The Investigations Required Before Referring a Patient to a Gynaecologic Oncologist

Rachel Kupets, MD, MSc, FRCSC,[1] K. Christopher Giede, MD, MSc, FRCSC,[2] Patti Power, MD, FRCSC,[3] Anita Agrawal, MD, FRCSC,[2] for the Executive of the Society of Gynecologic Oncology of Canada

[1]Division of Gynaecologic Oncology, University of Toronto, Toronto ON

[2]Division of Gynecologic Oncology, University of Saskatchewan, Saskatoon SK

[3]Division of Gynecologic Oncology, Memorial University, St. John's NL

Abstract

Objective: To provide guidance for referring physicians regarding what gynaecologic oncologists want and do not require in the referral package for a new patient.

Methods: An email survey was circulated to all members of the Society of Gynecologic Oncology of Canada (GOC) asking what they felt was required in a new patient referral package so that they could provide a timely consultation and management plan.

Results: The survey had a 79% response rate among 121 GOC members. Before referral of patients with endometrial cancer, 50% of respondents did not want additional investigations; only 4% wanted an MRI performed prior to them seeing the patient. For patients with high-grade cancers of the uterus (including serous), 40% wanted to see the patient without further investigations, while 42% wanted a CT scan report to be included in the referral package. For patients with cervical cancer, 56% of respondents wanted to see the patient without any further investigations, while 24% wished to have an MRI report included in the referral package. For patients with vulvar cancer, 50% of respondents did not want any further investigations; for patients with a pelvic mass, the majority of respondents wanted a serum CA 125 level in the referral package, while 0% to 3% only wanted an MRI. The preferred modality for imaging of the chest was a chest X-ray only.

Conclusion: Our survey indicated that gynaecologic oncologists want little information in the referral package beyond the biopsy result. MRI is not required in the workup of most patients with a pelvic mass or uterine cancer.

Résumé

Objectif : Offrir des lignes directrices aux médecins orienteurs à l'égard de ce que les gynéco-oncologues souhaitent obtenir et de ce qu'ils ne souhaitent pas obtenir dans le dossier d'orientation d'une nouvelle patiente.

Méthodes : Nous avons fait parvenir (par courriel) un sondage à tous les membre de la Société de gynéco-oncologie du Canada (GOC) pour leur demander de nous indiquer ce que le dossier d'orientation d'une nouvelle patiente devait comprendre (selon eux) pour leur permettre de procéder à une consultation et de formuler un plan de prise en charge en temps opportun.

Résultats : Le sondage a obtenu un taux de réponse de 79 % parmi les 121 membres de la GOC. Avant de se voir orienter des patientes présentant un cancer de l'endomètre, 50 % des répondants ne souhaitaient pas obtenir des explorations additionnelles; seuls 4 % des répondants souhaitaient la tenue d'une IRM avant qu'une patiente soit orientée vers leurs services. Dans le cas des patientes qui présentent des cancers de l'utérus de haut grade histologique (y compris les cancers séreux), 40 % des répondants souhaitaient voir la patiente sans qu'aucune autre exploration ne soit menée au préalable, tandis que 42 % souhaitaient qu'un rapport de tomodensitographie soit inclus dans le dossier d'orientation. Dans le cas des patientes qui présentent un cancer du col utérin, 56 % des répondants souhaitaient voir la patiente sans qu'aucune autre exploration ne soit menée au préalable, tandis que 24 % souhaitaient qu'un rapport d'IRM soit inclus dans le dossier d'orientation. Dans le cas des patientes qui présentent un cancer de la vulve, 50 % des répondants souhaitaient voir la patiente sans qu'aucune autre exploration ne soit menée au préalable; dans le cas des patientes qui présentent une masse pelvienne, la majorité des répondants souhaitaient que le taux sérique de CA-125 soit inclus dans le dossier d'orientation, tandis que de 0 % à 3 % ne souhaitaient obtenir qu'une IRM. La modalité privilégiée pour ce qui est de l'imagerie thoracique consistait en la seule tenue d'une radiographie.

Conclusion : Notre sondage indique que les gynéco-oncologues ne souhaitent obtenir que peu de renseignements, outre les résultats de biopsie, dans le dossier d'orientation. La tenue d'une IRM n'est pas nécessaire dans le bilan de la plupart des patientes qui présentent une masse pelvienne ou un cancer de l'utérus.

