**TRIAGE for GYNECOLOGIC CANCER REFERRAL**

Requested information to enable appropriate triage- per disease site

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| Endometrium | Vulva | Cervix | Ovary |
| History and physical examinationEndometrial biopsy or curetting’sMMR IHC, p53 IHC, ER IHC on tumour\*CA125 (can be elevated with extrauterine disease)CT CT C/A/P needed if grade 3, and/or p53abn and/or non endometrioid histology and/or examination suggests disease spread beyond the uterus and/or elevated CA125 not otherwise explained | History and physical examination. Essential to detail the size and location of the lesion and proximity to other critical structures- anus, clitoris, urethra.Inguinal lymph node examination.Vulvar biopsy- for histology and depth of invasion For vulvar squamous cell lesions need HPV status (p16 IHC), and for p16 negative/HPV- independent disease need p53 status (IHC) and details of dVIN and p53 at margins.PET scan may be requested by triaging MD for lesions > 4 cm, or clinically palpable groin LNs or other examination findings suggesting metastatic disease. | History and physical examination. Essential to detail the size of the cervical lesion at minimum, comment on vaginal, parametrial, or sidewall disease if possibleCervical biopsy with HPV status (p16 IHC). LEEP if unsure of lesion size or presumed stage IA lesion.MRI pelvis (request with vaginal contrast gel) if margins on LEEP are positive and/or stage IB onwards and/or for consideration of trachelectomy. PET scan may be indicated and requested by triaging MD e.g. enlarged nodes on MRI, tumors >2cm size, locally advanced disease  | -     History and physical examination-     Pelvic imaging (USS at minimum)-     Tumor markers:>40 yo: CA125, CA15-3, CA19-9, CEA<40yo: as above and add bHCG, LDH, AFP-      Other imaging: -CT C/A/P (preferred) to rule out disease beyond the ovary- Pelvic MRI may be requested in select situations (indeterminant lesions, considering observation or community surgery)-      For patients with metastatic disease where NACT likely pursued, please order core biopsy\*\*/arrange with your local radiologists ASAP. This will expedite the process for patient and better inform the medical oncology and gynecologic oncology teams in making treatment decisions.  |

***MMR- mismatch repair; IHC-immunohistochemistry; ER- estrogen receptor; HPV- human papilloma virus; CT C/A/P – computed tomography of the chest, abdomen and pelvis. NACT-neoadjuvant chemotherapy.***

**\*IHC can and should be performed on biopsy/curettage. See further details in the endometrial cancer manual regarding triage (surgery with general gynecology vs gynecologic oncology). If referral is post-hysterectomy for consideration of adjuvant therapy, these assays can be performed on hysterectomy specimen. All tests are achievable by your local pathology team and are all now considered standard of care in BC.**

**\*\*Biopsy confirmed high grade serous ovarian cancer will get reflex somatic BRCA testing through BC Cancer.**

**See also algorithms for early stage cervical cancer, vulvar cancer and endometrial cancer**