise from fertilization of an empty oocyte with 1 sperm that is then duplicated (more common) or 2 sperm (less common)
   B. Partial: Arises from fertilization of an apparently normal oocyte with 2 sperm

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Complete Mole</th>
<th>Partial Mole</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karyotype</td>
<td>46XX (90%)</td>
<td>Triploid (90%)</td>
</tr>
<tr>
<td></td>
<td>46XY (10%)</td>
<td>69XXX or 69XXY</td>
</tr>
<tr>
<td></td>
<td>All paternal</td>
<td>Diploid (10%)</td>
</tr>
<tr>
<td></td>
<td>chromosomes</td>
<td>46 paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>chromosomes</td>
</tr>
<tr>
<td>Fetus</td>
<td>Absent</td>
<td>Often present</td>
</tr>
<tr>
<td>Villous edema</td>
<td>Prominent and diffuse</td>
<td>Focal if at all</td>
</tr>
<tr>
<td>Fetal RBC</td>
<td>None</td>
<td>Usually present</td>
</tr>
<tr>
<td>Proliferation of trophoblast</td>
<td>Prominent</td>
<td>Mild to moderate</td>
</tr>
<tr>
<td>Likelihood of local invasion</td>
<td>15%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Likelihood of metastasis</td>
<td>4%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

V. Clinical Features
   A. Presenting Symptoms of Moles

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Complete</th>
<th>Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal Bleeding</td>
<td>97%</td>
<td>73%</td>
</tr>
<tr>
<td>Excessive Uterine Size</td>
<td>51%</td>
<td>8%</td>
</tr>
<tr>
<td>Theca Lutein Cysts (&gt;6 cm)</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Preeclampsia</td>
<td>27%</td>
<td>3%</td>
</tr>
<tr>
<td>Hyperemesis</td>
<td>26%</td>
<td>0%</td>
</tr>
<tr>
<td>Hyperthyroidism</td>
<td>7%</td>
<td>0%</td>
</tr>
<tr>
<td>Trophoblastic Emboli (over all)</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>If size of uterus is &gt; 16 weeks</td>
<td>27%</td>
<td></td>
</tr>
</tbody>
</table>

B. Diagnosis of hydatidiform moles
   1. Usually diagnosed in first trimester. Workup often initiated because of symptoms (Section V.A.)
   2. Ultrasound:
      a. Complete mole: vesicular pattern, “snowstorm pattern”
b. Partial mole: focal cystic change in placenta and ratio of transverse to AP dimension of gestational sac of > 1.5. A small for dates fetus with multiple anomalies may be present.

3. β-hCG elevated, especially in complete moles. 46% of complete moles have β-hCG > 100,000 mU/mL. Only 6% of partial moles have β-hCG > 100,000 mU/mL. Partial moles may have higher percentage of α-hCG.

VI. Treatment of hydatidiform moles
A. Pre-treatment workup: CBC and platelet count; clotting function studies; β-hCG; liver, renal and thyroid function tests; blood type with Rh and antibody screen; chest X-ray
B. Curettage, suction and sharp, using oxytocin. Do not begin oxytocin until uterus evacuated to minimize intra-uterine tone and trophoblastic emboli. Hysterectomy acceptable, if fertility no longer desired
C. Post-treatment follow-up: Follow β-hCG every week until normal for 3 weeks, then monthly for 6 months. Contraception to prevent confusion over interpretation of β-hCG values is important. OCPs do not increase the likelihood of persistent disease.
D. If β-hCG levels plateau x3 weeks or rise x2 weeks, then metastatic workup and chemotherapy is initiated. Repeat curettage occasionally useful.
E. Management Flow Diagram

F. Two randomized trials show that high risk moles may be treated with prophylactic chemotherapy. High risk defined as β-hCG >100,000 mU/mL, uterine size > dates and ovary(s) > 6 cm. Results in reduced risk of post-molar invasion (47 vs. 14%). If persistence occurs, more cycles of chemo needed. Deaths have been reported with prophylactic chemo using methotrexate and folinic acid or dactinomycin regimens.
G. Choriocarcinoma can arise from a normal pregnancy (1 : 22,000-100,000 pregnancies). Mother is at increased risk of medical complications of pregnancy. Karyotype of
pregnancy may be required to confirm diagnosis. Genetics different than other GTN. Worse prognosis.

H. Phantom hCG (false positive) can confuse diagnosis. Usually seen with low hCG levels. Caused by heterophilic antibodies in circulation. Should be suspected if clinical response to methotrexate does not occur. Should be ruled out before doing hysterectomy or multi-agent chemotherapy. Can be tested for by urine pregnancy test (negative) with positive blood test, or by doing serial dilution tests.

VII. Incidence of invasive gestational trophoblastic disease (GTD)
A. Invasive mole noted after 15% of complete moles and 3.5% of partial moles
B. Metastases occur following 4% of complete moles and 0.6% of partial moles
C. Choriocarcinoma occurs following 3-7% of hydatidiform moles and 1:40,000 term pregnancies. Of all choriocarcinoma cases, 50% preceded by mole, 25% by SAb, 25% by term pregnancy
D. Placental Site Trophoblast Tumor (PSTT) is a rare variant of GTD (55 cases by 1991)

VIII. Pathology of GTD
A. Invasive mole: hyperplastic trophoblasts with villi invading myometrium
B. Choriocarcinoma: trophoblasts without villi invading myometrium or other tissues. Necrosis and hemorrhage common
C. PSTT comprised of intermediate cytotrophoblasts
D. Tumor marker: β-hCG useful for all types except PSTT (hPL may be elevated in PSTT)
E. Metastases, when present, occur in: lung (80%), vagina (30%), pelvis (20%), brain or liver (10%), bowel or kidney or spleen (<5%)

IX. Evaluation for metastatic disease
A Metastatic workup:
1. Initial Labs: CBC; β-hCG; liver, thyroid, renal function tests; chest X-ray
2. If chest X-ray positive or if choriocarcinoma is present or if vaginal mets present, then: CT of head, chest, abdomen and pelvis
3. Lumbar puncture for β-hCG if CXR positive, but head CT negative. Serum/CSF β-hCG ratio <60 indicates CNS disease.
4. Pelvic ultrasound with or without Doppler may be helpful to detect sites of persistent intra-uterine disease.
5. Avoid biopsy of vaginal lesions due to tendency to hemorrhage
B. FIGO Anatomic Staging for Gestational Trophoblastic Neoplasia (GTN)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Disease confined to the uterus</td>
</tr>
<tr>
<td>Stage II</td>
<td>GTN extends outside of uterus, but is limited to genital structures</td>
</tr>
<tr>
<td></td>
<td>including adnexa, vagina, broad ligament</td>
</tr>
<tr>
<td>Stage III</td>
<td>GTN extends to lungs with or without genital tract involvement</td>
</tr>
<tr>
<td>Stage IV</td>
<td>All other metastatic sites</td>
</tr>
</tbody>
</table>

C. Current staging combines anatomic staging with the modified WHO prognostic scoring system. For stage I disease, risk is usually low. For stage IV disease, risk is usually high. Stage II and III disease is best stratified with the modified WHO prognostic scoring system
D. Stage is recorded as Anatomic Stage and FIGO modified WHO score, separated by colon. Example of format. Stage IV: 8
E. Modified WHO Prognostic Scoring System as adapted by FIGO

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>0</td>
</tr>
<tr>
<td>Antecedent pregnancy type</td>
<td>Mole</td>
</tr>
<tr>
<td>Preg. to Treatment interval (m)</td>
<td>&lt; 4</td>
</tr>
<tr>
<td>Pretreatment β-hCG (IU/L)</td>
<td>&lt; 10³</td>
</tr>
<tr>
<td>Tumor size including uterus (cm)</td>
<td>-</td>
</tr>
<tr>
<td>Site of Metastases</td>
<td>Lung</td>
</tr>
<tr>
<td>Number of Mets</td>
<td>0</td>
</tr>
<tr>
<td>Previous failed chemo regimens</td>
<td>Single</td>
</tr>
</tbody>
</table>

Total: If score is ≥ 7, then patient is high risk and requires intensive, multi-agent chemotherapy

X. Treatment of Invasive or Metastatic GTD

A. Stage I, Low Risk

1. Fertility desired: Treat with single agent chemo. 87% will be complete responders (CR) with a single regimen. If a second single agent regimen is needed for persistent disease, the CR increases to 92%. Rarely, resistance may require hysterectomy or multiagent chemotherapy regimens (EMA/CO). Results in CR of 100% remissions (2 reported failures in literature). First line regimen is methotrexate with folinic acid. Treatment conversion to dactinomycin is made if resistance or dose-limiting toxicity occurs.
   a. Methotrexate (1.0 mg/kg IM days 1,3,5,7) and Leucovorin (0.1 mg/kg IM days 2,4,6,8). Repeated every 2 weeks.
   b. Dactinomycin (1.25 mg/m² IV, Q14 days)
   c. Other dose schedules for both drugs are published (Rubin)
   d. 5 fluorouracil is widely used for treatment of GTN in other countries, with excellent results
2. Fertility not desired: hysterectomy and adjuvant single agent chemotherapy as above.
3. Treatment continues until the β-hCG is negative. Surveillance includes weekly β-hCG during treatment, then β-hCG every 2 weeks x 3, then monthly β-hCG for 12 months after completion of therapy.

B. Stages II and III, High Risk

1. Multi agent chemotherapy with EMA/CO is the preferred regimen
   a. Etoposide 100 mg/m² IV on day 1 and 2, dactinomycin (Actinomycin-D) 0.5 mg IV on day 1 and 2, methotrexate 100 mg/m² IV push on day 1 then 200 mg/m² IV over 12 hours on day 1 (alkalinize urine). Leucovorin 15 mg IM or PO q 6 hours x 4 doses beginning 12 hours after methotrexate is completed.
   b. Cyclophosphamide 600 mg/m² IV on day 8, vincristine 1 mg/m² on day 8
   c. Repeat cycle every 2 weeks
   d. If resistance occurs, cisplatin 80 mg/m² IV on day 8 and etoposide 100 mg/m² IV on day 8 is administered in the EMA/EP regimen as a replacement of the cyclophosphamide and vincristine portion of the EMA/CO regimen. The EMA portion of the regimen is unchanged.
   e. If brain metastasis is present, high dose EMA/CO is used. EMA/CO doses are the same as above except the methotrexate dose: 1000 mg/m² by 24 hour infusion on day 1 (alkalinize urine), Leucovorin 15 mg IV, IM or PO q 8 hours x 9 doses after MTX infused. May also need to add intrathecal methotrexate 12.5 mg every 2 weeks.
2. **Treatment continues for three full cycles after the β-hCG becomes negative.**
   Surveillance includes weekly β-hCG during treatment, then β-hCG every 2 weeks x 3, then monthly β-hCG for 24 months after completion of therapy.

C. **Stage IV, High Risk**
   1. Treatment is urgent and includes EMA/CO, selective surgery and selective radiation therapy depending on the sites of metastases. Liver lesions may hemorrhage and resection is occasionally needed.
   2. Brain metastasis is usually symptomatic and is considered an oncologic emergency. Treatment is either with radiation therapy (30 Gy in 10 fractions) or intrathecal methotrexate or high dose EMA/CO (see section X.B.1.e, above).
   D. If resistant disease develops, diagnosis may be aided by PET scan, angiography, or radiolabelled antibody to β-hCG. Surgical resection of resistant foci of disease in uterus, lung, brain, or liver may improve prognosis.

E. **Placental site trophoblastic tumor (PSTT) is refractory to chemotherapy.** When identified, surgical treatment including hysterectomy is indicated.

<table>
<thead>
<tr>
<th>XI. Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rx</td>
</tr>
<tr>
<td>Low Risk MTX-FA, Act-D</td>
</tr>
<tr>
<td>High Risk EMA/CO</td>
</tr>
<tr>
<td>High Risk, CNS EMA/CO, CNS RT</td>
</tr>
</tbody>
</table>

Note that low risk disease includes lung metastases.

XII. Fertility is essentially unchanged once the disease has been cleared.

**References**


Rev. 3/2005
Ovarian Cancer

I. Incidence:
   A. Second most common gyn malignancy in U.S. Largest number of gyn cancer deaths. In 2006, incidence 20,180 cases with 15,310 deaths (Jemal)
   B. Incidence rises with age, peak incidence age 54-64
   C. Individual lifetime risk of any ovarian neoplasm 5-7%. Individual lifetime risk of ovarian cancer 1.8%. Risk that adnexal mass is malignant 7-13% (premenopause), and 30-45% (postmenopause) (Koonings)
   D. Differential diagnosis for adnexal masses
      1. Ovary
         a. functional cysts
         b. endometriosis
         c. benign neoplasm: epithelial, germ cell, stromal
         d. malignant neoplasm: epithelial invasive, epithelial low malignant potential, germ cell, stromal
      2. Uterus (e.g. pedunculated fibroid, sarcoma, etc.)
      3. Fallopian tube (e.g. hydrosalpinx, paratubal cyst, Fallopian tube carcinoma, etc.)
      4. GI tract (e.g. diverticulosis, appendiceal abscess or tumor, rectal carcinoma, etc.)
      5. Urinary tract (e.g. neurogenic bladder, bladder carcinoma, etc.)
      6. Other: (e.g. aneurysm or A-V malformation, pelvic fracture, etc.)

II. Epidemiology
   A. Incidence increased 200% between 1930-2004
   B. Risk Factors, Epithelial Ovarian Carcinoma
      | Risk Factor                                      | RR  |
      | Positive Family History                         | 29  |
      | History breast cancer                           | 2   |
      | Nulliparity (vs. P >5)                          | 4-5 |
      | Age at 1st pregnancy (>25 vs < 20)              | 3   |
      | Talc (rare cause of cancer because exposure is low) | 3   |
      | Obesity                                         | 2   |
      | OCP use                                         | 0.5 |
   C. Risk factors, germ cell: 50% risk of dysgerminoma in patients with dysgenetic gonads
   D. Proposed etiologies, epithelial carcinomas
      1. "Incessant ovulation". Probably accounts for the majority of ovarian cancers.
         a. Prolonged stimulation by pituitary gonadotropins
         b. Repetitive surface trauma / healing due to ovulation or inflammation
      2. Genetic: autosomal dominant gene with variable penetrance. Three known pedigrees for Familial Breast / Ovarian Cancer (FBOC): site specific, breast-ovary, "cancer family syndrome" (Lynch II). FBOC accounts for 5-10% of ovarian cancers
         c. Criteria to determine high risk individual for BRCA1 or BRCA2 testing:
            i. Personal history of breast cancer < age 40, bilateral breast cancer, or breast and ovarian cancer.
            ii. Family history predictive of >10% chance of mutation: breast cancer in ≥ 2 relatives at age < 50, or 1 breast cancer at age < 50 and any ovarian cancer,
III. Diagnosis and Screening for Ovarian Mass

A. Obtain family history and initiate genetic counseling and gene testing for high risk individual. (See Section II.D.2.a-e.)

B. Regular pelvic exams per ACOG recommendation.

C. Ultrasound for screening controversial due to cost and sensitivity/specificity (DePriest). When used to triage a known mass 75-100% sensitive, 83-95% specific (Sassone, Kawai, Kurjak)

D. Tumor Markers. Sensitivity and specificity too low for screening. CA-125 has 55% false negative rate for stage I epithelial ovarian cancer. See Pathology Section (VII.A-D.) for markers associated with each tumor type. New markers such as Ovacheck (proteomics-based chip) and LPA are in development.

E. Prospective, randomized trial does not show benefit to screening for ovarian cancer with combined CA-125 and ultrasound (Jacobs)

IV. Preoperative Testing and Preparation (Guidozzi, Ozols)

A. Tumor marker(s) appropriate for patient's age

B. Ultrasound helpful for triage of clinically palpable cystic masses

C. Chest X-ray abnormal in 9% of new cases, to rule out metastases or effusions

D. Liver function tests, important if ascites present to rule out primary liver disease

E. Barium enema or colonoscopy abnormal in 39% of new cases with large or fixed masses. Order if > 45 years old or if GI symptoms present

F. Abdominal and pelvic CT scan useful for some new cases with large or fixed masses. Not necessary for all new cases
G. Intravenous pyelogram abnormal in 45% of new cases. CT scan more useful particularly if large or fixed mass present

H. Head CT or abd/pelvic MRI; liver, spleen, and bone scans NOT routinely indicated

I. Patients with suspicious adnexal masses should be prepared for definitive staging procedure
   1. Preoperative consultation with or referral to gynecologic oncologist
   2. Consent for primary staging and cytoreductive surgery
   3. Mechanical bowel preparation
   4. Pre-operative antibiotics
   5. Thromboembolic prophylaxis with SCDs and / or heparin or fractionated heparin
   6. Appropriate positioning of the patient
      a. Low lithotomy for patients with cul de sac masses
      b. Supine for all others
   7. Appropriate incision
      a. Vertical incision preferred if malignancy is likely
      b. Maylard incision is acceptable alternative
      c. Pfannenstiel incision not desirable for high risk cases. Can be converted to Cherney incision for improved upper abdominal exposure
      d. Laparoscopic approach requires careful triage (Reynolds)

J. Adnexal mass decision tree:

```
Palpable Adnexal Mass

Exclude Non-Gyn Problem

Premenopausal

Premenarchal
- Any adnexal mass ≥ 2 cm
  - Tumor Markers Favor germ cell: AFP, ß-hCG, LDH, CA-125
  - Karyotype: rule out (46XY)

Reproductive Age
- Cystic, or ultrasound finding of ≤6 cm with no complex features
  - Observation or optional OCP hormonal suppression for 6 wks

Postmenopausal

Ultrasound > 5cm, or complex features

Reproductive Age
- Solid, or ultrasound finding of >6 cm, or complex features
  - Larger or Stable
    - Tumor Markers: Favor epithelial
    - Order germ cell / stromal markers selectively based on clinical features

Wrong

Mass Smaller
- No Surgery

Correct

Surgery and possible staging procedure
```
V. Surgical Procedures for Ovarian Cancer
   A. Initial surgical procedure for diagnosis and staging:
      1. Objective is to define stage and to remove as much of the tumor as possible.
      2. Staging requires biopsy or removal of affected ovary, pelvic and para-aortic lymph nodes, omentum, peritoneal biopsies (pelvic sidewall, cul de sac, bladder serosa, pericolic gutters, and diaphragm), intraperitoneal cytology, and any suspicious lesions.
      3. Debulking removes macroscopic disease. Residual disease is described in terms of diameter of largest remaining nodules and percentage of tumor removed.
      4. Techniques and procedures for debulking include. Aggressiveness of resection depends on the likelihood of attaining optimal debulking. If a patient has non-resectable disease, radicality of debulking will be decreased to minimize morbidity.
         a. TAH-BSO
         b. Modified posterior exenteration
         c. Small or large intestinal resection
         d. Splenectomy
         e. Peritoneal stripping
         f. Ablation or resection of surface lesions with CUSA, LEEP, laser or excision
         g. Resection of portions of affected organs such as ureter, liver, and stomach
   B. Interval cytoreductive surgery
      1. Debulking surgery following neoadjuvant (“induction”) chemotherapy for patients who could not have an optimal primary cytoreductive surgery due to extent of disease
      2. Significant survival benefit demonstrated in one prospective randomized clinical trial (van der Burg)
   C. Second look surgery
      1. Surgical reassessment for patients with complete response after primary surgery and chemotherapy
      2. May be used as part of treatment protocols with informed consent but should not be used as routine clinical practice
   D. Secondary cytoreductive surgery
      1. Debulking surgery for patients with persistent disease after completion of planned therapy or with recurrent disease after a period of remission.
      2. Best candidates for this surgery have localized recurrences.
      3. Predictors of successful secondary cytoreduction include relapse 12 months or longer from completion of therapy, tumors that were responsive to primary chemotherapy, high performance status, and potential for complete resection based on preoperative evaluation (Eisenhauer)
      4. Patients able to be debulked to microscopic residual disease have 51% survival at 5 years compared to 10% survival at 5 years if any residual disease remained. (Hoskins)
   E. Palliative secondary surgery
      1. Surgery to relieve symptoms associated with progression of ovarian carcinoma such as bowel obstruction.
      2. Palliative surgery is kept to a minimum and is offered to patients likely to receive symptomatic relief
      3. Selection of patients likely to benefit from palliative surgery for bowel obstruction associated with progression of ovarian cancer can be objectively scored (Krebs)
         a. If score < 6, 84% chance of palliative benefit from surgery resulting in survival of at least 8 weeks.
         b. If score > 6, 20% chance of palliative benefit from surgery resulting in survival of at least 8 weeks.
c. Scoring system

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; 45</td>
<td>0</td>
</tr>
<tr>
<td>45-65</td>
<td>1</td>
</tr>
<tr>
<td>&gt;65</td>
<td>1</td>
</tr>
<tr>
<td><strong>Nutritional Deprivation</strong></td>
<td></td>
</tr>
<tr>
<td>None or minimal</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>1</td>
</tr>
<tr>
<td>Severe</td>
<td>2</td>
</tr>
<tr>
<td><strong>Tumor Status</strong></td>
<td></td>
</tr>
<tr>
<td>No palpable intraabdominal masses</td>
<td>0</td>
</tr>
<tr>
<td>Palpable intraabdominal masses</td>
<td>1</td>
</tr>
<tr>
<td>Liver involvement or distant mets</td>
<td>2</td>
</tr>
<tr>
<td><strong>Ascites</strong></td>
<td></td>
</tr>
<tr>
<td>None or mild (asymptomatic, no distension)</td>
<td>0</td>
</tr>
<tr>
<td>Moderate (abdominal distension)</td>
<td>1</td>
</tr>
<tr>
<td>Severe (requiring frequent paracentesis)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Previous chemotherapy</strong></td>
<td></td>
</tr>
<tr>
<td>None or no adequate trial</td>
<td>0</td>
</tr>
<tr>
<td>Failed single drug therapy</td>
<td>1</td>
</tr>
<tr>
<td>Failed combination therapy</td>
<td>2</td>
</tr>
<tr>
<td><strong>Previous radiation therapy</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>Pelvic radiotherapy</td>
<td>1</td>
</tr>
<tr>
<td>Whole abdominal radiotherapy</td>
<td>2</td>
</tr>
</tbody>
</table>

F. Prophylactic oophorectomy (Berchuck, NIH consensus)

1. Candidates for prophylactic oophorectomy should have documented hereditary ovarian cancer pedigree (ovarian site specific, breast-ovary, or hereditary non-polyposis colorectal cancer) or proven gene mutation (BRCA-1, BRCA-2, MSH-2, MLH-1, PMS-1, PMS-2)

2. Ovaries removed after age 35 or completion of childbearing

3. Primary peritoneal carcinoma can occur in women who have undergone prophylactic oophorectomy in 2–10% of cases but risk of dying from ovarian cancer drops from RR 24 to RR13 in the surgically treated group

G. Management of the pelvic mass in pregnancy (Carney)

1. Surgical intervention usually deferred until second trimester, if possible, in order to minimize anesthetic risks to developing embryo.

2. Staging may be abbreviated due to suboptimal exposure secondary to uterine enlargement

3. If tumor is of advanced stage or high grade, chemotherapy during pregnancy may be needed. Literature supports use of chemotherapy but data on effects upon pregnancy are scant. Treatment for lower risk disease deferred until postpartum.

H. Surgical pitfalls. Ovarian cancer outcome may be hampered by poor surgical technique, inadequate or incomplete staging, and absence of aggressive debulking. Adequacy of staging and survival is improved when treatment is performed by a gynecologic oncology specialist (Gershenson, Carney, Elit, McGowan)

I. Surgical controversies

1. Rupture of ovarian cyst during surgery does not worsen prognosis (Sevelda)

2. Delay of definitive surgery after initial diagnosis worsens prognosis (Lehner)

3. Role of restaging after incomplete staging procedures (Soper)

4. Role of laparoscopic surgery (Maiman, Reynolds)

5. Attaining optimal debulking is the result of:
   a. Favorable tumor biology (Covens)
   b. Surgical expertise (Eisenkop)
VI. Intra-operative steps for initial assessment and staging of adnexal masses regardless of laparotomy versus laparoscopy approach.

Washings for cytology followed by exploration of abdomen and pelvis

Suspected metastases

Frozen section

Benign

Cystectomy or oophorectomy

Malignant

All Germ Cell, Stage I-II LMP, Sertoli-Leydig

All Other Types

Benign

No Further Treatment

Adjuvant therapy according to histology and stage

VII. Pathology

A. Epithelial Ovarian Tumors: 80-90% of ovarian cancers. Subdivided into low malignant potential (LMP, "borderline"), and malignant types. LMP tumors account for 15-20% of epithelial cancers, and 40-80% are detected while stage I. Malignant epithelial tumors present beyond Stage I in 60-80% of cases.

1. Serous: 50% of epithelial CA. Bilateral >33%. Marker: CA-125
2. Mucinous: 10-15% of epithelial CA. Bilateral 5-10%. Marker: CA 19-9, CEA
4. Clear Cell: 5% of epithelial CA. Bilateral 5-10%. Marker: CA-125
5. Brenner: <1% of epithelial CA. Marker: CA-125

B. Germ Cell Tumors: 3-5% of ovarian cancers (15% in oriental or black populations). 65-70% present Stage I. Almost always unilateral, except for dysgerminoma.

1. Dysgerminoma: 50% of malignant germ cell tumors. 75% occur between age 10-30, rare after 35. 15% have mixed histology. 5% associated with dysgenetic gonad. 75% present Stage I; node mets ≥ 25%. Bilateral 15-20%. Marker: LDH, PLAP
   a. Immature: 20% of malignant germ cell tumors. 50% occur between ages 10-20.
   b. Malignancy arises in 1-2% of mature teratomas (usually squamous carcinoma).
3. Endodermal Sinus Tumor (yolk sac tumor): 20% of malignant germ cell tumors. Median age at incidence 17, 33% occur before menarche. 75% present with pain. Spontaneous rupture common. Marker: AFP
5. Mixed germ cell tumors: 10-15% of malignant germ cell tumors, components: DG 80%, EST 70%, choriocarcinoma 70%, IT 53%. Marker: AFP, hCG
6. Rare types: polyembryoma, choriocarcinoma, gonadoblastoma
C. Sex Cord/Stromal Tumors: 5-6% of ovarian cancers. Usually diagnosed while Stage I
1. Granulosa Cell Tumor
   b. Juvenile type: rare tumor, 97% occur before 30y. Usually produces estrogen.
2. Sertoli-Leydig Cell Tumor: <1% of ovarian cancers. Average age at incidence 25. 70-85% hormonally active, usually virilizing. Bilateral <1%. Marker: testosterone
3. Thecoma-Fibroma: rare. Usually benign, 1-5% of all ovarian tumors. Bilateral 10%
4. Rare types: Sertoli cell tumor (Pick's adenoma), Leydig cell tumor, hilus tumor, sex cord tumor with annular tubules, gynandroblastoma
D. Tumors metastatic to ovary: 5-6% of ovarian cancers.
1. Gyn sites: endometrial CA 5% metastasize to ovary, cervical adenocarcinoma 1%
2. Breast: at autopsy, 24% with metastases to ovary
3. GI: Krukenberg tumors account for 30-40% of ovarian metastatic lesions
4. Lymphoma: 5% with advanced stages have ovarian metastases

VII. FIGO Staging for Ovary, Revised 1989

<table>
<thead>
<tr>
<th>Stage I:</th>
<th>Growth limited to the ovaries.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I a</td>
<td>Growth limited to one ovary; no ascites. No tumor on the external surface; capsule intact.</td>
</tr>
<tr>
<td>I b</td>
<td>Growth limited to both ovaries; no ascites. No tumor on the external surface; capsule intact.</td>
</tr>
<tr>
<td>I c</td>
<td>Tumor on the surface of one or both ovaries; or with capsule ruptured; or with ascites present containing malignant cells or with positive peritoneal washings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage II:</th>
<th>Growth involving one or both ovaries with pelvic extension.</th>
</tr>
</thead>
<tbody>
<tr>
<td>II a</td>
<td>Extension and/or metastases to the uterus and/or tubes.</td>
</tr>
<tr>
<td>II b</td>
<td>Extension to other pelvic tissues.</td>
</tr>
<tr>
<td>II c</td>
<td>Tumor of stage II with tumor on surface of one or both ovaries; or with capsule(s) ruptured; or with ascites present containing malignant cells or with positive peritoneal washings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage III:</th>
<th>Tumor involving one or both ovaries with peritoneal implants outside the pelvis and or positive retroperitoneal or inguinal lymph nodes. Superficial liver metastasis equals Stage III.</th>
</tr>
</thead>
<tbody>
<tr>
<td>III a</td>
<td>Histologically confirmed microscopic seeding of abdominal peritoneal surfaces.</td>
</tr>
<tr>
<td>III b</td>
<td>Histologically confirmed implants of peritoneum, ≤ 2 cm in diameter. Nodes negative.</td>
</tr>
<tr>
<td>III c</td>
<td>Abdominal implants &gt;2 cm and/or positive retroperitoneal or inguinal lymph nodes.</td>
</tr>
</tbody>
</table>

| Stage IV: | Distant metastases. If pleural effusion is present, there must be positive cytologic test results to allot to a stage IV. Parenchymal liver metastasis equals stage IV. |
VIII. Treatment Plans

Note that complete surgical staging and debulking is required even if uterus and contralateral ovary are to be preserved

A. Epithelial carcinomas

1. Low malignant potential
   a. Stage I, II: unilateral salpingo-oophorectomy (USO) or TAH-BSO, depending on reproductive desires. Complete surgical staging and debulking is required. No adjuvant therapy if no residual disease.
   b. Stage III-IV: TAH-BSO. Complete surgical staging and debulking is required. Then:
      i. No adjuvant therapy if no residual disease
      ii. If residual disease is present or for either invasive implants or micropapillary architecture, then carboplatin and paclitaxel (Taxol) IV chemo x 6 cycles. Consider intraperitoneal therapy if residual disease / adhesions minimal
      iii. Consider clinical trial for primary, consolidation or recurrent disease therapy
      iv. Second look laparotomy only if on clinical trial

2. Invasive epithelial carcinoma
   a. Stage Ia grade 1, Ib grade 1: USO, BSO or TAH-BSO, depending on reproductive desires. Complete surgical staging and debulking is required. No adjuvant therapy.
   b. Stage Ia grade 2, Ib grade 2, Ib grade 3: TAH-BSO Complete surgical staging and debulking is required. Then:
      i. Carboplatin and paclitaxel (Taxol) IV chemotherapy x 3-6 cycles, or
      ii. Consider clinical trial for primary, consolidation or recurrent disease therapy, or
      iii. Consider intraperitoneal chemotherapy if residual disease and adhesions minimal
   c. Stage III, IV: TAH-BSO. Complete surgical staging and debulking is required. Then:
      i. Carboplatin and paclitaxel (Taxol) chemotherapy x 6 cycles, or
      ii. Consider clinical trial for primary, consolidation or recurrent disease therapy, or
      iii. Strongly consider intraperitoneal chemotherapy if, or
      iv. Consider whole abdominal radiation therapy, if residual disease < 5 mm (not a standard therapy)
      v. Second look laparotomy only if on clinical trial
      vi. If unable to be debulked, consider neoadjuvant chemotherapy followed by secondary cytoreductive surgery

B. Germ cell malignancies (carboplatin is NOT equivalent to cisplatin for these tumors)

1. Dysgerminoma
   a. Stage Ia: USO. Complete surgical staging and debulking is required. No adjuvant therapy.
   b. All others: USO or TAH-BSO, depending on reproductive desires. Complete surgical staging and debulking is required. Then:
      i. BEP regimen: cisplatin, etoposide, bleomycin repeated q 3-4 weeks x 3-6 cycles, or until markers negative x 3; or,
      ii. VAC: vincristine, dactinomycin (Actinomycin-D), cyclophosphamide repeated q 3-4 weeks x 3-6 cycles, or until markers negative x 3; or
      iii. Whole abdominal radiation therapy (not preferred therapy because chemotherapy has excellent chance of cure while preserving fertility whereas radiation will cause ovarian failure)
2. Teratoma
   a. Stage Ia grade 1: USO. Complete surgical staging and debulking is required. No adjuvant therapy.
   b. All others: USO or TAH-BSO, depending on reproductive desires. Complete surgical staging and debulking is required. Then: BEP or VAC chemo x 3-6 cycles, or until markers negative x 3.