J Obstet Gynaecol Can 2016;38(2):164-167

Key Words: Referral information, gynaecologic cancer

Received on May 11, 2015

Accepted on August 12, 2015

http://dx.doi.org/10.1016/j.jogc.2015.12.016

INTRODUCTION

The majority of women who develop gynaecologic malignancies do not initially present to gynaecologic oncologists. Although women with gynaecologic cancers

should be referred to gynaecologic oncology specialists for definitive management, the investigations these women undergo before referral are determined by non-subspecialists.

Investigations that may be ordered in the evaluation of women with suspected gynaecologic cancers can be extensive, and may include hematology, blood chemistry, and endocrine investigations, CT scans, MRIs, ultrasound scans, and sometimes positron emission tomography scans. These investigations are not necessarily required by gynaecologic oncologists before they begin definitive management. Because ovarian, endometrial, and vulvar cancer are typically staged surgically and cervical cancer is staged clinically, there is a limited role for multiple imaging procedures in asymptomatic patients.[1,2]

Extensive testing not only places a burden on resources, it also increases the time to definitive surgical treatment for women with endometrial cancer and ovarian masses.[3,4] The adverse effect of extensive wait times on rates of survival in women with endometrial cancer increases significantly if time from diagnosis to surgery is delayed by more than two weeks. This has been documented to be the case when preoperative CT scans and MRIs are performed before referral of patients with endometrial and ovarian cancer.[3–5]

Given the ad hoc pre-referral evaluation of women with confirmed or suspected gynaecologic malignancies, there is a need for clearer guidance for what gynaecologic oncologists actually require as part of the referral package when seeing a woman with a newly diagnosed or possible new gynaecologic cancer.

We summarize here the results of a survey of gynaecologic oncologist members of the Society of Gynecologic Oncology of Canada (GOC), conducted to identify what they consider to be necessary investigations before the referral of women with either a suspected gynaecologic cancer or a newly diagnosed confirmed gynaecologic cancer.

METHODS

A questionnaire based on common referral scenarios was compiled by members of the GOC Policy and Practice Guidelines Committee. The scenarios were intended to represent the spectrum of patient referrals, including women with vulvar, cervical, endometrial (low and high risk separately), and ovarian cancer, and examples of pelvic mass diagnoses.

The questionnaire was distributed via email on February 13, 2014, to all gynaecologic oncologists who are members of the GOC.

The questionnaire and responses are provided in the eTable.

RESULTS

The questionnaire was sent to the 121 gynaecologic oncologists who are members of the GOC, and 96 responded (a 79% response rate). There are presently 93 gynaecologic oncologists in practice in Canada; the response rate among these Canadian physicians was 72%, with 60% of the responses derived from gynaecologic oncologists in Ontario or Quebec.

For patients being referred for an asymptomatic low-risk endometrial cancer, 46% of respondents preferred no further investigations be performed before referral of the patient to a gynaecologic oncology practice. Thirty percent of gynaecologic oncologists requested that a chest X-ray report be included in the referral package, while only 4% requested an MRI.

For patients being referred for an asymptomatic high-grade serous endometrial cancer, 40% of gynaecologic oncologists did not want any further investigation by the referring physician, preferring to order any tests they needed at their primary hospitals. Forty-three percent of gynaecologic oncologists requested chest imaging, either chest X-ray or chest CT scan, while 42% preferred that a CT scan of the abdomen and pelvis be included in the referral package.

For a postmenopausal woman being referred for a 10 cm pelvic mass that appeared on ultrasound to be unilocular, only 2% requested that a pelvic MRI be included in the referral package, while 82% requested measurement of serum CA 125. A CT scan of the abdomen was requested by only 12% before referral.

For a 55-year-old woman being referred for a 10 cm pelvic mass that appeared on ultrasound to be cystic with septations, 91% of gynaecologic oncologists requested that measurement of serum CA 125 be included in the referral package; only 3% felt that such a patient required a pelvic MRI. Twenty-five percent of gynaecologic oncologists felt that a CT scan of the abdomen and pelvis should be performed before referral.

For a 55-year-old woman being referred with a 10 cm pelvic mass that appeared on ultrasound to be cystic with solid excrescences showing vascular flow, none of the gynaecologic oncologists felt that MRI should be