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Organizational Guideline for Gynecologic Oncology Services in Ontario

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[Fung-Kee-Fung M, Kennedy EB, Biagi J, Colgan T, D'Souza D, Elit LM, et al. An organizational guideline for gynecologic oncology services. Int J Gynecol Cancer. 2015;25\(4\):551-8.](#)

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Table of Contents

| | |
|--|-----------|
| Organizational Guideline for Gynecologic Oncology Services in Ontario | 1 |
| Section 1: Guideline Recommendations | 2 |
| Section 2: Guideline Development Methods..... | 15 |
| Section 3: Internal and External Review | 18 |
| References..... | 29 |
| Appendix 1: Affiliations and Conflict of Interest Declarations..... | 30 |
| Appendix 2: 2015 Systematic Review | 32 |
| Appendix 3: Guideline Document History | 33 |

Organizational Guideline for Gynecologic Oncology Services in Ontario

Section 1: Guideline Recommendations

PURPOSE OF THIS GUIDELINE

The purpose of this guideline is to provide recommendations for the optimal organization of gynecologic oncology services in Ontario and to improve access to multidisciplinary care and appropriate treatment, thereby improving outcomes for patients.

This guideline was originally developed in 2013 to describe the optimal structure to build high-quality gynecologic oncology services in Ontario. At that time there were significant gaps in timely access and quality of care: many patients were receiving care in lower-volume hospitals and were less likely to have access to multidisciplinary care, often resulting in inadequate surgical staging, which has independently been associated with worse survival. Gynecologic oncology surgery wait times were often problematic with only 69% and 67% of surgeries being completed within the wait time target for the first and second quarter of 2012/2013, respectively (1).

Since 2013, nine Gynecologic-Oncology Centres (GOCs) have been established, including the development of three new GOCs. In addition, Affiliated Centres (AC) were created that provide less complex gynecologic-oncology care and form partnerships with GOCs. Ontario-based research utilizing administrative data was conducted to examine the impact of regionalization on patient outcomes. A 2021 publication showed that the policy led to an increase in the proportion of high-grade endometrial cancer surgeries performed by gynecologic oncologists, which resulted in significant improvement in patient survival (2). A 2022 study of assessment and treatment of epithelial ovarian cancer by gynecologic oncologists showed improved survival (3). Since that time, access to care has improved, with 77% of patients being treated within target for 24/25-Q4.

Over the past decade there have been further advances in care and system changes prompting the need to revise the previous recommendations. This updated report builds upon the initial recommendations for the optimal organizational of gynecologic oncology services in Ontario. The updated report outlines the allocation of subspecialty care in designated GOCs, incorporating patient biomarker results and Ovarian-Adnexal Reporting and Data System (O-RADS™) for ovarian masses, defines the human and physical resources associated with the delivery of care, describes the characteristics of the relationship between designated GOCs and designated ACs hosted in other hospitals, and describes the role of the multidisciplinary team. This guideline incorporates related Ontario Health (Cancer Care Ontario) (OH (CCO)) guidelines published since 2013 related to new technologies (e.g., robotic surgery, the use of magnetic resonance [MR]-guided intracavitary and interstitial brachytherapy, hyperthermic intraperitoneal chemotherapy [HIPEC], and imaging) and the organization of care for gynecologic sarcomas. (See the list of [Related Guidance](#) in this document)

With an expected increase in the patient population, there is a need to establish a network that will facilitate the flow of these patients through the care continuum.

This updated guideline is based on the original 2013 version (Evidence-Based Series 4-11 Organizational Guideline for Gynecologic Oncology Services in Ontario). In 2025, a Working Group and Expert Panel (see Appendix 1 for membership) was convened to review the guideline and incorporate recent guidance from OH (CCO) related to the organization and delivery of care of patients with gynecologic cancers. The recommendations are listed below, with additions and modifications to the original version labelled as “2025 Endorsed or Revised.”

