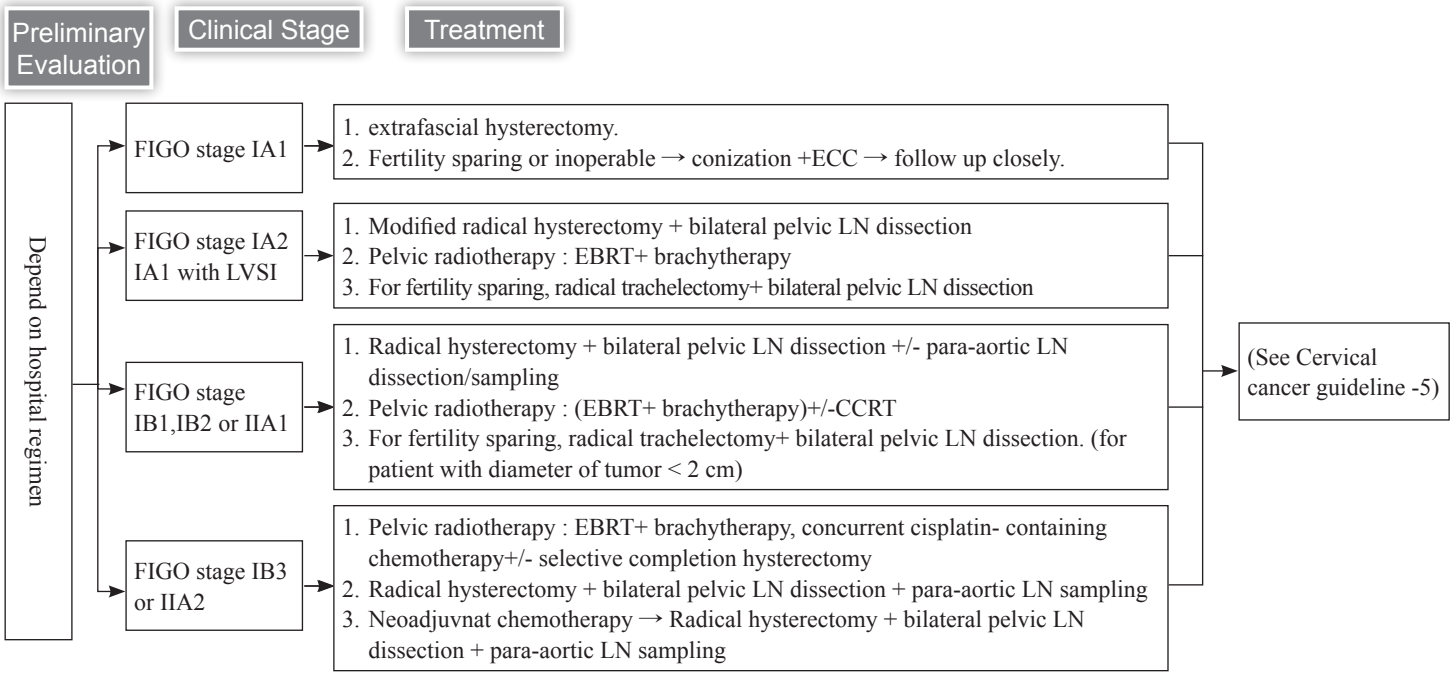
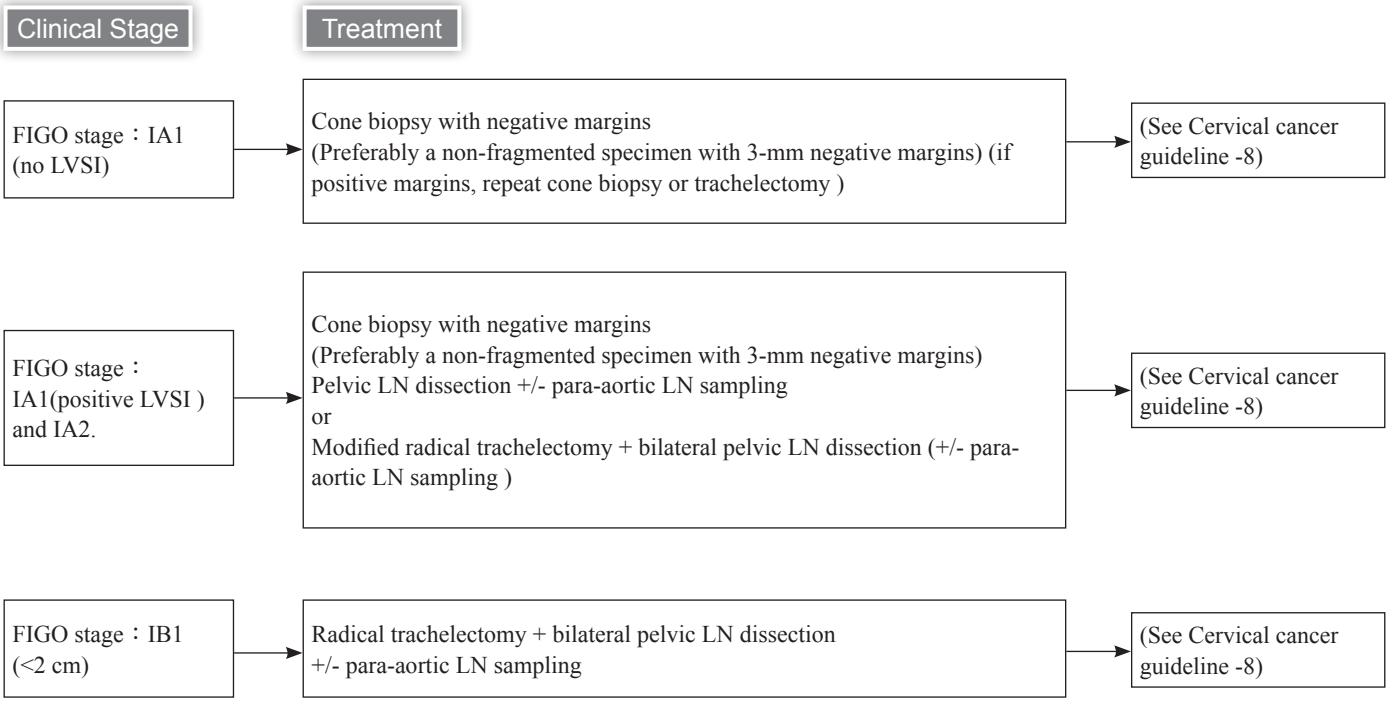
Gynecologic Cancers

《 Cervical cancer guideline-1 》

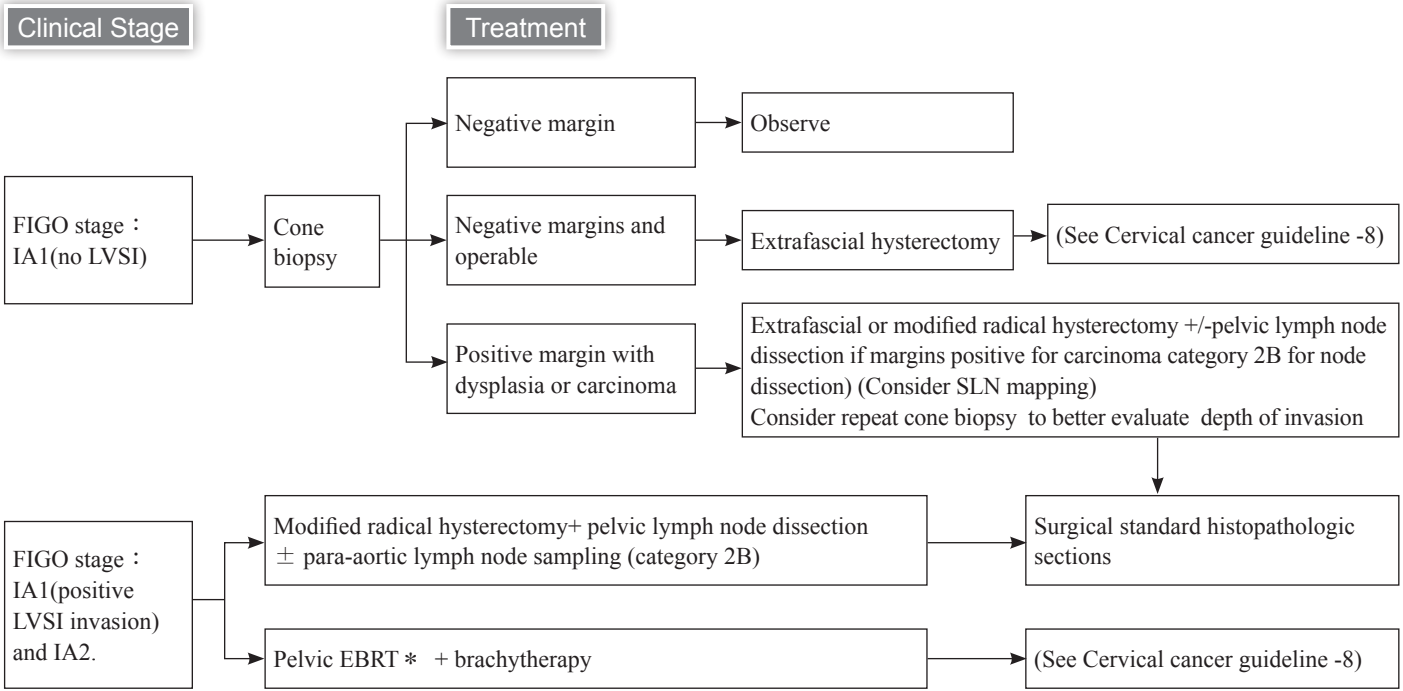


Note: Cervical cancer is diagnosed as adenocarcinoma or squamous cell carcinoma , Because of the high degree of malignancy and poor prognosis, if surgery is suitable, the tumor should be removed as much as possible after imaging evaluation. Postoperative radiotherapy or simultaneous chemoradiation or systemic therapy will be given depending on the situation