3. All Other germ cell tumors, all stages: USO or TAH-BSO, depending on reproductive desires. Complete surgical staging and debulking is required. Then: BEP or VAC chemo x 3-6 cycles, or until markers negative x 3.

C. Sex-cord stromal malignancies
   1. Stage Ia grade 1: USO. Complete surgical staging and debulking is required. No adjuvant therapy. D&C required to rule out synchronous endometrial tumor.
   2. All others: USO or TAH-BSO, depending on reproductive desires. Complete surgical staging and debulking is required. Then cisplatin, vinblastine, bleomycin (PVB); or BEP x 3-6 cycles or until markers negative x 3. D&C required if uterus not removed to rule out endometrial cancer or hyperplasia.

D. Tumors metastatic to ovary: Treat based on site of primary disease.

E. Relapse after primary treatment
   1. Epithelial tumors sensitive to platinum and with progression-free interval > 12-24 months: retreat with carboplatin + paclitaxel regimen.
   2. Epithelial tumors with resistance to platinum or progression-free interval < 6 months: treat with sequential monotherapy using FDA approved chemotherapy. Active drugs include liposomal doxorubicin (Doxil), etoposide, gemcitabine, topotecan, and docetaxel (Taxotere). Also active but used less often are: irinotecan, cyclophosphamide (Cytoxan), altretamine (Hexalen), melphalan, and vinorelbine (Navelbine).

IX. Survival
A. Epithelial Tumors
   1. Grade effects survival. Stage I, grades 1, 2, 3 5y survival 96%, 81%, 58%, resp.
   2. LMP tumors: excellent survival in all stages if tumor completely resected. Recurrences can be late (> 10 y.)
   3. Advanced stage disease successfully debulked to microscopic residual (NED) vs. <2 cm, vs. >2 cm (Cohen)

<table>
<thead>
<tr>
<th>Group</th>
<th>Survival</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>NED</td>
<td>100% @ 45m.</td>
<td>NED</td>
</tr>
<tr>
<td>≤2 cm</td>
<td>100% @44m.</td>
<td>50%AWD</td>
</tr>
<tr>
<td>&gt;2 cm</td>
<td>35% @15.9m.</td>
<td>100%AWD</td>
</tr>
</tbody>
</table>

4. Randomized clinical trials
   a. ICON 2: demonstrated that carboplatin alone was equally efficacious to cisplatin, doxorubicin and cyclophosphamide. ICON 3 reconfirmed this finding when single agent carboplatin was compared to carboplatin and paclitaxel. ICON 4 shows weak, but statistically significant benefit to the combination of carboplatin with paclitaxel.
   b. GOG #111: cisplatin with either cyclophosphamide or paclitaxel showed that paclitaxel-containing treatment arm had higher complete response (51 vs. 31%), higher overall response (73 vs. 60%), longer PFI (18 vs. 13 months), and longer median survival (38 vs. 24 months). (McGuire)
c. GOG #158: paclitaxel with either cisplatin or carboplatin was equally efficacious. Carboplatin arm had lower neurotoxicity and more severe thrombocytopenia. (Ozols)

d. Dose intensity trial tested single-agent carboplatin at escalating doses. Effectiveness was equivalent for all doses above AUC 4 using the Calvert formula. (Jakobsen)

e. Intraperitoneal versus intravenous therapy shows survival and progression-free interval advantages with IP therapy in 3 of 5 randomized trials (Markman). GOG # 172 randomized IV paclitaxel (135 mg/m$^2$ over 24 hours) and IV cisplatin (75 mg/m$^2$) q 21 days for 6 cycles versus IV paclitaxel (135 mg/m$^2$ over 24 hours on day 1), IP cisplatin (100mg/m$^2$ on day 2), and IP paclitaxel (60 mg/m$^2$ on day 8) q 21 days for 6 cycles. Median progression-free survival was 18.3 and 23.8 months, and overall survival was 49.7 versus 65.6 months, respectively. Only 42% of patients could complete the IP therapy largely due to catheter complications. Quality of life was significantly worse in the IP group during and shortly after Tx but not at 1 year. Grade 3-4 toxicity was higher in the IP group by the following ratios: GI (2x), renal (3.5x), infection (2.5x), fatigue (4x), pain (7x), and metabolic events (3.5x) (Armstrong)

5. Ovarian epithelial cancer survival, by stage

![Survival by Stage, Ovarian Epithelial Cancer](Morrow, 1998)
B. Germ Cell and Stromal Tumors

<table>
<thead>
<tr>
<th>Histology</th>
<th>Stage</th>
<th>Therapy</th>
<th>Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>DG</td>
<td>Ia</td>
<td>Surgery, VAC or RT if recurs</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>All others</td>
<td>Surgery plus VAC</td>
<td>85%</td>
</tr>
<tr>
<td>IT</td>
<td>Ia1</td>
<td>Surgery</td>
<td>90-95%</td>
</tr>
<tr>
<td></td>
<td>All others</td>
<td>Surgery plus BEP</td>
<td>85%</td>
</tr>
<tr>
<td>EST</td>
<td>All stages</td>
<td>Surgery plus BEP or PVB</td>
<td>75-95%</td>
</tr>
<tr>
<td>Granulosa Cell</td>
<td>All stages</td>
<td>Surgery ± chemotherapy (VAC, BEP, PVB, RT or hormone tx.)</td>
<td>95%, 68%</td>
</tr>
<tr>
<td></td>
<td>All stages</td>
<td>Surgery ± VAC or BEP or PVB</td>
<td>70-90%</td>
</tr>
</tbody>
</table>

X. Fertility

A. If anatomic structures are preserved, fertility excellent
B. Alkylating chemotherapy drugs cause ovarian failure as function of age and dose. If amenorrhea occurs, < 10% chance of resumed ovarian function
C. Radiation therapy causes ovarian failure as function of age and dose. All women receiving > 800 cGy to pelvis develop ovarian failure

XI. NIH consensus recommendations regarding management of ovarian cancer

A. Women with masses having a significant risk of malignancy should be given the opportunity to have surgery performed by a gynecologic oncologist
B. Aggressive cytoreductive surgery as primary management of ovarian cancer will improve chances for long term survival
C. Fully staged FIGO IA-1 and IB-1 ovarian cancers do not require postoperative adjuvant therapy
D. Second look laparotomy should only be done for patients enrolled in clinical trials or for those patients in whom surgery will affect clinical decision making
E. Platinum-based (carboplatin or cisplatin) and paclitaxel (Taxol) are optimal first line chemotherapy drugs following primary debulking surgery
F. There is no evidence to support screening of women with or without affected first degree relatives
G. Recommendations for prophylactic oophorectomy include
   1. Confirmed pedigree
   2. Annual U/S and CA-125 until 35y or completed childbearing
   3. Oophorectomy after 35y or completed childbearing

References:


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Rev. 12/2006
Uterine Sarcomas

I. Smooth Muscle Tumors
   A. Benign and Borderline Types
      1. Atypical smooth muscle tumors: leiomyoblastoma, clear cell leiomyoma, epithelioid leiomyoma, plexiform tumorlet. Very rare. Treated by excision, ≤ 10% recur.
      2. Intravenous leiomyomatosis. Rare. Usually premenopausal and hormonally sensitive. Treated by excision, ≤ 13% recur.
      4. Leiomyomatosis peritonealis disseminata. Rare. Risk factors: Black (67% of cases), pregnant (50% of cases), oral contraceptive users (30% of cases). May not require treatment.
   B. Leiomyosarcoma (LMS)
      1. Epidemiology. Mean age at diagnosis 53. Nulliparas account for 20% of LMS. LMS accounts for 35-40% of uterine sarcomas. Risk factors: poorly understood. Radiation not a risk factor
      2. Natural History and Prognostic Factors. Patients present with menometrorrhagia or postmenopausal bleeding (75%), pain, awareness of mass, vaginal discharge. Only 15% detected preoperatively. Recurrences detected locally <25%; lung mets common
      3. Pathology. LMS graded by mitotic index (mitoses/10 high power fields) and cytologic atypia. (<5 benign, 5-9 borderline, ≥10 malignant; recurrence rate <10%, 33%, 67%, respectively)
      4. Treatment
         a. TAH, BSO. Lymph node sampling not helpful due to likelihood of distant mets
         b. Adjuvant radiation probably not helpful, even for local control
         c. Adjuvant chemotherapy decreases distant mets from 55% to 27%, but does not improve survival. Use is controversial.
         d. Chemotherapy for metastatic disease. Active drugs: doxorubicin (27% response rate), ifosfamide, gemcitabine with docetaxel, VAC or MAI.

II. Endometrial Tumors
   B. Endolymphatic stromal myosis (ESM, low grade endometrial stromal sarcoma)
      1. Epidemiology. Rare. Patients usually premenopausal.
      2. Natural History and Prognostic Factors. Rarely diagnosed pre-op. Stage > I in 21% of cases. Indolent course despite 55% recurrence rate for stage I disease. Recurrence more likely if tumor > 5 cm. Long-term survival common, even with disease.
      4. Treatment
         a. Surgical resection. Radical hysterectomy preferred if diagnosed pre-op.
            Oophorectomy reduces recurrence risk. Measure hormone receptors in tumor
         b. Adjuvant RT improves local control; 40% have distant recurrences.
         c. Progestin therapy effective: 25% CR, 25% PR, 45% stable disease
         d. Post surgical RT or progestins warranted if tumor > 5 cm, or if VSI present.
         e. Chemotherapy has limited effectiveness. Doxorubicin active, 25%
C. Endometrial stromal sarcoma (ESS)
   1. Epidemiology. ESS accounts for 14% of uterine sarcomas. Patients usually postmenopausal.
   2. Natural History and Prognostic Factors. Patients present with PMB, menorrhagia, pain.
   3. Pathology. High mitotic index, homologous cell type.
   4. Treatment
      a. TAH, BSO, consider node sampling. Measure hormone receptor content
      b. Adjuvant RT improves local control, but doesn't prolong survival. Use for low stage disease
      c. Progestin therapy may be effective if receptors positive
      d. Receptor negative, advanced stage lesions should receive chemotherapy

III. Mixed Tumors
   A. Müllerian adenosarcoma. Rare. Benign glands, atypical stroma.
   B. Malignant mixed mesodermal tumors (MMMT)
      1. Epidemiology. MMMT accounts for 3-6% of all uterine cancers; 51% of uterine sarcomas. Risk factors: nulliparity (25% of cases), obesity (40% of cases), diabetes (15% of cases), prior radiation (10%, range 0-30% of cases). Estrogen not implicated.
      2. Natural History and Prognostic Factors. Patients present with bleeding (82%), prolapsing cervical mass (33%), pain (25%), abdominal mass (10%). Distant mets found in 10-20%, at presentation. Clinical stage I patients have 50% chance of extra-pelvic mets when initially explored.
         a. Homologous. Stromal differentiation into native uterine cell types. Also called carcinosarcoma.
         b. Heterologous. Stromal cell types not normally found in uterus (e.g. striated muscle, cartilage, bone).
      4. Treatment
         a. TAH, BSO, lymph node sampling
         b. Adjuvant radiation therapy indicated postoperatively to control high local recurrence rate (54% without RT, 23% with RT). Survival not prolonged
         c. Adjuvant chemotherapy may prolong survival if extrauterine disease present
         d. Chemotherapy for metastatic disease. Active drugs: doxorubicin, ifosfamide, cisplatin

IV. Rare Types
   A. Rhabdosarcoma
      1. Embryonal form: sarcoma botryoides, see Vaginal Cancer chapter.
      2. Adult form: pleomorphic histology, poor survival.
   B. Osteosarcoma
   C. Chondrosarcoma
   D. Hemangiopericytoma
   E. Peripheral Primitive Neuroectodermal Tumor (pPNET) or Ewing’s Sarcoma
V. Staging
By convention, uterine sarcomas are staged using FIGO endometrial cancer rules. Stage subdivisions are usually ignored (e.g. IIIa→III).

<table>
<thead>
<tr>
<th>FIGO Staging for Uterine Sarcoma</th>
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<tbody>
<tr>
<td>I</td>
</tr>
<tr>
<td>II</td>
</tr>
<tr>
<td>III</td>
</tr>
<tr>
<td>IV</td>
</tr>
</tbody>
</table>

VI. Survival

<table>
<thead>
<tr>
<th>Stage</th>
<th>LMS</th>
<th>ESM</th>
<th>ESS</th>
<th>MMMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>48%</td>
<td>89%</td>
<td>78%</td>
<td>36%</td>
</tr>
<tr>
<td>II</td>
<td>67%</td>
<td>75%</td>
<td>0%</td>
<td>22%</td>
</tr>
<tr>
<td>III</td>
<td>0%</td>
<td>67%</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>IV</td>
<td>0%</td>
<td>0%</td>
<td>6%</td>
<td></td>
</tr>
</tbody>
</table>

Schwartz SM, Thomas DB. A case-control study of risk factors for sarcomas of the uterus. Cancer 1989; 64: 2487-2492
Vaginal Cancer

I. Incidence: 1-2% of all gyn cancers.

II. Epidemiology and Natural History: Etiology and cell types stratified by patient age
   A. Childhood tumors
      1. Sarcoma botryoides: embryonal rhabdomyosarcoma. 90% occur before 5y of age. Appearance of red-tan grape clusters protruding from vagina. Frequent lymphatic mets to groin and pelvis. Hematogenous mets occur as well.
      2. Endodermal sinus tumor: germ cell origin (see ovary chapter). Occurs in infants. Can be mistaken for sarcoma botryoides.
   B. Tumors of adolescence and young adulthood: Clear cell carcinoma (CCC) associated with *in-utero* diethylstilbestrol (DES) exposure.
      1. Features of *in-utero* DES exposure: Risk of CCC (Vagina >> cervix) is 1:1000. History of *in-utero* DES exposure present in 67% of vaginal CCC, 33% of cervical CCC. Mean age of DES associated CCC 19y (range 7-42). Three histologic subtypes: tubulocystic, papillary, solid. Tubulocystic has better prognosis (88% vs 73% 5y survival) and usually occurs after age 19. Adenosis present in 33%. Squamous metaplasia in adenosis makes colposcopic evaluation of dysplasia difficult, but causes eventual regression of adenosis. Lifetime risk of vaginal dysplasia increased. Probably no significant increased risk of breast cancer (controversial). DES associated uterine anomalies (80%) and infertility widely reported.
      2. Recommended routine DES exam: Initial colposcopy, pap smear, and palpation of vagina. Take separate pap from vagina and cervix. If adenosis present, re-examine q6 months with colposcopy at least every 4th visit.
   C. Tumors of adults
      1. Squamous carcinoma: Mean age 60-65y. Most common in upper 1/3 of vagina, and on posterior wall. Lymphatic drainage mimics cervix for upper vaginal lesions, and vulva for lower vaginal lesions. Frequently associated with HPV (usually HPV 16, see cervix chapter).
      2. Malignant melanoma: Average age 55y (range 22-83). Usually in lower 1/3 of vagina, and on anterior wall. Pigmented in 95%, amelanotic in 5%.
      3. Rarely, tumors develop in Gartner's duct cysts (Wolffian system) and Müllerian duct cysts. They tend to be located anterolaterally, and anteriorly, respectively. Lymphoma and sarcoma (adult type) also occur rarely.
   D. Presenting symptoms: vaginal bleeding and foul discharge in 50-70%

III. Pathology

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Squamous Carcinoma</td>
<td>80%</td>
</tr>
<tr>
<td>Adenocarcinoma</td>
<td>14%</td>
</tr>
<tr>
<td>Melanoma/Sarcoma</td>
<td>6%</td>
</tr>
<tr>
<td>Germ Cell Tumors</td>
<td>Rare</td>
</tr>
</tbody>
</table>

IV. Diagnosis

A. Biopsy and pelvic exam. Must rule out cervical, vulvar, and rectal lesions. By convention, tumor extension to cervix or vulva reclassifies tumor as cervical or vulvar.
B. Cystoscopy for anterior lesions
C. Sigmoidoscopy for posterior lesions
D. CXR and IVP, or CT of abdomen and pelvis
E. Consider tumor markers: SCC (TA-4) and CEA for squamous lesions; CA-125 for adenocarcinoma
V. Staging

<table>
<thead>
<tr>
<th>FIGO Staging for Vaginal Cancer</th>
<th>determined by clinical examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Limited to vaginal wall</td>
</tr>
<tr>
<td>I I</td>
<td>Involvement of subvaginal tissue</td>
</tr>
<tr>
<td>I I</td>
<td>Extension to pelvic wall</td>
</tr>
<tr>
<td>IV</td>
<td>Spread beyond the true pelvis or involvement of bladder or rectal mucosa</td>
</tr>
<tr>
<td>IVa</td>
<td>Spread to adjacent organs</td>
</tr>
<tr>
<td>IVb</td>
<td>Spread to distant organs</td>
</tr>
</tbody>
</table>

Melanoma is staged using Breslow's system (see vulva chapter).

VI. Treatment

A. Carcinoma
1. Radiation therapy. Four field pelvic port (40-50 Gy) followed by interstitial implant (25-40 Gy to tumor volume). If lower 1/3 of vagina involved, inguinal nodes also treated. Patients with large or high stage lesions may benefit from addition of radiation sensitizers (cisplatin and/or 5-fluorouracil). Small stage I lesions can be treated with brachytherapy alone.
2. Surgery. Upper vaginal lesions treated with radical hysterectomy and vaginectomy. Better suited for superficial, posterior fornix lesions, or for patients who cannot be radiated. Recurrent tumors (after radiation) may be treatable by pelvic exenteration.
3. DES-associated CCC in young women. Treatment customized to include resection +/- radiation therapy. Possible to preserve fertility in some cases.

B. Melanoma. No standard therapy. Treatment includes excision +/- radiation therapy, radical surgery, and radiation therapy alone. Local excisions recur locally 80%. Radical excision impacts little on survival.

C. Sarcoma botryoides. Treatment individualized. Vincristine, dactinomycin (Actinomycin-D), cyclophosphamide (VAC) chemotherapy is crucial. Surgical resection ± radiation is suggested for the tumor site and positive margins, respectively. Local control with chemotherapy alone is 15%.

VII. Survival

A. Carcinoma

<table>
<thead>
<tr>
<th>Stage</th>
<th>Percent in Stage</th>
<th>5y Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>17</td>
<td>77%</td>
</tr>
<tr>
<td>II</td>
<td>25</td>
<td>45%</td>
</tr>
<tr>
<td>III</td>
<td>40</td>
<td>31%</td>
</tr>
<tr>
<td>IV</td>
<td>18</td>
<td>18%</td>
</tr>
</tbody>
</table>

B. Melanoma, all stages 15-20% at 5y
C. Sarcoma botryoides, all stages 75% at 5y
Vulvar Cancer

I. Incidence: 4.4% of all gyn malignancies, 0.5% of all malignancies in women. 3740 new cases and 880 deaths in the USA in 2006 (Jemal). Mean age 65

II. Epidemiology:
   A. Bimodal age distribution. In young women HPV linked to development of cancer. In older women, lichen sclerosis more common.
   B. HPV types associated with gynecologic neoplasia (Hoskins). Underlined lesions are predominant.

<table>
<thead>
<tr>
<th>Lesion</th>
<th>HPV Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condyloma</td>
<td>6, 11, 16, 30, 40, 41, 42, 44, 45, 54, 55, 61</td>
</tr>
<tr>
<td>VIN, VAIN</td>
<td>6, 11, 16, 18, 30, 31, 33, 35, 39, 40, 42, 45, 51, 52, 55, 59, 61, 62, 64, 66-70</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>16, 18, 31, 33, 35, 39, 45, 51, 52, 54, 55, 56, 58, 59, 66, 68</td>
</tr>
</tbody>
</table>

C. VIN and vulvar cancer etiology. N=235 with VIN and CA, from 24 N.Y. hospitals, case control study, 30 months duration (Trimble).

<table>
<thead>
<tr>
<th>HPV Positive</th>
<th>Mean Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>VIN, n=54</td>
<td>88.9%</td>
</tr>
<tr>
<td>Basaloid / Warty CA, n=21</td>
<td>85.7%</td>
</tr>
<tr>
<td>Keratinizing SCC, n=48</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

D. Association of vulvar cancer with prior vulvar dystrophy and VIN. (Trimble).

<table>
<thead>
<tr>
<th>LS&amp;A</th>
<th>Hyperplastic</th>
<th>VIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>KSCC, n=48</td>
<td>19%</td>
<td>33%</td>
</tr>
<tr>
<td>B-W, n=21</td>
<td>5%</td>
<td>19%</td>
</tr>
</tbody>
</table>

KSCC=keratinizing squamous cell carcinoma
B-W=basaloid-warty carcinoma

E. Comparison of relative risk for HPV and Non-HPV associated vulvar cancer (Trimble)

<table>
<thead>
<tr>
<th>Overall</th>
<th>B-W</th>
<th>KSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Partners, ≥2 (vs 1)</td>
<td>2.9</td>
<td>8.1</td>
</tr>
<tr>
<td>Coitarche, &lt;20y</td>
<td>1.5</td>
<td>7.4</td>
</tr>
<tr>
<td>Abnl Pap</td>
<td>2.3</td>
<td>4.7</td>
</tr>
<tr>
<td>Condyloma</td>
<td>5.9</td>
<td>10</td>
</tr>
<tr>
<td>Smoker, ever</td>
<td>4.9</td>
<td>12.3</td>
</tr>
</tbody>
</table>

F. Progression of untreated VIN to cancer
1. Age of women with VIN 3 fell from 52.7y to 35.8y between 1961 and 1992 (Jones)
2. Incidence of VIN rose exponentially between 1961 and 1992 (Jones)
3. Untreated VIN more likely to progress to cancer. (Jones)

<table>
<thead>
<tr>
<th>Status</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated VIN (n=105)</td>
<td>3.8%</td>
</tr>
<tr>
<td>Untreated VIN, ≤ 8 years (n=8)</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

G. Relative Risks in Non-HPV Associated Vulvar Cancer RR

| Coffee (>2 cups/day vs. none) | 2.8 |
| Occupation (laundry, dry cleaning) | 3.8 |
| Hx vulvitis (granulomatous STD) | 8.5 |
| Hx leukoplakia | 13.0 |

H. Association with cervical malignancy in 15% of all vulvar cancers.
III. Pathology: (Dunton)

<table>
<thead>
<tr>
<th>Tumour Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Squamous carcinoma</td>
<td>85-90%</td>
</tr>
<tr>
<td>Melanoma</td>
<td>5-10%</td>
</tr>
<tr>
<td>Bartholin's Adenocarcinoma</td>
<td>4%</td>
</tr>
<tr>
<td>Basal Cell carcinoma</td>
<td>&lt;2%</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>&lt;2%</td>
</tr>
<tr>
<td>Paget's Disease</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

A. Melanoma occurs most often in 6th and 7th decades in Caucasian. One third occur in women younger than 50 (Wilkinson). Incidence 360 per year in USA in 2001 (Greenlee)

B. Melanoma Types
1. Superficial Spreading Melanoma. Accounts for 4% of vulvar lesions (Ragnarsson). Radial spread 4 or more rete lateral to the vertical or infiltrative growth (Wilkinson)
3. Lentiginous types account for 57% of vulvar lesions (Ragnarsson).
   a. Acral Lentiginous Melanoma, more common subtype on vulva.
   b. Lentigo Maligna Melanoma
4. Amelanotic melanoma, containing no melanin, occurs in up to 27% of vulvar lesions (Ragnarsson)

IV. Natural History
A. Symptoms
1. Mass (45%)
3. Pain (23%)
4. Ulcer (13%)
B. Spread
1. Indolent local invasion, followed by
2. Lymphatic spread: superficial inguinal to femoral to pelvic nodes. Spread is usually ipsilateral, but 0.4% positive contralateral nodes with ipsilateral negative nodes reported

V. Diagnosis
A. Differential Diagnosis
1. Benign solid neoplasms including leiomyoma, lipoma, syringoma, trichoepithelioma, granular cell tumor, neurofibroma, schwannoma
2. Glandular neoplasms including papillary hidradenoma, nodular hidradenoma, ectopic breast or nipple, endometriosis
3. Cysts including Bartholin’s cyst, epithelial inclusion cyst (sebaceous cyst), Wolfian cyst (mesonephric cyst), cyst of canal of Nuck (mesothelial cyst)
4. Vascular lesions including angiokeratoma, capillary hemangioma, cavernous hemangioma, cherry angioma, varicose veins
5. Nevi and pigmented lesions including vitiligo, fibroepithelial polyp (skin tag, acrochordon), seborrheic keratosis, vulvar melanosis, nevus, dysplastic nevus
6. Infectious diseases including HPV, HSV, condyloma lata, molluscum, chancroid, lymphogranuloma venereum, granuloma inguinale
7. Vulvar dystrophy
B. Biopsy indicated for obtaining diagnosis. Complete excision not required.
C. Punch biopsy technique: use Keys punch or Kevorkian forceps with local anesthetic. No suture required. Apply silver nitrate or Monsel’s solution for hemostasis (Reid). Excision of small lesion: make elliptical incision following lines of tension in skin. Incise, undermine and remove lesion with minimal margin, if benign in appearance. Undermine surrounding skin to mobilize for closure. Use mattress or subcuticular stitch with fine absorbable suture (Jenison, Karlen).
D. Shave biopsy technique contraindicated for possible melanoma lesions

