CREOG REVIEW
ONCOLOGY AND CRITICAL CARE
January 11, 2008
A 45-year-old woman is seen for a follow-up evaluation after a total abdominal hysterectomy, a BSO, and a PPALND for a stage IB, grade 2, adenocarcinoma of the endometrium. Her postoperative course has been unremarkable except for marked vasomotor symptoms and emotional lability. Her medical history is significant only for hypertension. The most appropriate therapy is

a. observation
b. tamoxifen cirate (Nolvadex) therapy
c. estrogen and progesterone therapy
d. estrogen therapy
e. antidepressant therapy
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ENDOMETRIAL CANCER STAGING

Stage I: uterine involvement only
   A: limited to endometrium
   B: invasion < 50%
   C: invasion >50%

Stage II: cervical involvement
   A: endocervical glandular involvement only
   B: cervical stromal invasion

Stage III:
   A: tumor has invaded serosa and/or adnexa, and/or positive peritoneal cytology
   B: vaginal metastases
   C: metastases to pelvic and/or para-aortic lymph nodes

Stage IV:
   A: tumor has invaded bladder and/or bowel mucosa
   B: distant metastases including intraabdominal and/or inguinal lymph nodes
Women’s Health Initiative

• continuous use of .625 mg CEE plus 2.5 mg MPA daily
• 40% of study subjects in both the HT arm and the placebo arm stopped using their study drugs during the course of the study
<table>
<thead>
<tr>
<th>Health Event</th>
<th>Hazard Ratio (95% CI)</th>
<th>Absolute Risk-benefit per 10,000 woman-years</th>
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<tbody>
<tr>
<td>Coronary artery disease</td>
<td>1.29 (1.02-1.63)</td>
<td>7</td>
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<tr>
<td>Stroke</td>
<td>1.41 (1.07 – 1.85)</td>
<td>8</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>1.26 (1.00 – 1.59)</td>
<td>8</td>
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<tr>
<td>Pulmonary embolism</td>
<td>2.13 (1.39 – 3.25)</td>
<td>8</td>
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<tr>
<td>Venous thromboembolism</td>
<td>2.11 (1.58-2.82)</td>
<td>18</td>
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<tr>
<td>Hip fracture</td>
<td>.66 (.45 -.98)</td>
<td>5</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>.63 (.43 -.92)</td>
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• Estrogen therapy for endometrial cancer is controversial
• Theory that exogenous estrogen increases the risk of recurrent disease (unproven by 4 retrospective studies)
• ACOG and FDA have stated that both hormone therapy and estrogen therapy provide the most effective treatment for menopausal symptoms (hot flashes), but women should take the lowest effective dose for the shortest possible duration
• Tamoxifen - affects risk of breast cancer and improves BMD, but does not reduce vasomotor symptoms
A 32-year-old woman, gravida 3, para 2, with two previous uncomplicated vaginal deliveries, is seen at 25 weeks of gestation. On pelvic examination, a 1.5-cm exophytic lesion of the cervix is noted. A biopsy of the cervical lesion shows invasive squamous cell carcinoma. The metastatic findings are consistent with stage 1B1 cervical cancer. The woman does not desire future childbearing but wants to continue with this pregnancy, if possible. The best management is:

a. an immediate radical hysterectomy with PPALND
b. a cesarean delivery followed by a radical hysterectomy and LND at the time of FLM
c. a radical hysterectomy and a lymphadenectomy 6 weeks postpartum
d. an immediate cone biopsy of the cervix
e. immediate radiation therapy to the pelvis
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b. a cesarean delivery followed by a radical hysterectomy and LND at the time of FLM
c. a radical hysterectomy and a lymphadenectomy 6 weeks postpartum
d. an immediate cone biopsy of the cervix
e. immediate radiation therapy to the pelvis
• No apparent increase in maternal risk or risk at delivery incurred by a delay of therapy for stage IA or nonbulky stage IB cervical carcinoma.

• Immediate therapy is recommended for patients who have bulky lesions (>4 cm) stage IB cervical carcinoma or more advanced disease at any time during pregnancy.