《 Cervical cancer guideline-2 (Fertility considerations) 》

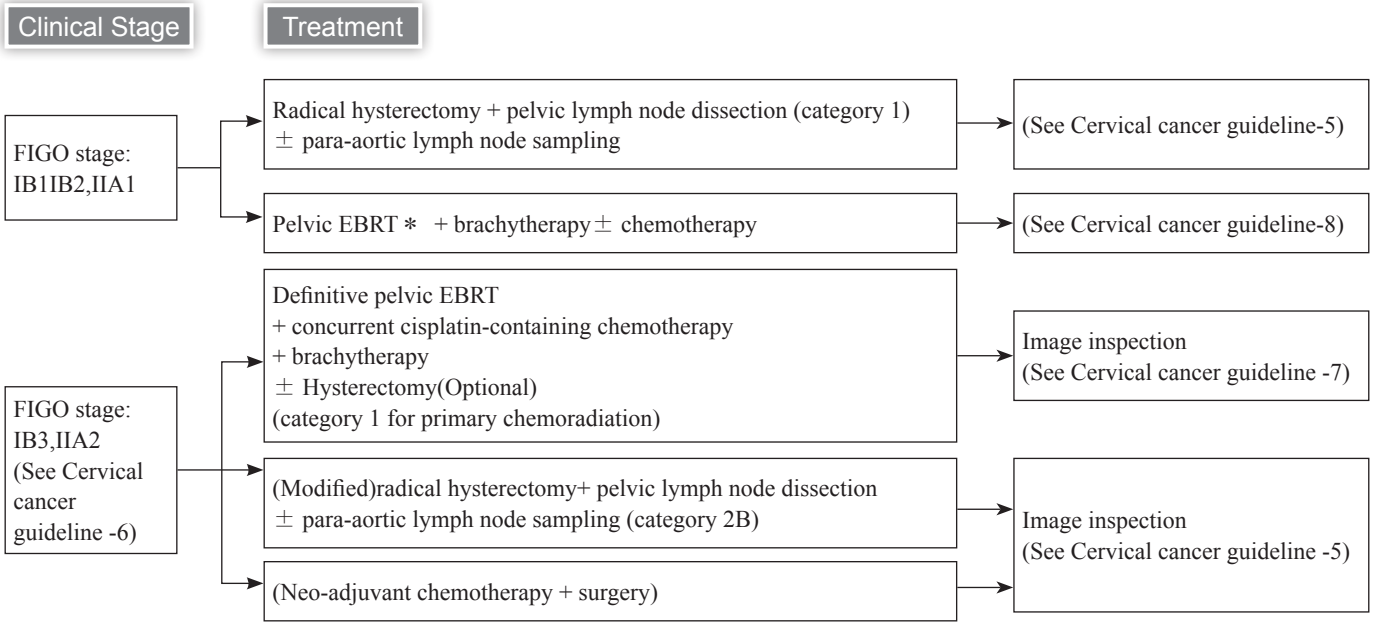


《 Cervical cancer guideline -3 (No Fertility considerations) 》



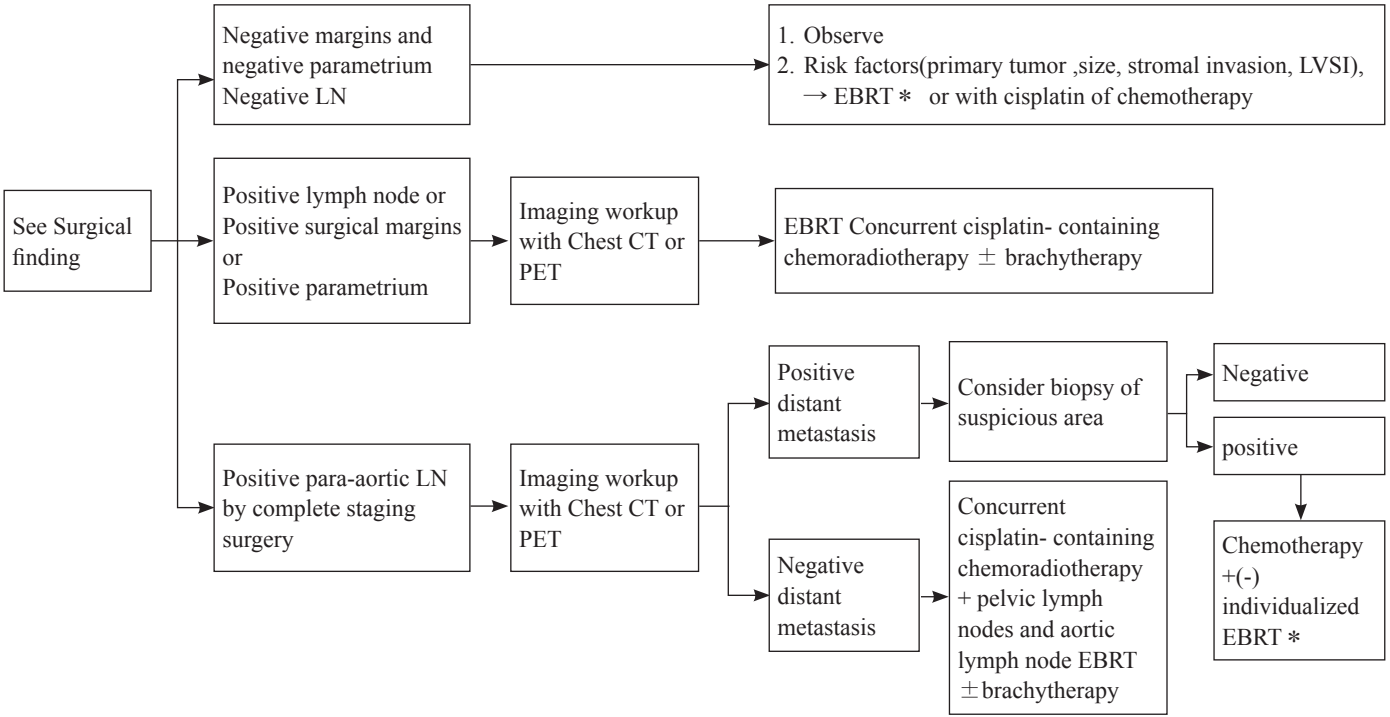
＊ EBRT(External Bean Radiation Therapy)

《 Cervical cancer guideline -4 (No Fertility considerations) 》



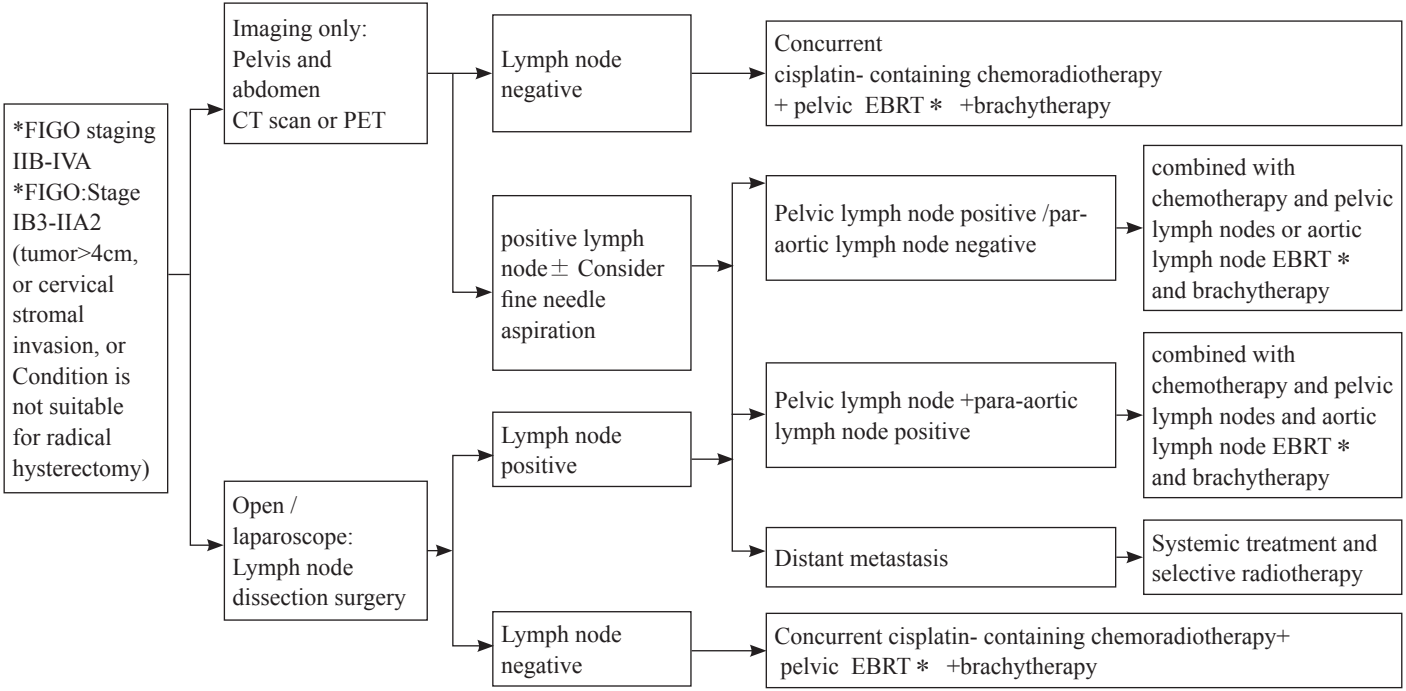
Note: Cervical cancer is diagnosed as adenocarcinoma or squamous cell carcinoma , Because of the high degree of malignancy and poor prognosis, if surgery is suitable, the tumor should be removed as much as possible after imaging evaluation. Postoperative radiotherapy or simultaneous chemoradiation or systemic therapy will be given depending on the situation

《 Cervical cancer guideline -5 》

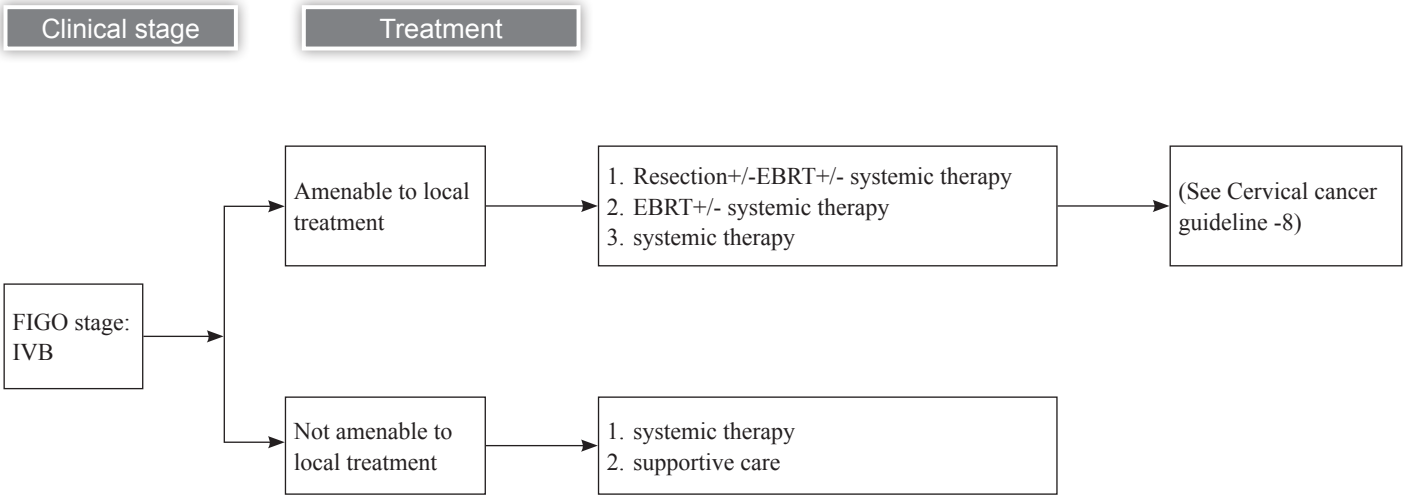


《 Cervical cancer guideline-6 》

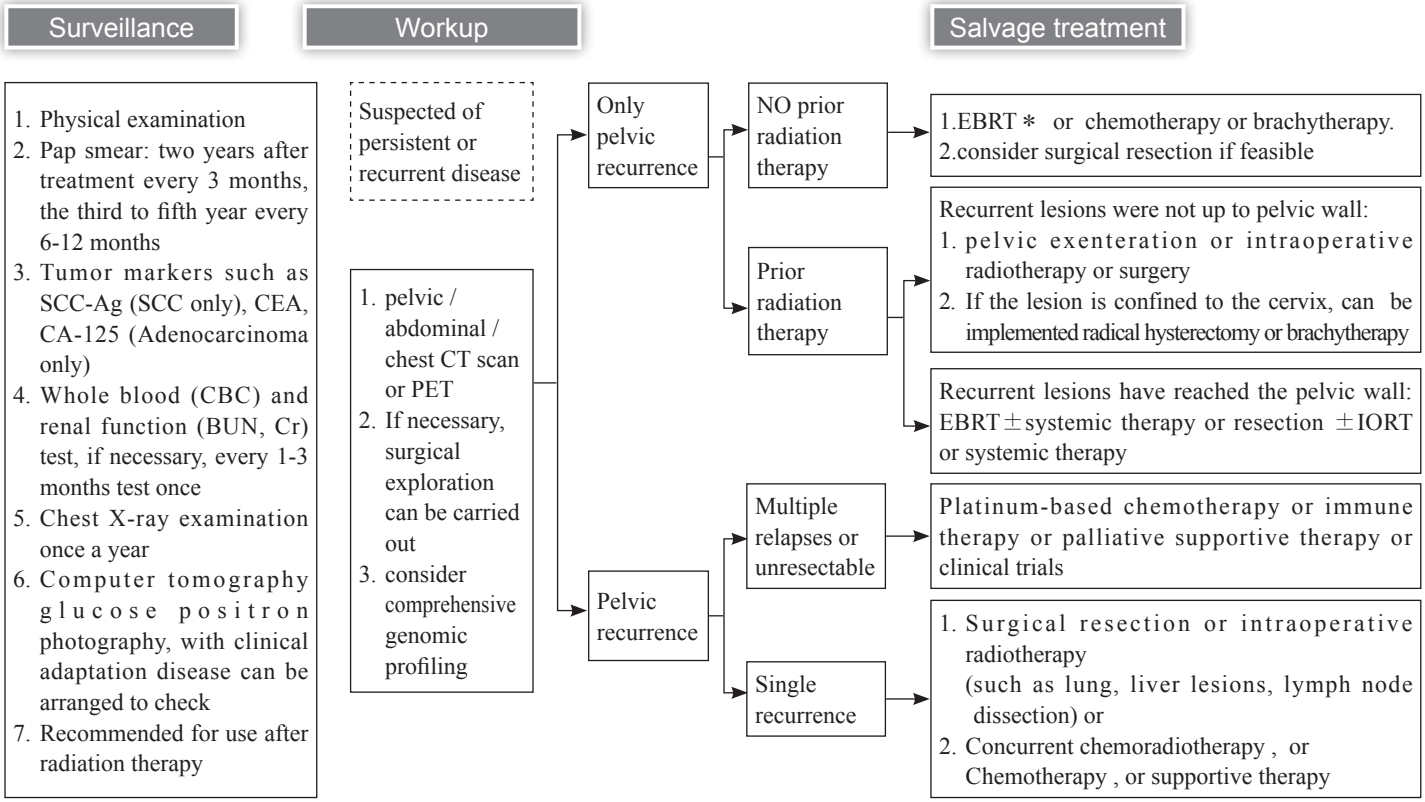
◆ radiation therapy, including in vitro radiotherapy and adjuvant therapy
◆ squamous cell carcinoma with cisplatin containing chemotherapy; non-squamous cell carcinoma can be used different from cisplatin chemotherapy drugs