E. Colposcopy of the Vulva
   1. Indications
      a. Persistent condyloma or visible lesion
      b. Chronic pruritus or pain
   2. Colposcopy technique
      a. Soak vulva with gauze moistened with acetic acid. Let soak for several minutes
      b. Inspect methodically
      c. Lesions may appear white, red, or pigmented. Mosaic and punctuation uncommon
      d. Biopsy anything which does not appear normal

VI. Treatment of Pre-Invasive Disease

A. Condyloma
   1. TCA (≥85%): apply topically 1-3x per week. Safe during pregnancy
   2. Laser (CO2): requires anesthesia. See technique below.
   3. LEEP: requires local anesthetic. Best method for debulking large condylomata.
   4. Imiquimod (Aldara): apply to skin 3 times per week for up to 16 weeks. Apply at h.s. and leave on 6-10 hours, then wash off
   5. Podofilox 0.5% topical gel (Condylox): apply b.i.d. for 3 days x 4 weeks. No more than 10 cm² area.
   6. α-Interferon: 1,000,000 units s.c. 3x per week for 4-6 weeks
   7. Efudex cream (5 FU, 5%): massage small amount into skin 2 nights per week for 10 weeks. Cleanse skin next AM. Alert patient to expected symptoms (burning).
      Contraindicated in pregnancy

B. Ablative techniques indicated for condyloma and vulvar intraepithelial neoplasia
   1. Laser (CO₂) or ultrasonic surgical aspiration: best cosmetic result on mucosal surfaces
   2. Wide local excision: best results on hair-bearing surfaces (Wright VC)

C. Laser ablation
   1. Clinical utility depends on use of appropriate wavelength. The CO₂ laser is most applicable to ablation of condyloma, dysplasia, and carcinoma-in-situ. The 10,600 nM wavelength is absorbed by water, resulting in tissue vaporization. Absorption occurs at the surface. Thermal damage to underlying tissue is minimized
   2. Power density must be adequate to prevent char
      a. PD (Watts/cm²)=(Watts x 100)/πr², r = spot radius (not diameter).
      b. Use of a motorized handpiece (Silk Touch) will result in a smoother and more uniform depth of ablation
      c. A colposcope may be used to guide the laser. Low power Helium Neon laser (red beam) is used for aiming. Eye protection mandatory
   3. Depth of laser ablation must be below the basement membrane for dysplasia treatment
      a. Ablate to a depth of 1-2 or 2.5 mm in non-hairbearing skin and hairbearing skin, respectively (Morrow, Baggish)
B. Surgical Planes defined by Reid use visual landmarks to determine depth

<table>
<thead>
<tr>
<th>Plane</th>
<th>Tissue vaporized</th>
<th>Healing</th>
<th>Landmark</th>
<th>Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Condy</td>
<td>Proliferating epithelium</td>
<td>No scar</td>
<td>&quot;Opalescent debris&quot;</td>
<td>Single brush, wipe with moist gauze Plane 1, then rapid brush</td>
</tr>
<tr>
<td>2</td>
<td>Superficial papillary dermis</td>
<td>No scar</td>
<td>&quot;Chamois&quot;</td>
<td>Plane 1, then slow brush</td>
</tr>
<tr>
<td>3 VIN</td>
<td>Superficial reticular dermis</td>
<td>Mild scar</td>
<td>&quot;Water-logged cotton&quot;</td>
<td>Plane 3, then slow brush</td>
</tr>
<tr>
<td>4</td>
<td>Deep reticular dermis</td>
<td>Scar</td>
<td>&quot;Sand grains&quot;</td>
<td></td>
</tr>
</tbody>
</table>

4. Operative Technique
   a. Requires anesthesia
   b. Ice vulvar skin and drape surrounding area with wet towels
   c. Stain epithelium with 5% acetic acid and mark lesions
   d. Set power density to 600-750 W/cm²; 15-20 W with spot size of 2 mm
   e. Frequently wipe char from area during ablation

5. Post Operative Care
   a. Sitz bath b.i.d. until re-epithelialized
   b. Blow dry on low setting, then apply neomycin-bacitracin ointment
   c. Separate labia b.i.d. to prevent coaptation. Foley if periurethral tissues ablated
   d. For discomfort, moist tea bag compresses b.i.d. after sitz baths
   e. Follow weekly until re-epithelialization complete

6. Treatment Results
   a. Condyloma and VIN: 70-90% success at 2 years

D. Ultrasonic Surgical Aspiration (Rader)
   1. Uses mechanical vibration to cavitate tissue allowing aspiration of the disease
   2. Unlike laser, specimen can be submitted for histology

3. Operative Technique
   a. Stain epithelium with 5% acetic acid and mark lesions
   b. Set power to 5-6 on CUSA and ablate to a depth of 2-2.5 mm

4. Post Operative Care as for laser ablation, although pain less severe

5. Treatment Results: Condyloma and VIN 78% success at 50 weeks

E. General Principles of Electrosurgery
   1. Radio frequency current (350 KHz-3.3 MHz) results in kinetic energy transfer to intracellular ions which vaporizes intracellular water. Avoid Faradic Effect (50 Hz-200 KHz), which stimulates muscle and nerve causing pain by using proper equipment
   2. Cutting: sine-wave RF current; coagulation: pulsed ("spark gap") RF current

F. Loop Electrosurgical Excision Procedure
   1. Technique
      a. Lesion outlined using acetic acid and colposcope
      b. Anesthetize with 1% Lidocaine with epinephrine
      c. Choose loop to excise lesion
      d. Excise tissue in single pass, using 34 - 40 W, blend mode
      e. Cauterize base with ball electrode at 50 W, coagulation mode
      f. Apply Monsel's solution
   2. Advantages
      a. Diagnostic and therapeutic intervention, potentially with one clinic visit
      b. Histologic specimen improves diagnostic accuracy
      c. Equipment less costly than laser
VII. Staging of Invasive Disease.
A. Vulvar cancer staging is surgical. AJCC and FIGO staging systems are identical. This system applies for all tumor types other than melanoma.
B. Staging assessment may require cystoscopy, sigmoidoscopy, and chest X-ray for locally advanced lesions.

<table>
<thead>
<tr>
<th>TNM system (FIGO, Revised 1995)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1: Tumor confined to vulva, $\leq$2 cm in largest diameter.</td>
</tr>
<tr>
<td>T1a Tumor invades $\leq$ 1mm</td>
</tr>
<tr>
<td>T1b Tumor invades $&gt;$ 1mm</td>
</tr>
<tr>
<td>T2: Tumor confined to vulva, $&gt;$2 cm in largest diameter.</td>
</tr>
<tr>
<td>T3: Tumor of any size with spread to urethra, vagina, or anus.</td>
</tr>
<tr>
<td>T4: Tumor of any size infiltrating bladder or rectal mucosa, and/or fixed to bone.</td>
</tr>
<tr>
<td>N0: No lymph node metastases.</td>
</tr>
<tr>
<td>N1: Unilateral regional node metastases.</td>
</tr>
<tr>
<td>N2: Bilateral regional node metastases.</td>
</tr>
<tr>
<td>M0: No clinical metastases.</td>
</tr>
<tr>
<td>M1: Spread to pelvic nodes or distant metastases.</td>
</tr>
</tbody>
</table>

Stage Grouping
Stage I: T1a-b N0 MO
Stage II: T2 N0 MO
Stage III: T3-2-1 N0-1 MO
Stage IVa: T3-2-1 N2 MO; T4 N(any) M0
Stage IVb: T(any) N(any) M1


C. Melanoma staging is separate from the above and is based primarily on lesion thickness.
1. Microstaging systems for melanoma (Breslow, Chung, Clark)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Breslow</th>
<th>Chung</th>
<th>Clark</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>$&lt;0.76$ mm</td>
<td>Intraepithelial</td>
<td>Intraepithelial</td>
</tr>
<tr>
<td>II</td>
<td>0.76-1.5 mm</td>
<td>$\leq$ 1 mm</td>
<td>Into papillary dermis</td>
</tr>
<tr>
<td>III</td>
<td>1.51-2.25 mm</td>
<td>1-2 mm</td>
<td>Filling dermal papillae</td>
</tr>
<tr>
<td>IV</td>
<td>2.26-3.0 mm</td>
<td>$&gt;$ 2 mm</td>
<td>Into reticular dermis</td>
</tr>
<tr>
<td>V</td>
<td>$&gt;3$ mm</td>
<td>Into subcutaneous fat</td>
<td>Into subcutaneous fat</td>
</tr>
</tbody>
</table>

2. American Joint Commission on Cancer (AJCC) TNM system for melanoma, 2001

<table>
<thead>
<tr>
<th>Primary Tumor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tis</td>
</tr>
<tr>
<td>T1a</td>
</tr>
<tr>
<td>T1b</td>
</tr>
<tr>
<td>T2a</td>
</tr>
<tr>
<td>T2b</td>
</tr>
<tr>
<td>T3a</td>
</tr>
<tr>
<td>T3b</td>
</tr>
<tr>
<td>T4a</td>
</tr>
<tr>
<td>T4b</td>
</tr>
</tbody>
</table>
### Regional Lymph Nodes

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N0</td>
<td>No regional node metastasis</td>
</tr>
<tr>
<td>N1a</td>
<td>1 lymph node metastasis, microscopic</td>
</tr>
<tr>
<td>N1b</td>
<td>1 lymph node metastasis, macroscopic</td>
</tr>
<tr>
<td>N2a</td>
<td>2-3 lymph node metastases, microscopic</td>
</tr>
<tr>
<td>N2b</td>
<td>2-3 lymph node metastases, macroscopic</td>
</tr>
<tr>
<td>N3</td>
<td>&gt; 4 lymph node metastases, or matted nodes, or in-transit / satellite metastases</td>
</tr>
</tbody>
</table>

### Distant Metastasis

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0</td>
<td>No distant metastasis</td>
</tr>
<tr>
<td>M1a</td>
<td>Distant skin, subcutaneous or nodal metastasis and normal serum lactate dehydrogenase</td>
</tr>
<tr>
<td>M1b</td>
<td>Lung metastasis and normal serum lactate dehydrogenase</td>
</tr>
<tr>
<td>M1c</td>
<td>All other visceral metastases or any distant metastasis with elevated serum LDH</td>
</tr>
</tbody>
</table>

### Stage Grouping

<table>
<thead>
<tr>
<th>Stage</th>
<th>Clinical</th>
<th>Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td>Tis N0 M0</td>
<td>Tis N0 M0</td>
</tr>
<tr>
<td>Stage IA</td>
<td>T1a N0 M0</td>
<td>T1a N0 M0</td>
</tr>
<tr>
<td>Stage IB</td>
<td>T(1b or 2a) N0 M0</td>
<td>T(1b or 2a) N0 M0</td>
</tr>
<tr>
<td>Stage IIA</td>
<td>T(2b or 3a) N0 M0</td>
<td>T(2b or 3a) N0 M0</td>
</tr>
<tr>
<td>Stage IIB</td>
<td>T(3b or 4a) N0 M0</td>
<td>T(3b or 4a) N0 M0</td>
</tr>
<tr>
<td>Stage IIC</td>
<td>T4b N0 M0</td>
<td>T4b N0 M0</td>
</tr>
<tr>
<td>Stage III</td>
<td>T(any) N1-3 M0</td>
<td>T(1-4a) N(1a or 2a) M0</td>
</tr>
<tr>
<td>Stage IIIA</td>
<td>T(1-4b) N(1a or 2a) M0</td>
<td>T(1-4a) N(1b or 2b) M0</td>
</tr>
<tr>
<td>Stage IIIB</td>
<td>T(1-4a) N(1b or 2b) M0</td>
<td>T(1a or 1b) N2c M0</td>
</tr>
<tr>
<td>Stage IIIC</td>
<td>T(1-4b) N(1b or 2b) M0</td>
<td>T(Any) N3 M0</td>
</tr>
<tr>
<td>Stage IV</td>
<td>T(Any) N(Any) M1</td>
<td>T(Any) N(Any) M1</td>
</tr>
</tbody>
</table>

### VII. Treatment

A. Stage Ia microinvasive squamous carcinoma: Wide local excision without inguinal node dissection

B. Stage I and II squamous carcinoma: Hemivulvectomy with unilateral inguinal lymphadenectomy. Bilateral lymphadenectomy if lesion within 1-2 cm of midline (Moore).

1. Margin adequacy. At UCLA 135 patients were retrospectively assessed for risk of recurrence based on margin of resection. If margin was > 1 cm, 0% recurred locally (0/91) and if margin was < 8 mm, 47% (21/44) developed local recurrence. Of the 23 who did not recur locally, 39% (9/23) developed distant metastases. (Heaps)

2. Depth of resection is the superficial fascia of the urogenital diaphragm

3. If < 2 positive groin nodes: dissect contralateral groin, no adjuvant therapy

4. If ≥ 2 positive nodes, then radiation therapy to pelvis and groin increases survival from 30% to 60% by GOG randomized trial (Homesley).
C. Stage III-IV
   Treatment is individualized according to size and location of the lesion. Options include:
   1. Radical vulvectomy with unilateral or bilateral groin node dissection. For lesions involving anal mucosa or urethra, treatment options are:
   2. Exenteration for locally advanced disease in an individual who has been radiated previously or who is not a candidate for chemoradiation.
   3. Neoadjuvant radiation therapy and chemotherapy with 5-fluorouracil (and optional mitomycin), followed by standard surgical therapy if any residual disease is detected (Burke). 70% chance of local control with chemoradiation alone (Boronow)
D. Lymphadenectomy is both therapeutic and diagnostic. Conventional approach is superficial and deep lymphadenectomy. Superficial node dissection without removal of deep nodes may have an 8% local recurrence rate representing a significant false negative rate.
E. Sentinel node mapping is the standard of care for melanoma cases and is being tested prospectively by the GOG for squamous vulvar carcinoma. Both radiolymphoscintigraphy and blue dye are used to localize the sentinel node. The radiocolloid used is technetium 99 (450 µCi 99Tc) sulfur colloid (filtered to 0.2 µm) is injected intradermally in 4 sites at the periphery of the tumor 2-4 hours pre-op. Gamma scan is performed and sentinel node(s) is marked. Films are brought with the patient to the OR. At beginning of surgical procedure, 8 ml of 1% isosulfan blue dye is injected intradermally at 4 sites around the periphery of the tumor. Incision is made over the sentinel node determined by lymphoscintigraphy and blue dye is located. Hand held gamma probe assists in localization of node(s). Specimen is submitted for frozen section. If negative, no further nodes are removed unless hand held probe identifies a second node(s) with > 10% of the sentinel node activity or > 150% of background activity. If the frozen section is positive, full lymphadenectomy may be warranted depending on the clinical protocol. The specimens are held for 2-6 t1/2 before processing. (Fiorica, Moore, Levenback).

<table>
<thead>
<tr>
<th></th>
<th>Accuracy (Ross, Albertini)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue dye alone</td>
<td>69-89%</td>
</tr>
<tr>
<td>Lymphoscintigraphy</td>
<td>83%</td>
</tr>
<tr>
<td>Both</td>
<td>96-99%</td>
</tr>
</tbody>
</table>

Histologic evaluation of sentinel nodes requires 10-15 serial sections. Immunohistochemistry staining for S-100 and HMB-45 may improve sensitivity and specificity. (Johnson 1998)
F. Special cases
   1. Verrucous and basal cell carcinoma rarely spreads to nodes. Wide local excision or hemivulvectomy is sufficient therapy.
   2. Paget’s Disease is rarely invasive and rarely metastasizes. Wide excision is indicated.
   3. Melanoma
      a. Older approach included radical vulvectomy with lymphadenectomy.
      b. Newer approach is to perform wide local excision (WLE) with sentinel node dissection on selected cases based on lesion thickness. (Johnson 1995-1998, Look, Piura, Rose)
c. Surgical margin guidelines

<table>
<thead>
<tr>
<th>Lesion Thickness</th>
<th>Surgical Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 1 mm</td>
<td>1 cm</td>
</tr>
<tr>
<td>1.1-2.0 mm</td>
<td>1-2 cm (latter preferred)</td>
</tr>
<tr>
<td>2.1-4.0 mm</td>
<td>2 cm</td>
</tr>
<tr>
<td>&gt; 4 mm</td>
<td>3 cm</td>
</tr>
</tbody>
</table>

d. University of Michigan Treatment Guidelines for AJCC Stage I-II Melanoma. (Johnson 1995)

<table>
<thead>
<tr>
<th>Breslow Depth</th>
<th>Margin &amp; Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 0.75 mm</td>
<td>1 cm margin</td>
</tr>
<tr>
<td>0.76-1.49 mm</td>
<td>1-2 cm (1 cm for depth ≤ 1mm)</td>
</tr>
<tr>
<td>1.50-4.0 mm</td>
<td>1-2 cm margin (2 cm for depth &gt; 2 mm)</td>
</tr>
<tr>
<td></td>
<td>Sentinel node dissection</td>
</tr>
<tr>
<td></td>
<td>+/- Adjuvant therapy with Interferon or clinical trial</td>
</tr>
<tr>
<td>&gt; 4.0 mm</td>
<td>3 cm margin</td>
</tr>
<tr>
<td></td>
<td>+/- Adjuvant therapy with Interferon or clinical trial</td>
</tr>
</tbody>
</table>

VIII. Surgical Complications, and Reconstruction

A. Wound breakdown
1. Acute breakdown following radical vulvectomy 50% and following radical hemivulvectomy 14% (Burrell)
2. Use of flaps for closure of large defects increases primary intention rate of healing to 89% (Reid 1997)
3. Chronic defects include 5-25% incidence of rectocoele, cystocoele, and uterine prolapse (Morrow)

B. Infections
1. Vulvar surgery is "Clean Contaminated" by American College of Surgeons classification
2. Risks for postoperative infection (Snyder)
   | Increased risk of post-op infection | Decreased risk of post-op infection |
   | Age > 66 or < 14 years              | Age 15-65 years                    |
   | Lengthy procedure                   | Short procedure                    |
   | Shaving skin pre-op                 | Clipping skin pre-op               |
   | Excessive electrosurgery            | Irrigation                         |
   | Foreign bodies                      | Inert or absorbable suture material|
3. Most common organisms identified: Staphylococcus aureus, Staphylococcus epidermidis, Streptococcus A & B, Enterococcus, Streptococcus viridans, gram negative enterobacteriaceae and mixed anaerobes. (Snyder)
4. Antibiotic prophylaxis to cover likely organisms warranted

C. Lymphocysts (Morrow)
1. Occur following 7-28% of inguinal lymphadenectomy
2. Prevent with closed suction drainage and minimization of resection
3. Treat with frequent aspiration
4. If aspiration unsuccessful, instill absolute ethanol or betadine to sclerose
D. Lymphedema (Morrow)
   1. Occurs following 7-19% of cases.
   2. Treat with elevation and compression.
   3. Diuretics sometimes helpful.
   4. Lymphedema clinic referral for pneumatic compression and massage.
   5. Chronic lymphedema increases risk for life threatening cellulitis and DVT. These problems may be chronic.

E. Incontinence of urine or feces

F. Sexual dysfunction

G. Psychological problems

H. Reconstruction techniques
   1. Split thickness skin graft (Morrow)
      a. Indicated for coverage of superficial resections too wide for primary closure and with preservation of subcutaneous fat pad. Typical case is resection for dysplasia, or Paget’s disease.
      b. Dermatome used to harvest epithelium (0.016-0.018 inch thick) from anterior thigh or superior border of buttocks. Graft may need to be meshed to increase coverage. Non-meshed grafts require drainage incisions.
      c. Graft is sutured in place, Foley and rectal tubes are placed and a bolus (pressure dressing) is applied for 5 days
   2. Cutaneous flaps for closure of small to intermediate sized defects
      a. Rhomboid (Gallup Figs. 15-6, 15-8, 15-9).
         i. Indicated for closure of intermediate size defects, particularly on perineal body and posterior perineum.
         ii. Measure flap length to equal size of defect. Undermine surrounding skin to allow mobility of the flap. Close with modified mattress suture, keeping knots away from the flap side of the incision.
         iii. Apply pressure dressing for 24 hours and keep patient at bedrest for 5 days. Delay defecation for 2-3 days for posterior flaps.
      b. Lateral transposition (Knapstein Fig. 13)
         i. Indicated for closure of intermediate size defects, particularly on perineal body and posterior perineum.
         ii. Measure flap length to equal size of defect. Flap length to width ratio should be 2 or less. Undermine surrounding skin to allow mobility of the flap.
   3. Myocutaneous flaps for closure of large defects or defects in a previously radiated field
      a. Gracilis (Knapstein, Morrow Figs. 8-29, 8-31, Reynolds Figs. 5B, 5C).
         i. Muscle origin is the anterior portion of the inferior pubic arch and insertion is to the medial tibial condyle. Blood supply is the medial femoral circumflex artery, entering the muscle 8-10 cm inferior to the pubic tubercle between the adductor longus and adductor magnus muscles. The saphenous vein is preserved anterior to the flap.
         ii. The flap design can be either an island or rotational flap. During dissection the skin should be sutured to the muscle and tissue handling should be gentle.
         iii. The flap is carefully rotated posteriorly and is sutured in place with closed suction drains in place.
      b. Tensor fascia lata (Knapstein, Hacker Fig. 10-13)
         i. Muscle origin is the anterior superior iliac spine and insertion is the fibrous portion of the fascia lata. Blood supply is the lateral femoral circumflex artery.
ii. The flap design is a rotational flap. During dissection the blood supply should be carefully preserved and tissue handling should be gentle. The flap can be up to 6 x 30 cm in size.

c. Gluteus maximus (Knapstein, Hacker Fig. 10-14)
   i. The muscle origin is the dorsal pubic ramus, posterior sacrum and sacrotuberal ligament. Insertion is the posterior upper femur and fascia lata. Blood supply is the inferior gluteal artery.
   ii. The flap design can be either an island or rotational flap. The muscle is partially transected to the posterior skin incision to allow rotation. The flap can be up to 8 x 20 cm in size.

d. Rectus abdominis (Knapstein, Morrow, Figs. 8-21, 8-23)
   i. Indicated for closure of large vulvar defects only if the bladder or rectum has also been removed as in the case of an exenteration.
   ii. Muscle origin is the symphysis pubis and insertion is the thorax into the fascia of the intercostal muscles and cartilage of the rib cage. Blood supply for pelvic flaps is the inferior epigastric artery.
   iii. The flap design is an island flap.

IX. Prognostic Factors and Survival

A. Incidence of node metastases in squamous carcinoma of vulva

<table>
<thead>
<tr>
<th>By lesion diameter (cm)</th>
<th>By depth (mm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤1</td>
<td>≤1</td>
</tr>
<tr>
<td>1-2</td>
<td>1.1-2</td>
</tr>
<tr>
<td>2-4</td>
<td>≥8</td>
</tr>
<tr>
<td>&gt;4</td>
<td>≥25</td>
</tr>
<tr>
<td></td>
<td>≥37</td>
</tr>
</tbody>
</table>

Pelvic nodes positive 5% overall, but 44% if ≥ 3 positive groin nodes

B. Survival for Squamous Cancers

<table>
<thead>
<tr>
<th>Stage</th>
<th>5 yr Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>91.1%</td>
</tr>
<tr>
<td>I (negative nodes)</td>
<td>95.0%</td>
</tr>
<tr>
<td>II</td>
<td>80.9%</td>
</tr>
<tr>
<td>III</td>
<td>48.4%</td>
</tr>
<tr>
<td>IV</td>
<td>15.3%</td>
</tr>
</tbody>
</table>

If nodes positive but ≤2 on one side, survival 75%. If nodes positive but >2, or any number bilateral, survival 25%

C. Survival for Malignant Melanoma

<table>
<thead>
<tr>
<th>Breslow's Depth</th>
<th>5 yr Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;0.76 mm</td>
<td>100%</td>
</tr>
<tr>
<td>0.76-1.5 mm</td>
<td>89%</td>
</tr>
<tr>
<td>1.51-3.0 mm</td>
<td>72%</td>
</tr>
<tr>
<td>&gt;3.0 mm</td>
<td>22%</td>
</tr>
</tbody>
</table>

References
Brand E, Fu YS, Lagasse LD, Berek JS. Vulvovaginal melanoma: report of seven cases and literature review. Gynecol Oncol 1989; 33: 54
Hoffman MS, LaPolla JP, Roberts WS, Fiorica JV, Cavanagh D. Use of local flaps for primary anal reconstruction following perianal resection for neoplasia. Gynecol Oncol 1990; 36: 348
Iverson T, Aas M. Lymph drainage from the vulva. Gynecol Oncol 1983; 16: 179


Mayer AR, Rodriguez RL. Vulvar reconstruction using a pedicle flap based on the superficial external pudendal artery. Obstet Gynecol 1991; 78: 964


NIH Consensus Development Panel on early melanoma. Diagnosis and treatment. JAMA 1992; 268: 1314

North JH, Spellman JE. Role of sentinel node biopsy in the management of malignant melanoma. Oncology 1996; 10: 1237


Reid GC. Surgical aspects of vulvar melanoma. Operative Techniques in Gynecologic Surgery. 1998; 3: 262
Reid R. Local and distant skin flaps in the reconstruction of vulvar deformities. Am J Obstet Gynecol 1997; 177: 1372
Reynolds RK. Pelvic exenteration for treatment of locally advanced primary or recurrent vulvar carcinoma. Operative Techniques in Gynecologic Surgery. 1998; 3: 268
Ross MI. Surgical management of stage I and II melanoma patients: approach to the regional lymph node basin. Semin Surg Oncol 1996; 12: 394

Rev. 12/2006
Nutrition, Fluids and Electrolytes

I. Types of Malnutrition

<table>
<thead>
<tr>
<th>Protein Stores</th>
<th>Adipose Stores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kwashiorkor</td>
<td>Loss</td>
</tr>
<tr>
<td>Marasmus</td>
<td>Stable</td>
</tr>
<tr>
<td>Cachexia</td>
<td>Loss</td>
</tr>
</tbody>
</table>

II. Risk Factors for Malnutrition

A. Body weight ≤20% below ideal
   (Ideal = 100 lbs for 60" height + 5 lbs for each additional inch)

B. Recent weight loss ≥10% of usual weight
C. Alcohol abuse
D. Chronic diseases or cancer
E. NPO for ≥7 days with only IV hydration
F. Increased nutritional needs: burns, trauma, surgery, fever, sepsis, wounds, pregnancy
G. Nutritional losses: malabsorption, short bowel syndrome, dialysis, effusions, chronic bleeding or diarrhea
H. Catabolic drugs: steroids, immunosuppressants, chemotherapy agents
I. Protracted emesis

III. Nutritional Assessment

A. Anthropomorphic Measurement. e.g. triceps skin fold thickness.
B. Protein Store Assessment

<table>
<thead>
<tr>
<th>Normal</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss, 1 month, %</td>
<td>-</td>
<td>3 - 4</td>
<td>5</td>
</tr>
<tr>
<td>3 months, %</td>
<td>-</td>
<td>6 - 7</td>
<td>7.5</td>
</tr>
<tr>
<td>6 months, %</td>
<td>-</td>
<td>8 - 9.5</td>
<td>10</td>
</tr>
<tr>
<td>Transferrin, mg/dL</td>
<td>200 - 350</td>
<td>180 - 200</td>
<td>160 - 180</td>
</tr>
<tr>
<td>Albumin, mg/dL</td>
<td>≥ 3.5</td>
<td>3 - 3.5</td>
<td>2.5 - 3</td>
</tr>
<tr>
<td>Pre-albumin, mg/dL</td>
<td>&gt; 13</td>
<td>10 - 13</td>
<td>6.5 - 10</td>
</tr>
<tr>
<td>Tot Lymphocyte Count</td>
<td>&gt; 1800</td>
<td>1500 - 1800</td>
<td>900 - 1500</td>
</tr>
<tr>
<td>Skin test antigens, mm</td>
<td>&gt; 15</td>
<td>10 - 15</td>
<td>5 - 10</td>
</tr>
</tbody>
</table>

C. Nitrogen Balance Estimate. Not accurate with fistulas, diarrhea, burns, dialysis

\[ N\ Bal = [(P I / 6.25) - (UUN + 3)] \]

Where UUN=24 hour urine urea nitrogen in grams, PI=24 hour protein intake in grams

IV. Estimation of Nutritional Requirements

A. Caloric Intake
   1. Harris-Benedict Basal Energy Expenditure (BEE) equation:

   \[ BEE(kcal) = 655 + 9.6(wt, kg) + 1.7(ht, cm) - 4.7(age, yr) \]

<table>
<thead>
<tr>
<th>Coefficient of Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed rest</td>
</tr>
<tr>
<td>Ambulatory</td>
</tr>
<tr>
<td>Sepsis</td>
</tr>
<tr>
<td>Anabolic/Burns</td>
</tr>
</tbody>
</table>

Increase BEE 12% for each degree of fever >37° C.
2. Respiratory Energy Expenditure (REE). Using measured O₂ consumption or difference in arterial and venous O₂ saturation. Accuracy ±15%.

\[ \text{REE} = (\text{VO}_2) \times (5 \text{ kcal/L}) \times (60 \text{ min/hour}) \times (24 \text{ hours/day}) \]

where: \( \text{VO}_2 = \frac{(aO_2-vO_2)}{CO} \)

and \( \text{VO}_2 = \text{O}_2 \) consumption in L/min; \( aO_2-vO_2 = \) difference in a-vO₂ content = \( (Hb) \times (O_2 \text{ sat}) \times (1.36) \);

\( \text{CO} = \) cardiac output in L/min

3. Respiratory Quotient: ratio of CO₂ produced for oxygen consumed \( \text{RQ} = \frac{VCO_2}{VO_2} \)

<table>
<thead>
<tr>
<th>Fat</th>
<th>0.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protein</td>
<td>0.8</td>
</tr>
<tr>
<td>Carbohydrate</td>
<td>1.0</td>
</tr>
</tbody>
</table>

B. Protein Requirement (usually 10-20% total caloric intake) \( 4 \text{Kcal/g} \) Take into account the patient’s renal function, hepatic function and nutritional status (see section III)

| Maintenance | 0.8 - 1 g/kg-day |
| Repletion   | 1.3 - 1.5 g/kg-day |

Use Adjusted Ideal Body Weight = \( [(\text{Actual BW} – \text{IBW}) \times 25\%] + \text{IBW} \)

C. Carbohydrate Requirements: usually 50-60% of total caloric intake. \( 3.4 \text{ Kcal/g} \). Keep infusion less than 4 mg/kg-min in stressed individuals (surgery, trauma, burns, steroids)

D. Lipid Requirements: Usually 20-30% of total calories. Should not exceed 60% of total. \( 9 \text{ Kcal/g} \). Lower respiratory quotient than CHO helpful with borderline respiratory failure). Emulsion is isotonic. Essential fatty acids are linoleic and linolenic acids: absolute requirements for essential fatty acids is 3-5% of total caloric intake.