• Vaginal delivery is an option or women with microinvasive cervical cancer in pregnancy, for more advanced stage I disease, a CS is recommended.
After a 60-year-old woman has hysterectomy, oophorectomy, and PPALND, her pelvic cytology results show a surgical stage 1C, grade 2, endometrial adenocarcinoma. The most cost-effective postoperative management for this patient would be

a. brachytherapy
b. teletherapy
c. hormone therapy
d. chemotherapy
e. observation
Question 3/Prolog47
After a 60-year-old woman has hysterectomy, oophorectomy, and PPALND, her pelvic cytology results show a surgical stage 1C, grade 2, endometrial adenocarcinoma. The most cost-effective postoperative management for this patient would be
a. brachytherapy
b. teletherapy
c. hormone therapy
d. chemotherapy
e. observation
ENDOMETRIAL CANCER SURGICAL STAGING

- Exploratory laparotomy
- Hysterectomy - type?
- BSO
- Washings
- Lymphadenectomy
## ENDOMETRIAL CANCER TREATMENT

<table>
<thead>
<tr>
<th>Stage</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
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<tbody>
<tr>
<td>IA</td>
<td>Observe</td>
<td>Observe</td>
<td>VB XRT</td>
</tr>
<tr>
<td>IB</td>
<td>Observe</td>
<td>VB XRT</td>
<td>VB XRT</td>
</tr>
<tr>
<td>IC</td>
<td>VB XRT</td>
<td>VB XRT</td>
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</table>
ENDOMETRIAL CANCER TREATMENT

- IIA, B, IIIC $\rightarrow$ pelvic radiation tx + VB (IIB dx intraop $\rightarrow$ rad hyst)
- IIIA, IVA, serous $\rightarrow$ whole abdominal radiation or chemo
- IIIA (+washings), IIIC $\rightarrow$ progestins
A 62-year-old thin, active woman presents with PMB. A serous endometrial cancer was diagnosed on an office biopsy. The patient underwent abdominal hysterectomy, BSO, bilateral PPALND, omentectomy, and washings. An omental cake was found along with residual “plaquelike” disease on the diaphragm. The final pathology report listed a papillary serous endometrial cancer with deep myometrial invasion, positive washings, and omental involvement. The best treatment is

a. progestin therapy
b. pelvic irradiation
c. whole-abdominal irradiation
d. systemic chemotherapy
A 62-year-old thin, active woman presents with PMB. A serous endometrial cancer was diagnosed on an office biopsy. The patient underwent abdominal hysterectomy, BSO, bilateral PPALND, omentectomy, and washings. An omental cake was found along with residual “plaquelike” disease on the diaphragm. The final pathology report listed a papillary serous endometrial cancer with deep myometrial invasion, positive washings, and omental involvement. The best treatment is

a. progestin therapy  
b. pelvic irradiation  
c. whole-abdominal irradiation  
d. systemic chemotherapy
TYPES OF ENDOMETRIAL CANCER

• Type 1 malignancies - estrogen dependent, atypical hyperplasia → endometrial cancer

• Type II - non estrogen dependent, more aggressive
  
  Ex - serous (act like ovarian cancer)
Question 5/Prolog 71

A 19-year-old nulligravid woman is referred to you by her family physician because of the recent onset of left lower quadrant pain. MRI shows a 12-cm cystic and solid left ovarian mass, which is suggestive of a malignant germ cell tumor. The serum assay most appropriate to evaluate the possibility is

a. CA 125
b. AFP
c. CA 19.9
d. inhibin
e. CEA
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b. AFP
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d. inhibin
e. CEA
TYPES OF OVARIAN CANCER

GERM CELL

• Dysgerminoma - LDH, plac alk phos
• Endodermal sinus tumor – AFP (like yolk sack)
• Embryoma
• P olembryonal
• Choriocarcinoma (nongestational) – hcg
• Teratoma

• Gonadoblastoma
TYPES OF OVARIAN CANCER

SEX CORD STROMAL

- Granulosa – estrogen, inhibin B, BEP
- Leydig – testosterone
- Sertoli – MIS
- Thecoma – progesterone
- Fibroma – Meigs
TYPES OF OVARIAN CANCER