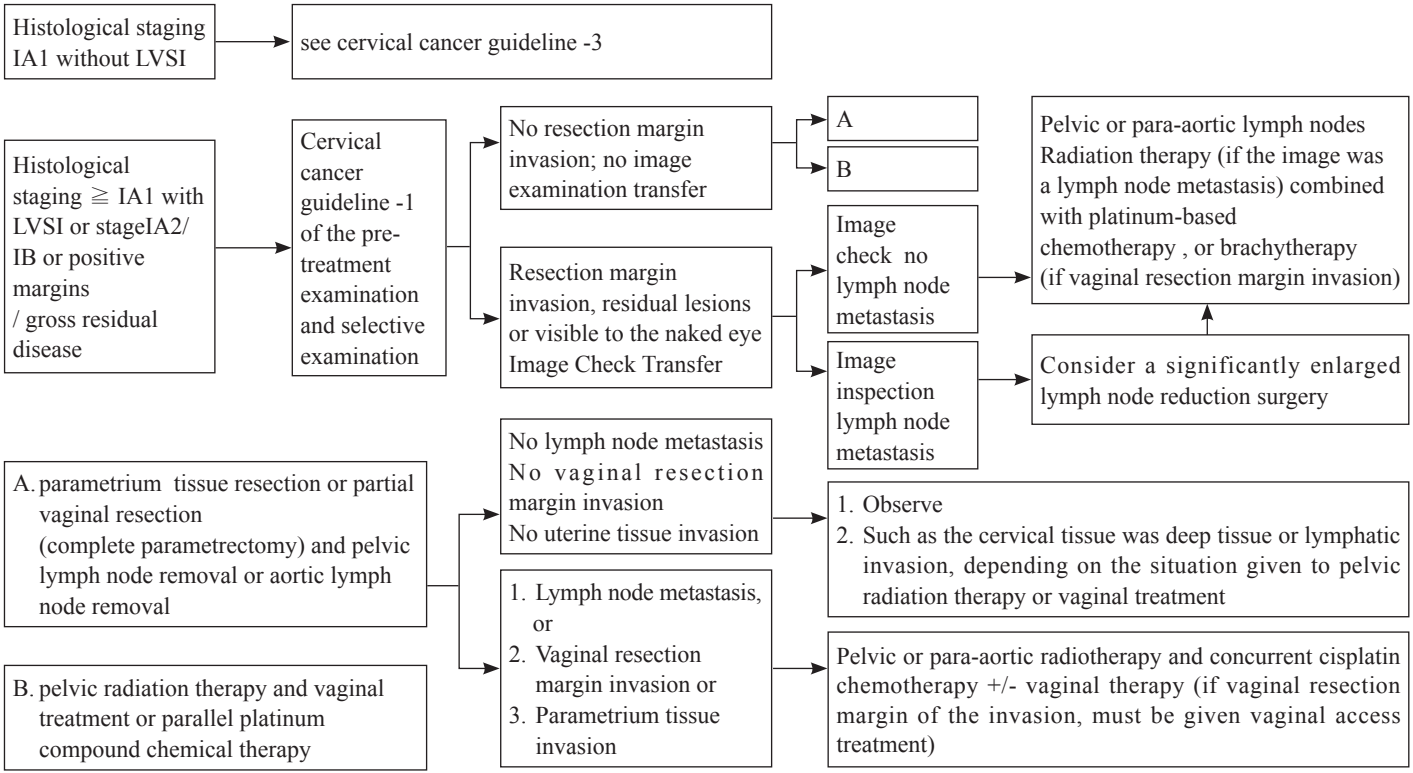
《 Cervical cancer guideline-7 》



《 Cervical cancer guideline-8 》

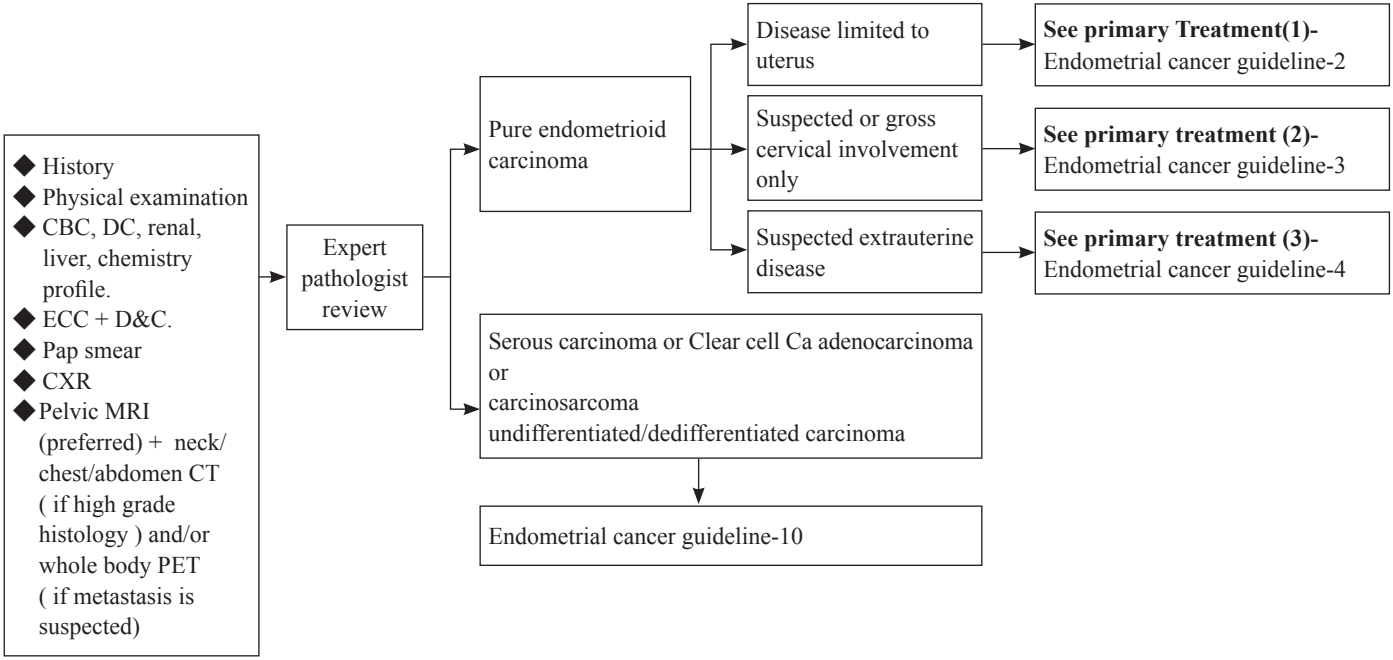


《 Cervical cancer guideline-9(Invasive cancer found only after hysterectomy) 》



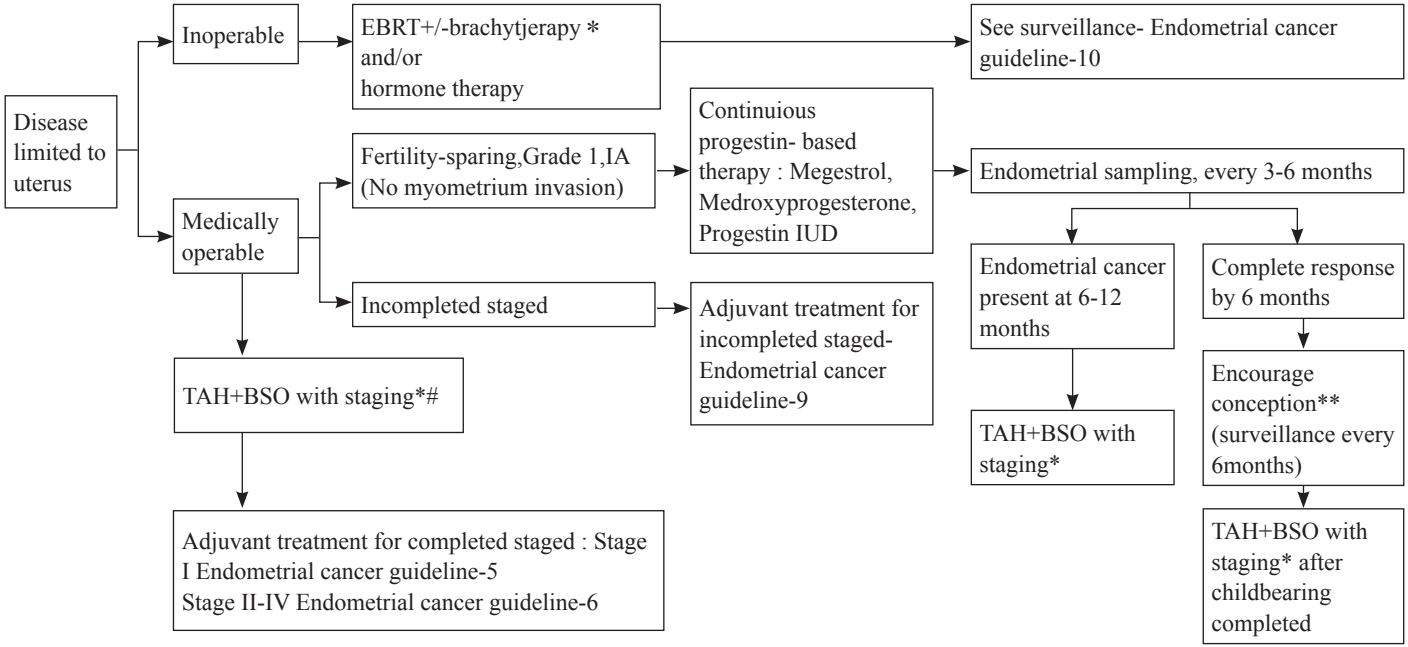
《 Endometrial cancer guideline -1 》

Preliminary evaluation



《 Endometrial cancer guideline -2 》

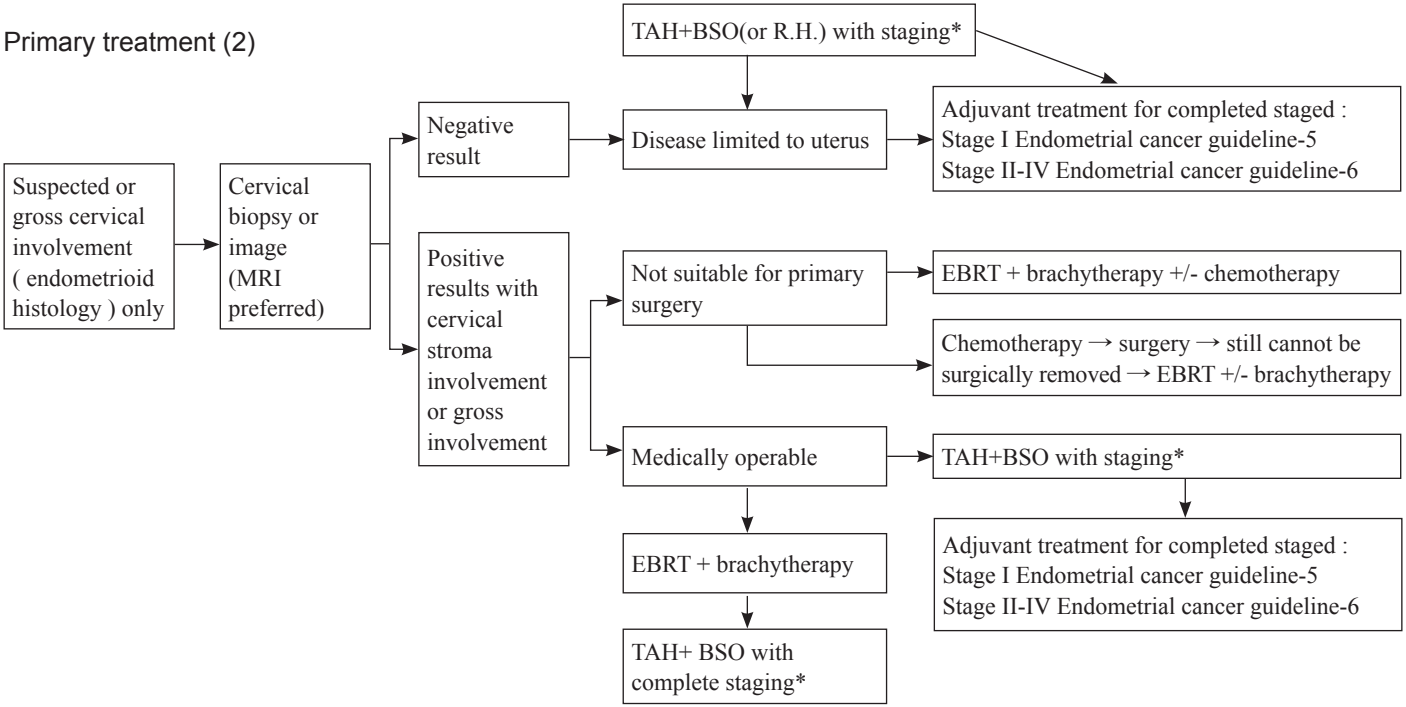
Primary treatment (1)



* TAH+ BSO with completed staging：total hysterectomy , bilateral salpingo-oophorectomy、pelvic LN +/- para-aortic LN dissection、washing /ascites cytology.
* EBRT(External Bean Radiation Therapy)
\# Ovarian preservation maybe safe in select premenopausal women with early stage endometrial cancer. Salpingectomy is Preferred.
** Endometrial sampling every 6month and progestin-based therapy are recommended if patient is not in the active process of trying to conceive.

