mater education

RMO GYNAECOLOGY ONCOLOGY HANDBOOK

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MEU CONTACT DETAILS

The Medical Education Unit would like to welcome you to this rotation. Please read this handbook in conjunction with the RMO Orientation Handbook which is accessible on the MEU website via Zenworks or http://mededu.matereducation.qld.edu.au/handbooks/

MEU Contact Details

If you're experiencing difficulty with any aspect of the term, clinical or otherwise, please contact the term supervisor and/or PVMEO as early as possible.

Director of Clinical Training (DCT)	Ph. 8229
Medical Education Officer (MEO)	Ph. 8431
Principal Medical Education Officer (PMEO)	Ph.1560
Medical Education Admin Officer	Ph. 8272
Medical Education Manager	Ph. 8114

KEY DAYS / TIMES / LOCATIONS

Contact Details

Phone Number – 3163 2545 / 0402 013 693

Fax – 3163 2406

Email – gynae-oncology@mater.org.au

Locations

Office Location – Level 8, Mater Hospital Brisbane (MHB)

Resident Office – Level 8, Mater Hospital Brisbane (MHB)

Team Members

A/Prof Lew Perrin – Consultant / HOD / Term Supervisor

Dr Naven Chetty – Consultant Gynaeoncologist

Dr Nisha Jagasia – Consultant Gynanaeoncololgist

Dr Nim Cabraal – Consultant Gynaeoncologist

Fellow – rotate every 4 months, refer to DocRost: L:\ALLUSERS\doctrost\2020

Registrar – rotate every 6 weeks, refer to DocRost: L:\ALLUSERS\doctrost\2020

Resident – rotate every 5-10 weeks, refer to DocRost: L:\ALLUSERS\doctrost\2020

Senior Admin Coordinator – Talitha Ketchell - 2153

Research Staff – Beck 0488 638 040, Kerry 3646 2144

Ward round (meet at 8B if not in office)

- Monday 7 am

- Tuesday 7 am
- Wednesday 7 am
- Thursday 7 .30 am
- Friday 7 am

Clinic Level 4 MHB

- Monday 8.30 am – 11.30 am
- Thursday 8.30 am – 12.30pm
- Telehealth Thursday 8.30 am – 12.30pm Weeks 2 and 4 (NC)

Theatre Lists

Tuesday

Dr Chetty 8 am all day list

Dr Jagasia/Cabraal alternating 8 am all day list

Friday

Dr Jagasia/Cabraal alternating 8 am – All Day List weeks 2, 3 and 4

Dr Chetty/Jagasia/Cabraal 1 pm – PM list weeks 1 and 2

(This is a robotic session at the Mater Private Hospital Theatres. Patients need to report to L6 MPH but are admitted to the public ward).

Meetings

- Research / Team / HIPEC / Team (alternating weekly)

  Monday 7.30 am - 8.30 am, Generally Level 3 MHB, Conference room 4

- Radiology

  Monday 11.30 am – 12noon, Level 6 MPH QLD X-Ray Conference Room

- Tumour Board

  Monday 12noon – 1.30 pm (approx.), Level 6 MPH QLD X-Ray Conference Room

- Multi-discipline meeting (MDM)

  Monday 1 pm – 1.30 pm, Level 6 MPH QLD X-Ray Conference Room

- Allied Health

  Thursday 12.30 pm – 1 pm, Level 8, 8B Family Room

Key IT Resources

- L drive → MMH → Gynae-oncology

• Sharepoint via Intranet →Applications → Departments → Department of Surgical Services → Gynae-Oncology → Gynae Oncology Library

• L Drive → All Users → Medical Handover → Gynae Onc → Daily Lists/Yellow Forms

RESIDENT DAILY ROLES AND RESPONSIBILITIES

Monday

• Attend ward round 7 am

• Check if any booked admissions today for OT tomorrow

• Meeting Attendance – alternates weekly

• OPD clinic attendance

- You will see patients in clinic
- Take a thorough history and perform abdominal and pelvic (spec and VE) examinations. Take your time.
- Always ask for a chaperone for pelvic examinations.
- Discuss patients with a consultant. Call the consultant in during the examination if you need a second set of eyes or find something unusual
- Presenting the patient to consultant: diagnosis/reason for referral, investigations/surgery completed and then current symptoms/examination. Include BMI
- If booking a procedure, complete a booking and consent form, the relevant carepath, and enter the patient's details into the theatre booking spreadsheet for the chosen date. Complete POMs and anaesthetic referrals on Verdi if required. Ask the patient to sit in the waiting room and the clinic nurses will direct them to preadmission clinic on level 4 after you give them all the paperwork.
- If you collect any smears or biopsies, put the patient's sticker into the results follow up folder at the nurses desk
- Dictate a letter on ozescribe (77180, letter 1, location 19) to the GP/referring team. Always include BMI for our reference.
- Keep some notes because you will present the patients you saw at tumour board. (brief: age, BMI, diagnosis, comorbidities, plan/date of surgery)

