# Pelvic masses in primary care

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# ADHB referral Guidelines

- **Management:**
- **1.For a detailed discussion on GP ultrasound follow up of ovarian cysts see the "Pelvic Ultrasound – Referral Guidelines" document under the "Protocols/Guidelines" section of this website.**
- **2. If >5cm or solid refer - to Gynaecology Outpatients Department Fax (09) 638 0402 - Central Referrals Office. (include Ca125 and LFTs)**
- **3. If <5 cm and simple/haemorrhagic and the patient is: oPre-menopausal and simple analgesia failing – discuss with acute gynaecologyregistrar. Ph (09) 307 2800 if the patient becomes symptomatic or cyst clinically increasing - arrange a repeat ultrasound scan after 1-3 months. If the scan shows the cyst has increased, refer to Gynaecology Outpatients Department. Fax (09) 638 0402 - Central Referrals Office**
- **post-menopausal - check Ca125. If >35 u/ml, refer to Gynaecology Outpatients Department. if <35 u/ml, repeat scan and Ca125 in 4 months. If the scan shows the cyst has increased or Ca125 >35 u/ml, refer to Gynaecology Outpatients Department Fax (09) 638 0402 - Central Referrals Office.**

# Referral form

**Gynaecology Oncology Referral Form**

**On receipt this referral will be triaged either to Gynae Oncology CLINIC or MDM**

**Date of Referral** **NHI Number**

**Patient Name** **DOB**
**Address**

**Phone/Mobile**

NB: Incomplete referrals are unable to be processed. Please note on page 2 the minimum set of pre-referral investigations.

Please EMAIL completed form to gynaeoncteam@adhb.govt.nz, but if unable please fax it to 09 6309791 (external) or 27791 (internal).

**REFERRING SPECIALIST**

- Consultant name:
- Hospital/DHB:
- Email address:

**GP name and address:**

**HISTORY:**

- Age:
- Brief history:
- Co morbidities:
- Tumour markers:
- BMI:

**RADIOLOGY:**

- Type of diagnostic performed:
- Date that diagnostic performed:
- Location that diagnostic performed:
- Key findings:

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- Type of other diagnostic:
- Date of other diagnostic:
- Location of other diagnostic:
- Key findings:

**OPERATION:**

- Date:
- Surgeon:
- Procedure:
- Findings:

**HISTOLOGY**

- Histology type, e.g., pipelle/cervical, biopsy/specimen:
- Date and location of histology:
- Key findings:

**DATE OF DIAGNOSIS: Minimum set of investigations prior to referral :**

| | |
|---|---|
| **Carcinoma of the vulva** | Biopsy result:<br>CT abdomen and pelvis:<br>CXR: |
| **Carcinoma of the Vagina** | Biopsy result:<br>CT abdomen and pelvis:<br>CXR: |
| **Carcinoma of the cervix** | Biopsy result:<br>UECS < Renal Function, FBC:<br>CXR: |
| **Endometrial Carcinoma** | Histology (pipelle or curettings):<br>MRI pelvis and abdomen:<br>CXR: |
| **Pelvic Mass** | RMI (risk of malignancy index) score:<br>Abdominal pelvic imaging (CT or MRI):<br>CA125, CEA:<br>If age < 40 AFP, HCG:<br>UEC, LFT, albumin: |

**Note 1:** USS for Endometrial Carcinoma and Pelvis Mass may be accepted as an alternative to MRI in exceptional case only (where MRI or CT is not available) with prior agreement with regional service provider.
**Note 2:** Date of diagnosis – confirmed by histology +/- radiology