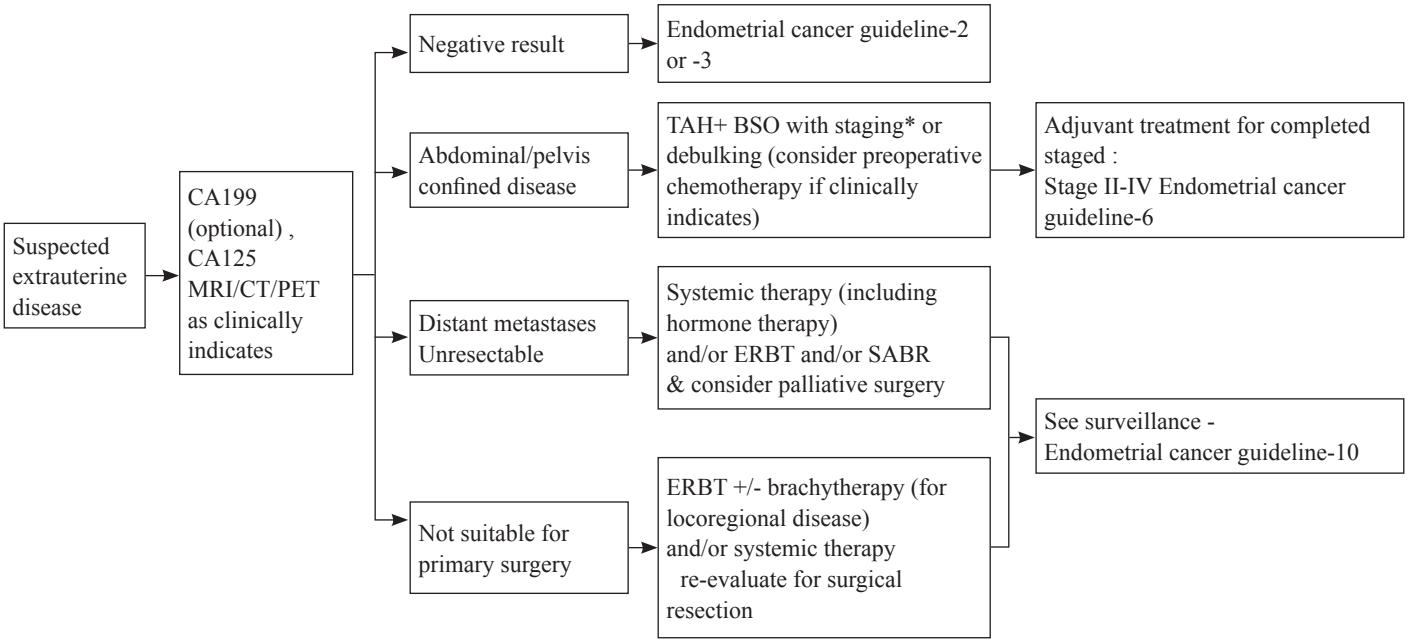
《 Endometrial cancer guideline-3 》

Primary treatment (2)



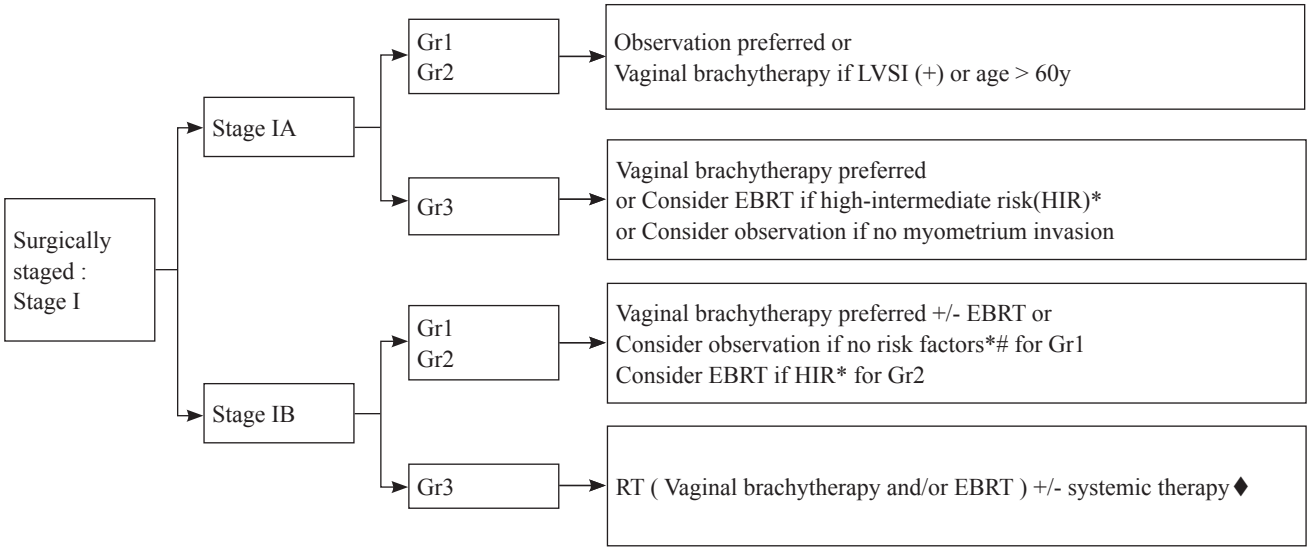
* TAH+BSO with staging：total hysterectomy , bilateral salpingo-oophorectomy、pelvic LN +/- para-aortic LN dissection、washing /ascites cytology.

Primary treatment (3)



* TAH+BSO with staging：total hysterectomy , bilateral salpingo-oophorectomy、pelvic LN +/- para-aortic LN dissection、washing /ascites cytology.

《 Endometrial cancer guideline-5 》



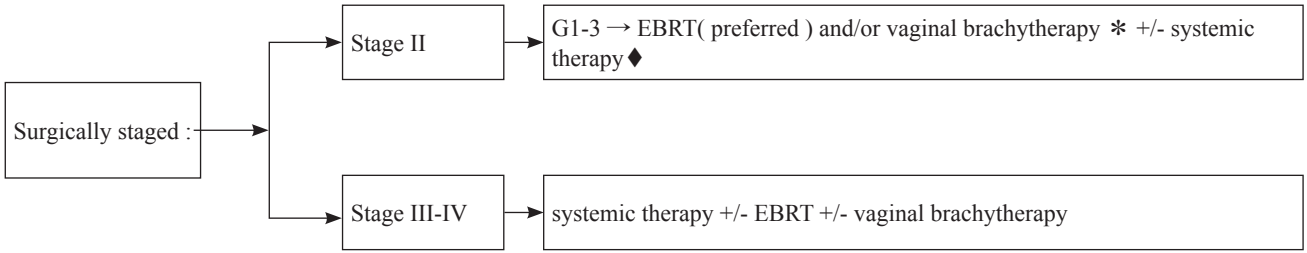
Risk factors：

* age 50-69y with two risk factors or age <50y with three risk factors, or age ≥ 70y with one risk factor, include grade 2 or 3, depth of invasion to outer half, and LVSI (GOG 249)。

\# Potential adverse risk factors: age ≥ 60yrs, depth of invasion, and/or LVSI。

♦ risk of recurrence is higher with older age (especially > 60y), extensive LVSI, and deeper myoinvasion (>50%)。

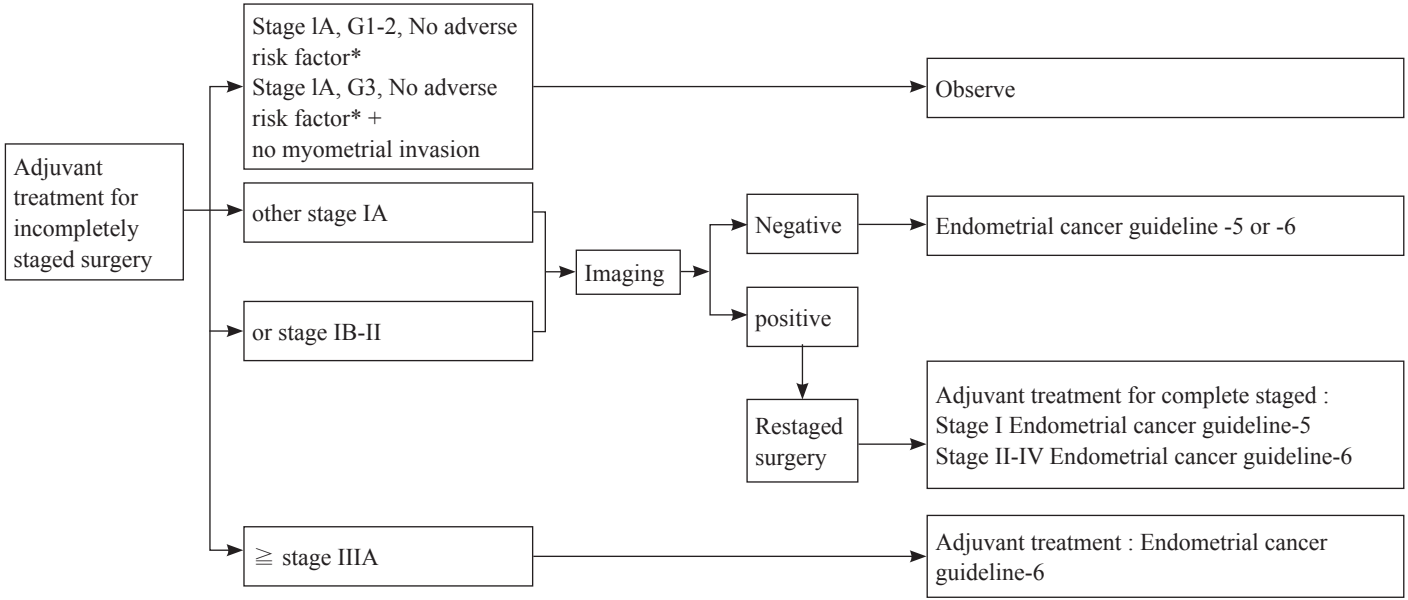
《 Endometrial cancer guideline-6 》



✻ vaginal brachytherapy is also an option for G1/G2 + < 50% myometrium invasion + LVSI (-) + microscopic cervical invasion stage II disease.
♦ risk of recurrence is higher with older age (especially > 60y), extensive LVSI, and deeper myoinvasion (>50%)。

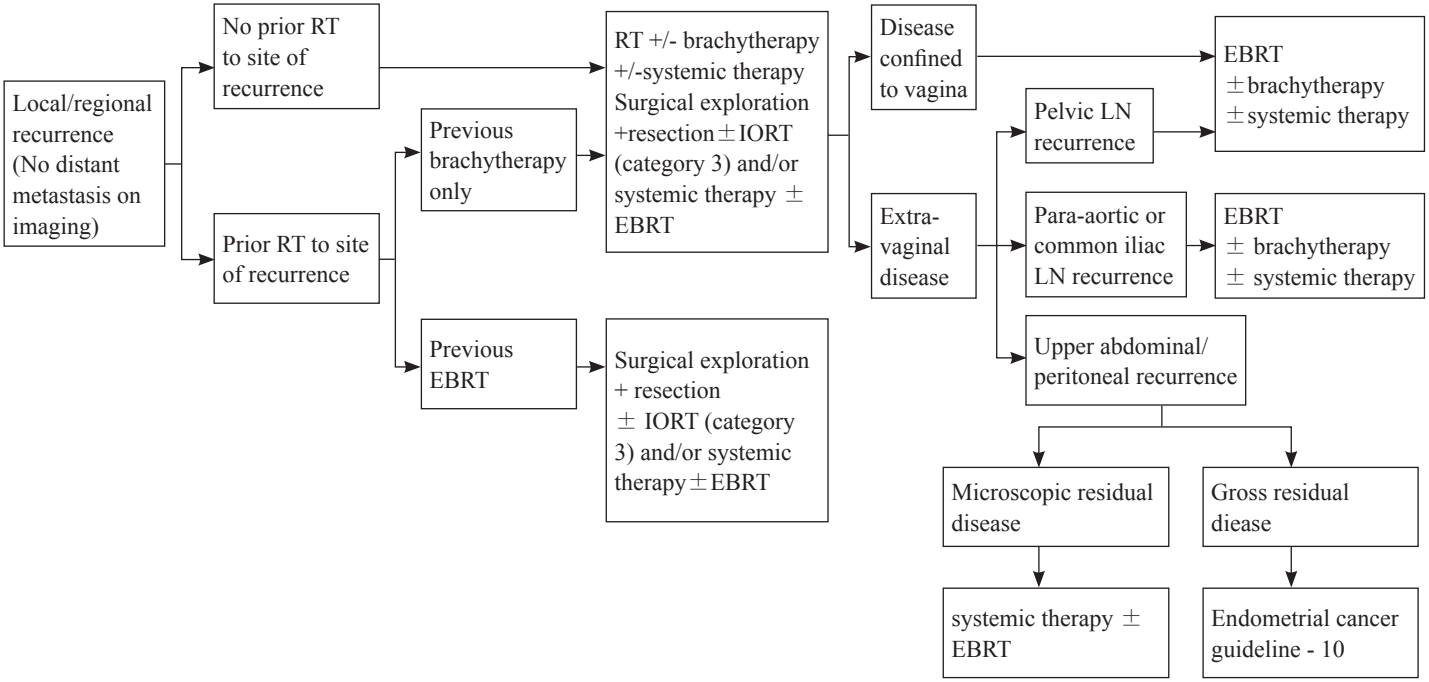
《 Endometrial cancer guideline-7 》

Incomplete staged surgery (or found accidentally): TAH only or +/- bilateral /Unilateral salpingectomy.