• Attend radiology meeting

- The fellow and registrar will present imaging for discussion.
- Take notes on the list they give you of the plan. You will probably need to order scans/pathology request forms based on the MDT outcome.
- If ordering a USS or CT guided biopsy you will need to include a pathology request form ('histology sample small') and FBC/Coags +- ELFT. Give these to the Gynae Onc nurse and they will fax them off

• Attend TB meeting

- Food is usually provided.
- Medical oncology, radiation oncology, and pathology will attend. They will discuss histology results and recommendations for follow up.
- New patients from clinic will be presented at the end of the meeting. Briefly present the presenting complaint, significant comorbidities, and plan for your patients.

- CNC will email out jobs at the end of the meeting. Discuss with the registrar who will do which jobs.

• PM Ward Round

• ***Essential**: check the pre-op bloods for the Tuesday theatre patients. If missing or concerning need to speak to Fellow ASAP. Use the theatre booking spreadsheet to find these patients.

Tuesday

• Attend ward round 7 am

- Organise investigations as per review
- Discharge medications, discharge summaries, travel documentation

• All Day Theatre Lists

- Two all day theatre lists usually in OR10 and OR12.
- You may be required to assist in theatre.

• Post Op Patients

- Chart patients' regular medications
- Post op orders (laxatives, anticoagulation):
  - Almost every patient - heparin 5000 units BD. Start around 6 hours post op. Check with surgeon if unsure or if Enoxaparin is permissible.
  - Laparoscopic surgery - coloxyl 240mg BD (No senna).
  - Laparotomy - metoclopramide 10mg TDS and pantoprazole 40mg OD. Add coloxyl later pending extent of bowel surgery. Dr Chetty likes to choose when coloxyl is commenced.
- Post op bloods: patients who have a hysterectomy or laparotomy should have a FBC and eLFT the next day. Minor procedures may not require bloods post op. Check with fellow.

• PM Ward Round - Update the PM list during the day and add the location of post op patients. The board in 8B will have the expect patients on them.

Wednesday

• Attend ward round 7 am

- Organise investigations as per review
- Discharge medications, discharge summaries, travel documentation

• Half Day - Request bloods for Thursday, print out the PM list and handover to the registrar at 1200.

Thursday

• Attend ward round 7.30 am

- Organise investigations as per review
- Discharge medications, discharge summaries, travel documentation

• Check if any booked admissions today for OT tomorrow

• OPD clinic attendance

- Review patients
- Discuss cases with consultant
- Consent / book for theatre as per recommendations
  - Add patients to theatre spreadsheet

        - Fill out specific care path
    - There is a general guide for the follow up schedule of common gynae cancers in the clinic folder.
    - Dictate letters to the GP on ozescribe.
    - **Chaperone required for all exams**
- Attend Allied Health MDT
    - Present inpatients
        - discuss the progress of inpatients and flag issues that require allied health input.
    - Fellow / Consultant will present upcoming OT cases
- **Essential**: check the pre-op bloods for the Friday theatre patients. If missing or concerning need to speak to Fellow ASAP. Use the theatre booking spreadsheet to find these patients.
- PM Ward Round

Friday

- Attend ward round 7 am
    - Organise investigations as per review
    - Discharge medications, discharge summaries, travel documentation
    - Have as much of discharge prepared for any potential weekend discharges
- Theatre Lists
- Essential: Complete discharge scripts for patients who may be going home over the weekend.
    - Laparotomy patients: usually Clexane for 20 days on discharge, Oxycodone 5mg (box of 10-20), Coloxyl 120mg I-II BD PRN (bottle of 100), Metoclopramide 10mg (box of 25)
    - Laparoscopic patients: Oxycodone 5mg (box of 10), and Coloxyl (100)
- Request bloods for the weekend.
- General plan for all hysterectomy patients – phone call in 1-2 weeks after MDT tumour board discussion with histology results and further follow up plan (Reg/Fellow call). Do not need to book OPD appointments.
- Check the plan for patients with the fellow and email the inpatient list to all gynae oncology fellows.
- PM Ward Round

WARD ROUNDS

Medical Officer Responsibilities

- The resident will print out a patient list daily with enough copies for each medical and nursing member of the team. Can be found in L Drive as above
- Daily update of blood results on patient list
- The registrar will support the resident to review the patient bed charts and write in the patient notes.
- Complete discharge summaries
- Complete discharge scripts
- Organise post-operative blood tests
- Acknowledge results for all patients
- Resident & CNC to handover to nursing team leader

Upon Discharge From Hospital

- All patients should leave hospital with a completed discharge summary.