Definitions

Gynecologic Oncology Centre (GOC)

A GOC in Ontario provides specialized care for patients with cancers of the female reproductive system. These centres offer multidisciplinary treatment approaches, including surgery, systemic therapy (chemotherapy, targeted therapy, immunotherapy), and radiation therapy. The centres focus on treating cancers of the uterine corpus, cervix, ovaries, vulva, and vagina and gestational trophoblastic disease (GTD). These centres meet clear safety, quality and resource (HHR and equipment/ services) standards for a particular procedure or type of care. (Sources: GOC definition obtained through Google AI summary; [OH \(CCO\) Designated Cancer Surgery Centres](#) webpage)

Affiliated Centre (AC)

An AC provides cancer treatment for low-grade endometrioid endometrial cancer that are considered low risk by specialists in general gynecology based on molecular characteristics (e.g., estrogen receptor positive, p53wt, mismatch repair-intact [MMRi]*) and has developed a formal affiliation with one or more GOCs to ensure accountability and support for the provision of care to people with gynecological cancers as outlined in recommendations 6 through 10 below.

*Note: MMRi is synonymous with MMR-proficient (MMRp)

GUIDELINE OBJECTIVES

To determine the optimal organization of gynecologic oncology services in Ontario for patients who have a gynecologic malignancy to ensure high-quality care and optimal cancer treatment outcomes.

TARGET POPULATION

Inclusions

The target population refers to all patients that should receive their definitive treatment at a GOC or an AC.

The target patient population includes people in Ontario who are suspected of having or have a confirmed diagnosis of gynecologic malignancy or have an ovarian/adnexal neoplasm with an O-RADS™ score of 4 and 5, or High-Risk equivalent.

Exclusions

The scope of this guidance document does NOT include the following non-invasive conditions:

- Cervical intraepithelial neoplasia *
- Vaginal intraepithelial neoplasia*
- Vulvar intraepithelial neoplasia*.
- Ovarian neoplasms with an O-RADS™ score of less than 4 because such cases are less likely to be invasive; ([Standardized Ultrasound Reporting for Ovarian-Adnexal Masses in Ontario](#))
- Partial or complete molar pregnancy with normalization of human chorionic gonadotropin after uterine evacuation.

*Precancers are not within the scope of this document. For guidance on precancers see: [Ontario Cervical Screening Program Recommendations for Cervical Screening and Colposcopy with Human Papillomavirus Testing in Ontario](#).

INTENDED USERS

This guideline is intended for use in Ontario by hospital and cancer centre facility partners, policy makers and clinicians involved in the care of gynecologic cancer patients.

RECOMMENDATIONS

Overview of Guideline Recommendations

Specific recommendations are outlined below. In summary, the consensus of the Guideline Development Group is a vision for gynecologic cancer care in the province that includes:

- Access to treatment for all patients with invasive cancer at GOCs and ACs, effectively creating networks of care.
- Strong, well-defined accountable partnerships between GOCs and ACs.
- Consistent high-quality treatment provision within and between regional networks, regardless of geographic location.
- Access to multidisciplinary care for all gynecologic oncology patients.

I. TREATMENT PROVIDERS

Recommendation 1: Surgical Treatment by General Gynecologists and Gynecologic Oncologists

1.1 General gynecologists at GOCs or ACs may provide the following surgical services:

- Definitive surgical treatment of patients with endometrial cancer that are determined preoperatively to be lower risk (i.e., Grade 1 endometrioid adenocarcinoma that are estrogen receptor positive, MMRi, and p53 normal ([Endometrial Cancer Molecular Testing Recommendations Report](#)))
- Borderline ovarian neoplasms or O-RADS™ 3 and 4 can be operated on at affiliated centres. For O-RADS™ 4 patients, a discussion with a gynecologic oncologist can be considered. O-RADS™ 5 patients should be treated at a GOC.

1.2 Upon assessment, definitive surgical treatment of all in-scope gynecologic malignancies not listed in Recommendation 1.1, should be performed by gynecologic oncologists at a GOC.

2025 Revised Recommendation: Recommendations 1.1 and 1.2 were endorsed from the original guideline and modified to clearly differentiate the roles of general gynecologists and gynecologic oncologists.

1.3 Robotic surgery for patients with appropriate indications may be performed at a GOC or an AC by either gynecologic oncologists or general gynecologists that are trained in robotic procedures ([Robotic-Assisted Hysterectomy for Endometrial Cancer in People With Obesity](#)), and as outlined in Rec 1.1.