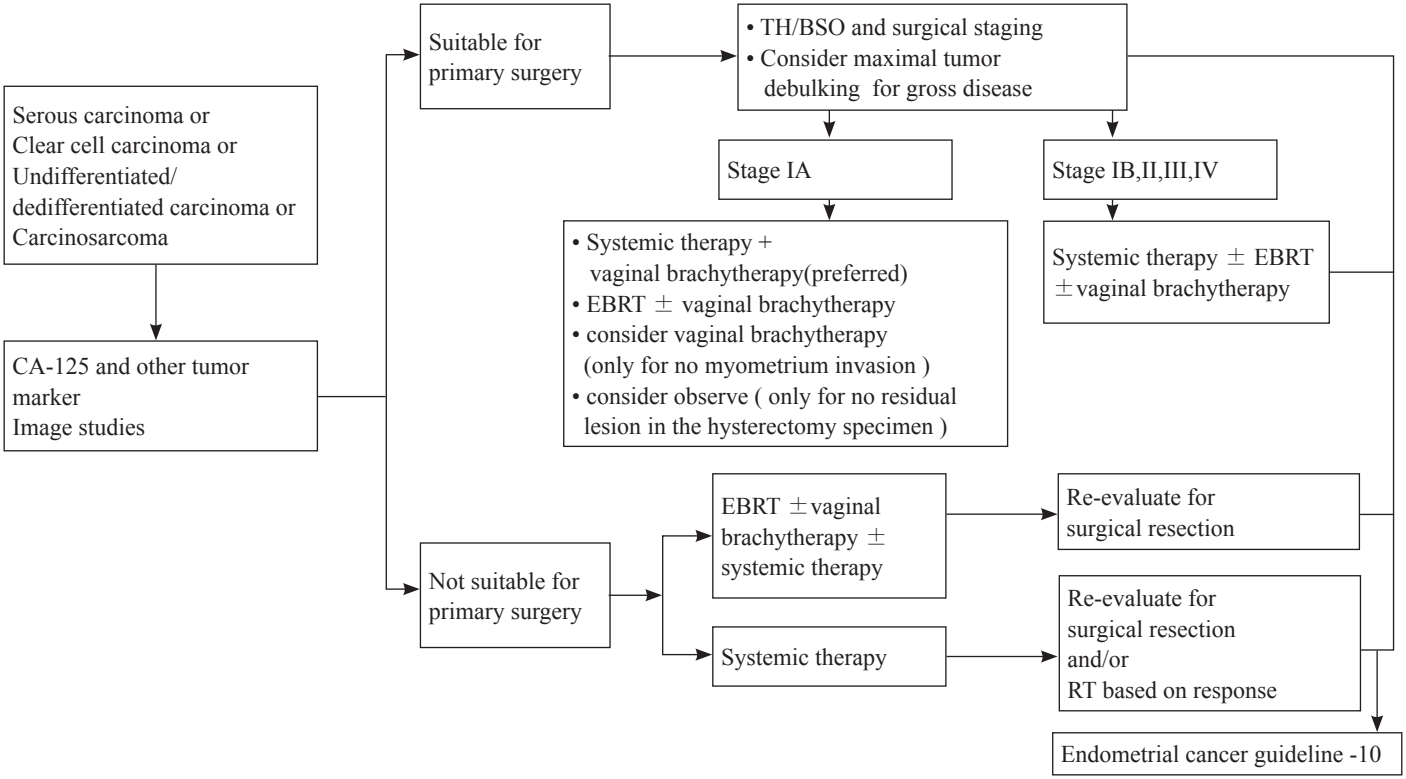


＊ ：Adverse risk factosr including : age > 60, LVSI(+) 、tumor size >= 2cm

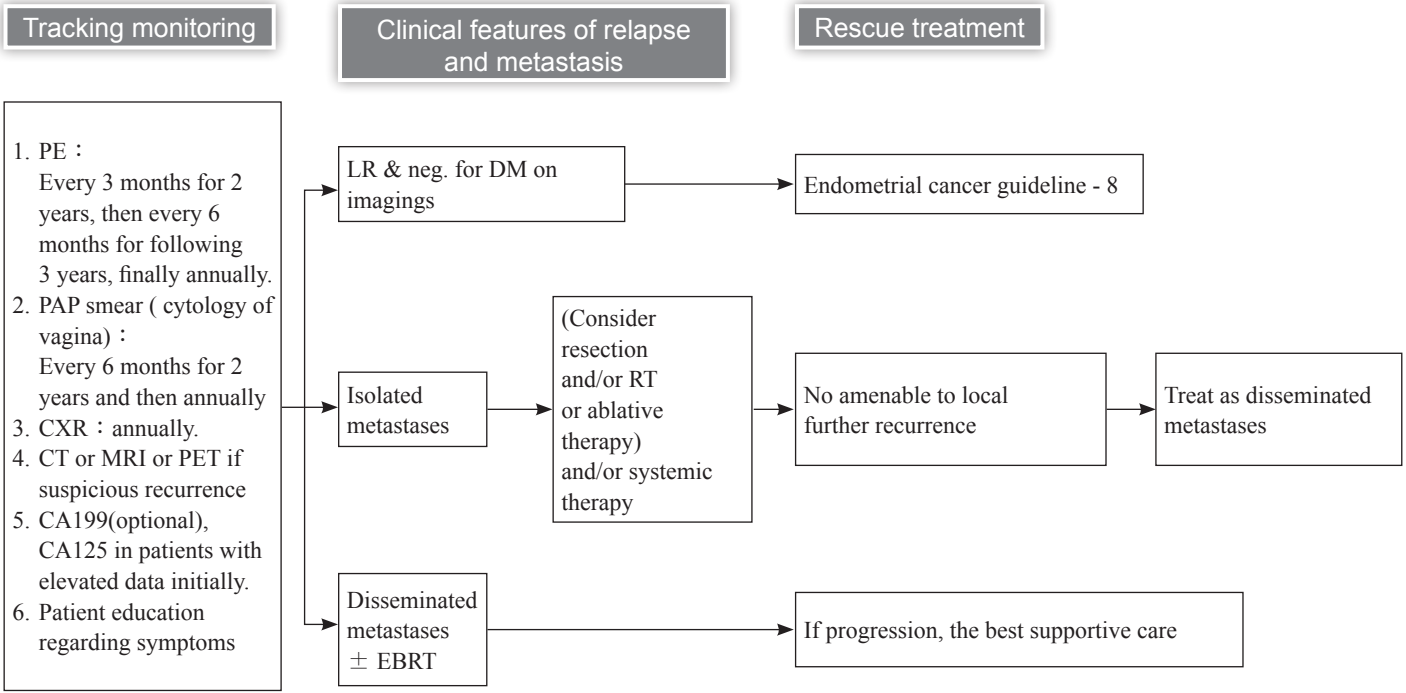
《 Endometrial cancer guideline-8 》



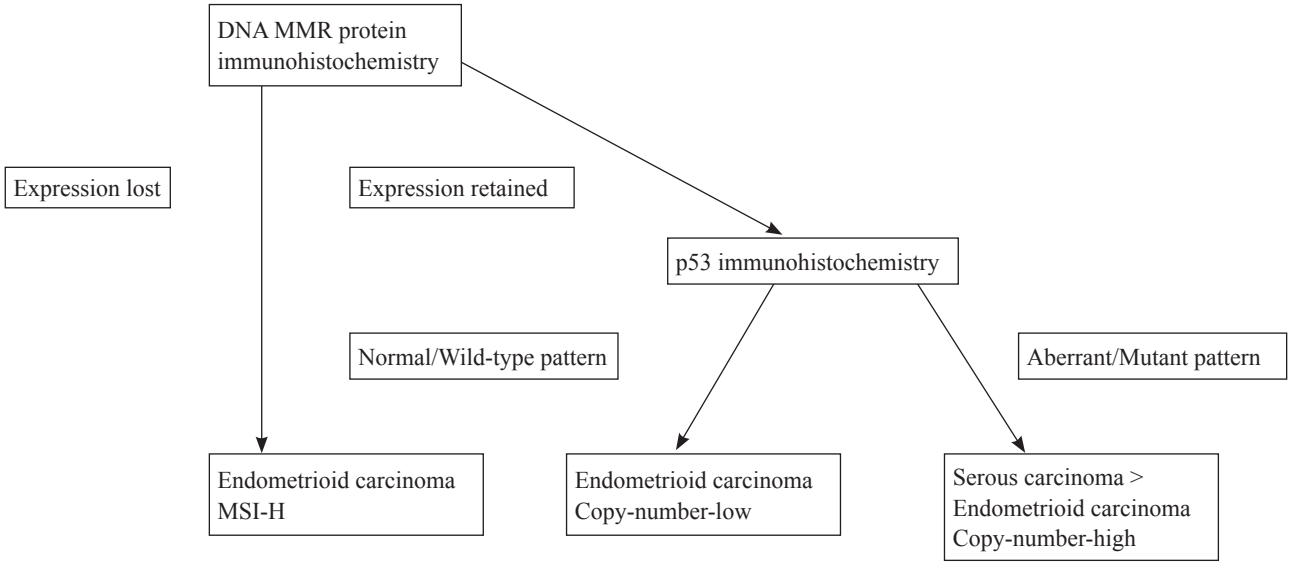
《 Endometrial cancer guideline-9 》



《 Endometrial cancer guideline-10 》



《附件 -1》


DNA MMR protein immunohistochemistry
Expression lost
Expression retained
p53 immunohistochemistry
Normal/Wild-type pattern
Aberrant/Mutant pattern
Endometrioid carcinoma MSI-H
Endometrioid carcinoma Copy-number-low
Serous carcinoma > Endometrioid carcinoma Copy-number-high

Debulking surgery

Standard condition of the debulking surgery

- ◆For the ovarian / fallopian tube outside the proliferation of lesions, should be possible to achieve the greatest degree of reduction surgery
- ◆ Consider adding further surgery (such as removal of part of the intestine or organ) in order to achieve the ideal deconvolution (optimal debulking; individual remnants of the maximum diameter of the tumor less than 1 cm)
- ◆ Super-eradication of the surgery should not be in this surgery and hinder postoperative adjuvant chemotherapy under the premise of considering to do
- ◆ If the surgery to achieve the ideal if the surgery to reduce the product, the peritoneal cavity no more than 1 cm of residual lesions, then consider the systematic aortic and pelvic lymph node removal

Do preoperative adjuvant chemotherapy of the situation

- ◆Applicable to: clinical signs or imaging findings showed a wide range of removal can not be clean, or physical condition Not suitable for major surgery
- ◆ Procedures: the use of fine needle aspiration, biopsy or abdominal puncture and other treatment in order to obtain the specimen, the diagnosis of cell pathology Confirmed, and then three to six back to the preoperative chemotherapy, followed by surgery

Standard condition of the reduction surgery (completion surgey)

- ◆Applicable to: part of the first operation can not be ideal for tumor resection (suboptimal debulking) of the patients
- ◆Procedure: Firstly give three to six rounds of chemotherapy, followed by interval debulking surgery (IDS), and then give subsequent chemotherapy. The total number of chemotherapy before and after IDS surgery can reach at least 6 times. , If even the patient responds well to the treatment and has no obvious side effects, it can be more than 6 times
- ◆If Avastin is used in combination with chemotherapy before surgery, it is recommended that Avastin be suspended for 4-6 weeks before IDS surgery
- ◆HIPEC with Cisplatin (100mg/m^2) can be considered at IDS for stage II status

preoperative examination

- Ultrasonic examination Chest x-ray; chest biopsy for cytology if pleural effusion is present
- Tumor indicators: Before surgery, it is advisable to measure CA-125 in the blood; additional tests such as CEA or CA199 (especially mucinous ovarian cancer) can also be measured. For young patients under 35 years old, it is recommended to test AFP, LDH and beta- HCG
- Complete blood count, serum biochemical examination
- Computed tomography (CT scan) or magnetic resonance imaging (MRI) can be arranged to assist in judging the nature and extent of the tumor and formulating an appropriate surgical plan
- If there is clinical suspicion of intestinal compression or obstruction, or suspected metastatic cancer originating elsewhere, it is advisable to perform gastrointestinal examinations such as upper gastrointestinal endoscopy, colonoscopy or barium imaging

