Recommendations for Follow-Up Care for Gynecologic Cancer Survivors

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Question 1:

Which patients can receive menopausal hormone therapy after a diagnosis of gynecologic cancer? What is the optimal time period after diagnosis or treatment to start therapy?

Response from Drs. Elit and Reade:

The use of postsurgical hormone therapy depends on the symptoms the woman is having, her history of other medical issues (ie, thromboembolic disease), as well as her cancer diagnosis. For example, if her hot flushes or vaginal dryness symptoms are significant and do not respond to other medical options and she had a grade 1 superficially invasive endometrial cancer, which has a low likelihood of recurrence, then supplemental low-dose estrogen (oral or topical) is an option. The patient must be counseled regarding the safety of using this medication with respect to breast cancer risk, especially after 4 years of continuous postmenopausal use. Women with a history of nonestrogen-dependent cancers, such as cervical or most ovarian cancers, can be offered hormone therapy as long as they do not have personal medical contraindications.

Question 2:

Is a Pap test indicated for a patient with history of endometrial cancer with vaginal bleeding who does not have a visible lesion? Are radiographic studies indicated?

Response from Drs. Elit and Reade:

A patient with vaginal bleeding after a diagnosis of endometrial cancer requires a full history (ie, new anticoagulant therapy, relationship of bleeding to coital activity, voiding, or bowel movement), and physical examination (inspection and palpation of the vulva and vagina). If no lesion is seen, cytology is an option as is magnetic resonance imaging of the pelvis to assess the back of the bladder, the top of the vagina, and the front of the rectum. The history will guide the necessity of a cystoscopy or colonoscopy/flexible sigmoidoscopy.
Question 3:

What are the recommendations for colonoscopy screening for women with endometrial cancer? Do these change with diagnosed genetic syndromes?

Response from Drs. Elit and Reade:

Women with a personal history of endometrial cancer and a family history of Lynch-associated cancers should be offered genetic counseling and possibly testing for Lynch syndrome. However, there is currently no evidence that women with a history of endometrial cancer, but no family history or suspicion of Lynch syndrome, should be screened any differently from the general population. In our jurisdiction, men and women aged 50–74 years with no family history of colorectal cancer are screened every 2 years with fecal occult blood testing. People who have a first-degree relative (ie, parent, sibling, or child) with a history of colorectal cancer are at increased risk and colonoscopy is recommended beginning at age 50 years or 10 years earlier than the age at which their relative was diagnosed, whichever occurs first. Women with Lynch syndrome should be screened by colonoscopy at least every 1–2 years beginning at age 20–25 years of age. There are other, much rarer, genetic syndromes that may increase the risk of uterine cancer such as Cowden disease, for which colonoscopy is recommended by age 35 years at 5-year intervals.

Question 4:

Does a history of ovarian cancer influence the frequency and timing of mammography screening for breast cancer?

Response from Drs. Elit and Reade:

In our jurisdiction, women of average risk begin mammography screening at the age of 50 years. This is repeated every 2 years. Women with a personal history of ovarian cancer or a first-degree relative with ovarian cancer can be screened annually with mammography. If the history is of high-grade serous ovarian cancer, then these women are also eligible for referral to genetic counseling and testing for BRCA gene mutations in order to determine if they are at high risk and eligible for breast magnetic resonance imaging.

Question 5:

What are some therapy options for radiation-induced vaginal dryness after treatment for cervical cancer?

Response from Drs. Elit and Reade:

Topical medications include commercial vaginal lubricants or oils (coconut, almond or olive) that are hypoallergenic and can be used at the time of coitus; Replens™, which is applied twice a week and increases the vaginal hydration; RepaGyn®, a hyaluronic acid suppository for intravaginal daily use for 8 weeks; or estrogen (suppository, cream, ring). The use of vaginal dilators or regular intercourse is important to maintain vaginal caliber.

Question 6:

Is there evidence to support the use of vitamins, dietary supplements, or herbs to prevent recurrence of gynecologic cancers?

Response from Drs. Elit and Reade:

We are not aware of any evidence-based information to show that these agents prevent recurrence of gynecologic cancers. Vitamin D and calcium are certainly recommended for the prevention of osteopenia/osteoporosis.
Question 7:

What role does colposcopy have in surveillance for recurrent vulvar cancer? Are there any specific procedural recommendations for visualization or for biopsy?

Response from Drs. Elit and Reade:

*We are not aware of any evidence-based information that colposcopy is superior to clinical follow-up by inspection at the bedside in the assessment of women with a history of vulvar cancer. Any suspicious lesion should be biopsied.*