2025 New Recommendation: Recommendation 1.3 was added to guide current practice of robotic surgery.

1.4 Gestational Trophoblastic Disease (GTD)

- Patients who have GTD and require chemotherapy need to be assessed and treated by gynecologic oncologists and/or medical oncologists with expertise at a GOC. Complex cases should be discussed at a multidisciplinary cancer conference (MCC) with GTD expertise or at a GTD Tumour Board.
- Very high-risk GTD cases (FIGO 2000 score 12 and greater) who require multi-agent treatment should be discussed with/treated by a gynecologic oncologist or medical oncologist with special expertise and also should be discussed at an MCC with GTD expertise or a GTD Tumour Board. Cases should be reviewed by a pathologist with subspecialty training or special/dedicated interest in gynecologic pathology including GTD expertise.

2025 Revised Recommendation: Recommendation 1.4 was endorsed from the original guideline and was modified to ensure appropriate care for patients with GTD. (For guidance regarding the diagnosis, treatment and follow-up of patients with pre-malignant and malignant gestational trophoblastic disease (GTD), refer to [An Endorsement of the 2025 Practical Guidelines for the Treatment of Gestational Trophoblastic Disease: Collaboration of the EOTTD, ESGO, GCIG, ISSTD.](#))

II. GYNECOLOGIC ONCOLOGY CENTRES (GOCs)

Recommendation 2: Treatment at GOCs

2.1 Care by gynecologic oncologists should be delivered within designated GOCs.

2.2 In addition to surgical care, GOCs will be equipped to provide radiation therapy and systemic therapy for all invasive gynecologic oncology disease sites, and act as the hub for management of all invasive cases.

2025 Endorsed Recommendation: Recommendations 2.1 and 2.2 were endorsed from the original guideline.

Recommendation 3: Human Resources at GOCs

3.1 The multidisciplinary team at a GOC should include:

- A minimum of four full-time gynecologic oncologists.
- A minimum of two radiation oncologists with a special/dedicated interest in gynecologic malignancies. The two radiation oncologists should be experienced in the use of MR-guided intracavitary and interstitial brachytherapy or refer patients to another GOC for MR-guided intracavitary and interstitial brachytherapy when needed.
- A minimum of two specialists in Medical Oncology, with a special/dedicated interest in gynecologic malignancies.
- A minimum of two pathologists with subspecialty training or special/dedicated interest in gynecologic pathology. (This may include support through consultation with a gynecologic pathologist at another GOC using digital pathology.)

- Sub-specialists in Radiology, including one with expertise in each of gynecologic diagnostic imaging and interventional radiology (IR).
- Interventional Radiologists are on call 24/7.
- Specialized oncology, wound, stoma and advanced-practice nursing.
- Specialized medical physicists and radiation therapists experienced in MR-guided brachytherapy.
- Access to molecular pathology for comprehensive diagnostic and prognostic testing.
- Pharmacy

2025 Revised Recommendation: Recommendation 3.1 was endorsed from the original guideline and was modified to ensure adequate human resources for gynecologic oncologists, medical oncologists, pathologists and oncology nursing for sustainable patient care.

3.2 The following medical specialists should be on site at GOCs:

- Psychosocial and sexual counselling and support.
- Palliative care physician or specialist, which may include assessment at the GOC, with seamless linkage to and coordination with providers in the patient's home community.
- Specialists in general, colorectal, anesthesia, urology, plastic surgery, and other areas as needed.

Access to the following specialties:

- Dietitians.
- Geneticist/genetic oncology clinic where patients with hereditary predisposition to cancer can receive counselling and testing when indicated.
- Lymphedema care.

2025 Revised Recommendation: Recommendation 3.2 was endorsed from the original guideline and was modified to include lymphedema care.

3.3 Access to the following medical specialists or specialized care should be available as required:

- Oncofertility (reproductive infertility specialists) assessment for gynecologic cancer treatment
- Management of treatment-induced menopause

2025 Revised Recommendation: Recommendation 3.3 was endorsed from the original guideline and was modified to ensure patient care for oncofertility and menopause.