Treatment principles

For epithelial ovarian cancer, fallopian tube cancer, and peritoneal cancer, the principles of treatment are the same:

- Complete surgical staging
- Surgical resection of all ovarian cancer and extra-ovarian cancer tissue as much as possible
- After surgery, adjuvant chemotherapy based on platinum compounds is used for patients who need chemotherapy
- It should be treated by a specialist in gynecological cancer

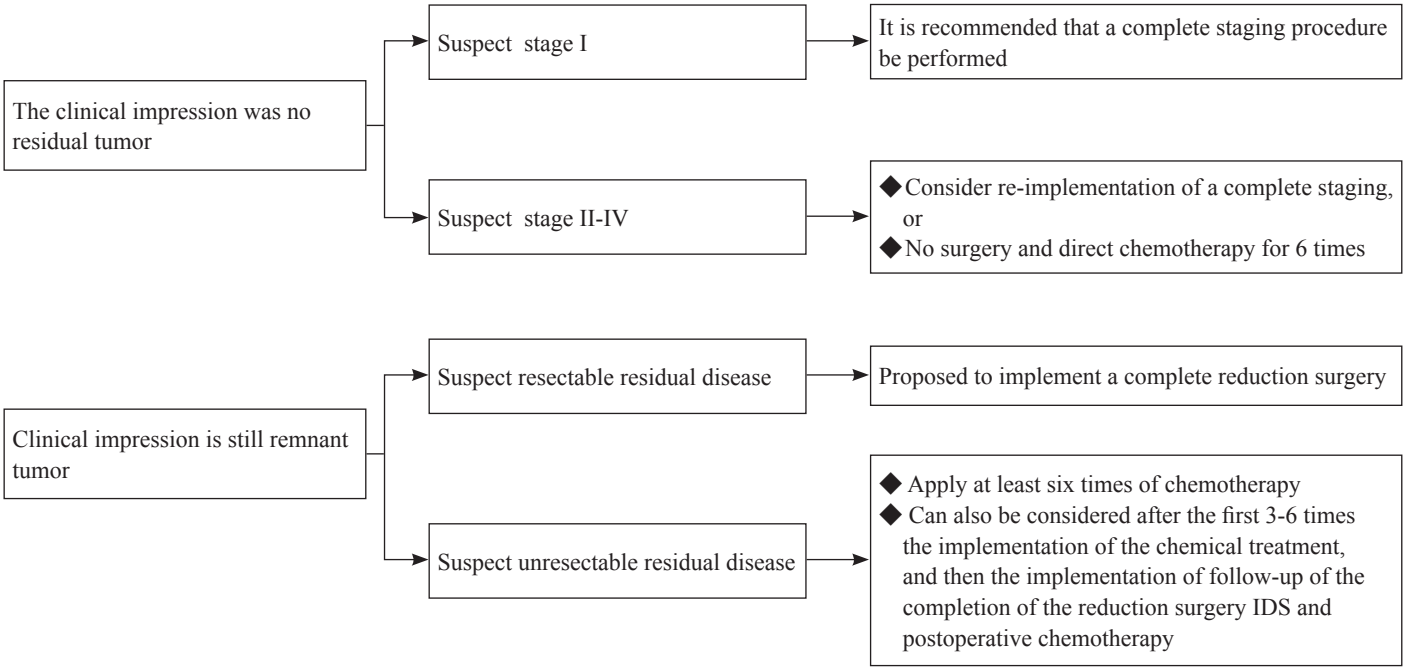
standard staging surgery

- Bowel preparation before surgery
- In principle, traditional laparotomy is adopted. Laparoscopic surgery by an experienced gynecologist-oncologist may be considered in some suitable patients with stage I ovarian cancer Into the peritoneal cavity, that is, to extract ascites or obtain peritoneal cavity cytology specimens through peritoneal lavage
- The tumor should be taken out as completely as possible, and the specimen should be sent for pathological examination as soon as possible, and routinely sent for frozen section
- If the frozen section shows mucinous adenocarcinoma, the upper and lower gastrointestinal tract should be carefully checked for primary gastrointestinal cancer that was not found before surgery
- Total hysterectomy and bilateral ovariosalpingectomy
- Consider removing the pelvic ligament of the infundibular part of the fallopian tube as much as possible
- The sticky parts need to be sliced to send. All bowel surfaces are evaluated and all suspicious areas are biopsied
- If there is no obvious extraovarian spread, random peritoneal sampling is required
- Omentumectomy
- Take bilateral para-aortic lymph nodes and pelvic lymph nodes for pathological examination. Lymph nodes next to the aorta generally need to be sampled at least to the IMA, but it is recommended to get as high as the renal vein
- Appendectomy: In the case of mucinous ovarian cancer, it is suspected that the appendix has been affected
- Consider removal of laparoscopic trocar tracks
- Complete surgical records: all lesions before surgery, the surgical method used, and the size and location of residual tumors after surgery must be stated
- Third-stage epithelial ovarian cancer/fallopian tube cancer/peritoneal cancer, after surgery, if there is no residual lesion larger than 1 cm in the abdominal cavity, an intraperitoneal chemotherapy catheter can be considered
- Minimal Invasive Surgery can be used in 1. Selective early stage patients (Optimal debulking surgery can be achieved under the evaluation of

gynecological cancer specialists), 2. For Interval Debulking Surgery (If it is found that Optimal debulking cannot be achieved during surgery, it needs to be changed to Laparotomy), 3. .Evaluate whether Primary Debulking Surgery or Neoadjuvant chemotherapy combined with Interval Debulking Surgery can be done before Neoadjuvant chemotherapy

《 Ovarian cancer guideline -2 》

If the patient has not previously received a complete operation



《 Ovarian cancer guideline -3 》

Retained the fertility of the staged operatio

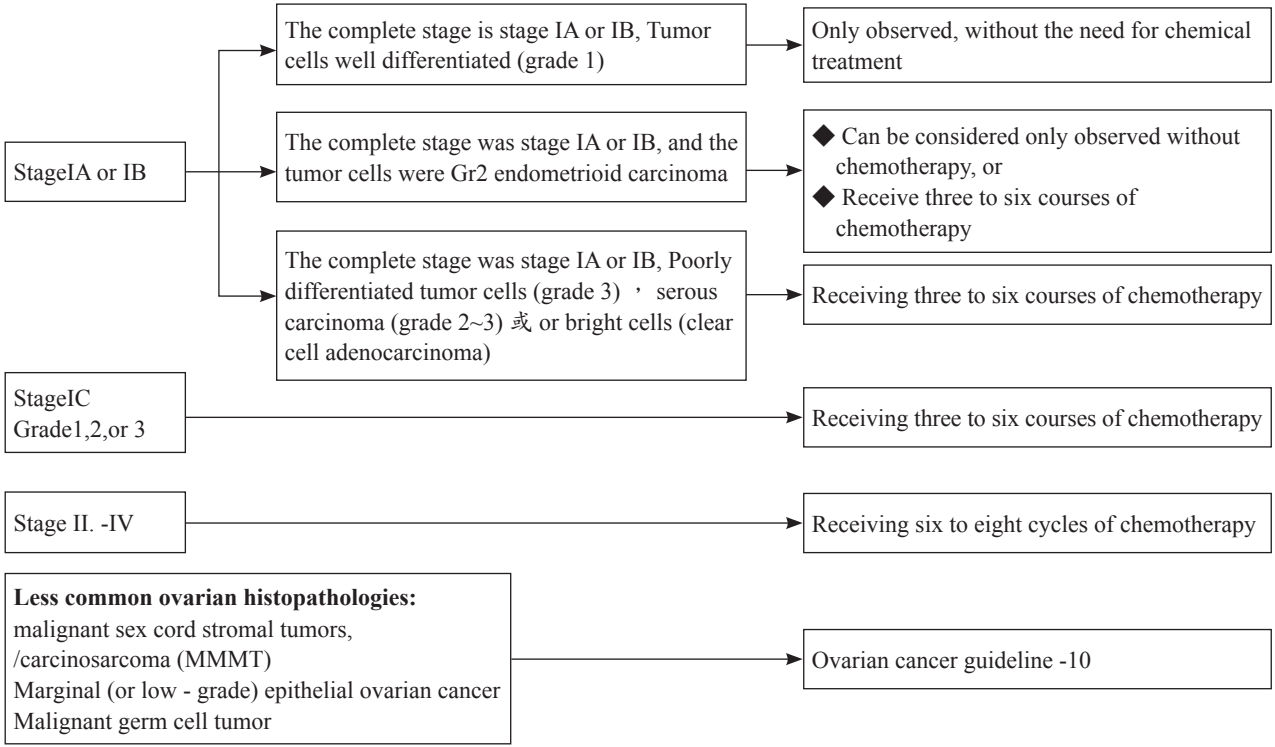
For those who strongly want to retain fertility

- ◆ If the first-stage unilateral ovarian lesion is seen by the naked eye during the operation, it can be to consider preserving the uterus and contralateral ovary, but must be completed other Items for Whole Stage Surgery
- ◆ If the other ovary has no visible lesions, it is not necessary to do it Wedge slices so as not to hamper fertility
- ◆ If it is bilateral ovarian cancer, the uterus may be preserved after examination stay, but both ovaries should be removed; the rest of the steps are the same as the complete staged surgery
- ◆ For patients with preserved uterus, hysteroscopy and intrauterine membrane scraping
- ◆ Selectively for stage IC patients based on histology (e.g. mucinous, LMP, sex cord-stromal, malignant germ cell tumors)

If previously retained uterus or contralateral ovaries
Fallopian tubes of patients

After completion of fertility, consider completed staging surgery

Postoperative treatment



Postoperative follow-up

- Pelvic examination should be done at least once every two times
- routine blood routine examination according to clinical needs
- do biochemical examination as clinical needs
- If the tumor index before surgery that is abnormal, before each chemotherapy, and all chemotherapy after the end of a month should check its index for the assessment of chemistry Therapeutic effect
- If the clinical need, do imaging examination

- If use AVASTIN during the initial treatment, consider using AVASTIN again for patients who have achieved partial remission.
- Consider conducting comprehensive genetic screening (Germline or Somatic mutation) to provide maintenance or recurrence drug treatment options

《 Ovarian cancer guideline-5 》

Maintenance PARP inhibitor

Post-primary treatment

◆Certain patients with newly diagnosed stage II-IV disease (G2-3 serous, G2-3 endometrioid, BRCA1/2-mutated CCC or carcinosarcoma) may benefit from maintenance therapy with PARPi if CR/PR is achieved after primary treatment with surgery and platinum-based first-line therapy.

Post recurrence treatment

◆Certain patients with recurrent disease may benefit from maintenance therapy with PARPi after recurrence therapy, if in CR/PR after platinum-based recurrence therapy, and if no prior progression on a PARPi.

Regimen	Setting	Dose	Duration
Olaparib+ Bevacizumab	Maintenance post primary chemotherapy + bevacizumab	Olaparib 300mg PO twice daily Bevacizumab 15mg/kg IV every 21 days	Olaparib: until disease progression or unacceptable toxicity or up to 24 months Bevacizumab: until disease progression or unacceptable toxicity or up to 15 months
Niraparib monotherapy	Maintenance post primary chemotherapy	300mg PO once daily	Until disease progression or unacceptable toxicity or up to 36 months
	Maintenance post recurrence chemotherapy	300mg PO once daily	Until disease progression or unacceptable toxicity
Olaparib monotherapy	Maintenance post primary chemotherapy	300mg PO twice daily	Until disease progression or unacceptable toxicity
	Maintenance post recurrence chemotherapy	300mg PO twice daily	Until disease progression or unacceptable toxicity

《 Ovarian cancer guideline -6 》

Follow-up evaluation after treatment

- 2 years before the return of every 2-4 months, the third to fifth year of every 3-6 months return, depending on the patient after the decision to return frequency
- physical examination should be implemented when returning
- If necessary in the clinic, can be biochemical tests, whole blood count, abdominal and pelvic CT or MRI, chest X-ray, the child Photography and other checks
- CA-125 and other tumor indicators can be considered for blood sampling, but the need to be discussed