E. Fluid Requirements. Add 10% for fever >38° C.

| Wt ≤10 kg | 100 mL/kg-day |
| 10 kg <Wt ≤20 kg | (+)50 mL/kg-day |
| Wt >20 kg | (+)20 mL/kg-day |

F. Electrolytes, Recommended Daily Supplements. Combined Calcium and phosphorous must be < 30mEq / L

<table>
<thead>
<tr>
<th>Na⁺</th>
<th>60-150 mEq</th>
<th>Cl⁻</th>
<th>60-150 mEq</th>
</tr>
</thead>
<tbody>
<tr>
<td>K⁺</td>
<td>60-120 mEq</td>
<td>PO₄²⁻</td>
<td>20-40 mM</td>
</tr>
<tr>
<td>Mg²⁺</td>
<td>8-24 mEq</td>
<td>Ca²⁺</td>
<td>10-15 mEq</td>
</tr>
</tbody>
</table>

G. Vitamins, AMA daily therapeutic recommendations, and metabolic function

| A (fat soluble) | 3300 IU | Vision (rhodopsin), growth, reproduction |
| D (fat soluble) | 200 IU  | Calcium and phosphorous homeostasis |
| E (fat soluble) | 10 IU   | Antioxidant |
| K (fat soluble) | 150 mcg | Synthesis of blood clotting factors II, VII, IX, X |
| B₁ Thiamine    | 6 mg    | Coenzyme: oxidative decarboxylation, transketolase |
| B₂ Riboflavin  | 3.6 mg  | Coenzyme: electron transport |
| B₃ Niacinamide | 40 mg   | Component of NAD, NADP: red-ox reactions |
| B₅ Dexpanthenol | 15 mg  | Part of coenzyme A: acyl transfers, essential for energy production from protein, fat, carbohydrates |
| B₆ Pyridoxine  | 4 mg    | Coenzyme in amino acid metabolism. Essential for neurotransmitter & heme synthesis |
| B₁₂ Cyanocobalamin | 5 mcg | Coenzyme for DNA synthesis, conversion of homocysteine to methionine, general metabolism |
| Biotin         | 60 mcg  | Cofactor for carboxylation for protein, carbohydrate, fatty acid and nucleic acid metabolism |
| C Ascorbic Acid | 100 mg  | Antioxidant, hydroxylating cofactor, regulation of intracellular oxidation-reduction, role in synthesis of neurotransmitters, collagen, and vasoactive amines |
| Folic Acid     | 400 mcg | Transport of single carbon units, nucleic acid synthesis, metabolism of amino acids |
H. Trace Elements
1. Replace if deficient or on parenteral alimentation
2. Metabolic function

<table>
<thead>
<tr>
<th>Trace Element</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zinc</td>
<td>Metabolism of protein, carbohydrates, lipids, nucleic acids</td>
</tr>
<tr>
<td>Copper</td>
<td>Cofactor for oxidative enzymes, collagen synthesis, iron interactions</td>
</tr>
<tr>
<td>Manganese</td>
<td>Mucopolysaccharide metabolism, oxidative phosphorylation</td>
</tr>
<tr>
<td>Chromium</td>
<td>Potentiation of insulin effects via glucose tolerance factor</td>
</tr>
<tr>
<td>Selenium</td>
<td>Cofactor for glutathione peroxidase</td>
</tr>
</tbody>
</table>

Also: Iron, Molybdenum, Iodine, Fluoride

Patients with high output fistulas are usually deficient in zinc and copper.

I. Nutrient deficiency syndromes

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1</td>
<td>Beriberi (Wernicke's encephalophathy), paresthesia, cardiac failure, cerebellar signs, anorexia, weakness</td>
</tr>
<tr>
<td>B2</td>
<td>Sore lips and tongue, stomatitis, desquamation, anemia</td>
</tr>
<tr>
<td>B6</td>
<td>Seborrhea facies, cheilosis, glossitis, anemia, peripheral neuritis</td>
</tr>
<tr>
<td>B12</td>
<td>Weakness, fatigue, sore tongue, paresthesia, anorexia, diarrhea, alopecia, depression, pernicious anemia</td>
</tr>
<tr>
<td>Biotin</td>
<td>Alopecia, dermatitis</td>
</tr>
<tr>
<td>Folic acid</td>
<td>Fatigue, sore tongue, anemia, stomatitis, nausea</td>
</tr>
<tr>
<td>Niacin</td>
<td>Dermatitis, painful tongue, stomatitis, diarrhea, headache, pellagra (neuropsychiatric symptoms)</td>
</tr>
<tr>
<td>Dexpanthenol</td>
<td>Fatigue, paresthesia, weakness, burning feet</td>
</tr>
<tr>
<td>C</td>
<td>Weakness, irritability, gingivitis, joint pain, loose teeth, easy bleeding, scurvy, heart failure, poor wound healing</td>
</tr>
<tr>
<td>A</td>
<td>Night blindness</td>
</tr>
<tr>
<td>D</td>
<td>Tetany, muscle weakness, rickets, osteopenia</td>
</tr>
<tr>
<td>E</td>
<td>Areflexia, gait disturbance, paresis of gaze, hemolytic anemia</td>
</tr>
<tr>
<td>K</td>
<td>Bruising or bleeding</td>
</tr>
<tr>
<td>Iron</td>
<td>Anemia, stomatitis</td>
</tr>
<tr>
<td>Manganese</td>
<td>Ataxia, retarded skeletal growth, decreased reproductive function</td>
</tr>
<tr>
<td>Chromium</td>
<td>Neuropathy, ↑ free fatty acids, insulin resistant glucose intolerance</td>
</tr>
<tr>
<td>Copper</td>
<td>Neutropenia, anemia, diarrhea, scurvy symptoms</td>
</tr>
<tr>
<td>Zinc</td>
<td>Facial and extremity rash, skin ulcers, alopecia, confusion, apathy, hypogonadism, night blindness</td>
</tr>
<tr>
<td>Selenium</td>
<td>Muscle weakness, cardiac failure</td>
</tr>
<tr>
<td>Fatty acids</td>
<td>Scaling dermatitis, coarse hair, alopecia, diarrhea, numbness, paresthesia, weakness, blurred vision, poor wound healing</td>
</tr>
</tbody>
</table>

J. Sites of nutrient absorption
1. Stomach: intrinsic factor secretion
2. Duodenum: vitamins A & B, iron, calcium, glycerol and fatty acids, monoglycerides, amino acids, mono and disaccharides
3. Jejunum:
   a. Entire: glucose, galactose, vitamin C, amino acids, glycerol and fatty acids, monoglycerides, folic acid, biotin, copper, zinc, potassium, pantothenic acid
   b. Proximal: vitamins A & B, folic acid, iron, lactose
   c. Distal: isomaltase, maltose, trehalose, sucrose
5. Ileum:
   a. Entire: chloride, sodium
   b. Proximal: isomaltase, maltose, trehalose, sucrose
   c. Distal: B₁₂ and intrinsic factor
5. Colon: water, synthesis of biotin

V. Hyperalimentation
A. Parenteral
1. Indications: pre-op and post-op support where malnutrition exists, or patient anticipated to be NPO>5-7 days, or patient with protracted emesis. Enteral feeding preferred if GI tract is functional
2. Access: must be infused through a large caliber, high flow vein
3. Formulations (in most hospitals): standard, peripheral, and custom ordered.

<table>
<thead>
<tr>
<th>University of Michigan Standard Formulation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amino Acids (5%)</td>
</tr>
<tr>
<td>Dextrose (20%)</td>
</tr>
<tr>
<td>Ca²⁺</td>
</tr>
<tr>
<td>Mg²⁺</td>
</tr>
<tr>
<td>K⁺</td>
</tr>
<tr>
<td>Na⁺</td>
</tr>
<tr>
<td>Acetate</td>
</tr>
<tr>
<td>Cl⁻</td>
</tr>
<tr>
<td>PO₄²⁻</td>
</tr>
<tr>
<td>Heparin</td>
</tr>
<tr>
<td>Multivitamins</td>
</tr>
<tr>
<td>Trace Elements</td>
</tr>
<tr>
<td>Vitamin K</td>
</tr>
</tbody>
</table>

4. Lipids: Liposyn 20%, contains soybean and safflower oil, egg phospholipids, and glycerin in 500 mL bottles. Must not pass through IV line filter. Provides 2 Kcal/mL at 260 mOsm/L. Minimum essential fatty acid requirements met with two 300 mL bottles of Liposyn weekly.

5. Initiation of Total Parenteral Nutrition (TPN). Begin infusion at 40 mL/hour and taper up to calculated full infusion rate. Tapering of TPN must be done in a similar fashion to prevent hypoglycemia. Rule out hypoglycemia 1 hour after stopping

6. Recommended lab monitoring for TPN

<table>
<thead>
<tr>
<th>Test</th>
<th>Initial</th>
<th>During Taper-Up</th>
<th>Stable TPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose, finger stick</td>
<td>x</td>
<td>q6h</td>
<td>2x weekly</td>
</tr>
<tr>
<td>CBC, Plts, Diff</td>
<td>x</td>
<td>weekly</td>
<td></td>
</tr>
<tr>
<td>Electrolytes</td>
<td>x</td>
<td>daily</td>
<td>2x weekly</td>
</tr>
<tr>
<td>BUN, Creatinine</td>
<td>x</td>
<td>2x weekly</td>
<td></td>
</tr>
<tr>
<td>Ca²⁺,PO₄²⁻</td>
<td>x</td>
<td>daily</td>
<td>2x weekly</td>
</tr>
<tr>
<td>Liver enzymes</td>
<td>x</td>
<td>2x weekly</td>
<td></td>
</tr>
<tr>
<td>Bilirubin</td>
<td>x</td>
<td>weekly</td>
<td></td>
</tr>
<tr>
<td>Triglycerides</td>
<td>x</td>
<td>prn</td>
<td></td>
</tr>
<tr>
<td>Mg²⁺</td>
<td>x</td>
<td>daily</td>
<td>weekly</td>
</tr>
<tr>
<td>PT, PTT</td>
<td>x</td>
<td>prn</td>
<td></td>
</tr>
<tr>
<td>Albumin, Prealbumin</td>
<td>x</td>
<td>weekly</td>
<td></td>
</tr>
</tbody>
</table>

7. TPN can be cycled in home administration setting to improve quality of life.
8. Complications of TPN
   a. IV access: pneumothorax, hemothorax, infection, nerve injury, air embolism
   b. Metabolic
      i. Hyperglycemia/hypoglycemia, affected by infusion rates, stress, infection
      ii. Hypophosphatemia: "Refeeding Syndrome" results in respiratory failure, cardiomyopathy. Requires slow advancement of TPN, careful monitoring of \( \text{PO}_4^{2-} \), \( \text{Mg}^{2+} \), and \( \text{K}^+ \)
      iii. Hypertriglyceridemia, associated with lipid and carbohydrate infusion
      iv. Vitamin/Trace Element deficiencies
      v. Hypercapnea: \( \text{CO}_2 \) production associated with carbohydrate infusion in excess of patient needs
   c. Hepatobiliary complications
      i. Cholestasis: most common hepatotoxicity. Associated with long term TPN, lack of gut stimulation, recurrent sepsis, short bowel syndrome,
      ii. Overfeeding
   d. Electrolyte disturbances

B. Enteral
1. Indications: nutrition for patients with functional GI tract
2. Access: Dobhoff feeding tubes are more suitable than Salem sump NG tubes. Metoclopramide and/or fluoroscopy aids in tube placement
3. Formulations
   a. Nutritionally complete, lactose free, 1 kcal/mL. Standard protein (<20% kcal as protein): (This list is not comprehensive and formulations change frequently.) Oral: Boost, Carnation Instant Breakfast, Ensure
      Tube Feeding: Isocal, Osmolite HN, Vivonex.
      Fiber containing: Jevity, Enrich
      Low fat, oligomeric: Criticare HN
      High Protein (>20% kcal as protein): Isotelin HN
   b. Specialized formulas: Travasorb Renal, Amin-Aid, Pulmocare
4. Initiation
   a. Start with half strength formula at 40-60 mL/h. Advance rate by 60-100 mL/h every 12-24 hours. When planned infusion rate reached, advance concentration to 3/4 strength formula for 24 hours, then to full strength
   b. If gastric residual is >100 mL, hold feeding for 2 hours, then remeasure
   c. Dobhoff tubes should be irrigated after each bolus feeding, or q6h if on continuous infusion
   d. Head should be elevated ≥30° during feeding to prevent aspiration
5. Monitoring

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Weights</td>
<td>daily</td>
</tr>
<tr>
<td>Accurate I&amp;O's</td>
<td>q8h</td>
</tr>
<tr>
<td>Confirmation of correct tube placement</td>
<td>every feeding</td>
</tr>
<tr>
<td>Glucose, finger stick</td>
<td>q8h, 2x weekly when stable</td>
</tr>
<tr>
<td>Electrolytes, hepatic enzymes, BUN, creatinine</td>
<td>prn</td>
</tr>
</tbody>
</table>

6. Complications: diarrhea, nausea/vomiting, constipation, dehydration, aspiration, electrolyte disturbance, lactose intolerance

References
12/18/2006
Radiation Therapy

I. Ionizing radiation: >10 eV, the binding energy of electrons. UV light does not ionize.

II. Energy, \( E=\hbar \nu \); where \( \hbar \) is Planck's constant, \( \nu \) = frequency. Energy attenuates proportional to the inverse square of the distance from the source.

III. Absorption=energy loss.
   A. Types of energy absorption
      1. Photoelectric Effect: energy absorbed by inner shell electrons. Absorption proportional to cube of atomic number, a useful property for diagnostic X-rays. Energy range: 10-100 keV
      2. Compton Effect: portion of energy absorbed by outer shell electron. Residual energy transmitted. Energy range: 100 keV-3 MeV
      3. Pair Production: photon (\( E > 1.02 \text{ MeV} \)) interacts with nucleus to produce electron + positron pair
   B. Linear Energy Transfer (LET): energy absorption over distance, a function of particle charge squared, particle velocity squared, and electron density of the target. \( -\frac{dE}{dx} = Z^2 \rho / \nu^2 \), where \( x \) = distance, \( Z \) = charge, \( \rho \) = electron density, \( \nu \) = velocity
   C. Absorbed Dose. Current unit: \( \text{Gray} = (\text{Joules/kg}) \); Old unit: rad = (100 ergs/g); 1 Gy = 100 rads.

D. Isodose Curves

IV. Biological Effect of Radiation
   A. Cells are most radio-resistant in S and early G2 phases of cell cycle. Radiation causes delay of cell cycle by blocking progression from G1 \( \rightarrow \) S and G2 \( \rightarrow \) M.
   B. \( h\nu \) causes direct base damage and strand breaks. Oxygen free radicals indirectly cause DNA damage and formation requires presence of \( O_2 \)
   C. Cell Survival
      1. Three theoretical models
         a. Single hit kinetics: \( N = N_0 \exp(-D/D_0) \), \( N \) = surviving cell number, \( D \) = radiation dose.
            High LET \( h\nu \) kills cells with single hit kinetics
         b. Multiple hit kinetics: \( N = N_0 \{1-\exp(-D/D_0)^n\} \), \( n \) = number of targets per cell
         c. Linear quadratic kinetics: \( N = N_0 \exp(-\alpha D - \beta D^2) \), \( \alpha \) and \( \beta \) describe probability of interacting lesions caused by single and double tracks, respectively. Low LET \( h\nu \) (i.e. therapeutic megavoltage radiation therapy) effects best approximated by linear quadratic model
      2. DNA repair mechanisms: endonuclease, exonuclease, DNA polymerase, DNA ligase, and photolyase enzymes. The more time a cell has before entering S phase, the more likely it is that successful repair will occur. 4-6h after radiation is sufficient for sub lethal damage repairs
3. Survival Curve (Low LET $h$)

$D_0 =$ dose defined by slope of log-linear region. Represents dose to reduce survival:
$N \to 0.37N$

$D_q =$ indication of capacity of cells to repair damaged DNA. Varies by cell type.
$D_q = 0$ Gy for marrow
$D_q = 3$ Gy for skin

4. Oxygen Enhancement Ratio: oxygenated cells are about 3x more sensitive to radiation than hypoxic cells. Hypoxia slows cell cycle, which increases time for repair, and hypoxia inhibits fixation of damage to DNA caused by free radicals

5. Principles of Fractionation (the "4 R's"): Repair, Repopulation, Redistribution, Reoxygenation

V. Radiation Sources

A. Types of radiation
1. Gamma rays ($\gamma$): arise naturally in atomic nucleus, no mass, no charge
2. X-rays: manufactured by electron beam striking tungsten target, no mass or charge
3. Beta particles ($\beta$): free electrons, negative charge, small mass
4. Alpha particles ($\alpha$): Helium nucleus, positive charge, large mass

B. Useful Isotopes

<table>
<thead>
<tr>
<th>Isotope</th>
<th>Energy (MeV)</th>
<th>Half Life</th>
<th>RCM</th>
</tr>
</thead>
<tbody>
<tr>
<td>$^{60}$Co</td>
<td>$\gamma$ 1.17, 1.32</td>
<td>5.26y</td>
<td>13.1</td>
</tr>
<tr>
<td>$^{198}$Au</td>
<td>$\gamma$ 0.41-1.1</td>
<td>2.7d</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td>$\beta$ 0.96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$^{192}$Ir</td>
<td>$\gamma$ 0.32-0.61</td>
<td>74d</td>
<td>4.7</td>
</tr>
<tr>
<td>$^{226}$Ra</td>
<td>$\gamma$ 0.83 ave</td>
<td>1620y</td>
<td>8.25</td>
</tr>
<tr>
<td>$^{137}$Cs</td>
<td>$\gamma$ 0.662</td>
<td>30y</td>
<td>3.3</td>
</tr>
<tr>
<td>$^{32}$P</td>
<td>$\beta$ 1.7, 0.698 ave</td>
<td>14.3d</td>
<td></td>
</tr>
</tbody>
</table>

RCM = roentgen/milliCurie/hour (dose rate).
Beta particles from $^{32}$P penetrate 5-8 mm; those from $^{198}$Au penetrate 3 mm

VI. Gynecologic Applications

A. Cervix: Indicated for primary treatment of Stage I, II, III, and IVa disease. Also indicated for localized recurrences, and emergent control of bleeding. Treatment technique:
1. External Beam: 4-field technique to pelvis using megavoltage photons. Dose: 45-50 Gy ± midline block. Fraction size: 180-200 cGy / day
2. Implants
   a. Low dose rate (LDR) brachytherapy technique: Fletcher Suite applicator with $^{137}$Cs sources. Two implants, spaced 1-2 weeks apart near conclusion of teletherapy, and removed after 24-48h. Dose rate: 50 cGy / hour to Point A.
b. High dose rate (HDR) brachytherapy technique: Teflon sleeve sutured into cervix. Five weekly implants provide about 1000 cGy in outpatient setting
c. Desired total dose to Point A=75-85 Gy, and to Point B=55-60 Gy. Bladder and rectal doses ≤ 65, 70 Gy, respectively

3. Chemosensitization administered concurrently with radiation using cisplatin, 5-fluorouracil, or both. Supported by 5 randomized clinical trials (see cervical cancer chapter)

B. Endometrium
1. Adjuvant for Stage I disease
   a. Pre-op: Out of favor
   b. Post-op: Benefit of adjuvant therapy after surgical staging with negative nodes not yet demonstrated (See endometrial cancer chapter). Technique: external beam, 4-fields to pelvis using megavoltage photons. Dose: 45-50 Gy, followed by optional vaginal brachytherapy if vaginal apex recurrence risk is significant. In some settings (lower uterine segment disease or stage II A), vaginal brachytherapy alone may be adequate
2. Primary therapy for medically inoperable patients with Stage I – II disease
3. Advanced or recurrent disease: Pre-op therapy indicated for clinical Stage II lesions, followed by TAH/BSO. Localized recurrences amenable to radiotherapy for local control

C. Ovary
1. Whole Abdomen Radiation Therapy (WART). Historically reported for Stage IC- II-IIIA epithelial tumors successfully debulked to minimal residual disease (≤5 mm) as either primary or salvage therapy, as well as for Stage I-II-III dysgerminoma. Technique: open field AP-PA, to dose of 30 Gy with blocks to liver (22 Gy) and kidney (18 Gy). Fraction size of 100-150 cGy/d (Dembo)
2. Intraperitoneal ³²P. Historically reported for Stage Ib-Ic epithelial tumors with no residual disease and no significant adhesions. Dose 15 mCi

D. Vulva
1. Post-operative therapy: Indicated for >1 positive inguinofemoral node, any positive pelvic nodes, and for residual disease of the vulva. Treatment ports customized, electrons commonly used for vulva/groins to maximize surface dose
2. Pre-operative therapy: Indicated for bulky T3-4 lesions to reduce tumor size, allowing less radical surgery. Concurrent chemotherapy using 5-fluorouracil, cisplatin, and/or mitomycin C improves likelihood of remission
3. Primary treatment: High failure rate if RT utilized without resection of primary site. Radiation of verrucous carcinoma contraindicated

E. Radiosensitizers: 5-fluorouracil and cisplatin used most often for radiosensitization outside of clinical trials

VII. Clinical Complications (Reynolds):
A. Acute: diarrhea, nausea, vomiting, myelosuppression, ovarian failure, skin burns
B. Chronic: radiation enteritis, vaginal stenosis, bowel obstruction, GI/GU fistulas, ureteral strictures, hepatic and renal injury, radiation carcinogenesis (after 10-20 years).

VIII. Common Questions
A. What is the relationship of anemia to cervical cancer treatment? A: Tumor hypoxia decreases efficacy of radiation by reducing oxygen free radical mediated cell damage.
B. What is the difference when using electrons instead of photons for treatment? A: Electrons have mass and charge causing them to slow when they encounter tissue. This results in clinically useful control of treatment depth
C. What is Point A? A: A point 2 cm above and 2 cm lateral to the tandem flange (external os) and represents the crossover point of the uterine artery over the ureter. Point B is 3 cm lateral to Point A and represents the location of the obturator nodes.

References
Chemotherapy

I. Cancer Cell Kinetics
   A. Cell cycle:

   1. Static: (e.g. muscle, nerve) well differentiated, rarely undergo mitosis in adults
   2. Expanding: (e.g. liver) proliferate in response to stress or injury
   These 2 population types are resistant to chemo as are G0 cells
   3. Renewing: (e.g. marrow, GI mucosa) constant proliferation. Renewing cells are sensitive to chemotherapy.
   4. Tumor growth rate is a function of cell cycle time, growth fraction, and death rate.
   5. Cancer cells do not divide more rapidly than normal cells.
   B. Gompertzian growth: as tumor mass increases, growth fraction decreases and doubling time increases. Doubling times usually range between 20-150 days
   C. Mechanisms of resistance
      1. Goldie-Coldman hypothesis: a mathematical model predicting the likelihood of somatic mutations capable of leading to drug resistance. Spontaneous mutations occur every 10,000 to 1,000,000 cell divisions. Hypothesis correctly predicts that multi-drug regimens minimize likelihood of developing resistant clones
      2. Mechanisms of resistance may include: defective drug transport into the cell, altered drug activation, reduced hormone receptor number or affinity, enhanced DNA repair, gene amplification, altered target proteins, and increased drug metabolism.
      3. Multi-drug resistance gene (MDR-1): codes for P-glycoprotein P-170, an energy dependent efflux pump that reduces intracellular drug levels. Once induced, cross resistance to multiple unrelated drugs occurs (e.g. vinca alkaloids, dactinomycin, doxorubicin, and paclitaxel)
      4. Sulphydryl mechanisms (glutathione, metallothionein, and glutathione S-transferase): involved in conjugation of toxic molecules, and inactivation of free radicals and peroxides. (e.g. cisplatin and radiation therapy). Future medications may block this mechanism

II. Pharmacokinetics
   A. Log kill hypothesis (Skipper): chemotherapy drugs act via first order kinetics, whereby a constant fraction of cells are killed with each treatment
   B. Therapeutic index (TI): ratio of therapeutic dose to toxic dose of a drug. Reflects differential sensitivity of normal and neoplastic cells to chemotherapy drugs. Chemotherapy drugs typically have low TI
   C. Dose Intensity (DI): DI=Drug, mg/m²/week. Especially important for cure of germ cell tumors.
   D. Cell cycle specificity, schedule dependency, drug distribution, drug metabolism and excretion, and drug interactions are all important in designing a treatment protocol

III. Drug Development
   A. Phases of drug development
      1. Phase I: determination of maximum tolerable dose, optimal schedule and dose limiting toxicity of a new drug
      2. Phase II: testing for responses of various tumors to a new drug
      3. Phase III: randomized study comparing efficacy of different treatment regimens
B. Evaluation of responses: standardized nomenclature
   1. Complete Response (CR): complete disappearance of all measurable and evaluable
disease. No new lesions
   2. Partial Response (PR): ≥50% decrease in the sum of the products of lesion
diameters. No progression of evaluable disease or new lesions
   3. Stable Disease
   4. Progression: ≥25% increase in the sum of products of measurable lesions, clear
worsening of any evaluable disease, or appearance of any new lesion

IV. Cytotoxic chemotherapy Drugs (Note: doses may vary widely from protocol to protocol.
Doses listed below are for general information only)

**Altretamine (Hexalen).** Class: miscellaneous alkylator
   Use: epithelial ovarian cancer
   Mechanism: possible DNA cross-linker or antimetabolite
   Cell Cycle Specificity: nonspecific
   Metabolism: T\(^{1/2}\) 4-10 hours. Requires metabolism in liver to active form. Metabolites
   excreted in urine (60% in 24 hours, < 1% in native form).
   Toxicity: 1°: myelosuppression (nadir 21-28 d), N/V, peripheral sensory neuropathy,
   renal toxicity; 2°: mood disorders, seizures, ataxia.
   Dose: 260 mg/m\(^2\)-day PO for 14 d, cycle repeated q 28 d. Reduce dose for prior
   myelosuppression, severe neuropathy. Cimetidine prolongs half-life (P-450 enzyme)

**Bleomycin.** Class: antibiotic
   Use: germ cell tumors, squamous cell carcinoma
   Mechanism: scission of single strand DNA, inhibits DNA repair (DNA ligase). Requires
   presence of metal ion cofactor, primarily copper and to lesser degree nickel,
manganese, cobalt.
   Cell Cycle Specificity: G2 phase specific
   Metabolism: T\(^{1/2}\) 3-5 hours. Rapidly inactivated by aminopeptidase in all tissues except
   lung, skin. Excreted unaltered in urine (25-50% in 24 hours).
   Toxicity: 1°: fever, stomatitis, interstitial pneumonitis (10%, especially in elderly) /
pulmonary fibrosis (1%; limit total dose to ≤ 400U), dermatologic (hyperpigmentation,
desquamation), alopecia; 2°: N/V (mild), allergy (hypotension), myelosuppression.
   Toxicity increased in presence of high oxygen concentration.
   Dose: varies; usually 30 U/m\(^2\) x IV weekly as part of BEP regimen. CXR and PFT's
   before each treatment. Discontinue for decreased DLCO ( decrease of ≥15% from
   baseline) or abnormal CXR. Dose reduce for creat. clearance 30-50 mL/min by 25%.