Qualifying Statement for Recommendation 3

The detailed requirements for human resources are the opinion of the guideline development group, based on the resources that the group determined would be necessary to support the treatment of patients with invasive gynecologic cancer in GOCs.

Recommendation 4: Physical Resources and Collaborating Services at GOCs

4.1 The following physical resources and collaborating services should be available at GOCs:

- Surgery services should be appropriately equipped and resourced to provide timely access to:
 - Minimally invasive surgery (laparoscopic/robotic). ([Robotic-Assisted Hysterectomy for Endometrial Cancer in People with Obesity](#))
 - An intensive care unit.
 - Dedicated surgical beds for gynecologic oncology patients, with nursing expertise.
 - A fully developed nutrition service, including total parenteral nutrition.
 - Access to specialized stoma care.
 - Access to ICG (Indocyanine Green) dye for sentinel lymph node evaluation.
 - Access (or referral) to designated centres for cytoreductive surgery with HIPEC when indicated ([GL 17-12 Indications for HIPEC with Cytoreductive Surgery](#))

- Radiation Therapy services should be appropriately equipped and resourced to provide, within timelines defined by provincial guidelines:
 - Onsite external beam radiotherapy using image-guided, volumetric modulated arc therapy (VMAT), or a defined referral pathway to another GOC or AC with the capacity to provide this treatment.
 - Onsite MR-guided intracavitary and interstitial brachytherapy for locally advanced cervical, inoperable or recurrent endometrial cancer and vaginal cancer. This includes access to the required brachytherapy applicators and other specialized devices, a suitable procedure space, inpatient beds, anesthesia support, nursing support, post-operative recovery, and near real-time MR imaging for each treatment fraction. ([GL 21-2 v2 Three-Dimensional MR-Guided Intracavitary and Interstitial Brachytherapy for Cervical Cancer](#)). If onsite MR-guided intracavitary and interstitial brachytherapy is not available, there should be a defined referral pathway to another GOC with the capacity to provide this treatment.

- Systemic Therapy services should be appropriately equipped and resourced to provide timely access to:
 - Chemotherapy, targeted therapies (biologic agents), immunotherapy, and oncology pharmacy support for inpatient and outpatient services.
 - Chemotherapy and biologic agents should be administered by registered nurses who have completed the de Souza Institute Chemotherapy and Biotherapy Provincial Standardized course.
 - Adjuvant intraperitoneal chemotherapy.
(Follow recommendations in [GL 12-10 V2 Regional Models of Care for Systemic Treatment: Standards for the Organization and Delivery of Systemic Treatment](#))

- Pathology services should be appropriately equipped and resourced to provide timely access to:
 - Intraoperative frozen-section analysis.
 - Comprehensive ancillary testing (follow recommendations in [Endometrial Cancer Molecular Testing Recommendations Report](#); and additional indications at [Comprehensive Cancer Biomarker Testing Program](#))
 - Cytopathology/cytology services.

- High-quality digital pathology if support from a gynecologic pathologist is required from another GOC.
- Radiology services should be appropriately equipped and resourced to provide timely access to:
 - A full range of diagnostic imaging, including ultrasound (all modalities, including Doppler), computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), angiography and IR.
 - Nuclear medicine capabilities to assess sentinel lymph nodes.

Note: For GOCs that do not have a modality or imaging service (i.e., PET) on site, they should have procedures and/or mechanisms in place to ensure access to these services is available through a partner site or Integrated Community Health Services Centre.

- Access to Home and Community Care ([Ontario Health atHome](#)).
- Support for clinical trials.

2025 Revised Recommendation: Recommendation 4.1 was endorsed from the original guideline and modified to reflect current practice and to reference additional detail provided in other OH (CCO) guidance.

Qualifying Statement:

The detailed requirements for physical and collaborating services are the opinion of the guideline development group, based on the resources that the group determined would be necessary to support the treatment of patients with invasive gynecologic cancer in gynecologic oncology centres.

Recommendation 5: Annual Volumes at GOCs

5.1 A minimum annual volume of 150 new surgical cases is recommended for each GOC.

2025 Endorsed and Revised Recommendations: Recommendation 5.1 was endorsed from the original guideline. The recommendations for annual volumes for external beam radiation therapy (EBRT) and MR-guided interstitial/intracavitary brachytherapy from the previous version of this guideline were removed; see qualifying statements below.