Suspected of recurrence

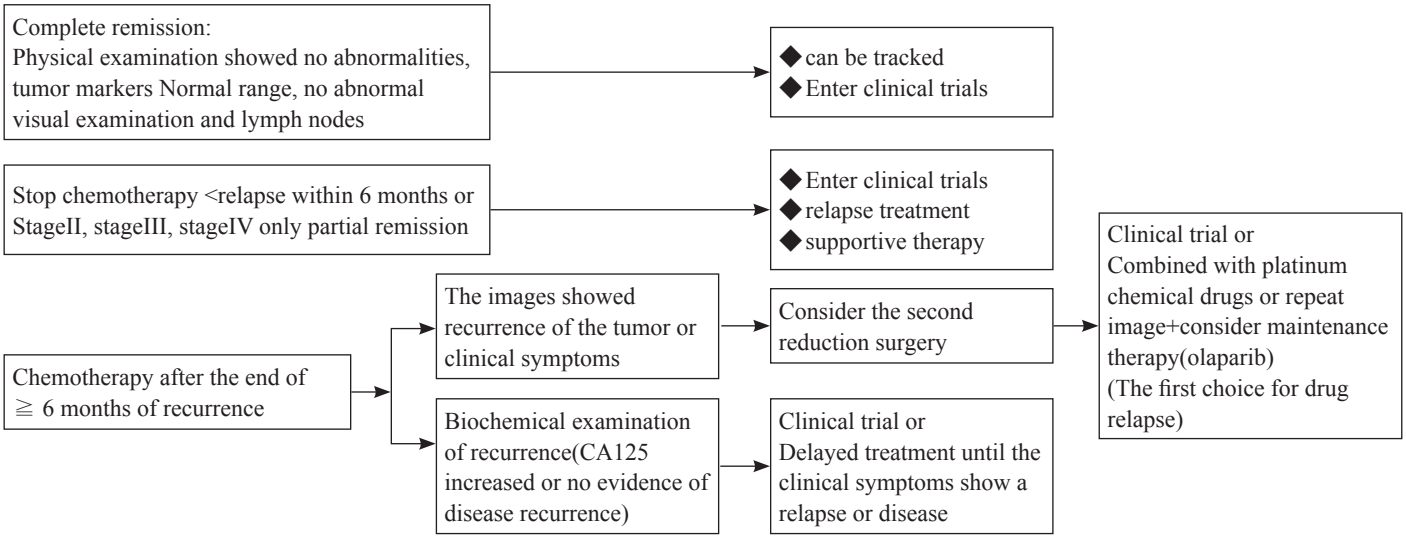
- clinical symptoms, physical examination or physical abnormalities, or increased tumor index and so on
- should first do imaging such as computer tomography, MRI, positron photography

Serum CA-125 concentration increased, but the physical examination and imaging examination no evidence of recurrence

- first observed, until after the clinical characterization of treatment, or
- Enter clinical trials, or
- direct chemotherapy (however, to today's existing prescriptions to do early chemotherapy, and its survival is not better than wait until the clinical recurrence of symptoms do chemotherapy
- reassessment surgical procedure (second-look operation), the current does not belong to the conventional treatment; need to be carried out by women's cancer specialist,And is limited to clinical trials

《 Ovarian cancer guideline -7 》

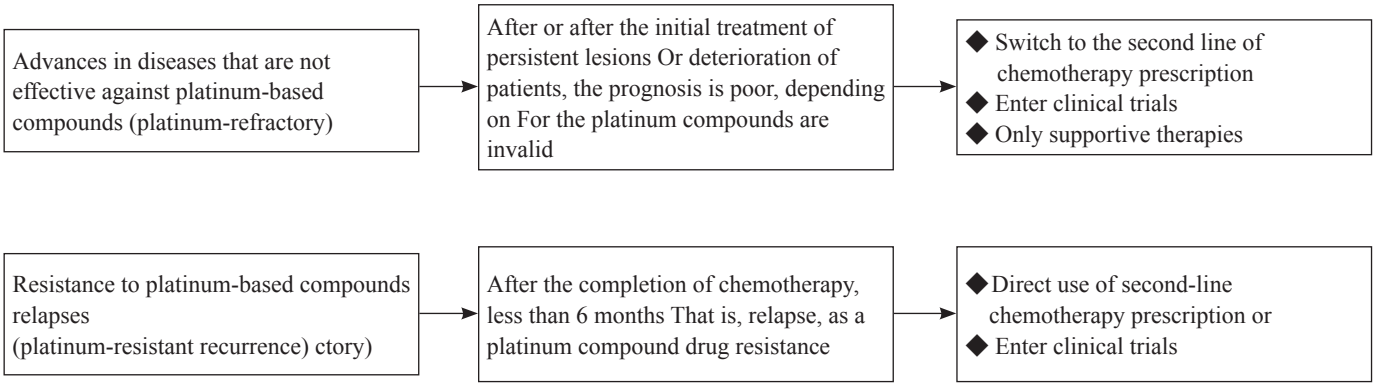
Follow-up assessment after treatment



- ◆ Patients who had not previously received chemotherapy had a relapse: Recurrence occurs in patients such as the original stage IA / IB grade 1/2 should consider the implementation of surgery, and then decided to further treatment as the pathological report On relapse after chemotherapy
- ◆ For patients who have undergone several previous chemotherapies, care should be taken to ensure that patients are less tolerant to subsequent chemotherapeutic toxicity than when they are undergoing primary chemotherapy
- ◆ For recurrent ovarian cancer, each treatment after 2-4 cycles of chemotherapy, the need to assess whether the clinical benefits if not ideal, then stop the prescription
- ◆ if patients with recurrence have not received tumor molecular testing, tests of recent available tumor specimen for RCA1/2, microsatellite instability/or DNA mismatch repair, or HR status, should be considered

《 Ovarian cancer guideline-8 》

A disease which is ineffective / resistant to a platinum-based compound



Second-line chemotherapeutic prescription for ineffective / resistant platinum-based

- ◆ For platinum-resistant or platinum-refractory patients, there is no first choice of second-line chemotherapy prescription
- ◆ Currently more popular prescription for pegylated liposomal doxorubicin, topotecan
- ◆ other prescription: change the treatment schedule and dose of paclitaxel, oral etoposide, gemcitabine, vinorelbine, altretamine, ifosfamide,Pemetrexed, capecitabine, cyclophosphamide, irinotecan, melphalan, oxaliplatin, anastrozole, letrozole, leuprolide, meges-Trol acetate, tamoxifen and the like

Platinum-sensitive compounds of the good response (platinum-sensitive) of the recurrence

Chemotherapy after the completion of more than six months after the recurrence. consider

- implementation of secondary decompression surgery (secondary cytoreductive surgery)
- compound containing platinum compound chemical treatment prescription
- or into clinical trials

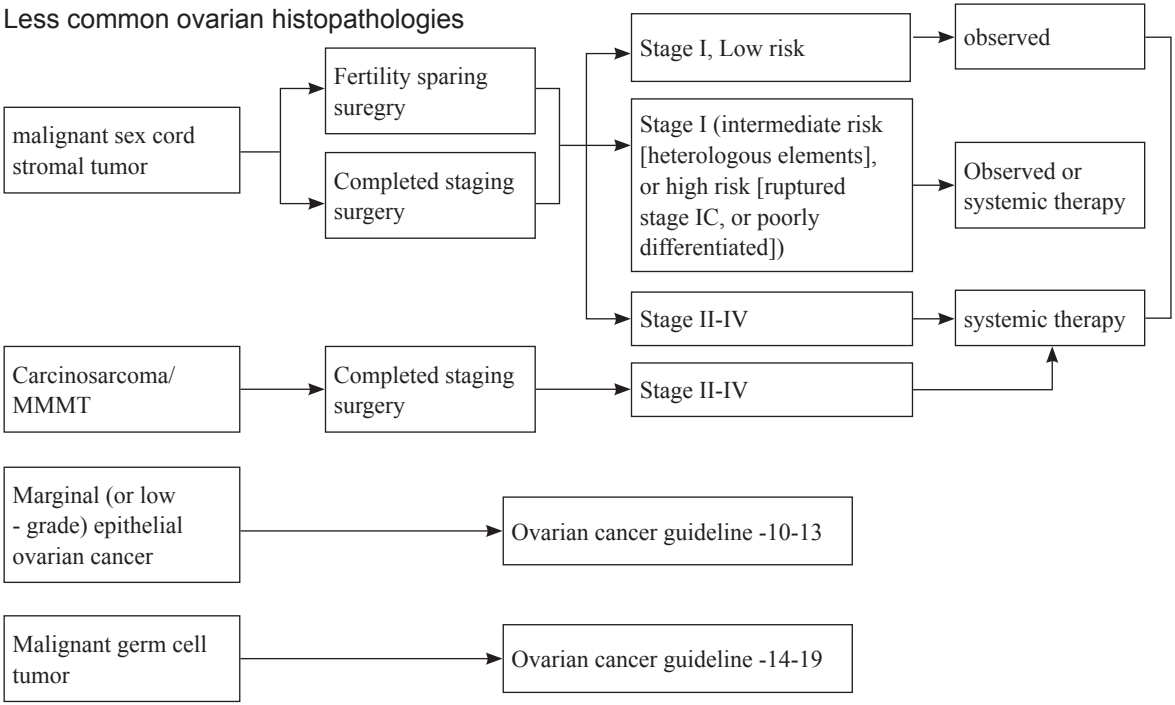
Second reduction surgery

- Suitable for: recurrence is platinum-sensitive
- surgical goal: the lesion is completely removed, not just optimal debulking

Chemotherapy regimens for relapses that respond well to platinum-based compounds

- carboplatin + pegylated liposomal doxorubicin
- carboplatin + paclitaxel
- If the patient can not tolerate paclitaxel side effects (such as neurotoxicity), then carboplatin + gemcitabine to replace, or only a single application of cisplatin or Carboplatin
- Platinum-resistant recurrence may also be considered for chemotherapy (but controversial)

《 Ovarian cancer guideline-9 》



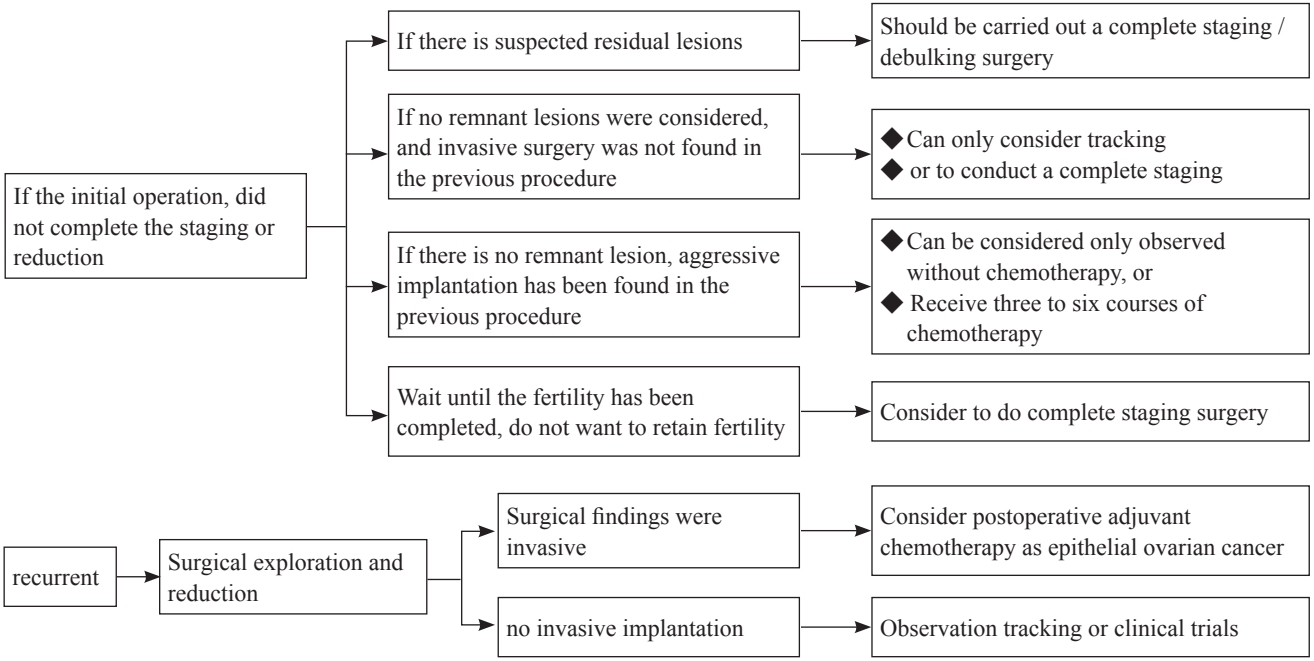
Marginal (or low - grade) epithelial ovarian cancer

Treatment principle:

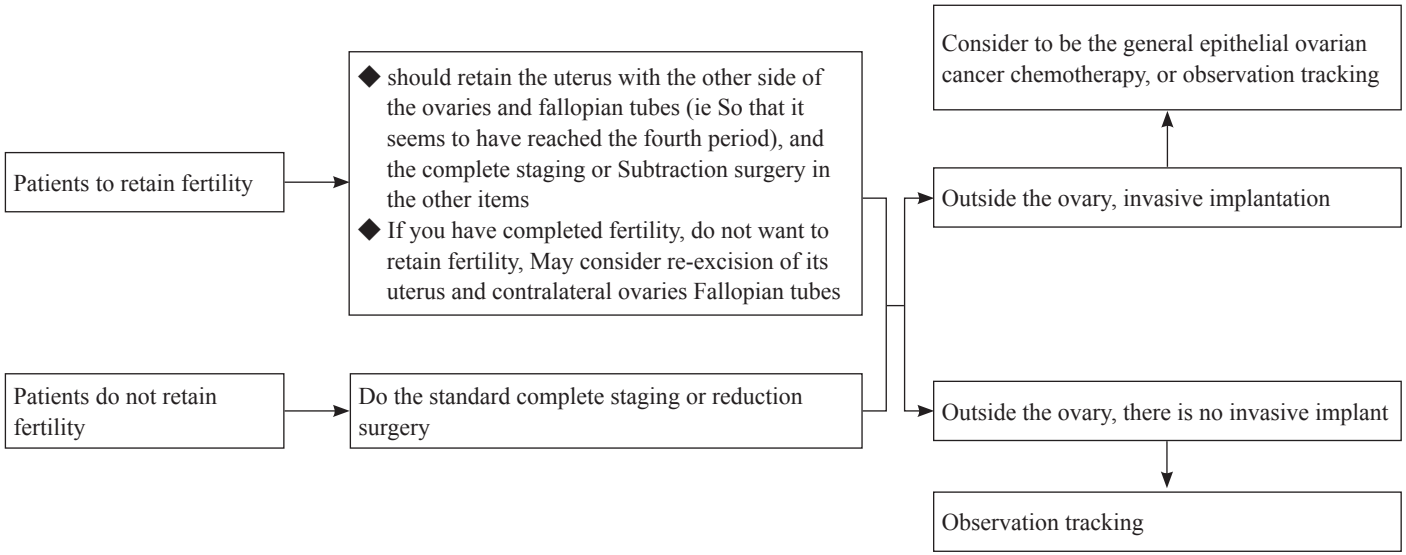
◆ treatment to surgery master
◆ For young patients, may consider preserving fertility
◆ recommendations should be carried out by the gynecological cancer specialist assessment, treatment
◆ family history should be assessed

《 Ovarian cancer guideline -11 》

Marginal (or low-grade) epithelial ovaries

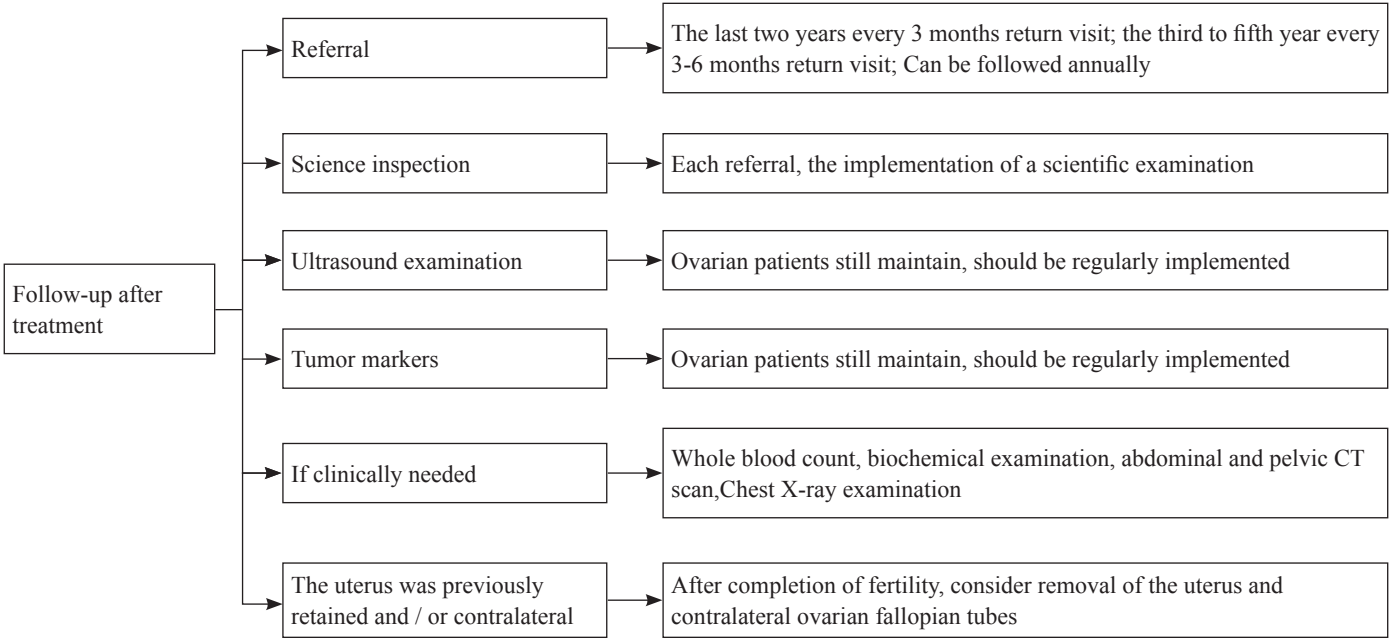


Adjuvant therapy for postoperative and postoperative marginal (or low - grade) epithelial ovarian cancer



《 Ovarian cancer guideline -13 》

Follow - up of marginal (or low - grade) epithelial ovarian cancer after treatment



Malignant ovarian germ cell tumor

Suspected young women with ovarian malignancies below the age of 35 patients, before starting treatment, the proposed check include:

◆ Pelvic ultrasound, abdominal and pelvic CT scan and other imaging tests

◆ Serum AFP, hCG, LDH, CA-125

◆ Full blood count, a full set of biochemical tests

◆ Lung X-ray

◆ If the symptoms of the gastrointestinal tract, it is appropriate for the assessment of the gastrointestinal tract examination

If the chromosome contains 46, XY

◆ Bilateral gonadectomy should be early: if 45, X / 46, XY mosaic type or 46, XY, and the gonad showed intra-abdominal dysplasia (dysgenesis) were

◆ Consider until after puberty and then remove the gonads: If 46, XY, males suffer from adverse reaction syndrome, and intra-abdominal gonad (ie, testicular) normal tissue type

《 Ovarian cancer guideline -15 》

Malignant ovarian germ cell tumor

Staging

If you want to be pregnant, you can keep the uterus and the contralateral ovary. If you want to complete a staged surgery, the precautions include:

- ◆Preoperative bowel preparation should be prepared with the intestinal surgery
- ◆Appropriate vertical central incision, to obtain adequate surgical field of vision
- ◆Into the abdominal cavity, that is, by ascites or peritoneal lavage by peritoneal lavage cytology specimens
- ◆Remove the tumor as completely as possible, the specimen should be sent as soon as possible pathological examination, and routine sent frozen section
- ◆If the patient does not want to retain fertility, the line of hysterectomy and ovarian salpingectomy on both sides; still want to pregnant patients, confirmed by frozen section of malignant germ cell tumors, uterine and contralateral ovarian can be retained
- ◆Should be a fine check the contralateral, if necessary, the implementation of contralateral ovarian biopsy
- ◆Consider as far as possible the main tumor side of the fallopian tube funnel pelvic ligament
- ◆Sticky place to be biopsy
- ◆Evaluate all bowel surfaces, and all suspicious areas should be biopsied
- ◆If there is no obvious spread of ovarian lesions, you need to random peritoneal sampling, such as uterine rectal lacunae, pelvic wall, bladder serosa, on both sides of the large intestine fossa, the diaphragm surface
- ◆Transverse colon surgery under the omentum
- ◆Lymph node assessment should include the pelvic lymph nodes and para-aortic lymph nodes, para aortic lymph nodes to take to the height of the inferior mesenteric artery, if possible, it is best to get the height of the left renal vein
- ◆Consider removal of the laparoscopic pathway prior to laparoscopic surgery
- ◆Complete surgery records the size and location of residual tumors

Malignant ovarian germ cell tumor

The first reduction surgery

◆Chemotherapy for ovarian malignant germ cell tumors is very effective, so even if the tumor has been widely disseminated, fertility surgery is still feasible to retain its normal uterus and positive Often contralateral ovaries

◆ The scope of surgery should be treated to take into account as much as possible to remove the lesion and does not cause surgical complications, surgical complications can not be delayed due to chemotherapy after surgery

In a more conservative surgery

◆Most of the patients are young women, while germ cell tumors are unilateral, and the chemotherapy is very effective, so even if the tumor has been widely disseminated, the majority of patients still Feasible fertility retention surgery, to retain its normal uterus and normal contralateral ovaries (but if patients do not consider to retain fertility, then all removed)

◆For patients with bilateral ovarian lesions, but still strongly want to keep the fertility of patients, clinicians and patients and their families to discuss the pros and cons of retaining unilateral ovarian gains and losses, may be considered Retaining the side of the ovaries and fallopian tubes, and then after chemotherapy for chemotherapy

◆Contralateral ovary if the appearance of normal, in addition to dysgerminoma or mixed with germ cell tumor of dysgerminoma, it is not appropriate to do unnecessary slices to Avoid premature ovarian failure or sticky, loss and future fertility

◆For stage IA grade 1 immature teratoma or stage IA dysgerminoma patients, but also as far as possible without prejudice to future fertility under the premise of doing a thorough Of the stage surgery; because if confirmed stage IA grade 1 immature teratoma or stage IA dysgerminoma, you can not accept post-operative chemotherapy

《 Ovarian cancer guideline -17 》

Malignant ovarian germ cell tumor

On the staging of patients is not complete

◆May not need chemotherapy (ie, clinical stage IA grade 1 immature teratoma or stage I dysger-minoma): further thorough Of staging operations to confirm, or track

◆Known to be chemotherapeutic: usually do not need to re-operation for further staging

Surgery without chemotherapy after the situation

◆ Stage 1 (full staging) after surgery

◆ Stage I dysgerminoma after adequate staging

◆ Stage IA, grade 2,3 immature teratoma after full staging (still controversial)

Malignant ovarian germ cell tumor

Follow-up after completion of treatment

◆ Tracking frequency：

- It is recommended to track every two to four months for the first two years
- Track every 3-6 months for three to five years
- Every 6-12 months thereafter

◆Tracking items:

- Ask about medical history and physical examination
- Ultrasound (if the patient still has the other side of the ovary)
- Blood tumor markers (if there is an increase in tumor markers before treatment)
- (Eg, CT, chest X-ray, etc.), especially for patients with normal blood tumor markers that can not be tracked with blood tumor markers before treatment

《 Ovarian cancer guideline -19 》

Malignant ovarian germ cell tumor

If the tumor persists or becomes larger

If the tumor markers have reached normal, may be：

◆Retained by the functional ovarian cyst，

◆Desmoplastic fibrosis (After dysgerminoma chemotherapy)，

◆Growing teratoma syndrome (After immature teratoma chemotherapy) Can consider it：

◆Continue to intensive tracking

◆Further reduction surgery, when the histological examination confirmed that there are still surviving malignant tumor tissue before the implementation of further chemotherapy

Palliative treatment

◆Supportive care

◆Palliative of the radiation therapy

◆Relief of the chemical prescription

Ovarian cancer fertility preservation

◆For certain patients who want to maintain fertility, consider using complete staging surgery preserved in the uterus.
(If necessary get the para-aortic lymph nodes)
- ◆ For patients with obvious first-stage disease
- ◆ Epithelial ovarian cancer, low malignancy, malignant germ cell tumor, mucinous, or sex cord stromal tumor
- ◆ Reserving fertility surgery and affecting the overall survival rate of patients

◆ Birth preservation should be discussed with physicians specializing in women's cancer and reproductive infertility

◆ Cryopreservation of eggs/embryos, or freezing of ovarian tissue
- ◆ If the attending physician believes that the treatment of gynecological cancer can be delayed long enough to stimulate the egg cell cycle, the reproductive treatment course can be started first

◆ Inhibition of menstrual cycle
- ◆ You can choose to use Medroxyprogesterone, Oral contraceptive, Gonadotropin-releasing hormone (GnRH) agonist
- ◆ It is still controversial whether menstrual cycle suppression can protect ovarian function
- ◆ There are data showing that the use of Gonadotropin-releasing hormone (GnRH) agonist for breast cancer patients can achieve the purpose of protecting ovarian function before chemotherapy

《 Ovarian cancer guideline-21》

prophylactic ovariosalpingectomy

(risk-reducing salpingo-oophorectomy)

- ◆ Genetic testing confirmed that BRCA1 mutations or BRCA2 mutations in women
- ◆ After completion of childbirth
- ◆ Suitable for 35-40 years of age (or reference family in the first occurrence of ovarian cancer or fallopian tube cancer age) for this operation
- ◆ Consider both the peritoneal wash cytology and peritoneum and omentum slices

If unwilling to reduce the risk of ovarian salpingectomy surgery

- ◆ Consider screening starting at age 35 (or from the first 5-10 years of age in the family where the first ovarian cancer or fallopian tube cancer occurred): Transvaginal ultrasound and CA-125 examination every six months
- ◆ Also consider the use of oral contraceptives to reduce the risk of ovarian cancer: However, oral contraceptives need to take into account the possibility of increased risk of breast cancer

《 Reference 》

1. NCCN Clinical Practice in Oncology: Cervical cancer V.1.2022.
2. NCCN Clinical Practice in Oncology: Uterine Neoplasms V.4.2022
3. NCCN Clinical Practice in Oncology: Ovarian cancer V.5.2022.