• EPITHELIAL
  Serous (fallopian tube)  CA125
  Mucinous (cervix)  CA 19-9
  Clear (vagina)  endometriosis
  Endometrioid (uterus)  endometriosis
  Transitional/Brenner (bladder)
  Carcinosarcoma/MMMT
TUMOR MARKERS

a. CA 125 --> epithelial ovarian
b. AFP --> germ cell (endodermal sinus
b. CA 19.9 --> GI malignancies, pancreas
d. Inhibin --> granulosa cell tumors
e. CEA --> GI
A 49-year-old woman reports several months of menometrorrhagia after having had normal menstrual cycles for many years. Her medical history is notable for mild hypertension and adult-onset diabetes mellitus. Findings of her examination are normal except that she is overweight. Her Pap test result was reported as atypical glandular cells, not otherwise specified (AGC-NOS). Colposcopy findings were normal, and an endocervical curettage showed benign endocervical cells. The most appropriate management is

a. cervical cone biopsy
b. endometrial biopsy
c. pelvic US
d. another Pap test in 3 months
e. HPV DNA testing
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a. cervical cone biopsy
b. endometrial biopsy
c. pelvic US
d. another Pap test in 3 months
e. HPV DNA testing
Initial Workup of Women with Atypical Glandular Cells (AGC)

All Subcategories (except atypical endometrial cells)

- Colposcopy (with endocervical sampling)
- AND HPV DNA Testing
- AND Endometrial Sampling (if > 35 yrs or at risk for endometrial neoplasia*)

Atypical Endometrial Cells

Endometrial AND Endocervical Sampling

NO Endometrial Pathology

Colposcopy

* if not already obtained. Test only for high-risk (oncogenic) types.
* includes unexplained vaginal bleeding or conditions suggesting chronic anovulation.
American Society for Colposcopy and Cervical Cytology

Subsequent Management of Women with Atypical Glandular Cells (AGC)

NO CIN and NO Glandular Neoplasia

HPV Status Unknown
- HPV (-)
- HPV (+)

Repeat Cytology @ 6 mos intervals for four times

Repeat Cytology and HPV DNA Testing @ 12 mos if HPV (-) @ 6 mos if HPV (+)

≥ ASC or HPV (+)
- BOTH Tests Negative
  - Routine Screening
- Colposcopy

CIN but NO Glandular Neoplasia

OR

Glandular Neoplasia irrespective of CIN

Manage per ASCCP Guideline

Initial Pap of AGC (favor neoplasia) OR AIS

Initial Pap of AGC - NOS

NO Invasive Disease

Diagnostic Excisional Procedure*

* Should provide an intact specimen with interpretable margins. Concomitant endocervical sampling is preferred.
• Squamous dysplasia, CIN, is the most common abnormality detected on cytologic screening with AGC

• Workup:
  -- colpo and ECC
  -- EMB
  -- CKC
  -- TVUS
A 64-year-old woman is seen for a 2-year history of a growth on the perineum and worsening pruritus. On PE, you note an ulcerative lesion of approximately 5 cm on her left labium majus. She has palpable lymphadenopathy in both groins. The biopsy specimen of the vulvar lesion shows basal cell carcinoma. She has a wide local excision with a bilateral inguinal lymphadenectomy. On pathologic review, 2 of 12 left groin lymph nodes are positive. The right groin lymph nodes are negative. The stage of her cancer is

a. I
b. II
c. III
d. IVA
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a. I
b. II
c. III
d. IVA
STAGING VULVAR CANCER

IA < 2 cm in diameter, <= 1 mm depth
IB <= cm in diameter, >1mm depth
II > 2 cm in greatest dimension
III spread to lower urethra, vagina, anus, or unilateral LNPs
IVA spread to upper urethra, bladder, rectum, pelvic bone, or bilateral LNs
IVB any distant met including pelvic LNs
VULVAR SURGICAL STAGING

T1a  wide local incision (1 cm margin)
T1b-lateral*  +ipsilateral groin dissection
T1b-medial  + bilateral groin dissection
T2-lateral*  +ipsilateral groin dissection
T2-medial  +bilateral groin dissection
T3  +bilateral groin dissection  XRT?, chemo? exent?
T4  +bilateral groin dissection  XRT?, chemo?, exent?