Qualifying statements:

The recommendations for volumes are the consensus of the Guideline Development Group, based on minimum numbers needed to ensure competency and quality of care. GOCs are expected to take regional leadership roles in the provision of complex systemic and radiation treatment plans.

Volumes for systemic therapy were addressed in [GL 12-10 Version 2 Regional Models of Care for Systemic Treatment](#), which concluded: “After numerous discussions, the Group determined that [systemic therapy] service volumes should depend on local conditions. A centre should have a sufficient patient volume to maintain competency and safety”.

Annual volumes for radiation therapy should be sufficient to maintain competency and safety, in consideration of the following:

- The proportion of surgical cases that receive EBRT varies widely among GOCs, reflecting differences in surgical case mix from one GOC to another, different practice patterns, or different referral patterns such that EBRT is delivered at an AC.
- MR-guided intracavitary/interstitial brachytherapy represents a paradigm shift in the treatment of patients with locally advanced cervical cancer, yielding improved tumour control and reduced side effects. However, MR-guided brachytherapy is considerably more demanding of resources. Optimized, efficient, and safe processes are of paramount importance in achieving the best possible outcomes. Barriers to implementation include the availability of MR for each brachytherapy fraction, initial and continuing education of all staff, the cost of MR-compatible intracavitary/interstitial applicators, and the added time necessary for applicator insertion, imaging, planning, and treatment. It is imperative that all members of the multidisciplinary team (radiation oncologists, medical physicists, and radiation therapists) are appropriately educated about best-practice MR-guided intracavitary/interstitial brachytherapy before undertaking procedures, and that continuing professional education is available. Furthermore, each centre and each practitioner must treat a sufficient number of patients with MR-guided intracavitary/interstitial brachytherapy annually to maintain clinical and technical competency. The required number of patients is not known. Previous studies in the two-dimensional brachytherapy and CT-guided brachytherapy era suggested a minimum of 10 patients per year, although more patients may be needed to maintain competency with MR-guided intracavitary/interstitial brachytherapy given the greater complexity at every step of the treatment planning and delivery process. ([GL 21-2 v2 Three-Dimensional MR-Guided Intracavitary and Interstitial Brachytherapy for Cervical Cancer](#))

III. AFFILIATED CENTRES

Recommendation 6: Treatment at Affiliated Centres (ACs)

6.1 ACs that develop a formal affiliation with GOCs may provide, in collaboration, any or all of the following services:

- Surgery including minimally invasive techniques (laparoscopic/robotic) for endometrial cancer patients that are determined preoperatively to be low risk (i.e., Grade 1 or O-RADS™ score of 4 or less), as described in Recommendation 1.
- EBRT (VMAT) for endometrial, cervical, vaginal, and vulvar cancers and postoperative intravaginal brachytherapy for endometrial cancer. Patients requiring MR-guided intracavitary or interstitial brachytherapy should be referred to a GOC.
- Systemic therapy for all gynecologic oncology disease sites.

2025 Revised Recommendation: Recommendation 6.1 was endorsed from the original guideline and was modified to reflect current practice and appropriate patient care.

6.2 An appropriate pathology review is necessary to ensure that the assignment of an accurate histotype/grade and molecular subgroup for patients with endometrial cancer is confirmed prior to surgery. This may include options such as:

- A quality-assurance program at the AC, including:
 - Review at an intra-departmental conference
 - Second intra-departmental signed consult
 - Quality assurance with a documented process should be included in the pathology report
- A review by a gynecologic pathologist at a GOC.

When biopsy specimens with endometrial carcinomas are sent to community/private pathology labs, immunohistochemical biomarker and/or molecular testing must be initiated.

2025 Revised Recommendation: Recommendation 6.2 was endorsed from the original guideline and was modified to reflect current practice and appropriate patient care.