• Post-operative patients – will be reviewed at subsequent TB meeting. They will receive a phone call following this with their follow up plan

• Other patients – check what timeframe doctors would like to see patient in OPD and liaise with CNC to book in.

MISCELLANEOUS

Yellow Forms

• A 'Yellow Form' needs to be completed for all patients who have surgery and sent to Sarah Tozer (Sarah.Tozer@health.qld.gov.au)

• The information must be accurately recorded as it is inputted into the QCGC database

• Please ask the Registrar or Fellow if you need help

• It is easiest to do the yellow forms as you are doing the discharge summaries, but staging and final pathology will not be available until they are discussed at tumour board

• Yellow form template can be found on L Drive as above

Indocyanine green dye

• For any patients booked for Sentinel Lymph Node biopsies/sampling on the theatre list, you'll need to order the indocyanine green dye from pharmacy.

• Identify patients who need it from the theatre spreadsheet

• Fill in a script of a med chart "indocyanine green dye 20mg intracervical injection stat".

• Fill in TGA Cat A form AND Pharmacy IPU form (pre-signed by Dr Chetty) in 2nd draw of registrar desk in Gynae Onc office (along with spare vials in case of unexpected cases)

• Give the documents to the pharmacist on 8B. They'll order it and you can collect it from the "in tray" in the med room on the ward.

• Every few weeks check with the fellow/consultant how much spare green dye is available in theatres and if any needs to be ordered

HIPEC Patients

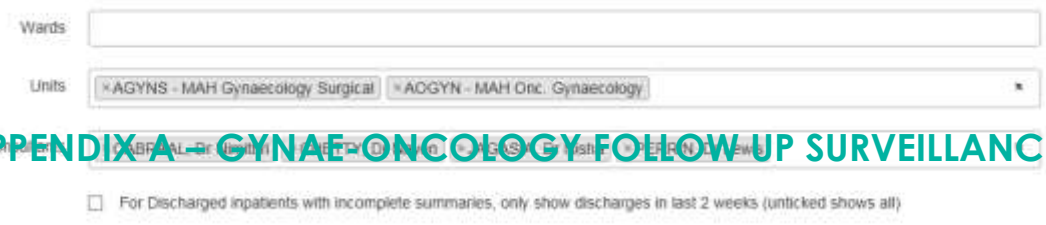
• Admitted 2 days prior to OT

• Admission coordinated by CNC / Research Coordinator

• Chart medications / diet requirements as per HIPEC sheet – (in Resident folder on L drive)

Discharge Summaries

• Chat discharge summary criteria to include the Gynae Onc patients



APPENDIX A – GYNAE ONCOLOGY FOLLOW UP SURVEILLANCE

Cancer subtype	0-1 years	1-2 years	2-3 years	3-5 years	>5 years

Endometrial					
Stage 1A, Grade 1/2	Single 6 month visit Discharge to GP care Annual GP visit for clinical review and pelvic examination	GP care	GP care	GP care	GP care
Stage 1B, Grade 1/2	6 monthly	Yearly	Yearly	Discharge to GP care Annual GP visit for clinical review and pelvic examination	GP care
Stage 2, Grade 1/2	6 monthly	Yearly	Yearly	Discharge to GP care Annual GP visit for clinical review and pelvic examination	GP care
Stage 3 or 4 (any Grade) or Grade 3, serous, clear cell (any stage) (alternate with medical or radiation oncology)	4 monthly	4 monthly	6 monthly	Yearly	Discharge to GP care Annual GP visit for clinical review and pelvic examination
Pap Smears	Not indicated				
Imaging	Not routinely indicated without symptoms	CT CAP or PET/CT preferred if required			
Borderline Ovarian tumours (BOT)					
Fertility preserving surgery	6 monthly	Yearly	Yearly	Discharge to GP care # Annual GP visit for clinical review and pelvic examination	GP care #
Pelvic USS **Tumour markers**	6 monthly 6 monthly	6 monthly 6 monthly	6 monthly 6 monthly	Yearly Yearly	Yearly Yearly
BOT with extra-ovarian disease (completion surgery or fertility sparing surgery)	6 monthly	6 monthly	6 monthly	Yearly	Discharge to GP care # Annual GP visit for clinical review and pelvic examination
Tumour markers **Imaging**	3 monthly 6 monthly Pelvic USS if residual ovary No routine imaging if completion surgery. CT CAP preferred if required	6 monthly 6 monthly Pelvic USS if residual ovary	6 monthly 6 monthly Pelvic USS if residual ovary	Yearly Yearly Pelvic USS if residual ovary	Yearly Yearly Pelvic USS if residual ovary
Completion surgery	Discharge to GP care Annual GP visit for clinical review and	GP care	GP care	GP care	GP care

