



OB/GYN REFERRAL AND MANAGEMENT CRITERIA

Guideline History

Date Approved	09/99,07/05, 01/08
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Next Review Date	01/10

These guidelines are promulgated by Sentara Healthcare (SHC) as recommendations for the clinical management of specific conditions. Clinical data in a particular case may necessitate or permit deviation from these guidelines. The SHC guidelines are institutionally endorsed recommendations and are not intended as a substitute for clinical judgment.

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DEFINITIONS OF GYNECOLOGIC ONCOLOGY SERVICES

A. GYN malignancies recommended consultation with decision for co-management or care by GYN Oncology (approval by GYN Oncologist for surgery by primary OB/GYN recommended to be documented)

1. Vulvar CA -Invasive
2. Vaginal CA -Invasive
3. Cervical CA -Microinvasive and Invasive
4. Endometrial CA -All Grades
5. Ovarian CA
 - a) Documented malignancy
 - b) High pre-op clinical suspicion by:
 - Evidence of advance disease is present: pelvic mass with omental caking; presence of effusion, ascites.
 - A clinically suspicious pelvic mass [large (>10 cm) complex, fixed, nodular, bilateral] is diagnosed.
 - Premenarchal girls require surgical treatment for pelvic mass.
 - Postmenopausal women have suspicious ovarian masses or elevated tumor marker, not to include simple cyst ≤ 5 cm.
 - Perimenopausal women have ovarian masses, particularly when associated with elevated CA-125. Elevation between 35 and 65 U/ml are associated with cancer risk of 50 to 60%. A CA-125 > 65 U/ml in a 50 – year – old or older women is virtually diagnostic of malignancy with a specificity of 98%.
 - Young patients have a pelvic mass and elevated tumor markers (CA-125, AFP, hCG).
 - Suspicious findings are present on imaging studies. The risk of malignancy in a postmenopausal woman with a unilocular mass without solid components is <1%, increasing to 8% in a multilocular mass and 70% in a mass with solid components.
 - Complex masses with solid components or excrescences or otherwise suspicious for cancer are present.
 - Suspicious pelvic masses are found in women with a significant family or personal history of ovarian, breast, or other cancers (one or more first-degree relative).
6. Intraoperatively encountered CA and borderline tumors.
7. PCP may directly refer to GYN Oncology if member is receiving ongoing treatment or has an established diagnosis.

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DEFINITIONS OF REPRODUCTIVE ENDOCRINOLOGY SERVICES

A. Conditions for which consultation from a Reproductive Endocrinologist should be considered for establishment of a treatment plan

1. Hyperprolactinemia with macroadenoma or failed medical therapy (serum prolactin, MRI + medical therapy by generalist)
2. Ovulation induction when clomiphene resistance exists (clomiphene dose >150 mg qd)
3. Severe hyperandrogenism
4. Ambiguous genitalia
5. Precocious puberty
6. Infertility with more than 2 years of unsuccessful therapy in women < 33 years old
7. Bilateral hydrosalpinx
8. Primary amenorrhea (excluding PCO and pregnancy)
9. Ovulation induction with insulin sensitizers.

B. Conditions for which a Reproductive Endocrinologist must assume total care or direct any co-management

1. Ovulation induction with gonadotropins
2. Infertility after 12 months of unsuccessful therapy (including time required for diagnostic workup) in women >33 years old

C. Procedures limited to Reproductive Endocrinologists

1. ART Services
 - a. In vitro fertilization and related techniques
 - b. Donor Egg
 - c. Surrogacy
 - d. Cryo-thaw transfer cycles
2. Severe male factor infertility (defined as <10 million sperm OR <35% by commercial lab or <4% by EVMS-Jones Institute lab normal morphology sperm)
3. Surgery for Mullerian anomalies excluding septate uterus

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