Recommendation 7: Human Resources at ACs

7.1 ACs should have the following human resources:

If surgery is offered:

- A minimum of one gynecologist with a special/dedicated interest in gynecologic oncology and skills to perform minimally invasive surgery. ACs should strive to have all gynecologic oncology surgeries performed by a small number of gynecologists who can triage, discuss and treat Grade 1 endometrial cancer or O-RADS™ 4 or less and discuss patients with a gynecologic oncologist at a GOC prior to surgery.
- A pathologist with a special/dedicated interest in gynecologic pathology who is networked to a GOC, including support through digital pathology with a gynecologic pathologist at a GOC.

If radiation therapy is offered:

- A minimum of one radiation oncologist with a special/dedicated interest in gynecologic radiation who is networked to a GOC.

If systemic therapy is offered:

- A medical oncologist [Level 1-3 Regional Systemic Treatment Program (RSTP)], or family physician or registered nurses who have completed the de Souza Institute Chemotherapy and Biotherapy Provincial Standardized course (Level 4 RSTP), networked to a gynecologic oncologist or medical oncologist at a GOC.

2025 Revised Recommendation: Recommendation 7.1 was endorsed from the original guideline and was modified to reflect current practice and include robotic surgery.

Qualifying statements:

The detailed requirements for human resources are the opinion of the guideline development group, based on the resources that the group determined would be necessary to support the treatment of patients with invasive gynecologic cancer in centres that are affiliated with GOCs.

Recommendation 8: Physical Resources and Collaborating Services at ACs

8.1 It is recommended that physical and collaborating services at ACs are appropriately equipped and resourced to provide:

Radiology Services:

- Resources to assess the risk of malignancy of a suspicious adnexal mass, including ultrasound and standardized ultrasound reports, using the O-RADS™ reporting tool. ([Standardized Ultrasound Reporting for Ovarian-Adnexal Masses in Ontario](#))
- Capability to perform biopsy of intraperitoneal malignancy, including access to IR-guided biopsies service.

Surgical Services:

- Minimally invasive surgery (laparoscopic/robotic) should be offered.
- Access or referral to Robotic surgery for appropriate patient indications ([Robotic-Assisted Hysterectomy for Endometrial Cancer in People with Obesity](#))

Pathology services:

- For endometrial cancer cases, in-house capability or access to external resources for reflex testing on the first diagnostic pathologic specimen (endometrial biopsy or first biopsy, e.g., omentum, if metastatic) is recommended and should be performed regardless of tumour histotype/grade or molecular subgroup ([Endometrial Cancer Molecular Recommendations Report](#)). Resources should also be available for biopsies of all other gynecologic cancers.

Systemic Therapy Services:

- Chemotherapy, targeted therapy (biologic agents), immunotherapy, and oncology pharmacy support for inpatient and outpatient services.

Radiation Therapy Services:

- Sufficient resources and capacity to deliver EBRT (VMAT) for endometrial, cervical, vaginal, and vulvar cancers and postoperative intravaginal brachytherapy for endometrial cancer within timelines defined by provincial guidelines.

2025 Revised Recommendation: Recommendation 8.1 was endorsed from the original guideline and was modified to reflect current practice and to reference additional detail provided in other OH (CCO) guidance.

8.2 Centres offering systemic therapy must be designated RSTPs. Where intra-peritoneal therapy is offered, centres must be Level 1-3 RSTPs ([GL 12-10 Version 2 Regional Models of Care for Systemic Treatment](#)).

2025 Endorsed Recommendation: Recommendation 8.2 was endorsed from the original guideline.

Recommendation 9: Annual Volumes at ACs

9.1 There is insufficient evidence to specify a target volume for an annual number of new surgical, radiation, or systemic therapy cases at ACs.

2025 Revised Recommendation: Recommendation 9.1 was endorsed from the original guideline and was modified to reflect current practice and appropriate patient care.

Qualifying statements:

Regarding volumes for systemic therapy: (see: ([GL 12-10 Version 2 Regional Models of Care for Systemic Treatment](#))).

- Ensure that there is sufficient patient volume at the location to maintain competency and skills of professional healthcare providers to address the acuity and complexity of the treatment modalities and/or to provide cost-effective use of resources and drugs (e.g., shared care program or collaboration with another program).
- Facilities with staff that see a lower volume of cancer patients should have an education and training plan to ensure competency of nurses, pharmacists and pharmacy technicians.
- The number of patients that can be treated will be determined by the complexity of treatment regimens.