	pelvic examination				
Cervical/Vaginal					
Low risk – surgical only **Stage 1A1**	6 monthly	6 monthly	6 monthly	Discharge to GP care. Annual GP visit for clinical review and pelvic examination	GP care
Stage 1A2/1B	4 monthly	6 monthly	6 monthly	Yearly	Discharge to GP care. Annual GP visit for clinical review and pelvic examination
Pap smear	Yearly	Yearly	Yearly	Yearly	Yearly for 10 years
High risk – primary or adjuvant ChemoRT (alternate with radiation oncology)	3 monthly	4 monthly	6 monthly	Yearly	Discharge to GP care Annual GP visit for clinical review and pelvic examination
Pap smear **Imaging**	Not indicated Not routinely indicated without symptoms	CT CAP or PET/CT preferred if required			
Vulva					
Pre-invasive	6 monthly	Yearly	Yearly	Discharge to GP care Annual GP visit for clinical review and genital examination	GP care
Low risk – surgical only	4 monthly	6 monthly	6 monthly	Yearly	Discharge to GP care Annual GP visit for clinical review and genital examination
High risk – primary RT or adjuvant (alternate with radiation oncology)	3 monthly	4 monthly	6 monthly	Yearly	Discharge to GP care Annual GP visit for clinical review and genital examination
Imaging	Not routinely indicated without symptoms	CT CAP or PET/CT preferred if required			
Epithelial ovarian cancer					
All stages (alternate with medical oncology	3 monthly	4 monthly	6 monthly	6 monthly	Discharge to GP care

if chemotherapy)					Annual GP visit for clinical review and pelvic examination
Tumour marker	3 monthly	4 monthly	6 monthly	6 monthly	Yearly
Imaging	Not routinely indicated without symptoms	CT CAP or PET/CT preferred if required			
Germ Cell tumours					
All stages (alternate with medical oncology if chemotherapy)	2 monthly	3 monthly	4 monthly	6 monthly	Discharge to GP care Annual GP visit for clinical review and pelvic examination
Tumour marker	2 monthly	3 monthly	4 monthly	6 monthly	Yearly
Imaging **CXR**	3 monthly	4 monthly	Discontinue in absence of symptoms	Discontinue in absence of symptoms	Discontinue in absence of symptoms
MRI abdo/pelvis (or CT abdo/pelvis)	3 monthly	4 monthly	6 monthly (non-dysgerminomas) Yearly (dysgerminomas)	6 monthly (non-dysgerminomas) Yearly (dysgerminomas)	Not routinely indicated without symptoms
Sex cord stromal tumours					
Early stage, low risk	6 monthly	6 monthly	6 monthly	Discharge to GP care Annual GP visit for clinical review and pelvic examination	GP care
Tumour marker	6 monthly	6 monthly	6 monthly	Yearly	Yearly
Imaging	Not routinely indicated without symptoms	CT CAP preferred if required			
High risk disease (alternate with medical oncology)	4 monthly	6 monthly	6 monthly	6 monthly	Discharge to GP care Annual GP visit for clinical review and pelvic examination
Tumour marker	4 monthly	6 monthly	6 monthly	6 monthly	Yearly
Imaging	Not routinely indicated without symptoms	CT CAP preferred if required			
Uterine sarcoma					
All stages (alternate with medical oncology if adjuvant treatment is recommended)	3 monthly	4 monthly	6 monthly	6 monthly	Discharge to GP care Annual GP visit for clinical review and pelvic

					examination
Imaging	6 month post treatment CT CAP	18 month post treatment CT CAP	36 month post treatment CT CAP	Not routinely indicated without symptoms CT CAP preferred if required	Not routinely indicated without symptoms CT CAP preferred if required