*2 cm from urethra, clitoris, posterior fourchette

groin dissection = inguinal femoral LAN - all superficial nodes above cribiform fascia and several nodes adjacent to fossa ovalis, including Cloquet’s node

• XRT if 3+ LN
Paget’s cancer:
--itching, irritation, burning
--associated with breast, bladder, colon, cervix - screen these areas
--treatment: WLE to below epithelium (about 6 mm) to Colles fascia (more than a skinning vulvectomy)

Verrucous cancer
--variant of invasive squamous cell
--pushing border rather than infiltrating border
--large exophytic condylomatous lesion
--treatment: WLE, no XRT, no chemo, no LAN

Sarcoma
--Treatment: WLE

Melanoma:
--Treatment: WLE with 2 cm margins in W, D .76

Bartholin:
--Treatment: WLE 2 cm margins, ipsilateral inguinal and femoral LND
GROUPED QUESTIONS (#8-10)

For each clinical scenario, in addition to radical resection of the primary tumor, select the most appropriate procedure:

A. bilateral lymphadenectomy
B. ipsilateral lymphadenectomy
C. bilateral lymphadenectomy with pelvic lymph node dissection
D. ipsilateral lymphadenectomy with pelvic lymph node dissection
Question 8
A 76-year-old woman, gravida 4, para 4 presents with a biopsy-proven grade 1, 1.5-cm invasive squamous cell carcinoma of the vulva on the midportion of the left labium majus. The maximum depth of invasion is 1.2 mm. On physical examination, no clitoral, vaginal, periurethral, or perinanual disease is noted. Palpation of the inguinal areas bilaterally reveals no enlarged lymph nodes.

A. bilateral lymphadenectomy
B. ipsilateral lymphadenectomy
C. bilateral lymphadenectomy with pelvic lymph node dissection
D. ipsilateral lymphadenectomy with pelvic lymph node dissection
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A. bilateral lymphadenectomy
B. ipsilateral lymphadenectomy
C. bilateral lymphadenectomy with pelvic lymph node dissection
D. ipsilateral lymphadenectomy with pelvic lymph node dissection
A 72-year-old woman, gravida 3, para 3, presents with painful urination. A 5-cm ulcerative lesion is noted at the base of the clitoris, anterior to the urethral meatus

A. bilateral lymphadenectomy
B. ipsilateral lymphadenectomy
C. bilateral lymphadenectomy with pelvic lymph node dissection
D. ipsilateral lymphadenectomy with pelvic lymph node dissection
Question 9

A 72-year-old woman, gravida 3, para 3, presents with painful urination. A 5-cm ulcerative lesion is noted at the base of the clitoris, anterior to the urethral meatus

A. bilateral lymphadenectomy
B. ipsilateral lymphadenectomy
C. bilateral lymphadenectomy with pelvic lymph node dissection
D. ipsilateral lymphadenectomy with pelvic lymph node dissection
Question 10

A 33-year-old woman, gravida 3, para 3, reports vulvar pruritus. Several popular lesions are seen on the left labium majus. A single excoriated area is noted, 1.5 cm in diameter and approximately 2 cm medial to the labiocrural fold. The specimen from a punch biopsy shows a well-differentiated squamous cell carcinoma with a 2-mm depth of invasion.

A. bilateral lymphadenectomy
B. ipsilateral lymphadenectomy
C. bilateral lymphadenectomy with pelvic lymph node dissection
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A. bilateral lymphadenectomy
B. ipsilateral lymphadenectomy
C. bilateral lymphadenectomy with pelvic lymph node dissection
D. ipsilateral lymphadenectomy with pelvic lymph node dissection
GROUPED QUESTIONS (Questions 11-13)

For each patient, select the most appropriate surgical treatment:

A. Laparoscopy-assisted hysterectomy, bilateral salpingo-oophorectomy, and peritoneal cytologic evaluation.

B. Radical abdominal hysterectomy, bilateral salpingo-oophorectomy, peritoneal cytologic evaluation, and pelvic and paraaortic lymphadenectomy

C. Extrafascial abdominal hysterectomy, bilateral salpingo-oophorectomy, lymphadenectomy, peritoneal cytologic evaluation, and omentectomy

D. Vaginal hysterectomy and bilateral salpingo-oophorectomy
Question 11/Prolog 185

A 57-year-old woman with clinically visible extension of endometrial cancer to the cervix

A. Laparoscopy-assisted hysterectomy, bilateral salpingo-oophorectomy, and peritoneal cytologic evaluation.

B. Radical abdominal hysterectomy, bilateral salpingo-oophorectomy, peritoneal cytologic evaluation, and pelvic and paraaortic lymphadenectomy