**Capecitabine (Xeloda).** Class: antimetabolite
   Use: epithelial ovarian cancer, cervical cancer
   Mechanism: oral prodrug that is converted in-vivo to 5-FU, conversion in tumor is more
   efficient than normal cells. Same mechanism as 5-FU.
   Cell Cycle Specificity: Cell Cycle Specificity: S phase specific
   Metabolism: Excreted in urine with T\(^{1/2}\) of 45 minutes. Dose reduce for creatinine
   clearance < 50 mL/min. Do not use for clearance of < 30 mL/min.
   Toxicity: Similar to 5-FU. Skin: palmar-plantar erythrodysesthesia.
   Dose: 2,500 mg/m\(^2\) total per day (range 1500-2500) divided PO q12 hours (1250
   mg/m\(^2\)/dose) 30 minutes after meals for 14 days out of each 21 day cycle. Reduce
dose based on creatinine clearance: 30-50 ml/min reduce by 25%, hold for creat.
clearance < 30 ml/min. Reduce dose if drug used in combination or for toxicities
including: diarrhea, emesis, PPE, abdominal pain, lymphopenia.
**Carboplatin (Paraplatin).** Class: non-classical alkylator

**Use:** most gyn tumors

**Mechanism:** covalent platinum adducts to DNA resulting in intra-strand DNA cross-links and 40° angulation of DNA strands (60%: adjacent G-G bases at N-7, 30%: adjacent A-G bases at N-7). Also forms platinum adducts to RNA and proteins; Inhibits DNA, RNA, protein synthesis

**Cell Cycle Specificity:** nonspecific

**Metabolism:** Requires intracellular conversion to di-hydroxy form. $T^{1/2}$ triphasic: 15-30 minutes, 80-100 minutes, and 22-40 hours. Excreted in urine (70% in 24 hours).

**Toxicity:** In general: more myelotoxicity and less nephrotoxicity/neurotoxicity than cisplatin. $1^\circ$: thrombocytopenia (nadir 14-21 d), leukopenia (nadir 18-25 d), anemia, N/V; $2^\circ$: allergy, peripheral neuropathy, renal toxicity, hepatotoxicity. Rare: optic neuritis

**Dose:** 360-400 mg/m$^2$ IV q 28 d. Reduce dose for prior myelosuppression, decreased creatinine clearance.

Calvert Formula: Total dose = C x (GFR+25), where GFR = Cr Cl using Cockcroft-Gault equation. C=7(previously untreated), 5(heavily pretreated), 5 (combination chemotherapy). Alternative dose algorithm: Jeliffe formula (used for all GOG trials).

**Cisplatin (Platinol).** Class: non-classical alkylator

**Use:** most gyn tumors

**Mechanism:** covalent platinum adducts to DNA resulting in intra-strand DNA cross-links and 40° angulation of DNA strands (60%: adjacent G-G bases at N-7, 30%: adjacent A-G bases at N-7). Also forms platinum adducts to RNA and proteins; Inhibits DNA, RNA, protein synthesis

**Cell Cycle Specificity:** nonspecific

**Metabolism:** Requires intracellular conversion to di-hydroxy form. $T^{1/2}$ triphasic, 20-30 min, 50-70 minutes, and 24 hours. Highly protein bound, excreted in urine (25% in 24 hours). Detectable in tissue 4 months after administration.

**Toxicity:** $1^\circ$: N/V, anemia, renal toxicity, ototoxicity, peripheral neuropathy (>300 mg/m$^2$), hypomagnesemia, hypokalemia; $2^\circ$: leukopenia, allergy, alopecia (uncommon), optic neuritis (rare), Reynaud’s, agitation or seizures.

**Dose:** 50-100 mg/m$^2$ IV q 21-28 d. with vigorous hydration. Requires intensive antiemetic therapy. Avoid NSAID’s and nephrotoxic drugs (e.g. aminoglycosides). Reduce dose for peripheral neuropathy, decreased creatinine clearance, hearing loss. Avoid NSAIDs, aminoglycosides, and IV contrast proximate to administration.

**Cyclophosphamide (Cytoxan).** Class: alkylator

**Use:** epithelial ovarian cancer, GTN

**Mechanism:** inter-strand DNA cross-links, usually at guanine N-7

**Cell Cycle Specificity:** nonspecific

**Metabolism:** $T^{1/2}$ 3-10 hours. Requires activation by hepatic cytochrome p450 enzymes to 4-hydroxy-cyclophosphamide. Subsequent metabolism in liver, excretion by kidney (50-70% in 48 hours, 12% as active drug)

**Toxicity:** $1^\circ$: leukopenia (nadir 8-14 d), N/V, alopecia; $2^\circ$: hemorrhagic cystitis (high doses), SIADH, pulmonary fibrosis, cardiac necrosis or myopericarditis (rare, high doses), dermatitis, chemical hepatitis. Increased toxicity with phenobarbitol, chloral hydrate, phenytoin (increased activation), and cimetidine (decreased clearance). Secondary malignancy: leukemia

**Dose:** varies; usually 500-1000 mg/m$^2$ IV q 21-28 d. Vigorous hydration decreases chance of hemorrhagic cystitis. Reduce dose for prior myelosuppression and in multi-drug regimens.
Dactinomycin (Actinomycin-D). Class: antibiotic
Use: germ cell tumors, GTN
Mechanism: DNA intercalation inhibiting DNA dependent RNA synthesis
Cell Cycle Specificity: nonspecific, but most active in G1
Metabolism: $T^{1/2}$: 36 hours. Drug not metabolized. Excreted in bile (50% in 24 hours) and urine (10% in 24 hours).
Toxicity: $1^\circ$: VESICANT, stomatitis, N/V, myelosuppression (nadir 1-7 d), alopecia; $2^\circ$: radiation recall dermatitis, hepatotoxicity.
Dose: varies. 1.25 mg/m² IV, repeat q 14 days. Reduce dose for prior myelosuppression, hepatotoxicity.

Docetaxel (Taxotere). Class: Taxane ($Taxus baccata$)
Use: epithelial ovarian cancer
Mechanism: promotes and stabilizes microtubule polymer formation, thus preventing cell division.
Cell Cycle Specificity: M phase specific
Metabolism: 95% protein bound. $T^{1/2}$ linear, between 5-52 hours. Metabolized in liver.
Primary route of elimination is hepatic (P-450 enzymes), excreted in bile, and unchanged in urine (5%).
Toxicity: $1^\circ$: myelosuppression, hypersensitivity (flushing, hypotension, urticaria), fluid retention, alopecia, irritant; $2^\circ$: mucositis, cough, dyspnea
Dose: Requires premedication: dexamethasone 8 mg bid x 3 days beginning 1 day prior to chemo.
100 mg/m² (range 60-100) IV over 1 hour, repeated every 3 weeks.

Doxorubicin (Adriamycin). Class: antibiotic
Use: endometrial adenocarcinoma, sarcoma, epithelial ovarian cancer
Mechanism: DNA intercalation inhibiting DNA dependent RNA and DNA synthesis.
Topoisomerase II-dependent DNA fragmentation. Produces $O_2^*$ free radicals (hydrogen peroxide) that cause DNA strand breaks, inhibit DNA repair, and disrupt membrane function. Requires iron to catalyze reaction. Peroxide is detoxified by intracellular enzyme catalase, present in very low levels in myocardium. Chelation of iron with Dexrazoxane reduces cardiomyopathy risk.
Cell Cycle Specificity: nonspecific
Metabolism: 70% protein bound. $T^{1/2}$ biphasic, 1.1 hours, 18-28 hours. Metabolized by liver, primary excretion in bile (50% as unchanged drug), 5-10% in urine.
Toxicity: $1^\circ$: myelosuppression (nadir 10-15 d), VESICANT, N/V, arrhythmia, cardiomyopathy (risk 3% if dose < 450 mg/m², 7% at 550 mg/m², 15% at 600 mg/m² and 40% at 700 mg/m²; cardiac toxicity more likely with pre-existing heart disease or prior mediastinal radiation), alopecia; $2^\circ$: radiation recall dermatitis, red urine.
Dose: varies. 60-75 mg/m² IV q 21-28 days. MUGA scan before first dose. Reduce dose for prior myelosuppression, hepatotoxicity. Discontinue for cardiac toxicity including 10% reduction from baseline ejection fraction or any ejection fraction < 50%. Dose reduce 50-70% if bilirubin $\geq$ 1.5. Limit total dose to $\leq$ 450 mg/m²

Doxorubicin, Liposomal (Doxil). Class: antibiotic
Use: endometrial adenocarcinoma, sarcoma, epithelial ovarian cancer
Mechanism: DNA intercalation inhibiting DNA dependent RNA and DNA synthesis.
Topoisomerase II-dependent DNA fragmentation. Produces $O_2^*$ free radicals (hydrogen peroxide) that cause DNA strand breaks, inhibit DNA repair, and disrupt membrane function. Peroxide is detoxified by intracellular enzyme catalase, present in very low levels in myocardium.
Cell Cycle Specificity: nonspecific
Metabolism: Small volume of distribution and longer $T^{1/2}$ than doxorubicin. Metabolized by liver, primary excretion in bile.
Toxicity: 1°: myelosuppression (nadir 10-15 days, milder than for doxorubicin), irritant, N/V (mild), palmar-plantar erythrodysesthesia (PPE), cardiomyopathy (less common than doxorubicin), alopecia; 2°: infusion reaction (7%) including pain, flushing, hypotension, dyspnea (slow down the infusion); radiation recall dermatitis.
Dose: varies. 40 mg/m$^2$ IV q 28 days. Measure ejection fraction (MUGA scan) before first dose. Reduce dose for prior myelosuppression, hepatotoxicity. Discontinue for cardiac toxicity including 10% reduction from baseline ejection fraction or any ejection fraction < 50%. Dose reduce 50-70% if bilirubin $\geq$ 1.5. Limit total dose to $\leq$ 450 mg/m$^2$

**Etoposide (VP-16).** Class: epidophyllotoxin (Mandrake plant)
Use: small cell carcinoma, GTN, epithelial ovarian cancer, germ cell tumor
Mechanism: activates endonucleases (DNA strand breaks), inhibits topoisomerase II. Also binds tubulin.
Cell Cycle Specificity: S-G2 specific
Metabolism: Extensively protein bound. $T^{1/2}$ biphasic, 1.5 hours, 11 hours. Predominant elimination in the urine as unmetabolized drug. Metabolized by liver, excreted in urine (60% in 24 hours) and bile (16% in 24 hours).
Toxicity: 1°: myelosuppression (nadir 7-16 d), N/V, alopecia; 2°: allergy, hypotension or hypertension (with rapid IV infusion), peripheral neuropathy, irritant. Secondary malignancy: leukemia
Dose: Varies, often incorporated in multidrug regimens (see BEP, EMA-CO, VCPBAE), given IV.
Ovarian cancer salvage regimen: 50 mg/m$^2$ PO per day on days q 1-21. Cycle repeats every 28 days. Reduce dose for myelosuppression or prior radiation.

**5-Fluorouracil (5-FU, Efudex cream).** Class: antimetabolite
Use: squamous cell carcinoma of cervix or vulva, ovarian carcinoma, GTN
Mechanism: pyrimidine antagonist inhibits DNA synthesis by inhibition of thymidylate synthetase. Also inhibits RNA synthesis by blocking uracil incorporation.
Cell Cycle Specificity: S phase specific
Metabolism: Inactive until converted to active metabolites 5-FdUMP(DNA) and 5-FUTP(RNA). $T^{1/2}$ 10-30 min. Catabolized by reduction in liver (80% excreted as inactive metabolite in urine, 10-15% un-metabolized in urine in 6 hours). Crosses BBB (2%).
Toxicity: 1°: myelosuppression (nadir 7-14 d), N/V, mucositis/diarrhea, alopecia, rashes and hyperpigmentation; 2°: cerebellar ataxia, photosensitivity, coronary vasospasm.
Dose: varies. 1000 mg/m$^2$ (range 750-1000) IV per day for 4-5 days as 24 hour infusion, q 28 d. Reduce dose for prior myelosuppression. Activity enhanced by administration with folic acid or pre-administration of MTX. Discontinue for diarrhea, rashes.

**Gemcitabine (Gemzar).** Class: antimetabolite
Use: epithelial ovarian cancer, sarcoma
Mechanism: active transport into cells, phosphorylated to triphosphate form (active) by deoxycytidine kinase. Inhibits ribonucleotide reductase that inhibits DNA precursor production and is incorporated into DNA causing strand termination. Also inhibits DNA polymerase.
Cell Cycle Specificity: Not limited to S phase (mechanism unknown)
Metabolism: $T^{1/2}$ 1 hour (prodrug) 24 hours (active metabolite). Primarily excreted in urine.
Toxicity: 1°: myelosuppression, N/V, stomatitis, infusion allergic reaction including hypotension (5%), flu-like symptoms, asthenia; 2°: maculopapular rash, radiation recall, hemolytic-uremic syndrome (rare), chemical hepatitis, acute respiratory distress syndrome (rare), somnolence, headache, peripheral edema.

Dose: 1000 mg/m$^2$ (range 750-1000) IV on day 1, 8, 15 out of each 28 day cycle. Infuse at 10 mg/m$^2$/min.

**Ifosfamide (Ifex).** Class: alkylator

Use: cervical cancer, epithelial ovarian cancer, sarcoma

Mechanism: inter-strand DNA cross-links, usually at guanine N-7

Cell Cycle Specificity: nonspecific

Metabolism: Requires activation by hepatic enzymes to 4-hydroxy-ifosfamide. Subsequent metabolism in liver, excretion by kidney.

Toxicity: 1°: leukopenia (nadir 7-10 d), hemorrhagic cystitis, N/V, alopecia; 2°: lethargy, confusion, coma, SIADH, renal tubular acidosis, hypophosphatemia, elevated transaminases.

Dose: varies; usually 1.4-1.8 g/m$^2$-d IV for 3-5 d, q 21-28 d. Must be given with uroprotector Mesna. Reduce dose for decreased albumin, creatinine clearance, prior myelosuppression

**Methotrexate.** Class: antimetabolite

Use: GTN

Mechanism: dihydrofolate reductase inhibitor, causes thymidine depletion.

Cell Cycle Specificity: S phase specific

Metabolism: T$^{1/2}$ 2-4 hours. 50-90% excreted unchanged in urine in 24 hours. Dose reduce if creatinine < 60 mL/min.

Toxicity: 1°: myelosuppression, mucositis/diarrhea, hepatic dysfunction (chronic doses), renal toxicity (high doses); 2°: interstitial pneumonitis, alopecia.

Dose: IM, IV or IT, regimens vary widely. High doses (>80 mg/m$^2$) administered with Leucovorin rescue and alkalization of urine. Reduce dose for prior myelosuppression, hepatotoxicity. Beware of effusions (reservoir). Avoid NSAID's.

- Usual dose for low risk GTN is 1 mg/kg IM or IV on days 1, 3, 5, and 7 alternating with leukovorin 0.1 mg/kg IV, IM or PO on days 2, 4, 6, and 8. Cycle repeats every 2 weeks until markers normalized. See GTN Chapter for more detail.

**Paclitaxel (Taxol).** Class: Taxane (*Taxus brevifolia*)

Use: epithelial ovarian cancer, endometrial cancer

Mechanism: promotes and stabilizes microtubule polymer formation, thus preventing cell division.

Cell Cycle Specificity: M phase specific

Metabolism: 95% protein bound. T$^{1/2}$ nonlinear, between 5-52 hours. Metabolized in liver. Primary route of elimination is hepatic (P-450 enzymes), excreted in bile (40% in 24 hours), and unchanged in urine (10% in 24 hours).

Toxicity: 1°: myelosuppression (nadir 8-11 days, increased with 24h infusion vs 3h infusion), hypersensitivity (related to vehicle, Cremophor), bradycardia, alopecia, paresthesia (increased with 3h infusion vs 24h infusion); 2°: N/V, mucositis, myalgia, ventricular arrhythmia

Dose: Varies, usually administered in multidrug regimens. Requires premedication, non-PVC IV tubing, and in-line filter. Common doses include: 175 mg/m$^2$ IV by 3 hour infusion, repeated every 3 weeks. 135 mg/m$^2$ IV by 24 hour infusion, repeated every 3 weeks. 65-80 mg/m$^2$ IV by 1 hour infusion, repeated weekly

**Topotecan (Hycamptin).** Class: camptothecin (*Camptotheca acuminata*)
Use: epithelial ovarian cancer  
Mechanism: binds topoisomerase I, causing covalent DNA-topoisomerase bond and single strand DNA breaks.  
Cell Cycle Specificity: M phase specific  
Metabolism: Eliminated by active biliary transport and renal excretion (50% in urine over 24 hours. $T_{1/2}$ 1.7-4.9 hours.  
Toxicity: 1°: leucopenia, thrombocytopenia, alopecia; 2°: N/V, rash, mucositis, diarrhea  
Dose: Varies, given either singly or in multidrug regimens. Common doses include:  
1-1.25 mg/m$^2$ over 30 minutes, daily x 5 days, repeated every 21 days  
4 mg/m$^2$ IV on days 1, 8, and 15 repeated every 28 days (Check)  

**Vincristine (Oncovin).** Class: vinca alkaloid  
Use: GTN, germ cell tumors  
Mechanism: inhibits microtubular polymerization of tubulin causing reversible mitotic arrest.  
Cell Cycle Specificity: M phase specific  
Metabolism: Extensive protein binding. $T_{1/2}$ triphasic, 5 min, 50-150 min, and 24-90 hours. Clearance is predominantly hepatic. Partially metabolized in liver, excreted in bile (70%), and urine (5-16%).  
Toxicity: 1°: leukopenia, neurotoxicity (paresthesia, ataxia, foot drop, muscle wasting), VESICANT, constipation, alopecia; 2°: SIADH, ARDS, cortical blindness (rare), elevated transaminases (mild), bronchospasm (rare), joint pain  
Dose: Varies, usually given in multidrug regimens (see EMA-CO). 1 mg/m$^2$ IV q 14 days, dose not to exceed 2 mg. Reduce dose for prior myelosuppression, neurotoxicity. Do not give if liver function is abnormal.  

**Vinorelbine (Navelbine).** Class: vinca alkaloid (semi-synthetic, from Madagascar periwinkle: vinca rosea)  
Use: ovarian epithelial cancer  
Mechanism: inhibits polymerization of tubulin causing reversible mitotic arrest.  
Cell Cycle Specificity: M phase specific  
Metabolism: Extensive protein binding. $T_{1/2}$ triphasic, 5 min, 50-150 min, and 24-90 hours. Clearance is predominantly hepatic. Partially metabolized in liver, excreted in bile (70%), and urine (5-16%).  
Toxicity: 1°: leukopenia, neurotoxicity (paresthesia, ataxia, foot drop, muscle wasting), VESICANT, constipation, alopecia; 2°: SIADH, ARDS, seizures (rare), elevated transaminases (mild), bronchospasm (rare), joint pain  
Dose: 30 mg/m$^2$ IV weekly. If heavily pretreated, regimen will require periodic “off” week  

**Other chemotherapy agents** occasionally used for gynecologic tumors include:  
chlorambucil (Leukeran), irinotecan (CPT-11), melphalan (Alkeran), mitomycin, mitoxantrone, oxaliplatin, vinblastine (Velban)  

**V. Targeted Therapy Drugs**  
**Bevacizumab (Avastin)**  
Use: ovarian epithelial cancer (Not FDA approved for this indication)  
Mechanism: monoclonal antibody binds and inhibits VEGF, decreasing angiogenesis. May increase chemo delivery to tumor by reducing interstitial pressure  
Metabolism: $T_{1/2}$ 20 days. Route of elimination: unknown.  
Toxicity: Common: Hypertension, headache, abdominal pain, diarrhea, constipation, stomatitis, DVT, neutropenia, bleeding, dermatitis, proteinuria. Rare GI perforation, impaired wound healing, CHF, nephrotic syndrome, MI, hypertensive crisis, stroke  
Dose: 5-10 mg/kg IV q 14 days. Do not administer until > 28 days after surgery and wound fully healed. Hold for proteinuria.
**Bortezomib (Velcade)**
Use: ovarian epithelial cancer (Not FDA approved for this indication)  
Mechanism: small molecule inhibitor 26S proteosome resulting in inhibition of NF-κB thereby promoting apoptosis.  
Metabolism: 80% protein bound. Route of elimination: hepatic via CYP-450 2C19 & 3A4  
Toxicity: peripheral neuropathy (frequent), myelosuppression (thrombocytopenia 39%, anemia 26%, neutropenia 19%), N/V, diarrhea, rash, elevated transaminases, dyspnea, hypotension, fever, myalgia, sudden cardiac death  
Dose: 1 to 1.3 mg/m² IV twice a week for 2 weeks

**Cetuximab (IMC-C225)**
Use: ovarian epithelial cancer (Not FDA approved for this indication)  
Mechanism: Chimeric monoclonal antibody to extracellular EGF receptor, blocking tyrosine kinase activity.  
Toxicity: nausea, rash, allergic reaction (fever, chills, erythema), elevated transaminases  
Dose: 200-250 mg/m² IV weekly.

**Erlotinib (Tarceva)**
Use: ovarian epithelial cancer (Not FDA approved for this indication)  
Mechanism: small molecule inhibitor of EGF receptor tyrosine kinase resulting in cell cycle arrest and inhibition of angiogenesis. May be synergistic with chemotherapy.  
Metabolism: T₁/₂ 36 hours. Route of elimination hepatic CYP-450 enzymes with 83% unchanged excretion in feces.  
Toxicity: diarrhea (severe), rash (severe), interstitial lung disease, elevated transaminases, corneal ulcer  
Dose: 150 mg PO q day.

**Gefitinib (Iressa, Investigational: currently available only for lung cancer protocols)**
Use: ovarian epithelial cancer  
Mechanism: small molecule inhibitor of EGF receptor tyrosine kinase resulting in cell cycle arrest and inhibition of angiogenesis. May be synergistic with chemotherapy.  
Metabolism: T₁/₂ 28 hours. Hepatic route of elimination.  
Toxicity: diarrhea, rash, interstitial lung disease, dyspnea, corneal ulcer, elevated transaminases, amblyopia, asthenia, anorexia  
Dose: 250 mg PO q day.

**Oregovamab (Ovarex, Investigational)**
Use: ovarian epithelial cancer in remission after primary therapy  
Mechanism: Murine monoclonal antibody Mab-B43.13 binds to CA-125 leading to induction of specific antibodies and T cells.  
Toxicity: minimal  
Dose: 2 mg IV every 4 weeks until relapse

VI. Medications Used in Conjunction with Chemotherapy
A. Management of Nausea and vomiting
1. Chemotherapy induced emesis mechanisms: Stimulation of the chemoreceptor trigger zone in the area postrema causes CNS secretion of dopamine, serotonin and histamine that activate adjacent vomiting center in brain. Other mechanisms include stimulation of GI serotonin receptors and psychological effects.  
2. There are 3 different forms of chemotherapy associated emesis: acute (first 24 hours after chemo), delayed (24-96 hours after chemo), and anticipatory.

B. Anti-emetics
1. 5-HT3 receptor antagonist. These drugs are very effective but expensive. They are used to prevent nausea and vomiting for the first 3-4 days after chemo and are not
appropriate for long-term continuous use or to treat pre-existing emesis. If Emend is used in the anti-emetic regimen, 5-HT3 receptor antagonists are used only prior to chemotherapy. See below for table regarding use

**Ondansetron (Zofran)**
- **Mechanism:** Serotonin (5-HT3) receptor blockade
- **Metabolism:** hepatic via CYP450 enzymes. Excreted in urine.
- **Toxicity:** Headache, elevated transaminases, constipation, diarrhea, potential prolongation of Q-T interval
- **Dose:** 8-16 mg IV or 8-24 mg PO 30 min before chemo. Given only on day 1 if combined with aprepitant. May also be given 8 mg PO or orally dissolving tabs tid first 3 days after chemo if no aprepitant given

**Granisetron (Kytril)**
- **Mechanism:** Serotonin (5-HT3) receptor blockade
- **Metabolism:** hepatic via CYP450 enzymes. Excreted in urine.
- **Toxicity:** Headache, elevated transaminases, constipation, diarrhea, potential prolongation of Q-T interval
- **Dose:** 1 mg IV < 30 min before chemo, or 1-2 mg PO 1 hour before chemo. Given only on day 1 if combined with aprepitant. May follow with 1 mg po bid first 3 days after chemo if no aprepitant given

**Dolasetron (Anzemet)**
- **Mechanism:** Serotonin (5-HT3) receptor blockade
- **Metabolism:** hepatic via CYP450 enzymes. Excreted in urine (70% and feces (30%), T₁/₂ < 10 min.
- **Toxicity:** Headache, elevated transaminases, constipation, diarrhea, potential prolongation of Q-T interval
- **Dose:** 100 mg IV 30 min before chemo or PO 1 hour before chemo. Given only on day 1 if combined with aprepitant. May follow with 100 mg PO q day x 3 days if no aprepitant given

**Palonosetron (Aloxi)**
- **Mechanism:** Serotonin (5-HT3) receptor blockade. 100 x higher binding affinity than other 5-HT3 antagonists
- **Metabolism:** hepatic via CYP450 enzymes. Excreted in urine (70% and feces (30%), T₁/₂ 40 hours vs.4-9 hours for other 5-HT3 antagonists.
- **Toxicity:** Pruritus, Q-T prolongation, headache, elevated transaminases, constipation, diarrhea. Caution if cardiac conduction problem, hypocalcemia, hypomagnesemia, erythromycins, prior anthracyclines. Use with phenothiazines may cause synergistic Q-T prolongation.
- **Dose:** 0.25 mg IV 30 min before chemo. Single dose provides 3 or more days of antiemetic effect.

2. Substance P / NK1 receptor antagonist. See table below regarding use.

**Aprepitant (Emend)**
- **Mechanism:** selective antagonism of human substance P-Neurokinin 1 receptors
- **Metabolism:** hepatic CYP3A4 enzymes with excretion in feces and urine
- **Toxicity:** fatigue, hiccups, constipation, diarrhea, anorexia, headache, abdominal pain, mucositis, neutropenia. May alter metabolism and effectiveness of many drugs including chemotherapy agents. Check with pharmacist.
- **Dose:** 125 mg PO 1 hour before chemo, then 80 mg PO qAM on day 2-3.
  Administer with dexamethasone 12-20 mg PO or IV pre-chemo and 8-12 mg PO daily on days 2-3

3. Motility agent
**Metoclopramide (Reglan)**  
Mechanism: Dopamine blockade; Serotonin (5-HT3) blockade at high doses.  
Stimulates gastric motility and emptying.  
Toxicity: Sedation (60%), diarrhea (15%), Extrapyramidal symptoms (EPS) (20%) if younger than 30. EPS usually treated with Benadryl, 25-50 mg IV.  
Dose: 5-10 mg PO or IV q 6 hours prn, or 20-40 mg PO for more severe nausea, or 25 –50 mg IV for more severe nausea

4. **Phenothiazine**  
**Prochlorperazine (Compazine)**  
Mechanism: Dopamine D2 receptor blockade  
Toxicity: Sedation, dry mouth, EPS, orthostatic hypotension  
Dose: 25 mg suppository PR q 12 hours or 10 mg PO or IV or IM q 6 hours prn

5. **Benzodiazepine**  
**Lorazepam (Ativan)**  
Mechanism: Sedative, anxiolytic via GABA neurotransmitter pathways  
Side Effects: Drowsiness, confusion, ataxia, amnesia (desirable)  
Dose: 0.5-2 mg IV, PO or sublingual, q 6 hours prn. Use lowest doe for elderly patients or if renal impairment.