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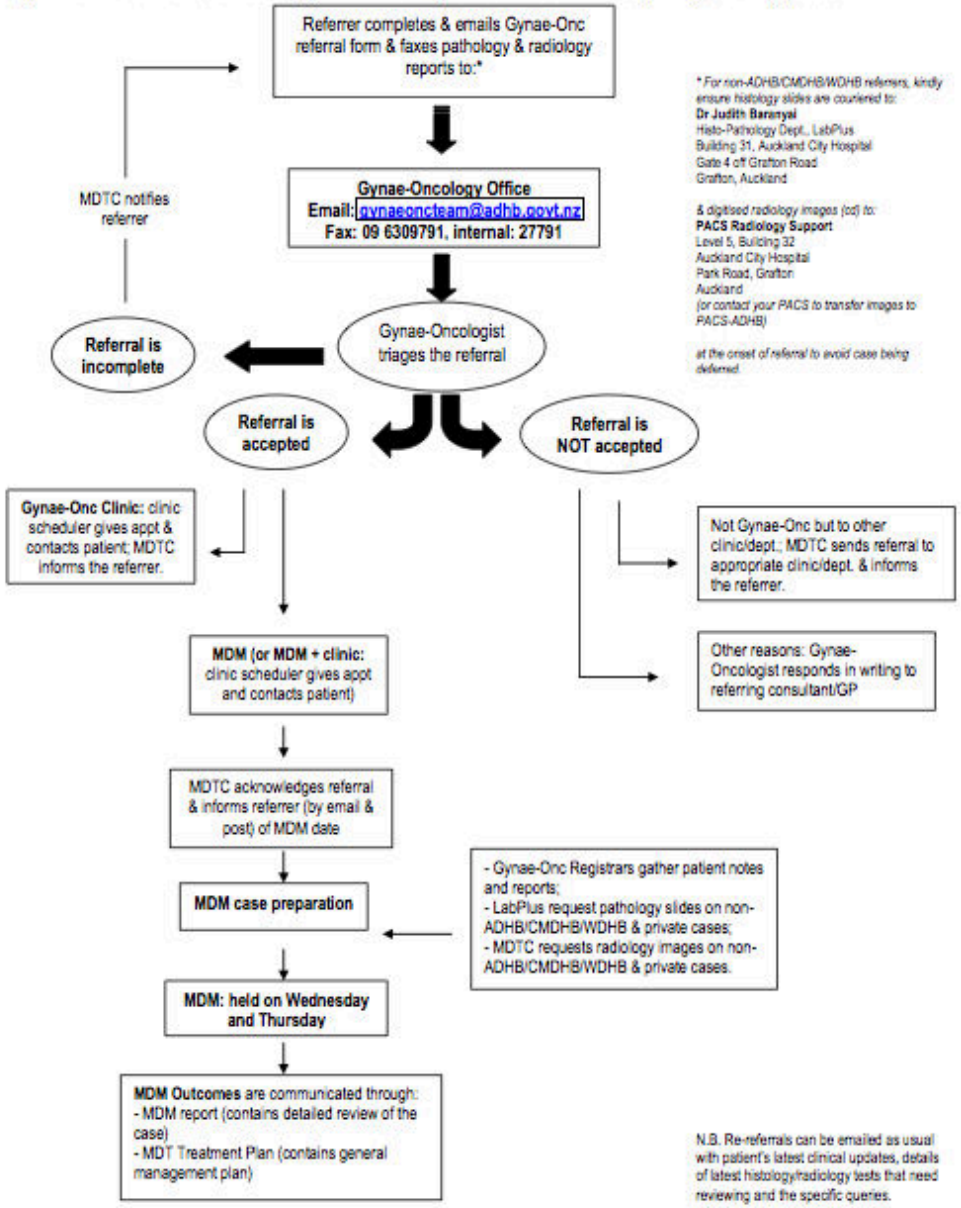
# Gynaecological Oncology Referral Pathway: for Medical Practitioners

This guide is intended to assist referring consultants/registrars/GPs on multidisciplinary meeting process.



# Multidisciplinary

- Two weekly meetings
- Specific referral forms for other hospitals/services
- Cases reviewed at MDM
- Patients then seen to discuss and plan treatment
- Decide if further investigations required
- Postop. cases discussed again
- Urgent patients seen in 1-3 weeks
- Some cases not gynae or cancer

# Investigations

- Clinical cancer cervix – biopsy
- Clinical vulval cancer – biopsy
- Endometrial cancer – biopsy
- Molar pregnancy – tissue – usually
- Pelvic masses – usually USS, tumour markers

# Private referral criteria

- Also hold weekly private sector MDM
- Same system with our secretary Jackie arranging the meetings and ensuring imaging available

# RMI – Risk of malignancy index

Trying to predict who might have a malignant mass.