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C. Extrafascial abdominal hysterectomy, bilateral salpingo-oophorectomy, lymphadenectomy, peritoneal cytologic evaluation, and omentectomy

D. Vaginal hysterectomy and bilateral salpingo-oophorectomy
A 50-year-old woman with atypical endometrial hyperplasia and a medical history of chronic obstructive disease

A. Laparoscopy-assisted hysterectomy, bilateral salpingo-oophorectomy, and peritoneal cytologic evaluation.

B. Radical abdominal hysterectomy, bilateral salpingo-oophorectomy, peritoneal cytologic evaluation, and pelvic and paraaortic lymphadenectomy

C. Extrafascial abdominal hysterectomy, bilateral salpigo-oophorectomy, lymphadenectomy, peritoneal cytologic evaluation, and omentectomy

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B. Radical abdominal hysterectomy, bilateral salpingo-oophorectomy, peritoneal cytologic evaluation, and pelvic and paraaortic lymphadenectomy

C. Extrafascial abdominal hysterectomy, bilateral salpigo-oophorectomy, lymphadenectomy, peritoneal cytologic evaluation, and omentectomy

D. Vaginal hysterectomy and bilateral salpingo-oophorectomy
Question 12/Prolog 186
A 50-year-old woman with atypical endometrial hyperplasia and a medical history of chronic obstructive disease

A. Laparoscopy-assisted hysterectomy, bilateral salpingo-oophorectomy, and peritoneal cytologic evaluation.
B. Radical abdominal hysterectomy, bilateral salpingo-oophorectomy, peritoneal cytologic evaluation, and pelvic and paraaortic lymphadenectomy
C. Extrafascial abdominal hysterectomy, bilateral salpigo-oophorectomy, lymphadenectomy, peritoneal cytologic evaluation, and omentectomy
D. Vaginal hysterectomy and bilateral salpingo-oophorectomy
A 50-year-old woman, para 4, with a diagnosis of uterine papillary serous carcinoma seen on an endometrial biopsy specimen.

A. Laparoscopy-assisted hysterectomy, bilateral salpingo-oophorectomy, and peritoneal cytologic evaluation.

B. Radical abdominal hysterectomy, bilateral salpingo-oophorectomy, peritoneal cytologic evaluation, and pelvic and paraaortic lymphadenectomy

C. Extrafascial abdominal hysterectomy, bilateral salpingo-oophorectomy, lymphadenectomy, peritoneal cytologic evaluation, and omentectomy

D. Vaginal hysterectomy and bilateral salpingo-oophorectomy
Question 13/Prolog 187

A 50-year-old woman, para 4, with a diagnosis of uterine papillary serous carcinoma seen on an endometrial biopsy specimen.

A. Laparoscopy-assisted hysterectomy, bilateral salpingo-oophorectomy, and peritoneal cytologic evaluation.

B. Radical abdominal hysterectomy, bilateral salpingo-oophorectomy, peritoneal cytologic evaluation, and pelvic and paraaortic lymphadenectomy

C. Extrafascial abdominal hysterectomy, bilateral salpigo-oophorectomy, lymphadenectomy, peritoneal cytologic evaluation, and omentectomy

D. Vaginal hysterectomy and bilateral salpingo-oophorectomy
Question 14/Prolog 6

A 35-year-old woman with no history of breast cancer comes to your office to discuss her risk of breast cancer. Her greatest risk of developing breast cancer is related to

A. a personal history of induced abortion
B. obesity
C. menarche at age 11 years
D. a personal history of benign proliferative breast disease
E. smoking
A 35-year-old woman with no history of breast cancer comes to your office to discuss her risk of breast cancer. Her greatest risk of developing breast cancer is related to

A. a personal history of induced abortion
B. obesity
C. menarche at age 11 years
D. a personal history of benign proliferative breast disease
E. smoking
RISK FACTORS FOR BREAST CANCER