6. **Steroid**  
**Dexamethasone (Decadron)**  
Mechanism: Unknown; possibly prostaglandin synthesis inhibitor  
Toxicity: Euphoria, fluid retention, insomnia  
Dose: Regimens vary widely (See table below). 20 mg IV 30 min before each chemo cycle. May also be given 2-8 mg PO bid for 2-4 days after chemo cycle. Reduce dose if giving with aprepitant due to decreased clearance of the steroid
C. Emetogenicity of chemotherapy drugs (Hesketh, NCCN) Drugs in parentheses rarely used for Gyn Oncology

<table>
<thead>
<tr>
<th>Agent and Dose</th>
<th>Frequency of Emesis</th>
<th>Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altretamine</td>
<td>&gt; 90 %</td>
<td>High</td>
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<tr>
<td>Cisplatin (&gt; 50 mg/m²)</td>
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<tr>
<td>Cyclophosphamide (&gt; 1500 mg/m²)</td>
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<tr>
<td>Doxorubicin + cyclophosphamide (Carmustine, dacarbazine, mechlorethamine, oral procarbazine, streptozocin)</td>
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<tr>
<td>Carboplatin</td>
<td>30-90 %</td>
<td>Moderate</td>
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<tr>
<td>Cisplatin (&lt; 50 mg/m²)</td>
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<td></td>
</tr>
<tr>
<td>Cyclophosphamide (&lt; 1500 mg/m²)</td>
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<tr>
<td>Dactinomycin</td>
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<tr>
<td>Doxorubicin (&gt; 60 mg/m²)</td>
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<tr>
<td>Etoposide (oral)</td>
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<tr>
<td>Ifosfamide</td>
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<tr>
<td>Methotrexate (250 - 1000 mg/m²)</td>
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<tr>
<td>(Amifostine, azacitidine, busulfan, cytarabine, daunorubicin, epirubicin, oral imatinib, irinotecan, lornustine, melphalan &gt; 50 mg/m², oxaliplatin &gt; 75 mg/m², oral temozolomide, oral vinorelbine)</td>
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<tr>
<td>Capecitabine</td>
<td>10-30 %</td>
<td>Low</td>
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<tr>
<td>Docetaxel</td>
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<td></td>
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<tr>
<td>Doxorubicin (&lt; 20 mg/m²)</td>
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<tr>
<td>Doxorubicin (liposomal)</td>
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<tr>
<td>Etoposide (IV)</td>
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<td>5-Fluorouracil</td>
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<tr>
<td>Gemcitabine</td>
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</tr>
<tr>
<td>Methotrexate (50 - 250 mg/m²)</td>
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<tr>
<td>Paclitaxel</td>
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<td></td>
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<tr>
<td>Topotecan</td>
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<tr>
<td>(Amifostine &lt; 300 mg/m², cetuximab, cytarabine 100-200 mg/m², oral fludarabine, mitomycin, mitoxantrone, pemetrexed)</td>
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<td></td>
</tr>
<tr>
<td>Bleomycin</td>
<td>&lt; 10 %</td>
<td>Minimal</td>
</tr>
<tr>
<td>Methotrexate (&lt; 50 mg/m²)</td>
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<td></td>
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<tr>
<td>Vincristine</td>
<td></td>
<td></td>
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<tr>
<td>Vinorelbine</td>
<td></td>
<td></td>
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<tr>
<td>(Bevacizumab, bortezomib, busulfan, oral chlorambucil, dextrazoxane, erlotinib, fludarabine, gefitinib, oral melphalan, rituximib, vinblastine)</td>
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</tbody>
</table>
### D. Anti-emetic regimens based on emetogenicity of the chemotherapy regimen

<table>
<thead>
<tr>
<th>Severity, (Route)</th>
<th>Anti-emetic Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe (PO)</td>
<td>Aprepitant, as described above, and Dexamethasone 12 mg PO then 4 mg PO bid x 3 days, and 5-HT3 inhibitor PO (granisetron, ondansetron, dolasetron or palonosetron pre-chemo, day 1 only. Doses noted above, VI.B.1), and Lorazepam (Dose noted above, VI.B.5) x 4 days (optional)</td>
</tr>
<tr>
<td>(unable to take PO)</td>
<td>Dexamethasone 20 mg IV then 8 mg PO or IV x 3 days, and 5-HT3 inhibitor IV (Using multi-day regimens noted above, VI.B.1), and Lorazepam (Dose noted above, VI.B.5) x 4 days (optional)</td>
</tr>
<tr>
<td>Moderate</td>
<td>Aprepitant, if receiving carboplatin, doxorubicin, ifosfamide, cyclophosphamide, or methotrexate, and Dexamethasone 12 mg PO then 4 mg PO bid x 3 days, and 5-HT3 inhibitor PO (granisetron, ondansetron, dolasetron or palonosetron pre-chemo, day 1 only. Doses noted above, VI.B.1), or Metoclopramide (Dose noted above, VI.B.3) x 3 days, and Lorazepam (Dose noted above, VI.B.5) x 4 days (optional)</td>
</tr>
<tr>
<td>Severe to moderate (delayed nausea)</td>
<td>Prochlorperazine 25 mg suppository PR q 12 hours or 10 mg PO q 6 hours, and/or Metoclopramide (Dose noted above, VI.B.3) with diphenhydramine as needed for extrapyramidal symptoms (EPS), and/or Lorazepam (Dose noted above, VI.B.5), or Haloperidol 1-2 mg PO or IV q 6 hours, or Dronabinal 5-10 mg PO or IV q 8-12 hours. Maximum 15 mg/m²/day, or Olanzapine 5 mg po bid-tid</td>
</tr>
<tr>
<td>Low</td>
<td>Dexamethasone (Dose noted above, VI.B.3), or Prochlorperazine (Dose noted above, VI.B.4), or Metoclopramaide (Dose noted above, VI.B.3), or Lorazepam (Dose noted above, VI.B.5)</td>
</tr>
<tr>
<td>Minimal</td>
<td>Treat nausea only if it occurs. No prophylaxis or compazine 10 mg po prior to treatment</td>
</tr>
</tbody>
</table>

### D. Cytokines. These drugs are very effective for treatment of chemotherapy-associated neutropenia and anemia, and somewhat less effective for treatment of thrombocytopenia. All are expensive and should only be ordered for appropriate indications.

1. **Filgrastim (Neupogen)**
   - **Mechanism:** colony stimulator factor (GCSF)
   - **Toxicity:** medullary bone pain (24%, may treat with NSAIDs), splenomegaly, elevated transaminases, abdominal pain, headache, thrombocytopenia, ARDS (rare), allergic reaction to *E. coli* proteins including anaphylaxis, splenic rupture (rare)
   - **Indications:** ASCO Guidelines 1996
   - Myelosuppression with > 40% expected incidence of febrile neutropenia, prior radiation, extensive prior chemotherapy, high dose intensity regimen, history of febrile neutropenia with prior chemo cycle, history of prior chemo dose reduction due to prolonged neutropenia
Dose: 5 mcg/kg per day SC (usually 300 mcg/day). Not to be given <24 hours before or after chemotherapy. Continue until absolute neutrophil count (ANC) > 1000 x 3 days and after expected nadir

**Pegfilgrastim (Neulasta)**
- **Mechanism:** liposomal colony stimulator factor (GCSF), much longer half-life than filgrastim
- **Toxicity:** medullary bone pain (24%), splenomegaly, elevated transaminases, abdominal pain, headache, thrombocytopenia, ARDS (rare), allergic reaction to *E. coli* proteins including anaphylaxis, splenic rupture (rare)
- **Indications:** Same as for filgrastim
- **Dose:** 6 mg SC x 1 dose. Not to be given <24 hours after chemotherapy or < 14 days before next chemo cycle. Safe use on day of chemo with chemo regimens requiring treatment q14 days has been reported in a small series.

### 2. Cytokines for treating anemia

**Epoetin alpha (Procrit, Epogen)**
- **Mechanism:** erythropoietin, a cytokine that stimulates erythroid progenitor cells
- **Toxicity:** HTN, headache, arthralgia, nausea, fever, tachycardia, edema, dyspnea, dizziness, fatigue, cough, congestion, red cell aplasia. Rare toxicities include: seizures, MI, stroke, CHF, thromboembolism, allergic reaction
- **Indications:** chemotherapy-associated anemia with starting hemoglobin (Hb) of <10-12 gm/dL
- **Dose:** 40,000 units SC q week until target Hb > 12 g/dL reached. Reevaluate Hb after 4-8 weeks: dose may be escalated to 60,000 units SC q week prn

**Darbepoeitin alpha (Aranesp)**
- **Mechanism:** erythropoietin-like cytokine that stimulates erythroid progenitor cells
- **Toxicity:** HTN, headache, arthralgia, nausea, fever, tachycardia, edema, dyspnea, dizziness, fatigue, cough, congestion, red cell aplasia. Rare toxicities include: seizures, MI, stroke, CHF, thromboembolism, allergic reaction
- **Indications:** chemotherapy-associated anemia with starting hemoglobin (Hb) of <10-12 gm/dL
- **Dose:** 200 mcg SC q 2 weeks until target Hb > 12 g/dL reached. Reevaluate Hb after 4-8 weeks: dose may be escalated to 400 mcg SC q 2 weeks prn. Alternate dosing is 300 mcg SC q 3 weeks.

### 3. Cytokine for treating thrombocytopenia

**Oprelvekin (Neumega)**
- **Mechanism:** IL-11, a cytokine that stimulates megakaryocytes
- **Toxicity:** dilutional anemia, edema, tachycardia and palpitations or arrhythmia, pulmonary edema, pleural effusion, ocular bleeding, stroke
- **Indications:** Thrombocytopenia with anticipation of nadir lasting at least one week
- **Dose:** 50 mcg/kg SC q day beginning 24 hours after chemo for a maximum of 21 days. Not to be given < 48 hours before or < 24 hours after chemotherapy. Continue until platelets are > 50,000 and past anticipated nadir

### E. Protectors

**Amifostine (Ethyol)**
- **Mechanism:** Binds to cisplatin metabolites. Used to treat platinum-associated renal toxicity (ovarian and lung cancer) and xerostomia associated with head and neck radiation. May reduce platinum-associated neuropathy (off label use)
Toxicity: severe nausea and vomiting, hypotension (stop anti hypertensive meds 24 hours before and pre-hydrate), hypocalcemia, flushing, fever. Rarely: apnea, dyspnea, seizures, syncope, allergic reaction, cardiac arrest, A-fib, Stevens-Johnson syndrome

Dose: 740 mg/m² IV over 15 minutes, administered 30 minutes before chemo (dose range 200 mg/m² for RT to 910 mg/m² for chemo).

Leucovorin (Citrovorum factor)
Mechanism: folic acid, a tetrahydrofolate derivative, is a cofactor in the synthesis of pyrimidines and purines. Its presence bypasses enzymatic block caused by methotrexate. Leucovorin may be preferentially taken up by normal cells and not by cancer cells.

Toxicity: non-toxic. Rare allergic reactions

Dose: varies based on methotrexate regimen and methotrexate levels.

Mesna
Mechanism: a sulfhydryl compound that inactivates toxic metabolites of ifosfamide and cyclophosphamide (acrolein) within the urinary tract.

Toxicity: N/V and diarrhea (at high doses), allergic reaction (rare)

Dose: varies. 20% of Ifosfamide dose infused IV 15 min before, 4 h and 8 h after each dose. Alternate oral dosing: give usual pre-chemo dose IV, then oral dose calculated at 40% of ifosfamide dose given 2 and 6 hours after. Continuous infusions sometimes used

VII. Treatment of Febrile Neutropenia

A. Definition: Fever (≥100.4°F) + Neutropenia (ANC < 1000/µl)

B. Workup: Comprehensive history and physical exam; CBC with differential and platelets; comprehensive panel; cultures of blood and urine; culture port, if present. If indicated by symptoms or findings, obtain Chest X-ray, wound cultures and stool culture for Clostridium difficile

C. Assess risk with MASCC Risk Index (www.NCCN.org Fever and Neutropenia Guideline)

<table>
<thead>
<tr>
<th>Burden of illness</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>No or mild symptoms</td>
<td>5</td>
</tr>
<tr>
<td>Moderate symptoms</td>
<td>3</td>
</tr>
<tr>
<td>No hypotension</td>
<td>4</td>
</tr>
<tr>
<td>No COPD</td>
<td>4</td>
</tr>
<tr>
<td>Solid tumor or no previous fungal infection</td>
<td>4</td>
</tr>
<tr>
<td>No dehydration</td>
<td>3</td>
</tr>
<tr>
<td>Outpatient status</td>
<td>3</td>
</tr>
<tr>
<td>Age ≤ 60 years</td>
<td>2</td>
</tr>
</tbody>
</table>

D. Risk score of ≥ 21 is LOW RISK

E. For Low Risk Patients: MASCC Score ≥ 21, GOG performance status of 0-1, and no other high risks, treat as follows:
   1. Outpatient therapy after 6-24 hour observation
   2. Oral antibiotics with ciprofloxacin 500 mg PO q 12 hours and amoxicillin/clavulanate 500 mg PO q 8 hours. If PCN allergic, substitute clindamycin 300 mg po q 6 hours for amoxicillin

F. For High Risk Patients: MASCC Score < 21, pneumonia, creatinine > 2 mg/dL, hepatic functions > 3x normal, or clinically unstable, treat as follows:
   1. Admit to hospital
   2. IV monotherapy with either meropenem (Merrem) 1g IV q8 hours or cefepime (Maxipime) 2g IV q8 hours (if community acquired). Adjust doses for renal impairment
3. If port or line infection suspected, start vancomycin 1 g IV q 12 hours, adjusted for renal function. Make sure drug is administered through the port.
4. If *C. difficile* infection suspected, start metronidazole 500 mg PO q 8 hours.

G. Alter therapy if:
1. ANC ≤ 100/microliter with short latency < 10 days from chemotherapy, sepsis or clinically documented infection, severe comorbidity, and/or performance status of 3-4, add G-CSF (Neupogen or Neulasta) Continue until ANC ≥ 3000
2. If clinical condition unstable or if fever does not respond, add gentamicin or vancomycin depending on suspected source. Consider antifungal therapy
3. If culture reveals site-specific infection such as *Clostridium difficile*, add metronidazole

H. Duration of therapy
1. No identified infection: antibiotics for at least 4 days, continuing until > 24 hours afebrile and ANC ≥ 500/microliter
2. Positive blood culture: antibiotics for 14 days depending on organism
3. Pneumonia: 14-21 days of antibiotics

VIII. Treatment of Extravasated Vesicant (See UM Policy #63-01-077)
1. “An ounce of prevention is worth a pound of cure!”
   - *Always* use a fresh IV site, flush the line (should note low resistance to flow), and check for back flash of blood (place IV bag on floor).
   - *Never* use hand IV, infiltrated, or painful IV.
   - Consider permanent central line placement for low risk access.
2. If infiltration occurs, aspirate as much drug back through IV as possible, then:
   
<table>
<thead>
<tr>
<th>Drug</th>
<th>Treatment (List is not all inclusive. Includes drugs used in Gyn Onc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Vesicants: capable of tissue necrosis</td>
<td></td>
</tr>
<tr>
<td>Dactinomycin</td>
<td>Cold compresses. Elevate extremity. Consider sodium thiosulfate</td>
</tr>
<tr>
<td>Doxorubicin</td>
<td>Ice packs, 30 min qid for 72 hours. Elevate extremity. Topical DMSO</td>
</tr>
<tr>
<td>Vincristine</td>
<td>Warm compresses. Avoid steroids or cooling.</td>
</tr>
<tr>
<td>Vinblastine</td>
<td>Warm compresses. Avoid steroids or cooling.</td>
</tr>
<tr>
<td>Vinorelbine</td>
<td>Warm compresses. Avoid steroids or cooling.</td>
</tr>
<tr>
<td>Venous Irritant: capable of local pain and irritation</td>
<td></td>
</tr>
<tr>
<td>Cisplatin</td>
<td>Cool compresses. 10% sodium thiosulfate 2 mL SC per 100 mg</td>
</tr>
<tr>
<td>Docetaxel</td>
<td>Cool compresses.</td>
</tr>
<tr>
<td>Doxil</td>
<td>Same as for doxorubicin</td>
</tr>
<tr>
<td>Etoposide</td>
<td>Warm compresses, 30 min qid for 24 hours. Hyaluronidase, (Wydase) 150 U/mL; 1-6 mL SC</td>
</tr>
<tr>
<td>5-Fluoruracil</td>
<td>Treat symptoms as they arise</td>
</tr>
<tr>
<td>Gemzar</td>
<td>Treat symptoms as they arise</td>
</tr>
<tr>
<td>Ifosfamide</td>
<td>Treat symptoms as they arise</td>
</tr>
<tr>
<td>Paclitaxel</td>
<td>Cool compresses. Hyaluronidase, (Wydase) 150 U/mL; 1-6 mL SC</td>
</tr>
</tbody>
</table>

3. Consult Plastic Surgery for wound management
4. If ulceration occurs, prompt surgical debridement and possible skin grafting needed

IX. Late Complications of Chemotherapy
1. Ovarian Failure: risk a function of drug type, cumulative dose, and patient age. Alkylators (e.g. cyclophosphamide) most strongly implicated.
2. Leukemia: relative risk increased 12 fold (range of RR 4.4-32). Greatest risk 4-5 years after chemotherapy. Long term chemotherapy implicated, particularly with alkylators (chlorambucil, melphalan), and less so with doxorubicin-cisplatin combination therapy.

X. Calculations and Equations
A. Body Surface Area (Dubois): \(0.007184 \times (\text{cm}^{0.725}) \times (\text{kg}^{0.425})\)

B. Creatinine Clearance (Cockcroft and Gault, females): \(\frac{(140-\text{age}) \times \text{kg} \times 0.85}{\text{Creatinine} \times 72}\)

C. Creatinine Clearance (Jelliffe) \(\frac{(98 - 0.8[\text{age} - 20]) \times 0.9}{\text{Creatinine}^*}\)

*: The creatinine value must be \(\geq 0.6\) mg/dL. If measured creatinine is < 0.6 mg/dL, then set the value at 0.6 mg/dL

D. Calvert Formula for Carboplatin Dosing: Use the Creatinine Clearance estimated from either the Cockcroft-Gault or Jelliffe methods:

Carboplatin dose = \([\text{Creatinine clearance} + 25] \times \text{AUC}\)

AUC = area under the curve, a chosen value between 4.5 and 7, that determines the dose intensity based on the chosen regimen

XI. Multidrug Regimens used for Gynecologic Tumors Preprinted orders on file at https://ummcpharmweb.med.umich.edu/chemotherapy/

BEP: Bleomycin / Etoposide / Cisplatin: (GOG 5-day regimen) for ovarian germ cell and stromal tumors).
Bleomycin 20 U/m² IV (maximum 30 U) weekly
Etoposide 100 mg/m² IV daily x 5 days, repeat every 3 weeks
Cisplatin 20 mg/m² IV daily x 5 days, repeat every 3 weeks
Total of 3-4 cycles depending on adequacy of resection and tumor markers (if any)

BEP: Bleomycin / Etoposide / Cisplatin: (3-day regimen) for ovarian germ cell and stromal tumors). Ref: J Clin Oncol 1990; 8: 715-20
Bleomycin 10 Units / day over 18 hours each day x 3 days
Etoposide 100 mg/m² IV daily x 3 days, repeat every 3 weeks
Cisplatin 75 mg/m² IV, repeat every 3 weeks
Total of 3-4 cycles depending on adequacy of resection and tumor markers (if any)

Cb-T: Carboplatin / Paclitaxel: standard regimen for ovarian epithelial carcinoma
Taxol 175 mg/m² IV as 3 hour infusion, followed by
Carboplatin Calvert AUC 4.5 - 7 (usually 5 – 6) IV
Repeated every 21 days for 6 cycles

DoG: Gemcitabine / Docetaxel: for leiomyosarcoma (Hensley)
Gemcitabine 900 mg/m² IV on days 1 and 8
Docetaxel 100 mg/m² IV on day 8
Filgrastim 300 mcg SC on days 9 – 15
Cycle repeats every 21 days
Patients with prior pelvic radiation are dose reduced 25% for both chemo drugs

EMA-CO: Etoposide / Methotrexate / Atinomycin D / Cyclophosphamide / Vincristine: for high risk gestational trophoblastic neoplasms
Etoposide 100 mg / m² IV on days 1, 2.
Methotrexate 100 mg / m² IV push followed by 200 mg / m² IV over 12 hours on day 1. If brain mets present, Methotrexate dose is changed to 1000 mg / m² as 24 hour infusion. Urine must be alkalinized. If brain mets present, intrathecal methotrexate may be needed, although radiation therapy is an alternative. See GTN Chapter for details.
Actinomycin-D 0.5 mg IV push on days 1, 2
Leucovorin 15 mg IV, IM or PO q 12 hours x 4 doses beginning 24 hours after methotrexate infusion complete
Cyclophosphamide 600 mg / m² IV on day 8
Vincristine 1 mg / m² IV push on day 8
Cycle repeats every 2 weeks. Filgrastim support required.

Etoposide 100 mg / m² IV on days 1, 2.
Methotrexate 1000 mg / m² IV over 24 hours on day 1
Actinomycin-D 0.5 mg IV push on days 1, 2
Leucovorin 15 mg IV, IM or PO q 12 hours x 9 doses beginning 24 hours after methotrexate infusion complete
Etoposide 100 mg / m² IV on day 8
Cisplatin 80 mg / m² IV on day 8
Cycle repeats every 2 weeks. Filgrastim support required.

Intraperitoneal chemotherapy for ovarian cancer
See ovarian cancer chapter, section IX.A.4.e.

MAI: Mesna, Adriamycin and Ifosfamide: for uterine sarcomas. (Adapted from Antman)
Ifosfamide 1500 mg / m² / day as 1 hour infusion on days 1 - 3
Mesna 20% of IFX dose IV 15 minutes prior to each IFX dose in addition to 4 and 8 hours after each IFX dose
Doxorubicin 20 mg / m² / day as 24 hour infusion for days 1 - 3

RT sensitization
Platinum Regimen (Cervix)
Cisplatin 40 mg/m² IV as 2 hour infusion with 25 g mannitol and 1 g magnesium sulfate. Cap dose at 70 mg / m² / week
Administer weekly throughout radiation treatment

5 Fluorouracil Regimen (Vulva)
5 Fluorouracil 1000 mg / m² / day as 24 hour infusion on days 1-4.
Repeat every 4 weeks during radiation treatment

TAC: Paclitaxel / Doxorubicin / Carboplatin: GOG regimen for endometrial carcinoma (Duska)
Doxorubicin 45 mg/m² IV slow push on day 1
Paclitaxel 160 mg/m² IV as 3 hour infusion on day 1
Carboplatin AUC 5 IV as 1 hour infusion on day 1
Neulasta 6 mg SC on day 2
Cycle repeats every 3 weeks for 6 cycles

TAP: Paclitaxel / Doxorubicin / Cisplatin: GOG regimen for endometrial carcinoma (Fleming)
Doxorubicin 45 mg/m² IV on day 1
Cisplatin 50 mg/m² IV as 2 hour infusion with 25 g mannitol and 1 g magnesium sulfate on day 1
Paclitaxel 160 mg/m² IV as 3 hour infusion on day 2, > 24 hours after doxorubicin
Neulasta 6 mg SC on day 3
Cycle repeats every 3 weeks for 6 cycles

**VAC: Vincristine / Actinomycin-D / Cyclophosphamide:** GOG regimen for ovarian germ cell tumors
Vincristine 1.5 mg/m² IV (maximum 2 mg), repeat every 2 weeks
Actinomycin-D 350 mcg/m² IV daily x 5 days, repeat every 4 weeks
Cyclophosphamide 150 mg/m² IV daily x 5 days, repeat every 4 weeks
Total of 4-6 cycles depending on adequacy of resection and tumor markers (if any)

**Other Regimens**
AC: Adriamycin + cisplatin: for endometrial cancer
CI: Cisplatin + ifosfamide: for cervical carcinoma
CP: Cisplatin + paclitaxel for cervical cancer
CT: Cisplatin + topotecan for cervical cancer
VCPBAGE: Vincristine, cyclophosphamide, cisplatin, bleomycin, doxorubicin, etoposide for small cell neuroendocrine ovarian cancer
VAC-El: Vincristine, doxorubicin, cyclophosphamide, etoposide, ifosfamide for pPNET tumors

References:
Antiemesis Clinical Practice Guideline [www.nccn.org](http://www.nccn.org)
Antman K, Crowley J, Balcerzak SP. An intergroup phase III randomized study of doxorubicin and dacarbazine with or without ifosfamide and mesna in advanced soft tissue and bone sarcomas, J Clin Oncol 1993; 11: 1276-85
Fever and Neutropenia Practice Guideline [www.NCCN.org](http://www.NCCN.org)

www.epocrates.com

Revised 12/25/2006
Perioperative Management

I. Preoperative risk stratification

Usual risk of death within 30 days of surgery estimated to be 0.7% to 1.7%

A. American Society of Anesthesiologists (ASA) Classification

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
<th>Mortality (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>No chronic medical problems</td>
<td>0.1</td>
</tr>
<tr>
<td>II</td>
<td>Optimal control of mild chronic disease</td>
<td>0.7</td>
</tr>
<tr>
<td>III</td>
<td>Severe disease that limits activity without incapacitation</td>
<td>3.5</td>
</tr>
<tr>
<td>IV</td>
<td>Severe, incapacitating disease with constant threat to life</td>
<td>18.3</td>
</tr>
<tr>
<td>V</td>
<td>Moribund, death likely within 24 hours with or without surgery</td>
<td>93.3</td>
</tr>
<tr>
<td>E</td>
<td>Emergency operation</td>
<td></td>
</tr>
</tbody>
</table>

B. Functional capacity

1. Duke Activity Status

Peri-operative cardiac and long-term risks increased in patients unable to meet a 4-MET demand during normal daily activities

MET = metabolic equivalent. 1 MET = Oxygen consumption (VO2) of a 70-kg, 40-year old man in a resting state is 3.5 mL / kg-minute

<table>
<thead>
<tr>
<th>Estimated Energy Requirements for Various Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 MET</td>
</tr>
<tr>
<td>4 METs</td>
</tr>
<tr>
<td>10 METs</td>
</tr>
</tbody>
</table>

2. New York Heart Association Functional Classification of Heart Disease

<table>
<thead>
<tr>
<th>Class</th>
<th>Tolerated Specific Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Carry 24 lb object up 8 steps, walk 5 mph, carry 80 lb object, shovel snow</td>
</tr>
<tr>
<td>II</td>
<td>Walk 4 mph, rake or weed garden, sexual intercourse, walk up 8 steps</td>
</tr>
<tr>
<td>III</td>
<td>Make bed, push lawn mower, shower, walk 2.5 mph, dress</td>
</tr>
<tr>
<td>IV</td>
<td>None of above</td>
</tr>
</tbody>
</table>

II. Cardiovascular System

A. Cardiac Risk Stratification for Noncardiac Surgical Procedures (Eagle)

Clinical Predictors of Increased Perioperative Cardiovascular Risks (Myocardial infarction, Heart Failure, Death)

1. Major (Reported cardiac risk often greater than 5%)

   - Unstable coronary syndromes; acute or recent MI with evidence of important ischemic risk; unstable or severe angina (Canadian class III or IV); decompensated heart failure; significant arrhythmias including high-grade A-V block, symptomatic ventricular arrhythmias in presence of underlying heart disease, supraventricular arrhythmias with uncontrolled ventricular rate; severe valvular disease

2. Intermediate (Reported cardiac risk generally less than 5%)

   - Mild angina (Canadian class I or II), previous MI by history or pathological Q waves, compensated or prior heart failure, diabetes (insulin dependent), renal insufficiency

3. Minor (Reported cardiac risk generally less than 1%)

   - Advanced age, abnormal ECG (LVH, LBBB, ST-T abnormalities), rhythm other than sinus (e.g. atrial fibrillation), low functional capacity (cannot climb one flight of stairs with a bag of groceries), history of stroke, uncontrolled hypertension
B. Cardiac Risk Index (Goldman)

1. Risk Factors

<table>
<thead>
<tr>
<th>Points</th>
<th>Age &gt; 70 y</th>
<th>MI &lt; 6 mo ago</th>
<th>S3 Gallop or JVD</th>
<th>Aortic Stenosis</th>
<th>EKG ≠ Sinus or PAC's</th>
<th>EKG &gt; 5 PVC's/Min</th>
<th>PO₂ &lt;60,PCO₂ &gt;50,K+ &lt;3.0,HCO₃ &lt;20,BUN &gt;50,Creat &gt;3.0,Abnormal</th>
<th>SGOT, or bedridden</th>
<th>Intraperitoneal / thoracic/aortic surgery</th>
<th>Emergency surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>10</td>
<td>11</td>
<td>3</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

2. Risk of Non-cardiac Surgery

<table>
<thead>
<tr>
<th>Points</th>
<th>Class</th>
<th>Morbidity</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>I</td>
<td>0.7%</td>
<td>0.2%</td>
</tr>
<tr>
<td>6-12</td>
<td>II</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>13-25</td>
<td>III</td>
<td>11%</td>
<td>3%</td>
</tr>
<tr>
<td>≥26</td>
<td>IV</td>
<td>12%</td>
<td>39%</td>
</tr>
</tbody>
</table>

C. Revised Cardiac Risk Index (Lee)

1. Risk Factors (add total score)

   - High risk surgical procedure (Intraperitoneal, intrathoracic, vascular), ischemic heart disease (excluding previous revascularization), CHF, Hx of stroke or TIA, pre-op insulin therapy, preop creatinine >2.0 mg/dl

2. Surgical Event Rate

<table>
<thead>
<tr>
<th>Class</th>
<th>Events</th>
<th>Event Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>2/488</td>
<td>0.4 %</td>
</tr>
<tr>
<td>II</td>
<td>5/567</td>
<td>0.9%</td>
</tr>
<tr>
<td>III</td>
<td>17/258</td>
<td>6.6%</td>
</tr>
<tr>
<td>IV</td>
<td>12/109</td>
<td>11.0%</td>
</tr>
</tbody>
</table>

Major events included MI, cardiac arrest, pulmonary edema, complete heart block

D. Dobutamine Stress Echocardiography for Risk Stratification

High negative predictive value (98-100%), but low positive predictive value (14-25%)

E. Anesthetic risks for specific heart problems

1. Angina: if stable, risk low. If unstable, mortality risk 2.4%. Use Swan-Ganz catheter and anti-anginal medications. Consider CABG (cumulative mortality risk 2.3%)
2. Recent MI: recurrent MI with / without Swan-Ganz 5.7% / 37% for MI ≤ 3 months old, 2.3% / 16% for 4-6 months old. Delay elective surgery ≥ 6 months post-MI
3. Valvular disease
   a. AS: fixed output. 13% mortality risk for significant AS. Avoid regional anesthesia and hypovolemia
   b. AR: bradycardia and high peripheral resistance increase regurgitation
   c. MS: overload causes pulmonary edema, hypovolemia causes severe drop in output. Small shifts in volume cause large changes in cardiac output
   d. MR: afterload reduction reduces regurgitation
4. CHF: high risk post-op pulmonary edema. Risk 3% for NYHA Class I, 25% for Class IV. Pulmonary edema established in < 1 hour post-op in 70% of affected patients

6. HTN: diastolic should be ≤ 110 pre-op. Watch for rebound HTN off medications.

F. Post-op MI risk high if intra-op hypotension occurs (40% drop for ≥15 min). Risk peaks 3-5d. Silent MI accounts for 60% of all post-op MI's.

