These follow-up guidelines have been developed and discussed over 3 successive meetings of the NZ Gynecological Cancer group (NZGCG) during 2014 and 2015. In the absence of good evidence in this area, a consensus has been reached, taking into account opinions and practices around NZ and involving Medical and Nursing in the NZGCG .

**Endometrial Cancer**

* Majority of recurrence in first 2-3y
	+ ~80% by 3y
	+ Majority will have symptoms
	+ Early stage – 2-15% recur
	+ Advanced stage – up to 50% recur
* ~50% of recurrence is local only
* Many local recurrences are curable
* No evidence for **routine** smears or imaging
	+ If subtotal hysterectomy done – needs cervical smears as per screening programme/risk of recurrence
* See 2 weeks post op for diagnosis
* All patients discussed at MDM
* Pelvic exam at each appointment
* Alternate follow up Surgeon and Radiation Oncologist as appropriate

Endometrial Cancer

Low Risk - Stage IA G1, 2

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **3 mth** | **6mth** | **1y** | **18m** | **2y** | **5y** |
| Gynaecological Surgeon |  |  |  X |  |  X | Collect 5yr data outcomes |
| Specialist Nurse\* |  XSP |  |  |  | Exit SP |
| GP |  |  X |  |  X |  |

Consider virtual clinic for well motivated/very rural patients

Discharge at 2 years if no symptoms/ongoing concerns

\*3mth and 2y nurse led survivorship clinic is recommended

Intermediate Risk – Stages IA G3, IB Grades 1, 2

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **6weeks** | **6mth** | **1y** | **1.5y** | **2y** | **2.5y** | **3y** | **5y** |
| Rad Onc/Surgeon | Post treatment | X | X | X | X | X | X | Collect clinical outcome data |
| CNS | SurvivorshipPlan (SP) |  |  |  |  |  | ExitSP |

If no radiotherapy then follow up by surgeon at 6 monthly intervals

Discharge at 3 years if no symptoms/ongoing concerns

High Risk - Stages IB G3, II, III, Serous, Clear cell, Carcinosarcoma

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **6wk** | **3mth** | **6mth** | **9mth** | **1y** | **1.5y** | **2y** | **2.5y** | **3y** | **5y** |
| Rad Onc/Surgeon | X | X | X | X | X | X | X | X | X | Data outcome collection |
| CNS | SP |  |  |  |  |  |  |  | ExitSP |  |

If no radiotherapy, surgical follow up only

If chemotherapy given, consider Medical Oncology follow up annually

Discharge at 3years if no ongoing symptoms/concerns

Consider earlier discharge if not fit/no salvage options available

**Cervical Cancer**

* >75% of recurrences occur in first 2-3y
* Local recurrences may be salvaged
* Majority will have symptoms
* Need annual data collection

Stage IA1 SCC Rx Surgery only

|  |  |  |  |
| --- | --- | --- | --- |
|  | **6 mth** | **1y** | **2y** |
| Gynaecologist | X smear |  |  |
| GP |  | X smear and HPV | X smear and HPV |

TAH and cone biopsy treated the same

Once 2 consecutive negative HPV tests, return to routine screening

Stage IB1, IA2 & all IA adenocarcinoma - Surgical management

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **3mth** | **6m** | **9m** | **12m** | **18m** | **24m** | **3 y** | **5 y** |
| Gynaecologist\*(Radiation oncologist)) | X | X | X | X | X | X | Only if RT | Data outcome collection |
| CNS | X\*SP |  | X 9-18 monthfollowup | XSP |  |

Discharge to GP at 2 years

Annual smears ongoing by GP if no radiation Rx (at least 10y)

If radiotherapy given, alternate with Radiation Oncologist as appropriate.

Continue to 3 years if had radiotherapy (for toxicity) then discharge to GP

\* Survivorship Plan

Primary Radiotherapy +/- chemo

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **6w** | **3 mth** | **6** | **9** | **12** | **18** | **2y** | **2.5y** | **3y** | **5y** |
| Rad Onc/ Gynaecologist | X | X | X | X | X | X | X | X | X | Data outcome collection |
| CNS | XSP |  |  |  | X12-18mfollowup |  |  | XSP |

Discharge at 3 years if no symptoms /ongoing concerns

No routine smears

Follow up: Notes

* Clinical Nurse Specialist (CNS) – Nurse-led clinics for survivorship plan (SP) soon after all treatment completed and again at discharge
	+ Education for patients (oral and written) regarding symptoms of recurrence, lifestyle changes (especially weight control and stop smoking), support services, managing toxicity
* Annual follow up data collection
* Patient initiated follow up (PIFU)
	+ Make space in clinics for patients with symptoms to be seen quickly

These recommendations are a **guide** **only** for the well patient – physician preferences may differ.

Any symptoms/patient concerns require more intensive follow up

References

Due to lack of evidence in the literature, these guidelines are based on the below:

SGO recommendations - *Salani et al AJOG 2011;204(6):466-78*