Regarding volumes for radiation therapy:

- Ensure that there is sufficient patient volume to establish and maintain the competency and skills of all members of the radiation treatment team (radiation oncologists, medical physicists, dosimetrists, and radiation therapists) while adhering to timelines defined by provincial guidelines.

IV. RELATIONSHIP BETWEEN GOCs AND ACs

Recommendation 10:

10.1 A formal partnership with processes to ensure accountability must be in place between ACs and GOCs. General gynecology and pathology leads at ACs can facilitate communications and patient care. As stated above under ACs, appropriate pathology review must be available for all new patients, and access to multidisciplinary team management, including an MCC review or documented collaborative discussion between at least two disciplines, or a multidisciplinary clinic appointment at a GOC must be provided.

2025 Endorsed Recommendation: Recommendation 10.1 was endorsed from the original guideline and was modified to reflect current practice.

V. MULTIDISCIPLINARY DISCUSSION/EVALUATION

Recommendation 11:

11.1 All patients with newly diagnosed gynecologic malignancy should have access to a GOC, MCC or be the subject of a collaborative discussion, which would include assessment at a multidisciplinary clinic, or a documented discussion with clinicians from at least two disciplines if needed.

The primary purpose of the MCC is to ensure that all appropriate diagnostic tests, treatment options, and treatment recommendations are generated for each cancer patient discussed prospectively in a multidisciplinary forum. (See guidance and tools at: [Multidisciplinary Cancer Conference Standards](#))

Required participants at an MCC include:

- Gynecologic oncologist
- Radiation oncologist
- Medical oncologist
- Pathologist
- Radiologist

Optional members include:

- Gynecologists performing endometrial cancer surgery
- Clinical nurse specialist
- Clinical genetics/genetic counsellors

This recommendation also applies to patients with diagnosed advanced gynecologic malignancies who are **not** at an AC or a GOC and are unable to travel but who should be discussed with a gynecologic oncologist, to ensure that they receive timely and comprehensive care.

2025 Endorsed Recommendation: Recommendation 11.1 was endorsed from the original guideline and was modified to reflect current practice.

11.2 Patients who are not discussed in an MCC, but rather are the subject of a collaborative discussion, should also undergo appropriate pathology review (see recommendation 6.2). This statement applies in particular to patients with low-grade and appropriate biomarker profile endometrial cancer, as accurate determination of grade will impact their location of treatment and extent of surgery.

2025 Endorsed Recommendation: Recommendation 11.2 was endorsed from the original guideline and was modified to reflect current practice.

11.3 Members of the MCC or multidisciplinary team must meet the specialist training required to practice in the province. Radiation and Medical Oncologists, Radiologists and Pathologists should have an interest and commitment in gynecologic oncology. Gynecologic oncologists must be certified in gynecologic oncology by the Royal College of Physicians and Surgeons or an equivalent.

2025 Endorsed Recommendation: Recommendation 11.3 was endorsed from the original guideline and was modified to reflect current practice.

IMPLEMENTATION CONSIDERATIONS

The intention of these recommendations is to ensure that patients with gynecologic cancers in Ontario have timely access to quality treatment and optimal outcomes throughout the patient journey without overwhelming available system resources (both physical and human resources). These organizational recommendations provide a platform for advocacy to support appropriate collaboration and communication within and among GOCs and ACs. Some sites have limited human resources, and the sustainability of programs is dependent on maintaining staffing levels and on sharing resources through collaboration and consultation among sites. Designated GOCs can articulate plans for how human and physical resources will be managed, ensuring that staffing ratios are scaled accordingly for patient/staffing volumes (e.g., if the number of surgeons at a site increases, the proportion of pathology and imaging resources

required should increase). Likewise, ACs need collaborative support to access resources (e.g., for the provision of MR-guided brachytherapy, sites need equipment and clinical expertise, and sufficient volumes to maintain expertise). Resource coordination and collaboration are particularly important for northern sites, in order to access specialized services such as IR and IR biopsy requests.

