NZGCG Follow up Recommendations for Endometrial and Cervical cancer (approved May 2015)

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

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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*	X SP				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	Survivorship Plan (SP)						Exit SP	

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								Exit SP	

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

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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 month followup			X SP		

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	X SP				X12-18m followup				X SP	

Discharge at 3 years if no symptoms /ongoing concerns
No routine smears

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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*