- Personal history benign proliferative breast disease (sclerosing adenosis, intraductal papilloma, hyperplasia) RR 1.5-2 (>with atypia)
- Inherited gene mutations
- Obesity 1.2
- Early menarche RR 1.3
- Late menopause RR 1.7
- Early childbearing RR 1.3
- Age
- Personal history of breast cancer
- Family history of breast cancer RR 1.4-2.0
- Radiation RR 1.3 - 3.0
- Alcohol use
- PMP HRT
- OCP use
Vaginal cytology in a 62-year-old postmenopausal woman not on hormone therapy shows a low-grade squamous intraepithelial lesion. Previously, the patient had a vaginal hysterectomy because of cervical dysplasia. Cytologic follow-up results since her hysterectomy have been normal. During the colposcopy you find no lesions, and a random vaginal cuff biopsy specimen shows no evidence of vaginal intraepithelial neoplasia. The most appropriate next step in management is

A. excision of the vaginal cuff
B. carbon dioxide laser ablation
C. intravaginal 5-fluorouracil cream
D. intravaginal estrogen cream
E. vaginal bracytherapy
Question 15/Prolog 18

Vaginal cytology in a 62-year-old postmenopausal woman not on hormone therapy shows a low-grade squamous intraepithelial lesion. Previously, the patient had a vaginal hysterectomy because of cervical dysplasia. Cytologic follow-up results since her hysterectomy have been normal. During the colposcopy you find no lesions, and a random vaginal cuff biopsy specimen shows no evidence of vaginal intraepithelial neoplasia. The most appropriate next step in management is

A. excision of the vaginal cuff
B. carbon dioxide laser ablation
C. intravaginal 5-fluorouracil cream
D. intravaginal estrogen cream
E. vaginal bracytherapy
VAGINAL INTRAEPITHELIAL NEOPLASIA
ACCEPTABLE TREATMENTS

- Excision (partial vaginectomy)
- Laser ablation
- Intravaginal 5-fluorouracil cream
- Vaginal brachytherapy
- If HSIL at cuff --> WLE
CERVICAL CYTOLOGY

- American Society for Colposcopy and Cervical Cytology
  http://www.asccp.org/consensus.shtml
Question 16

Which patient does not require colposcopy?

a. Pap ASCUS, HPV+

b. Pap ASCUS, HPV-

c. History of LSIL with colposcopy CIN1/adequate 12 months ago, now again with pap LSIL

d. AGC pap

e. HSIL pap
Question 16
Which patient does not require colposcopy?

a. Pap ASCUS, HPV+
b. Pap ASCUS, HPV-
c. History of LSIL with colposcopy CIN1/adequate 12 months ago, now again with pap LSIL
d. AGC pap
e. HSIL pap
Question 17
An excisional procedure is not recommended in which of the following patients?

a. AGC favor neoplasia with negative colposcopy and endometrial biopsy
b. 16 yo with LSIL on two paps, colposcopy CIN1, adequate
c. HSIL on pap, CIN2, inadequate colposcopy
d. LSIL pap, inadequate colposcopy
Question 17

An excisional procedure is not recommended in which of the following patients?

a. AGC favor neoplasia with negative colposcopy and endometrial biopsy
b. 16 yo with LSIL on two paps, colposcopy CIN1, adequate
c. HSIL on pap, CIN2, inadequate colposcopy
d. LSIL pap, inadequate colposcopy
Question 18
Clinical trials have demonstrated that the best radiosensitizing agent in cervical cancer treatment is:

a. 5-FU  
b. Bleomycin  
c. Taxol  
d. Cisplatin  
e. Vincristine
Question 18

Clinical trials have demonstrated that the best radiosensitizing agent in cervical cancer treatment is:

a. 5-FU
b. Bleomycin
c. Taxol
d. Cisplatin
e. Vincristine
Question 19
Which of the following is NOT a risk factor for cervical cancer?

a. Age at first intercourse
b. Use of tobacco or exposure to second-hand smoke
c. Infection with human papillomavirus (HPV)
d. Immunosuppression
e. Infection with Chlamydia
f. Infection with Epstein-Barr virus (EBV)
g. Race
h. Socioeconomic status
i. None of the above
Question 19
Which of the following is NOT a risk factor for cervical cancer?

a. Age at first intercourse
b. Use of tobacco or exposure to second-hand smoke
c. Infection with human papillomavirus (HPV)
d. Immunosuppression
e. Infection with Chlamydia
f. Infection with Epstein-Barr virus (EBV)
g. Race
h. Socioeconomic status
i. None of the above