Oncology Revision

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1. **Endometrial cancer:**

Type I	Type II
It's the Most common type its adenocarcinoma affected by hormones (estrogen) Its endometroid adenocarcinoma well differentiated Risk factors: DM + obesity + tamoxifen. etc. Also with family history of lynch syndrome ((hereditary none polyposis Colorectal cancer [HNPCC])) It involved Another CA: 1. Endometrial CA 2. Ovarian CA 3. Colorectal CA 4. Ureter CA 5. Bladder + pancreas CA 6. Brain CA (rare cases) Management: Surgical staging + TAH +BSO Diagnosis: endometrial biopsy (Gold standard)	Clear cell Not related to risk factor its more aggressive Management: TAH + BSO + omentectomy + Paraaortic lymph node + Chemotherapy

Note:
Tamoxphin caused endometrial cancer = risk factor!
OCP = protective √
PCOS = risk factor!
Smoking = protective √

Management of Endometrial Cancer type I based on staging: -

Stage IA: less than 50% of myometrium involved
NO Adjuvant therapy

Stage IB: more than 50% of myometrium involved
Vaginal brachytherapy

Stage II: cervical involved
- Radical Hysterectomy
  We take uterine artery + all margins
- Simple hysterectomy + pelvic radiation

Anything above stage II:
Chemo + Radiation

Stage IVB: Distant metastasis
ONLY Give Palliative chemo

2. **Cervical Cancer:**

Premalignant
(Abnormal pap test) screening test

When do we start? 21 years old
How frequent? every 3 years

(HPV)
Age = 30 → Every 5 years
Pap test = low grade 85% it will go by itself
↓ High grade "premalignant"
Then biopsy
CIN I: every age follow up
CIN II: if she is below than 25 follow, if more than 25 Cone+ LEEP
CIN III: every age cone + LEEP

Cervical cancer staging:

Early stage	Late stage (advanced)
Stage II "surgery" A-II The cut off of surgery is stage IIB→ Surgery ← IIB → no surgery	Non-surgical chemo radiation 4B→ palliative!

Stage I-BI ⇒ surgery [bleeding + fistulas]
⇒ chemo [Dermatitis]
depends on age and Desire for fertility √

The surgery in cervical cancer:
Radical hysterectomy with lymph node dissection ± paraortic Dissection
→if still positive = Chemotherapy

Cervical cancer: staging is Clinical

What I am allowed to to do for exam under anesthesia in OR:

1. Rectoscopy = proctoscopy
2. Cystoscopy = to examine the bladder
3. Digital exam = to assess extent of the disease [parametria]
4. Chest X-ray
5. Bone X-ray
6. IVP = to assess the kidney
   (I Can't do CT or MRI because it not part of the staging)
7. Exam under general anesthesia

How can I know if it reached the pelvis [stage IIIB]?
They will have → lymphedema + dropfeet +hydronephrotic + hydroureters

surgery WILL NOT change my stage because its clinical

Q In exam: If you have a patient who presents with mass in vagina
⇒ III or II: the options of cervical cancer management?

1. Radical hysterectomy
2. Chemo and radiation
3. Palliative chemo
4. Support palliative (only antiemetic + pain Relivers)

The most common cause = HPV 80%
16-18 = Malignancy
6-11 = Vaginal warts
16 = squamous cell carcinoma
18 = Adenocarcinoma [more aggressive]
Cervical cancer is the most common type of cancer in developing country

The vaccination = 3 types

1. bivalent
2. quadrivalent
3. nonavalent

it reduces the risk by 90%
the age of getting the vaccine = 9-14 (before exposure)

3. **Ovarian Cancer:**

Benign	Borderline	Malignant
Ovarian cyst when it is less than 5 cm [young age] [post menopause age] the cyst should not exceed 2 cm	It has malignant and benign features. Benign feature: not invasive its micro invasive Malignant features: metastasis stage (III) 5 years survival rate 95%Excellent the problems: 1. Recurrence 2. It can be malignant when it comes back	

Dysgerminoma:
usually young
Management only unilateral oovectomy
It's so sensitive to chemotherapy
Immature teratoma = very aggressive comes in young
Mucinous = aggressive [GI - Intestinal type]
not responsive to chemotherapy

Risk malignant index :
it combines three pre-surgical features

1. Age of the patient⇒ non-menopause → give 1 score
   ⇒ post-menopause→ give 4 scores
2. CA 125 volume = will be given in Q
3. Ultrasound findings ⇒ from 0 to 1 = 1 score
   ⇒ More than 1 = 4 scores

   {RMI = AGE X US X CA 125}

If the result is more than 200 it is malignant

Tumor markers:
Epithelial [serous] = CA 125
Epithelial [mucinous] = CA 19-9
Germs [Dysgerminoma] =LDH
Stromal cell [Granulosa]= Inhibin
And Anti Mullerian Hormone [AMH]

Granulosa = it is caused by estrogen
it can be ⇒ (secondary to endometrial cancer)

Ovarian cancer management:

Patient with ovarian usually come with ascites + none specific symptoms like: back pain
Usually 70-85% come at stage III or IV

It is contraindicated to take a biopsy
From ovary because you may, up the stage of the disease
SO, we biopsy the Omentum

2 ways in management [mostly for epithelial]

1. Primary surgery [primary Debulking] and give the patient 6 cycle of chemotherapy Primary debulking means we remove: TAH, BSO, Pelvic node dissection Paraaortic lymph nodes dissection + omentomy everything you see it you remove it chemotherapy =carbo toxal	2. Neoadjuvant chemo give 3 cycles we want to shrink the disease ↓ then surgery

The follow up = by measurement of Tumor makers
Mucinous → CA 19-9 if high do CT [Recurrence]

4. **Vaginal and vulvar cancer:**
   {it is rare}
1. Vaginal cancer: Usually its secondary cancer
   The most common type of vaginal cancer is (1) squamous followed by (2) melanoma

2. Vulvar cancer: squamous cell [because its skin]
   It can be primary, and its HPV related

   Management / chemo → surgery
   Presentation / mass + ulcer + itching

5. **GTD and GTN:**

Molar presentation = Large fundal height to date + early bleeding + hypertension + hyperthyroidism + hyperemesis gravidum

Molar pregnancy

Complete mole	Incomplete mole
2 sperm fertilizing one empty ovum or 1 sperm then divided in empty ovum THERE IS NO FETUS The most common Genotype is 46 XX The risk for transforming to GTN is 15-20 % [Snow storm appearance]	1 sperm fertilizing normal ovum there is maternal component THERE IS FETUS Genotype 69 XXY the risk for GTN 1-5% remember: Baby is there so less risk cuz babies are cute 😊

Mention 3 types of tumor of GTD ⇒ GTN?

1. Invasive mole
2. Choriocarcinoma
3. Placental site tumor

Diagnosis of molar pregnancy:
Quantitive B-hcG + Pelvic US

Management of molar pregnancy:
(suction and Evacuation)
to make sure all tissue is removed!!
follow up: by B-hcG

1. Weekly until 3 negative
2. Monthly for 6 months

Patient should be on OCP
Its contraindicated To put IUD → Perforation of Uterus
Advice the Patient → don't get pregnant for one year

GTN:
Primary from histopathology
= or secondary from GTD

Management:
The chemotherapy is Methotrexate

It's based on Scoring system

Low risk 6 or less → single agent of chemo
High risk 7 or more → 5 agents of chemo (EMACO)

Follow up = by B-hcG
Weekly for 3 months
Monthly for 12 months

Advice the Patient → don’t get pregnant for 2 years

Doctor concluded by: (staging is not important only know it by early and late stage)