Want to end up with a system where as few patients as possible are operated on inappropriately.

Different RMI scoring systems – all similar – we tend to use a modification of the original 1990 scoring system of Jacobs as per Tingulstad

Other systems such as referral just on basis of $Ca_{125}$ or using morphological index based on USS alone have also been used.

# Risk of malignancy index (RMI)

| Criteria | Scoring System | Score |
|---|---|---|
| Menopausal status: | | |
| Premenopausal | 1 | |
| Postmenopausal | 3 | A (1 or 3) |
| Ultrasonic features: | | |
| Multiloculated | no features = 0 | |
| Solid areas | one feature = 1 | |
| Bilaterality | > 1 feature = 3 | B (0, 1 or 3) |
| Ascites | | |
| Metastasis | | |
| Serum CA125 | Absolute level | C |
| Risk Of Malignancy Index (RMI) | | A x B x C |

As per Jacobs

# RMI

## Triage of ovarian masses

Yin Nin CHIA,[2] Donald E. MARSDEN,[1,2] Greg ROBERTSON[1,2] and Neville F. HACKER[1,2]

[1]*School of Obstetrics and Gynaecology, University of New South Wales, Sydney,* [2]*Gynaecological Cancer Centre, Royal Hospital for Women, Sydney, New South Wales, Australia*

Two hundred and four patients were eligible for RMI calculation.
An RMI of < 200 correctly identified 83 of 108 (77%) benign ovarian tumours.
An RMI of > 200 correctly identified 11 of 19 (58%)
borderline ovarian tumours and 70 of 77 (91%) invasive ovarian tumours

This study showed that using RMI at a cut-off of 200 for referral could have prevented 83 benign cases (41%) from being referred

> We propose that the RMI could be utilised more widely in order to prevent unnecessary referral of benign ovarian masses to gynaecological oncology units. This would free up operating time, allowing frankly invasive cancers to be dealt with more expeditiously.

# RMI

| Results of evaluation by RMI: total material | | |
|---|---|---|
| RMI | Benign[a] | Malignant |
| < 200 | 335 | 3 |
| ≥ 200 | 46 | 63 |

[a] Stage I disease considered “benign”.

Ulusoy et al 2006

# RMI

**Table 1.** FIGO stage and RMI sensitivity

| Stage | Total number | Sensitivity (%) |
|---|---|---|
| I | 38 | 78.9 |
| II | 10 | 70 |
| III | 83 | 91.6 |
| IV | 12 | 100 |

From Bailey et al 2006

# RMI

| | |
|---|---|
| False positives – | cystadenomas |
| | endometriosis |
| | functional cysts |
| | tubo-ovarian abscess |
| | fibromas |
| False negatives - | borderline tumours |
| | early ovarian cancers |
| | non-epithelial cancers |

# RMI

Pelvic mass assessment

RMI of value in deciding likelihood mass could be malignant and therefore –

<u>who should operate and where</u>

what method of entry

extent of surgery

whether frozen section may be of value

assists in counselling

# Other investigations

| | | |
|---|---|---|
| Tumour markers | - | Ca19.9 |
| | | CEA |
| | | BHCG / AFP |
| Imaging | - | CT scans |
| | | MRI scans |
| | | PET scans |

# Warning signs for ovarian cancer

- Often subtle and mimic symptoms of other diseases– multiple symptoms that persist are more sinister
- Abdominal pain discomfort
- Bloating and distension, tight clothing
- Early satiety, loss of appetite and indigestion
- Urinary frequency, constipation

# High risk women

- Some women at special risk
- Strong family history
- BRCA1 and 2
- Risk reducing surgery

  Prophylactic BSO or

  Prophylactic bilateral salpingectomy