Optima Health

OB/GYN
Subspecialty Referral

Guideline History

Original Approve Date	09/99
Review/ Revise Dates	06/01, 06/03, 07/05, 12/07, 01/08, 11/08,11/10, 11/12, 11/14, 11/16, 11/18
Next Review Date	11/20

OB/GYN
Subspecialty Referral Criteria

DEFINITIONS OF GYNECOLOGIC ONCOLOGY SERVICES

A. <u>GYN malignancies recommended consultation with decision for co-management or care by GYN Oncology</u> (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 abdominal or distant metastasis or ascites.
   - A clinically suspicious pelvic mass [>10 cm, complex, fixed, nodular, bilateral] is diagnosed.
   - Premenarchal girls requiring surgical treatment for pelvic mass.
   - Postmenopausal women who have suspicious ovarian masses or elevated tumor markers, not to include simple cyst < 5 cm.
   - Perimenopausal women who 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 who have a pelvic mass and elevated tumor markers (CA-125, OVA1, 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. <u>Conditions for which consultation from a Reproductive Endocrinologist should be considered for establishment of a treatment plan</u>

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). Clomiphene should not be used indefinitely. Once ovulation is achieved the clomiphene should only be used for 3 months.
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. <u>Conditions for which a Reproductive Endocrinologist must assume total care or direct any co-management)</u>

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. <u>Procedures limited to Reproductive Endocrinologists</u>

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