G. Cardiovascular Evaluation/Management Flow Chart

<table>
<thead>
<tr>
<th>Normal</th>
<th>Congestive Failure</th>
<th>Ischemic Disease</th>
<th>Valve Disease</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Optimize medications</td>
<td>Anticoagulate</td>
<td>Control pre-op BP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Avoid intra-op hypotension</td>
<td>Swan-Ganz</td>
<td>Anticipate labile BP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If severe, consider stenting or coronary bypass</td>
<td>AS / MS: no vasodilators</td>
<td></td>
</tr>
</tbody>
</table>

Intra-op hypotension

Monitor post-op EKG's qday

Serial cardiac enzymes

H. Hypotension/Shock

<table>
<thead>
<tr>
<th>Hypovolemia</th>
<th>Sepsis</th>
<th>Cardiogenic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Volume replacement with crystalloid, colloid, or blood</td>
<td>Volume replacement Broad spectrum Antibiotics</td>
</tr>
<tr>
<td></td>
<td>Vasopressor infusion</td>
<td>Vasopressor infusion</td>
</tr>
<tr>
<td></td>
<td>CVP; or Swan-Ganz</td>
<td>CVP; or Swan-Ganz</td>
</tr>
</tbody>
</table>

Treat underlying cause

Rales / (↓)
pO2

Fluid challenge

Swan-Ganz

If (↑) PCWP, and (↑) SVR: reduce afterload

If (↓) PCWP, and (↓) SVR: increase IV fluids

If (↑) PCWP, and (↓) SVR: vasopressor
I. Monitoring Values and Equations
   1. Systemic Vascular Resistance (SVR) = \([(\text{MAP}-\text{PAWP}) / \text{CO})\times 80\], where MAP = mean arterial pressure = \(1/3(\text{SBP}-\text{DBP})+\text{DBP}\), CO = cardiac output, PAWP = pulmonary artery wedge pressure. Normal SVR = 1170 dynes / sec / cm\(^5\) (range 700-1600).
   2. Swan-Ganz Catheter pressures, normal: RA 0-8 mmHg, RV 15-30 /2-8 mmHg, PA 15-30 / 4-12 mmHg, PAWP 8-12 mmHg (measured at end-expiration)
   3. Cardiac Index (CI) = CO / BSA, where CO = cardiac output, BSA = body surface area. Normal CI = 2.5 - 3.5 L/min/m\(^2\)
   4. Swan-Ganz pressure tracing

J. Pressors
   1. Dopamine. Increases renal, cerebral, and mesenteric flow at low doses (<5 mcg/kg/min). CO increases without changing BP. At doses >10 mcg/kg/min, \(\alpha\) receptor stimulation causes vasoconstriction, increased BP and pulmonary edema. Adverse effects: arrhythmia, ischemia, tissue necrosis (antidote: phentolamine 10 mg in 15 mL saline), nausea, MAO inhibitor (vasospasm) and phenytoin (hypotension) interactions. Premix: 400 or 800 mg in 250 mL D5W. Dose: 2-20 mcg/kg/min
   2. Dobutamine. Stimulates cardiac \(\alpha\) and \(\beta\)-1 receptors and peripheral \(\beta\)-2 receptors, resulting in increased CO and decreased SVR. CO increases and PAWP decreases without changing BP. Adverse effects: arrhythmia, ischemia, nausea. Premix: 1000 mg in 250 mL D5W. Dose: 2.5-20 mcg/kg/min
* Dopamine and Dobutamine are complimentary when used concurrently
   3. Norepinephrine. Stimulates cardiac \(\beta\)-1 receptors and peripheral \(\alpha\) receptors, resulting in inotropic and vasopressor effects. Adverse effects: arrhythmia, ischemia, tissue necrosis (antidote: phentolamine 10 mg in 15 mL saline). Prepare: 4 mg in 250 mL D5W. Dose: 2-12 \(\mu\)g/min
   4. Amrinone. Phosphodiesterase inhibitor that has both positive inotropic and vasodilator actions. Combined effects produce an increase in cardiac stroke output without an increase in cardiac stroke work. Indicated as single agent therapy for low output states caused by systolic heart failure. Initial loading dose 0.75 mg/kg, followed by continuous infusion ranging from 5 to 10 mcg/kg/min.
K. Vasodilators
1. Nitroprusside. Arterial and venous vasodilation. Adverse effects: ischemia, thiocyanate toxicity. Premix: 50 mg in 250 mL D5W with 500 mg sodium thiosulfate. Dose: 0.5-8 µg/kg/min
2. Nitroglycerine. Increases venous capacitance and dilates coronary arteries. Adverse effects: headache, hypotension. Premix: 100 mg in 250 mL D5W. Dose: 50-200 µg/min. Sublingual dose: 0.3-0.4 mg SL q5 min up to 3 doses

L. Anti hypertensive Medications
1. Esmolol. Ultra-short-acting, cardioselective, β-adrenergic blocking agent. Onset of action within 1 minute, with duration of 10–20 min. Metabolized via rapid hydrolysis of ester linkages by red blood cell esterases independent of renal or hepatic function. Available for IV use both as a bolus and as an infusion. Particularly useful in severe postop hypertension. It is a suitable agent in situations in which the cardiac output, heart rate, and blood pressure are increased. Typically given as a 0.5–1 mg / kg loading dose over 1 min, followed by an infusion starting at 50 mcg/kg-min and increasing up to 300 mcg/kg-min.
2. Fenoldopam. Dopamine DA1 agonist, short acting and has advantage of increasing renal blood flow and sodium excretion. Structure is similar to that of dopamine, but is highly specific for DA1 receptors and is 10 times more potent than dopamine as a renal vasodilator. Rapidly metabolized by conjugation in the liver, without cytochrome P450 enzymes. Onset of action is within 5 min, and maximal achieved by 15 min. Duration of action is 30 - 60 min, with the pressure gradually returning to pretreatment values without rebound once infusion stopped. No adverse effects reported. Starting dose is 0.1 mcg / kg-min. Causes a consistent dose-related decrease in blood pressure in the dose range 0.03–0.3 mcg / kg-min. Improves creatinine clearance, urine flow rates, and sodium excretion in severely hypertensive patients with both normal and impaired renal function. Is drug of choice in severely hypertensive patients with impaired renal function
3. Labetalol. A selective α₁- and nonselective β-adrenergic receptor blocker with an α / β blocking ratio of 1 / 7. Metabolized by liver to form inactive glucuronide conjugate. Hypotensive effect begins within 2 – 5 min after IV dosing, reaching a peak at 5 – 15 min and lasting for about 2 – 4 hours. Because of β-blocking effects, heart rate is maintained or slightly reduced. Unlike pure β-adrenergic blocking agents that decrease cardiac output, maintains cardiac output. Reduces systemic vascular resistance without reducing total peripheral blood flow. Cerebral, renal, and coronary blood flow is maintained. Used in pregnancy - induced hypertensive crises because little placental transfer occurs, mainly due to the drug's negligible lipid solubility. Labetalol may be given as a loading dose of 20 mg, followed by repeated incremental doses of 20 – 80 mg given at 10 - min intervals until the desired blood pressure is achieved. Alternatively, after the loading dose, an infusion starting at 1–2 mg / min is titrated until the desired effect is achieved. Bolus injections of 1–2 mg/kg produce precipitous fall in blood pressure and should be avoided.
4. Nicardipine. A second generation dihydropyridine derivative calcium channel blocker with high vascular selectivity and strong cerebral and coronary vasodilator. 100 times more water soluble than is nifedipine, and therefore can be administered IV. Onset of action of is 5 - 15 min with duration of 4 – 6 hours. Crosses the blood – brain barrier and reaches CNS, where it binds to L-type calcium channels primarily in the hippocampus. IV nicardipine reduces cardiac and cerebral ischemia. Appropriate dosage is independent of weight, with an initial infusion rate of 5 mg /
hour, increasing by 2.5 mg / hour every 5 min to a maximum of 30 mg / hour.

5. Hydralazine. A direct acting vasodilator. Following IM or IV administration, initial latency period of 5 – 15 min is followed by a progressive and often precipitous fall in blood pressure that can last up to 12 hours. Although circulating half-life is about 3 hours, the half-life of effect on blood pressure is 100 hours. Because of prolonged and unpredictable antihypertensive effects and the inability to titrate the drug’s hypotensive effect effectively, hydralazine is best avoided in the management of hypertensive crises.

6. Clonidine. $\alpha_2$-adrenergic receptor agonist. Dose: 0.1 mg sublingual for postop HTN.

7. CAUTION: Hold ACE inhibitors in the immediate post-op period due to risk of pronounced hypotension that is not correctable with IV fluid bolus.

III. Pulmonary System

A. Pulmonary disease categories with significance for surgery and anesthesia

1. Obstructive: asthma, chronic bronchitis, emphysema, COPD
2. Restrictive
   a. Musculoskeletal: scoliosis, multiple sclerosis, myasthenia gravis
   b. Pleural: malignant effusion, mesothelioma
   c. Interstitial-alveolar: pulmonary edema, interstitial fibrosis, lymphocytic CA
3. Vascular: pulmonary hypertension, pulmonary embolus
4. Smoking: increases mucus, carboxy - Hb inhibits myocardial O$_2$ extraction

B. Pre-operative Assessment

1. Patient-Related Risk-Factors: (Smetana)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Type of Surgery</th>
<th>Incidence of Pulmonary Complications (percent)</th>
<th>Unadjusted Relative Risk Associated with factor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Present</td>
<td>Absent</td>
</tr>
<tr>
<td>Smoking</td>
<td>CABG Abdominal</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15-46</td>
<td>6-21</td>
</tr>
<tr>
<td>ASA&gt;II</td>
<td>Unselected Thoracic/abdominal</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>26-44</td>
<td>13-18</td>
</tr>
<tr>
<td>Age&gt;70</td>
<td>Unselected Thoracic/Abdominal</td>
<td>9-17</td>
<td>4-9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17-22</td>
<td>12-21</td>
</tr>
<tr>
<td>Obesity</td>
<td>Unselected Thoracic/abdominal</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>19-36</td>
<td>17-27</td>
</tr>
<tr>
<td>COPD</td>
<td>Unselected Thoracic/Abdominal</td>
<td>6-26</td>
<td>2-8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18</td>
<td>4</td>
</tr>
</tbody>
</table>

2. Other risk factors: (Smetana)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Type of Surgery</th>
<th>Incidence of Pulmonary Complications (percent)</th>
<th>Unadjusted Relative Risk Associated with factor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Present</td>
<td>Absent</td>
</tr>
<tr>
<td>Surgery lasting &gt; 3 hours</td>
<td>Unselected Thoracic/abdominal</td>
<td>10-53</td>
<td>3-15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40</td>
<td>11</td>
</tr>
<tr>
<td>General Anesthesia</td>
<td>Unselected Thoracic/abdominal</td>
<td>8-19</td>
<td>0-17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>28-32</td>
<td>11-12</td>
</tr>
<tr>
<td>Intra-op pancuronium</td>
<td>Unselected</td>
<td>17</td>
<td>5</td>
</tr>
</tbody>
</table>
3. Significant postoperative pulmonary complications: Pneumonia, respiratory failure, prolonged need for mechanical ventilation, bronchospasm, atelectasis, exacerbation of COPD or other chronic lung

4. Procedure related risk factors: Upper abdominal and thoracic surgery carry the greatest risk of postoperative pulmonary complications, ranging from 10 to 40%

5. Preoperative clinical evaluation: Most important part of the pulmonary risk assessment. Clinical findings are generally more predictive of pulmonary complications than spirometry results.
   a. Elicit history of exercise intolerance, chronic cough, or unexplained dyspnea
   b. Physical exam:
      i. Auscultation for wheezes and crackles
      iii. Percussion of level of diaphragm.

<table>
<thead>
<tr>
<th></th>
<th>End Expiration</th>
<th>End Inspiration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Scapula (S)</td>
<td>S(↓)10-15 cm</td>
</tr>
<tr>
<td>Obstructive Disease</td>
<td>Below Scapula</td>
<td>Little Change</td>
</tr>
<tr>
<td>Restrictive Disease</td>
<td>Above Scapula</td>
<td>Little Change</td>
</tr>
</tbody>
</table>

6. Indications for detailed testing: Consider testing for thoracic or upper abdominal surgery patients and for those with symptoms of cough, dyspnea, or exercise intolerance that remain unexplained after careful history and physical. In addition spirometry may be helpful in a patient with COPD or asthma in assessing if the amount of airflow obstruction has been optimally reduced

7. Pulmonary Function Tests
   a. Spirometry. FEV<sub>1</sub> <1L, FEV<sub>1</sub>/FVC <75%, or MMV <50% predicted indicate high risk
   b. PaO<sub>2</sub> <50, wide A-a gradient, or PaCO<sub>2</sub> >45 may indicate high risk

   **The results of preoperative pulmonary function testing should not be used to deny surgery to a patient**

8. Interpreting pulmonary function tests

8. Pulmonary Complication Risk Reduction Strategies (Smetana and Qaseem)
a. Preoperative
   i. Encourage cessation of smoking for at least 8 weeks
   ii. Treat airflow obstruction in patients with COPD or asthma
   iii. Administer antibiotics and delay surgery if respiratory infection is present
   iv. Begin patient education regarding lung expansion maneuvers
b. Intraoperative
   i. Limit the duration of surgery to < 3 hours
   ii. Use spinal or epidural anesthesia
   iii. Avoid the use of pancuronium
   iv. Use laparoscopic procedures when possible
c. Postoperative
   i. Employ deep breathing exercises or incentive spirometry
   ii. Use continuous positive airway pressure
   iii. Use epidural anesthesia for postoperative pain control
   iv. Consider intercostals nerve blocks

C. Pulmonary Evaluation/Management Flow Chart

No Risk Factors

| COPD | Asthma |
| PFT's | Optimize Pre-op Bronchodilators Steroids |
| Arterial Blood Gas |  |

Pre-op Preventive Care
- Stop smoking (> 6wk)
- Incentive spirometry
- Antibiotics if bronchitis
- Bronchodilators if wheezing

Post-op Preventive Care
- Mobilize early
- Elevate head of bed
- Incentive spirometry

D. Post-Operative Morbidity (atelectasis, pneumonia)
1. With normal Pre-op PFT's: 3%; with abnormal PFT's: 70%
2. Vital capacity decreases 45% 1-2 days post-op
E. Respiratory Failure Flow Chart

Clinically stable
Mild hypoxia
\( (50 \leq pO_2 \leq 70) \)
Chronic hypercarbia

Agitation / somnolence
Moderate hypoxia
\( (40 \leq pO_2 \leq 50) \)
Hypercarbia, ? duration

Clinically unstable
Severe hypoxia
\( (pO_2 \leq 40) \)
Acute hypercarbia

<table>
<thead>
<tr>
<th>( pO_2 )</th>
<th>( pO_2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \geq 70 )</td>
<td>( \leq 40 )</td>
</tr>
</tbody>
</table>

O₂, prn
Follow ABG
Follow A-a gradient

Supplemental O₂
Follow ABG’s and A-a gradient
Consider intubation

Progressive hypoxia
Progressive hypercarbia

Intubate: largest diameter possible, low cuff pressure,
confirm position by auscultation & x-ray
Ventilator settings, initial: IMV or AC mode; TV=10 mL/kg;
Rate 12-14/min; MV 100 mL/kg/min; Fi O₂ 100%
Adjust with ABG’s
Wean Fi O₂ to \( \leq 60\% \) promptly
Hypoxemia: add PEEP 3-10 cm H₂O, or (*) Fi O₂
Hypercapnea: increase minute ventilation (MV)
Swan-Ganz catheter, keep PCWP low and Hct high
Antibiotics
Nutrition, high fat/low carbohydrate

F. Weaning
1. Wean to IMV \( \leq 10 \), FiO₂ \( \leq 40\% \).
   a. Reduce or eliminate sedating medications
   b. For difficult to wean patient consider pressure support
   c. For difficult to wean patient on TPN, reduce carbohydrates and increase lipids to
      reduce CO₂ production
2. Order weaning parameters: TV \( \geq 5 \) mL/kg, VC \( \geq 10 \) mL/kg, NIF \( \leq -20 \) cm H₂O,
   FiO₂ \( \leq 40\% \), RR \( < 25 \) / min, Compliance [TV / (PIP - PEEP) \( \geq 40 \) mL / cm H₂O
3. Procedure: 20-30 min on T-tube. If RR \( < 25 \) / min and P \( < 120 \), then extubate. If
   borderline, then get ABG. If PaO₂ \( \geq 60 \), PaCO₂ \( \leq 40 \), then extubate

G. Calculation of A-a gradient

\[
P(A - a)O_2 = [(P_B - PH_2O)FiO_2 - (PaCO_2 \times 1.2)] - PaO_2,
\]
where \( P_B \) = barometric pressure, and \( PH_2O=47 \) (vapor pressure of water)

Normal \( \leq 15 \) mm Hg on room air. Age adjusted normal = 2.5 mm Hg + 0.25(age)

H. Bronchodilators
1. Metaproteranol (Alupent) inhaler. A \( \beta \)-2 agonist. Dose: 2 puffs q 4-6 hours.
2. Albuterol (Ventolin) inhaler. A \( \beta \)-2 agonist. Dose: 2 puffs q 4-6 hours.

IV. Renal System

A. Types and Causes of Perioperative Renal Failure
1. Pre-renal
   a. Etiology: hypovolemia, CHF, sepsis
   b. Diagnosis: assess volume and cardiac status (see flow chart I.F. above)
2. Renal
   a. Etiology
      a. ATN from ischemia, intra-op hypotension, antibiotics, radiocontrast, sepsis
      b. SIADH (usually transient and not associated with rise in creatinine):
         anesthetics, narcotics, chemotherapy drugs, tumors
   b. Diagnosis: urinalysis, urine and serum electrolytes and osmolality
3. Post-renal: catheter obstruction, urethral or ureteral obstruction, stones
4. Differentiating pre-renal from renal etiology

<table>
<thead>
<tr>
<th></th>
<th>Pre-renal</th>
<th>Renal</th>
</tr>
</thead>
<tbody>
<tr>
<td>BUN/Creat ratio</td>
<td>&gt; 20:1</td>
<td>≤ 20:1</td>
</tr>
<tr>
<td>Urine osmolality</td>
<td>350 - 500 mOsm/kg</td>
<td>&lt; 350 mOsm/kg</td>
</tr>
<tr>
<td>Urine NA⁺</td>
<td>&lt; 20 mEq/L</td>
<td>&gt; 40 mEq/L</td>
</tr>
<tr>
<td>FENa</td>
<td>&lt; 1%</td>
<td>&gt; 1%</td>
</tr>
</tbody>
</table>

B. Flow Chart for Management of Rising Creatinine

C. Calculations
1. FENa: \[\left(\frac{U_{Na} \times P_{Cr}}{P_{Na} \times U_{Cr}}\right) \times 100\]. Normal ≤ 1%
2. Anion Gap (AG) = Na⁺ - (Cl⁻ + HCO₃⁻). Normal 12 ± 4 mEq / L
3. Osmolality (serum) = 2 [Na⁺ + K⁺ (in mEq/L)] + urea(mg / dL) / 2.8 + glucose(mg/dL) / 18
4. Deficit of HCO₃⁻ = (body weight, kg)(0.4)(desired - measured HCO₃⁻)
D. Acid-Base problems
1. Metabolic acidosis
   a. Increased anion gap: renal failure, lactic acidosis (e.g. shock or sepsis), keto-
      acidosis, drug intoxication
   b. Normal anion gap: loss of \( \text{HCO}_3^- \) and accompanying \( \text{K}^+ \) from diarrhea, ureteral
      diversion, renal tubular acidosis; obstructive nephropathy
2. Metabolic alkalosis: emesis, nasogastric suction, diuretic use, Cushing's syndrome
3. Respiratory acidosis: ventilatory failure
4. Respiratory alkalosis: anxiety, sepsis, salicylates, hypoxemia, hyperthyroidism

V. Hematologic System
A. Thromboembolic Complications
1. Virchow's Triad (stasis, intimal injury, hypercoagulability)
2. Risk factors: (Schunemann)
   
   | Surgery, previous VTE, myeloproliferative disorder, trauma, pregnancy, obesity, |
   | immobility / paresis, exogenous hormones, smoking, malignancy, increasing age, |
   | varicose veins, cancer therapy, heart / respiratory failure, central venous catheters, |
   | inflammatory bowel disease, nephrotic syndrome, thrombophilies |

3. Absolute Risk of DVT in Hospitalized Patients (Schunemann)

<table>
<thead>
<tr>
<th>Patient Group</th>
<th>DVT Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical patients</td>
<td>10-20</td>
</tr>
<tr>
<td>General surgery, gynecologic surgery, urologic</td>
<td>15-40</td>
</tr>
<tr>
<td>surgery, neurosurgery</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>20-50</td>
</tr>
<tr>
<td>Hip or knee arthroplasty</td>
<td>40-60</td>
</tr>
<tr>
<td>Major trauma</td>
<td>40-80</td>
</tr>
<tr>
<td>Spinal cord trauma</td>
<td>60-80</td>
</tr>
<tr>
<td>Critical care patients</td>
<td>10-80</td>
</tr>
</tbody>
</table>

4. Levels of Thromboembolism Risk in Surgical Patients Without Prophylaxis (Geerts)

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>DVT</th>
<th>PE</th>
<th>Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk: Minor surgery in pts &lt; 40 y with no other risk factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Risk: Minor surgery in pts with risk factors, OR Surgery in pts aged 40 - 60 yr with no other risk factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Risk: Surgery in pts &gt; 60y, or 40-60y with additional risk factors (prior VTE, cancer, hypercoagulability)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest Risk: Surgery in patients with multiple risk factors (age &gt;40y, cancer, prior VTE, hip or knee arthroplasty, major trauma)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Prevention Key: LDUH = Low dose unfractionated heparin; LMWH = Low molecular weight heparin; GCS = graduated compression stockings; IPC = intermittent pneumatic compression; VKA = Vitamin K antagonist.

5. Prophylaxis
   a. Mini-dose heparin: 5000 Units SC bid or tid. Thrombocytopenia rare. May be ineffective for patients with gyn malignancy
   b. Pneumatic compression stockings
   c. Low molecular weight heparin
      i. Enoxaparin (Lovenox): 40 mg SC daily or if weight > 150 kg, then 30 mg SC BID. Reduce dose for renal impairment. Do not administer with ketorolac (Toradol) due to risk of hemorrhage
      d. Greenfield filter: for patients at high risk who cannot be anticoagulated

   a. Patients undergoing brief procedures ≤ 30 minutes for benign disease require only early, aggressive mobilization
   b. Patients undergoing laparoscopic gyn procedures, in whom additional VTE risk factors are present should receive thromboprophylaxis with one or more of the following: LDUH, LMWH, IPC, or GCS (See key in section V.A.4 above)
   c. Thromboprophylaxis should be used in all patients undergoing major gynecologic procedures.
      i. Major gynecologic surgery for benign disease, without additional risk factors should receive LDUH 5000 U bid. Alternatives include daily LMWH, or IPC started just before surgery and used continuously while the patient is not ambulating
      ii. Patients undergoing extensive surgery for malignancy, and for patients with additional risk factors for VTE should receive LDUH 5000 U tid, or a higher dose LMWH. Alternative considerations include IPC alone continued until hospital discharge, or a combination of LDUH or LMWH plus mechanical prophylaxis with GCS or IPC
      iii. For patients undergoing major gynecologic surgery it is suggested that prophylaxis continue until discharge from hospital. In patients who are at particularly high risk, including those who have undergone cancer surgery and who are > 60 years of age, or have a previous history of VTE, it is suggested that prophylaxis continue for 2 to 4 weeks after hospital discharge.

7. Pulmonary embolus
   a. Diagnosis suggested by history, symptoms, and high clinical suspicion
   b. Spiral CT scan or V/Q scan may be used for diagnosis
   c. Gold standard is angiography, but morbidity is higher
   d. Treatment: full therapeutic anticoagulation with LDUH or LMWH

B. Transfusions: selective use indicated due to risk of infection, and transfusion reactions

VI. Endocrine System
A. Diabetes (Jacober 1999)
   1. Surgical stress and some general anesthetic agents increase counter regulatory hormones (epinephrine, norepinephrine, glucagons, growth hormone, and cortisol) and increase insulin resistance, thereby increasing hepatic glucose production and decreased peripheral insulin utilization. This leads to hyperglycemia and ketogenesis in pts with type 1 diabetes.
2. Operative morbidity and mortality in critically ill patients is decreased with tight glucose control. Post-operative goals and approaches to critically ill patients should target glucose 150 to 200 mg/dL. (Van den Berghe), although morbidity is better if glucose levels are maintained < 150 mg/dL.

3. On morning of surgery, give 1/2 usual dose of antihyperglycemics. Patients taking metformin should discontinue the drug on the day of surgery because complications or alterations in renal function arising intraoperatively may potentiate the risk of developing lactic acidosis. Maintain post-op glucose control with individualized sliding scale regimen using subcutaneous insulin on a sliding scale. In pts who are critically ill or who fail to respond to subcutaneous protocols, change to insulin drip.

4. Watch for signs of lactic acidosis (sepsis), ketoacidosis (hyperglycemia), electrolytes disturbances, and end-organ diseases (heart, kidneys, eyes) in diabetics.

B. Thyroid Disease
1. Hypothyroidism: Does not appreciably increase operative risk, but initiation of medication should not be delayed. Watch for pericardial effusion; decreased inspiratory reserve volume, stroke volume, EKG voltage and SVR.

2. Hyperthyroidism: Thyroid storm occurs in 10% of hyperthyroid patients undergoing surgery. Elective surgery should be delayed 3 months while disease controlled with PTU. For emergency surgery, treatment with β-blocker indicated.

C. Steroid Dependence
1. Patients on chronic steroid treatment (≥ 7.5 mg prednisone daily) have suppressed hypothalamic – pituitary - adrenal axis and require steroid pulse perioperatively. HPA axis can remain suppressed for a year after completing steroid therapy.

2. Usual steroid pulse: Hydrocortisone, 100 mg IVPB q6 - 8h. Pulse duration and rate of taper customized to fit patient needs.

3. Signs of HPA axis insufficiency: malaise, low fever, nausea, arthralgia, electrolyte disturbances.

4. Use of steroids in HPA suppressed patients can be of benefit, especially in patients who are critically ill and experiencing evidence of sepsis. (Annane)

VII. Gastrointestinal System
A. Pre-op bowel prep
   Fleets AcuPrep or 4 liters Golytely, or 2 bottles magnesium citrate given about 18 hours preop.

B. Post-op gastric erosions common in critically ill patients. 5% will have hemodynamically significant bleeding (80% mortality).

C. Gastric Erosion Prophylaxis:
   1. IV H2 blockers (e.g. Zantac 50 mg IVPB q8h).
   2. Nasogastric tube administered antacids, titrate gastric fluid to pH≥3.5.

VIII. Prophylactic Antibiotics: warranted for all gynecologic oncology surgery. 1-2 doses of cefoxitin (dose: 2 gm prior to incision then Q6 hours x 3 doses) or cefazolin adequate. First dose should be given 1-2 hours before incision.

References


Doyle RL. Assessing and modifying the risk of postoperative pulmonary complications. Chest, 1999; 115: 77S-81S.


Medical Clinics of North America. Preoperative Consultation. 1987; 71(3)


12/25/2006 RK Reynolds and William M. Burke, MD
Tools and Equipment for the Art of Surgery

I. Clamps and Forceps

A. Atraumatic tissue clamps
   1. Allis. Good for traction on vaginal mucosa or peritoneum.
   4. Intestinal clamps. Non-crushing clamps to occlude bowel for anastomosis without spill. May be used shod (rubber or foam pad) or unshod.
      - Allen
      - Bainbridge
      - Dennis
      - Doyen
      - Glassman
      - Mayo
      - Scudder

B. Crushing (traumatic) Clamps
   1. Clark clamp. Long clamp with vascular jaw. For tunneling ureters.
   2. Hysterectomy clamps
      - Heaney-Ballentine. Longitudinal ridge in jaw causes less slippage.
      - Zeppelin. Longitudinal ridge in jaw. Various lengths and degrees of curvature.

   Coller. Delicate tip with long jaws. Good dissector.
Mosquito. Delicate and short.
Pean / Kelly. Heavy duty.
Tonsil. Not for clamping soft tissue such as omentum due to cross hatch jaw pattern at tip only.
4. Kocher. Traumatic but able to hold tension on fascia due to tooth at tip of jaw.
5. Right angle / Mixter. Good for dissecting. May let tissue slip when cut due to jaw design.
6. Tenaculum. Teeth penetrate tissue to apply traction.
   Barrett: single tooth
   Schroeder vulsellum: double tooth
   Leahy vulsellum: triple tooth

C. Forceps. For grasping tissue.
   1. Adson. Delicate and short, with or without teeth and needle holding serrations. For skin
   2. Bonney. Heavy and has needle holding serrations. For fascia.
   3. DeBakey. Atraumatic with longitudinal groove in non-crushing jaw. For vessels
   4. Potts. Very fine tip, with or without teeth. For ureters
   5. Ring / Sponge
   6. Russian. Firm grip on tissue although traumatic as well.
   7. Singley. Atraumatic with fenestrated oval tip. For lymphadenectomy.
   8. Tissue. With or without teeth. For skin or non-delicate tissue
II. Needle Holders

Heaney. Curved jaw. Best for vaginal surgery.
Straight. Many different types from light to heavy duty, and short to long length.

III. Retractors

A. Self retaining
   2. Bookwalter. Complex but very flexible self-retaining design. Able to retract deep structures. Post clamps to OR table
5. Lone Star. Self-retaining ring for perineal exposure.
7. Weitlaner. For inguinal node dissection. Sharp or blunt tooth designs.

Self-Retaining Retractors

B. Hand held retractors
1. Abdominal
   Army-Navy: Small. For superficial tissues.
   Brewster: Curved, shallow blade, straight handle. For intermediate tissue depth.
   Deaver. Curved, deep blade
   Israel. Rake design good for skin flap elevation.
   Kelly. Larger version of the Richardson.
   Malleable / Ribbon. Can be bent to shape.
   Richardson
   St. Marks. Very deep for the “Midwest” patient
   Vein / Cushing. For retracting vessels
2. Vaginal
Breisky. Long, offset straight design for vaginal surgery.
Heaney
Weighted
  Auvard. Long weighted speculum
Sims

Hand Held Retractors

IV. Scissors
  Bandage. For cutting dressings. Not for tissue.
  Iris. Fine scissors with pointed blades.
  Jorgenson. Heavy right angle design for vaginal cuff.
  Mayo. Heavy short scissors. Straight or curved. Straight used for suture cutting, curved for fascia or dense tissue
  Metzenbaum. Delicate, long or short, curved. For dissecting soft tissue.
  Nelson. Long heavy scissors, curved or straight. For firm or rubbery tissues, e.g. uterosacral ligament.
  Potts-Smith. Delicate angled scissors with pointed tips. For urinary conduits or other fine cutting.
V. Scalpels
Blades are numbered. #10 used for most skin incisions. #15 used for small incisions or peritoneal entry. #11 used for laparoscopic incisions and cone biopsies.

VII. Dilators. For dilating the endocervix
   Hegar. Blunt tip, somewhat traumatic to firm cervix.
   Hank. Tapered tip with flange to indicate depth.
   Pratt. Tapered tip, no flange.

VIII. Suction Tips
   Pool tip. Used to aspirate large volumes of fluid such as ascites.
   Yankauer

IX. Sutures

<table>
<thead>
<tr>
<th>Absorbable</th>
<th>Tissue Reaction</th>
<th>Absorption Rate</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plain Gut</td>
<td>Moderate</td>
<td>7-10 days</td>
<td>1</td>
</tr>
<tr>
<td>Chromic Gut</td>
<td>Moderate</td>
<td>21-28 days</td>
<td>2</td>
</tr>
<tr>
<td>Monocryl</td>
<td>Slight</td>
<td>Fast</td>
<td></td>
</tr>
<tr>
<td>Vicryl (polyglactin 910)</td>
<td>Mild</td>
<td>40% at 2 weeks</td>
<td>3</td>
</tr>
<tr>
<td>Dexon (Polyglycolic acid)</td>
<td>Mild</td>
<td>40% at 2 weeks</td>
<td>3</td>
</tr>
<tr>
<td>PDS (Polydioxanone)</td>
<td>Slight</td>
<td>Delayed</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Permanent</th>
<th>Tissue Reaction</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silk</td>
<td>Moderate</td>
<td>2</td>
</tr>
<tr>
<td>Prolene / Novofil (Polypropylene)</td>
<td>Minimal</td>
<td>4</td>
</tr>
<tr>
<td>Ethibond (Braided synthetics)</td>
<td>Minimal</td>
<td>4</td>
</tr>
<tr>
<td>Nylon</td>
<td>Low</td>
<td>4</td>
</tr>
</tbody>
</table>
X. Needles
Cutting. For skin only.
Keith. Straight needle with cutting tip.
Taper. Many sizes and degrees of curvature. RB (very small for delicate tissue), SH (fine needle for soft tissue), CT (general closure), UR (urology needle with more circular arc)
Swaged. Needle must be cut from suture. Do not try to pull off. Needle can fly.
Controlled Release (“Pop-Off”). Important to pull off at correct angle.

XI. Knots
Granny. Bad because it slips
Square. Good because it does not slip
Surgeon’s. Good for fascia because first throw holds tight even when tissue on tension but not easily tensioned on vascular pedicles or soft tissue.
Best knot for monofilament mass closure on fascia is surgeon’s + surgeon’s + square knot.
XII. Energy Tools

A. Electrosurgery. Use of radiofrequency current to divide or coagulate tissue for hemostasis.
   1. Water Tower Analogy
      Volts equals water column (pressure)
      Current equals volume of water through pipe over time
      Resistance equals diameter of pipe

      **Ohm’s Law: V=IR**

   2. Types of electrosurgery in clinical use
      Monopolar
      Bipolar
      Cutting. High voltage sine wave. Divides tissue with less thermal damage than coagulation.
      Coagulation. Spark gap current heats tissue to coagulate vessels. Devitalizes tissue.
      Blend. Mixture of cutting and coagulation.
      Argon beam
3. Electrosurgical Effect on Cells
Radiofrequency current transfers energy to intracellular ions. Sine waveform results in oscillation of ions, imparting heat to intracellular water causing cell to burst.

4. Current Path Through Tissue
Current passes from the electrode through tissue and returns through the ground electrode.

5. Effect of Waveform on Tissue
   a. Cutting
      Sine wave
      Low voltage (1000 volts at 50 Watts power)
      Current arcs to tissue across steam envelope
      Less heating of tissue than coagulation waveform
   b. Coagulation (Fulguration)
      Uses spark gap current
      High voltage (5000 volts at 50 watts)
      Current arcs to tissue
      Causes heating and necrosis of tissue
   c. Desiccation
      Uses spark gap current
      High voltage (5000 volts at 50 watts)
      Direct contact to tissue
      Causes heating and necrosis of tissue
6. Monopolar vs. Bipolar
   a. Monopolar: Current passes from electrode to grounding pad through body of patient. More risk!
   b. Bipolar: Current passes from active electrode to return electrode only. Less surrounding tissue damaged
   c. Bipolar Vessel Sealers
      Microprocessor controls current to tissue to cause controlled tissue melting
      Capable of sealing vessels up to 7 mm
      Brands: Gyrus, Ligasure, Enseal
7. Complications of Electrosurgery
   a. Injury to adjacent structures by arcing or heating tissue
      Poor technique
      Instrument failure
   b. Consequence of injury may be delayed (e.g. bowel perforation or ureteral stricture)
   c. Capacitance: Occurs when energy is transferred to adjacent metal structure through an insulator. Can cause injury remote from instrument tip

<table>
<thead>
<tr>
<th>Capacitance is produced by the conductor within the insulated shaft of laparoscopic instruments</th>
<th>Capacitance injury can occur out of the visual field (rectangle) if an organ is near to the instrument shaft</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Diagram of capacitance" /></td>
<td><img src="image2.png" alt="Diagram of capacitance injury" /></td>
</tr>
</tbody>
</table>

B. Mechanical. Uses ultrasonic energy transmitted to tissue as mechanical vibration to heat tissue. Results in cell lysis. Protein melt seals vessels.

   ![Image of shears and scalpels](image3.png)

   2. Cavitron Ultrasonic Surgical Aspirator (CUSA). Oscillates at 55Khz. Used for tumor debulking. Shakes tumor apart

   ![Image of CUSA](image4.png)

1. Wavelength and laser type. The primary laser used for gynecology is the CO2 laser. It is an infra-red laser (10,600 nanometer wavelength). Absorption occurs superficially by intracellular water resulting in controlled surface ablation. In contrast, YAG lasers penetrate deeply and coagulates vessels, which is useful for bleeding tumor.

2. Power density determines whether tissue will be coagulated or vaporized. Power Density = power/spot size = watts/πr². To ablate without char, power density should be 750-1000 watts per cm².

3. Laser modes. Determines energy delivery as a function of time. Continuous
   Intermittent
   Superpulse
   Chopped pulse
   Silk Touch: motorized beam pattern improves cosmetic results
4. Eye protection is required for safety.

XIII. Staplers
A. Bowel
   1. Gastrointestinal anastomosis (GIA). Staples and divides. Use 3.8mm staples on small bowel. Use 4.8mm staples on colon or inflamed bowel. Available in different lengths and for both laparotomy and laparoscopy procedures. Used for dividing and anastomosis of bowel. Can be used for broad ligament and IP ligament (expensive)
   3. End-to-end anastomosis (EEA). Staples and divides with concentric ring design. Available in different diameters. Use largest diameter that bowel will accept.
Profile of bowel staples. “B” shape allows approximation without compromise of blood supply.

GIA stapler in use to divide bowel (above) and to anastamose bowel (right).

From top to bottom: TA stapler, GIA stapler, and EEA stapler.
TA stapler in use for anastamosis of colon.

EEA stapler in use for low rectal anastamosis after supralelevator pelvic exenteration.

B. Skin
C. Others
   1. Ligate-divide-staple (LDS). Gas powered stapler for dividing soft tissues such as omentum.
   2. Fascial staples. For hernia repairs.
## GOG Toxicity Criteria

<table>
<thead>
<tr>
<th>Grade</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood / Bone Marrow</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WBC / Gran.</td>
<td>3.0 - 3.9 / 1.5 - 1.9</td>
<td>2.0 - 2.9 / 1.0 - 1.4</td>
<td>1.0 - 1.9 / 0.5 - 0.9</td>
<td>&lt; 1 / &lt; 0.5</td>
</tr>
<tr>
<td>Platelets</td>
<td>75 - 99.9</td>
<td>50 - 74.9</td>
<td>25 - 49.9</td>
<td>&lt; 25</td>
</tr>
<tr>
<td>Hb / Hct</td>
<td>&gt; 10.0g / &gt; 30%</td>
<td>8.0 - 10.0g / 24 - 30%</td>
<td>6.5 - 7.9g / 19.5 - 23.9%</td>
<td>&lt; 6.5g / &lt; 19.5%</td>
</tr>
<tr>
<td>Lymphocytes</td>
<td>1.5-1.9</td>
<td>1.0-1.4</td>
<td>0.5-0.9</td>
<td>&lt;0.5</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>Mild, No transfusion</td>
<td>Gross, 1 - 2 units transfused</td>
<td>Gross, 3 - 4 units transfused</td>
<td>Massive, &gt; 4 units transfused</td>
</tr>
<tr>
<td><strong>Coagulation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fibrinogen</td>
<td>0.75-0.99 x N</td>
<td>0.5-0.74 x N</td>
<td>0.25-0.49 x N</td>
<td>&lt;0.25 x N</td>
</tr>
<tr>
<td>PT</td>
<td>1.01-1.25 x N</td>
<td>1.26-1.5 x N</td>
<td>1.51-2 x N</td>
<td>&gt; 2 x N</td>
</tr>
<tr>
<td>PTT</td>
<td>1.01-1.66 x N</td>
<td>1.67-2.33 x N</td>
<td>2.34-3 x N</td>
<td>&gt;3 x N</td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>Intake reasonable</td>
<td>Intake decreased</td>
<td>No significant intake</td>
<td>-</td>
</tr>
<tr>
<td>Emesis</td>
<td>1 per 24 h</td>
<td>2 - 5 per 24 h</td>
<td>6 - 10 per 24 h</td>
<td>&gt; 10 per 24 h, or TPN</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Increase of 2 - 3 per day over normal</td>
<td>Increase of 4 - 6 per day, or moderate cramping</td>
<td>Increase of 7 - 9 per day, or severe cramping</td>
<td>Increase of ≥ 10 per day, or bloody stool, or need for TPN</td>
</tr>
<tr>
<td>Constipation</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Ileus &gt; 96 hours</td>
</tr>
<tr>
<td>Stomatitis</td>
<td>Painless edema or ulcer, or mild soreness</td>
<td>Painful edema or ulcer, but can eat</td>
<td>Painful edema or ulcer, and can't eat</td>
<td>Requires TPN</td>
</tr>
<tr>
<td>Mechanical</td>
<td>&lt; 3 days ileus</td>
<td>Ileus, requires NG; narrow segment on X-ray or edema on proctoscopy</td>
<td>Surgically correctable defect, no stoma</td>
<td>Fistula, perforation, or chronic bleeding requiring diversion</td>
</tr>
<tr>
<td>Operative</td>
<td>Repair mucosal defect</td>
<td>Resect enterotomy</td>
<td>Temporary diversion</td>
<td>Permanent diversion</td>
</tr>
<tr>
<td>Bilirubin</td>
<td>-</td>
<td>&lt; 1.5 x N</td>
<td>1.6 - 3.0 x N</td>
<td>&gt; 3.0 x N</td>
</tr>
<tr>
<td>Transaminase</td>
<td>&lt; 2.5 x N</td>
<td>2.6 - 5.0 x N</td>
<td>5.1 - 20.0 x N</td>
<td>&gt; 20.0 x N</td>
</tr>
<tr>
<td>Alk. Phos.</td>
<td>&lt; 2.5 x N</td>
<td>2.6 - 5.0 x N</td>
<td>5.1 - 20.0 x N</td>
<td>&gt; 20.0 x N</td>
</tr>
<tr>
<td>Liver - Clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urinary Tract</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine</td>
<td>&lt; 1.5 x N</td>
<td>1.5 - 3.0 x N</td>
<td>3.1 - 6.0 x N</td>
<td>&gt; 6.0 x N</td>
</tr>
<tr>
<td>Proteinuria</td>
<td>1+ or &lt; 3 g/L</td>
<td>2 - 3+ or 3 - 10 g/L</td>
<td>4+ or &gt; 10 g/L</td>
<td>Nephrotic syndrome</td>
</tr>
<tr>
<td>Hematuria</td>
<td>Microscopic only</td>
<td>Gross, no clots</td>
<td>Gross, with clots</td>
<td>Transfusion required</td>
</tr>
<tr>
<td>Bladder / Ureter, Acute</td>
<td>Dysuria, frequency, repair</td>
<td>Bacterial UTI; Injury w/ reanastomosis or reimplantation,</td>
<td>Fistula or obstruction w/ 2° repair, loss of 1 kidney</td>
<td>Obstruction of 2 kidneys, V-V fistula w/ diversion</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Operative</td>
<td>Bladder atony post-op</td>
<td>Transient atony &gt;6 w</td>
<td>Atony, requiring intermittent self catheterization</td>
<td>-</td>
</tr>
<tr>
<td>Bladder, Chronic</td>
<td>Dysuria, frequency; minimal telangiectasia with edema on cystoscopy</td>
<td>Bladder volume &lt;150 mL; moderate telangiectasia or superficial ulceration on cystoscopy. Gross hematuria</td>
<td>Severe pain; deep mucosal ulceration on cystoscopy. Hematuria requiring transfusion. Permanent unilateral loss of kidney</td>
<td>Decreased volume requiring diversion or catheter; fistula; bilateral loss of renal function requiring dialysis</td>
</tr>
</tbody>
</table>

**Heart / Blood Pressure**

<table>
<thead>
<tr>
<th>Dysrhythmia</th>
<th>Asymptomatic, transient, no treatment needed</th>
<th>Recurrent or persistent, no treatment needed</th>
<th>Requires treatment</th>
<th>Hypotension, V-tach, V-fib; requires monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac function</td>
<td>Asymptomatic, E.F. ≥80% of baseline</td>
<td>Asymptomatic, E.F. &lt;80% of baseline</td>
<td>Mild C.H.F., responds to treatment</td>
<td>Severe or refractory C.H.F.</td>
</tr>
<tr>
<td>Ischemia</td>
<td>Non-specific T-wave flattening</td>
<td>Ischemic ST-T wave change suggesting ischemia; asymptomatic</td>
<td>Angina, no evidence M.I.</td>
<td>Acute M.I.</td>
</tr>
<tr>
<td>Pericardium</td>
<td>Asymptomatic effusion, no intervention required</td>
<td>Pericarditis (pain, rub E.C.G. changes)</td>
<td>Symptomatic effusion, requires drainage</td>
<td>Tamponade, drainage urgently required</td>
</tr>
<tr>
<td>HTN</td>
<td>Asymptomatic, transient ↑ &gt; 20mmHg or BP &gt;150/100 if previously normal. No treatment required</td>
<td>Recurrent or persistent ↑ &gt;20 mm Hg or BP &gt;150/100, no treatment required</td>
<td>Treatment required</td>
<td>Hypertensive crisis</td>
</tr>
<tr>
<td>Hypotension</td>
<td>No treatment required, includes orthostatic hypotension</td>
<td>Requires fluid replacement, no hospitalization</td>
<td>Requires Rx and hospitalization, resolves &lt; 48 h</td>
<td>Requires Rx and hospitalization, resolves &gt; 48 h</td>
</tr>
<tr>
<td>Venous problems</td>
<td>Superficial phlebitis, or 1° suture repair of injury with grade 0-1 blood loss</td>
<td>Ischemia not requiring surgery; or 1° suture repair of injury with ≥ Grade 2 hemorrhage</td>
<td>P.E.; or bypass of injured vessel</td>
<td>P.E. requiring embolectomy or caval ligation</td>
</tr>
<tr>
<td>Arterial problems</td>
<td>Spasm, or 1° suture repair of injury with grade 0-1 blood loss</td>
<td>Ischemia not requiring surgery; or 1° suture repair of injury with ≥ Grade 2 hemorrhage</td>
<td>Occlusion, thrombosis, or injury requiring bypass or resection</td>
<td>M.I. or resection of limb or organ</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Asymptomatic, Abnormal P.F.T</td>
<td>Dyspnea on significant exertion</td>
<td>Dyspnea at normal activity</td>
<td>Dyspnea at rest</td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensory</td>
<td>Mild paresthesia, loss of D.T.R.</td>
<td>Mild-moderate objective sensory loss, moderate paresthesia</td>
<td>Severe objective sensory loss; paresthesia that interferes with function</td>
<td>-</td>
</tr>
<tr>
<td>Motor</td>
<td>Subjective weakness; no objective findings</td>
<td>Mild objective weakness; no significant impairment</td>
<td>Objective weakness, with impairment</td>
<td>Paralysis</td>
</tr>
<tr>
<td>Cortical</td>
<td>Mild somnolence or agitation</td>
<td>Moderate somnolence or agitation</td>
<td>Severe somnolence or agitation, confusion, hallucination</td>
<td>Coma, seizure, toxic psychosis</td>
</tr>
<tr>
<td>Cerebellar</td>
<td>Slight incoordination, dysdiadokinesis</td>
<td>Intention tremor, dysmetria, nystagmus, slurred speech</td>
<td>Locomotor ataxia</td>
<td>Cerebellar necrosis</td>
</tr>
<tr>
<td>Mood</td>
<td>Mild anxiety or depression</td>
<td>Moderate anxiety or depression</td>
<td>Severe anxiety or depression</td>
<td>Suicidal ideation</td>
</tr>
<tr>
<td>Headache</td>
<td>Mild</td>
<td>Moderate or severe but transient</td>
<td>Unrelenting and severe</td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>Asymptomatic loss, noted on audiometry only</td>
<td>Tinnitus</td>
<td>Functional hearing loss, correctable</td>
<td>Deafness, not correctable</td>
</tr>
<tr>
<td>Vision</td>
<td>-</td>
<td>-</td>
<td>Symptomatic subtotal loss of vision</td>
<td>Blindness</td>
</tr>
<tr>
<td>Skin / Allergy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>Scattered, asymptomatic maculo-papular eruption or erythema</td>
<td>Scattered maculo-papular eruption, with pruritus or other symptoms</td>
<td>General, symptomatic maculo-papular or vesicular eruption</td>
<td>Exfoliative or ulcerative dermatitis</td>
</tr>
<tr>
<td>Wound</td>
<td>Cellulitis; incisional separation</td>
<td>Superficial infection; incisional hernia</td>
<td>Abscess; fascial defect without evisceration</td>
<td>Necrotizing fasciitis; fascial defect with evisceration</td>
</tr>
<tr>
<td>Local Injury</td>
<td>Pain</td>
<td>Pain, and swelling, with inflammation; or phlebitis</td>
<td>Ulceration</td>
<td>Plastic surgery indicated</td>
</tr>
<tr>
<td>Alopecia</td>
<td>Mild hair loss</td>
<td>Pronounced or total hair loss</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------</td>
<td>-------------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Allergy</td>
<td>Transient rash, drug fever &lt;100.4°F</td>
<td>Urticaria, mild bronchospasm, drug fever ≥100.4°F</td>
<td>Serum sickness or bronchospasm requiring treatment</td>
<td>Anaphylaxis</td>
</tr>
<tr>
<td>Lymphedema</td>
<td>Mild</td>
<td>Moderate, requiring compression; or lymphocyst</td>
<td>Severe, limiting function; or lymphocyst requiring surgery</td>
<td>Severe, limiting function, with ulceration</td>
</tr>
</tbody>
</table>

**Infection**

<table>
<thead>
<tr>
<th>Infection</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Life threatening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>37.1-38°C</td>
<td>38.1-40°C</td>
<td>&gt;40°C or 104°F for &lt;24 hours</td>
<td>&gt;40°C or 104°F for &gt;24 hours, or hypotension</td>
</tr>
<tr>
<td></td>
<td>98.7-100.4°F</td>
<td>100.5-104°F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Metabolic**

<table>
<thead>
<tr>
<th>Weight gain or loss</th>
<th>5 - 9.9%</th>
<th>10 - 19.9%</th>
<th>&gt; 20%</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperglycemia</td>
<td>116 - 160</td>
<td>161 - 250</td>
<td>251 - 500</td>
<td>&gt; 500, or ketoacidosis</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>55 - 64</td>
<td>40 - 54</td>
<td>30 - 39</td>
<td>&lt; 30</td>
</tr>
<tr>
<td>Amylase</td>
<td>&lt; 1.5 x N</td>
<td>1.5 - 2 x N</td>
<td>2.1 - 5 x N</td>
<td>&gt; 5 x N</td>
</tr>
<tr>
<td>Hypercalcemia</td>
<td>10.6 - 11.5</td>
<td>11.6 - 12.5</td>
<td>12.6 - 13.5</td>
<td>&gt; 13.5</td>
</tr>
<tr>
<td>Hypocalcemia</td>
<td>7.8 - 8.4</td>
<td>7 - 7.7</td>
<td>6.1 - 6.9</td>
<td>&lt; 6.1</td>
</tr>
<tr>
<td>Hypomagnesemia</td>
<td>1.2 - 1.4</td>
<td>0.9 - 1.1</td>
<td>0.6 - 0.8</td>
<td>&lt; 0.6</td>
</tr>
</tbody>
</table>

**Coagulation**

| Fibrinogen | 0.75 - 0.99 x N | 0.5 – 0.74 x N | 0.25 – 0.49 x N | < 0.25 x N |
| PT         | 1.01 – 1.25 x N | 1.26 – 1.5 x N | 1.51 – 2 x N | > 2 x N |
| PTT        | 1.01 – 1.66 x N | 1.67 – 2.33 x N | 2.34 x 3 x N | > 3 x N |
Performance Status

<table>
<thead>
<tr>
<th>GOG Score</th>
<th>Karnofsky Score</th>
<th>Activity Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>90-100</td>
<td>Fully active, unrestricted activities of daily living</td>
</tr>
<tr>
<td>1</td>
<td>70-80</td>
<td>Ambulatory, but restricted in strenuous activity</td>
</tr>
<tr>
<td>2</td>
<td>50-60</td>
<td>Ambulatory, and capable of self care. Unable to work. Out of bed for greater than 50% of waking hours</td>
</tr>
<tr>
<td>3</td>
<td>30-40</td>
<td>Limited self care, or confined to bed or chair 50% of waking hours. Needs special assistance</td>
</tr>
<tr>
<td>4</td>
<td>10-20</td>
<td>Completely disabled, and no self care</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>Dead</td>
</tr>
<tr>
<td><strong>Important Web Addresses</strong></td>
<td><strong>Address</strong></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
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<td></td>
</tr>
<tr>
<td>UM Documentation, Coding, HIPAA Compliance</td>
<td><a href="http://www.med.umich.edu/i/compliance/">www.med.umich.edu/i/compliance/</a></td>
<td></td>
</tr>
<tr>
<td>UM Paging and Clinical Resources, including CareWeb if in house</td>
<td><a href="http://www.med.umich.edu/clinical">www.med.umich.edu/clinical</a></td>
<td></td>
</tr>
<tr>
<td>CareWeb, from outside of hospital</td>
<td><a href="http://www.med.umich.edu/clinical">www.med.umich.edu/clinical</a></td>
<td></td>
</tr>
<tr>
<td>Reference tab: dictation instructions, medical and pharmacy references, literature search, UM policies, clinical calculators</td>
<td><a href="http://www.med.umich.edu/clinical">www.med.umich.edu/clinical</a></td>
<td></td>
</tr>
<tr>
<td>UM Gyn Oncology Home Page</td>
<td><a href="http://www.med.umich.edu/obgyn/">www.med.umich.edu/obgyn/</a></td>
<td></td>
</tr>
<tr>
<td>UM GYO Clinical Trials Home Page</td>
<td><a href="http://www.med.umich.edu/obgyn/gynonc/clinicalresearch.htm">www.med.umich.edu/obgyn/gynonc/clinicalresearch.htm</a></td>
<td></td>
</tr>
<tr>
<td>American Cancer Society (ACS)</td>
<td><a href="http://www.cancer.org">www.cancer.org</a></td>
<td></td>
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<tr>
<td>American College of Ob/Gyn (ACOG)</td>
<td><a href="http://www.acog.org">www.acog.org</a></td>
<td></td>
</tr>
<tr>
<td>American College of Surgeons (ACOS)</td>
<td><a href="http://www.facs.org">www.facs.org</a></td>
<td></td>
</tr>
<tr>
<td>American Society for Colposcopy and Cervical Pathology (ASCCP) (guidelines for diagnosis and treatment of dysplasia)</td>
<td><a href="http://www.asccp.org">www.asccp.org</a></td>
<td></td>
</tr>
<tr>
<td>National Comprehensive Cancer Network (NCCN) (guidelines for diagnosis and treatment)</td>
<td><a href="http://www.nccn.org">www.nccn.org</a></td>
<td></td>
</tr>
<tr>
<td>PDQ (listing of clinical trials)</td>
<td><a href="http://www.nci.nih.gov">www.nci.nih.gov</a></td>
<td></td>
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<tr>
<td>Society of Gynecologic Oncologists (SGO)</td>
<td><a href="http://www.sgo.org">www.sgo.org</a></td>
<td></td>
</tr>
<tr>
<td>Women’s Cancer Network (WCN) (addresses of gyn oncologists nationwide)</td>
<td><a href="http://www.wcn.org">www.wcn.org</a></td>
<td></td>
</tr>
</tbody>
</table>