Many implementation successes have occurred since this document was originally launched. Since 2013, three additional GOCs have been initiated to serve patients closer to home. A similar approach will be taken with implementation of the revised recommendations, which includes assessing GOCs and ACs to determine if they meet the minimum requirements and devising a plan to address deviations. Additionally, a few system indicators (new and existing) will be monitored to assess implementation progress.

RELATED GUIDANCE

- [Standardized Ultrasound Reporting for Ovarian-Adnexal Masses in Ontario](#) (Explanatory Notes Version January 2025)
 - Also see [OH \(CCO\) Imaging Toolkit](#) webpage for Ovarian-Adnexal Ultrasound O-RADS™ reporting documents:
 - The [Explanatory Notes](#) defines the standardized lexicon, explains how to use the risk stratification and management system, and provides radiologist reporting guidance and sample reports for the Ontario healthcare context.
 - [Ultrasound Worksheet](#) for adnexal lesions.
 - [Risk Categorization and Management Quick Reference](#), which is an abbreviated version of the explanatory notes.
- [Ontario Cervical Screening Program Recommendations for Cervical Screening and Colposcopy with Human Papillomavirus Testing in Ontario](#).
- [Endometrial Cancer Molecular Testing Recommendation Report](#) (November 2024)
- [Robotic-Assisted Hysterectomy for Endometrial Cancer in People with Obesity](#) (OHTAC Final Recommendation October 2023)
- [An Endorsement of the 2025 Practical Guidelines for the Treatment of Gestational Trophoblastic Disease: Collaboration of the EOTTD, ESGO, GCIG, ISSTD](#) (November 2025)
- [GL 17-12 Indications for Hyperthermic Intraperitoneal Chemotherapy with Cytoreductive Surgery](#) (September 2019)
- [GL 21-2 V2 Three-Dimensional MR-Guided Intracavitary and Interstitial Brachytherapy for Cervical Cancer](#) (November 2018)
- [GL 12-10 V2 Regional Models of Care for Systemic Treatment: Standards for the Organization and Delivery of Systemic Treatment](#) (Jul 2019)
- [OH \(CCO\) Comprehensive Cancer Biomarker Testing Program](#) (October 2025)
- [Multidisciplinary Cancer Conference Standards](#) (June 1006) Including links to Guideline-Based Clinical Tools
- [IMRT Guidance Document for Intact Cervix](#) (June 2018)
- [Guidance for the management of Gynecological Sarcomas in Ontario: Recommendations Report](#) (Version 2, July 2024)

Organizational Guideline for Gynecologic Oncology Services in Ontario

Section 2: Guideline Development Methods

This section summarizes the methods used to create the 2025 guideline. For the methods of the 2013 systematic review, see [Appendix 2](#).

THE PROGRAM IN EVIDENCE-BASED CARE

The Program in Evidence-Based Care (PEBC) is an initiative of the Ontario provincial cancer system, Ontario Health (Cancer Care Ontario). The PEBC mandate is to improve the lives of Ontarians affected by cancer through the development, dissemination, and evaluation of evidence-based products designed to facilitate clinical, planning, and policy decisions about cancer control.

The PEBC supports the work of Guideline Development Groups (GDGs) in the development of various PEBC products. The GDGs are composed of clinicians, other healthcare providers and decision makers, methodologists, and community representatives from across the province.

The PEBC is a provincial initiative of OH (CCO) supported by the Ontario Ministry of Health (OMH). All work produced by the PEBC and any associated Programs is editorially independent from the OMH.

BACKGROUND FOR GUIDELINE

This guideline project was initiated to update the guidance for the care of patients with gynecologic cancer in Ontario by ensuring the recommendations reflect current resources and practice and integrating other OH (CCO) guidance that had been published after the original 2013 organizational guideline. The same goals of improving the quality of care provided through greater access to multidisciplinary care, appropriate treatment and supporting a collaborative community of practice at a system-wide level apply in 2026.

At the outset of this project, it was determined that the original GL 4-11 Organizational Guideline for Gynecologic Oncology Services in Ontario remains valid, relevant, and still serves its intended purpose. Over the past decade the recommendations have guided the organization and delivery of services and are the current standard of care. The 2013 consensus recommendations were endorsed with some modifications in this updated version. A new literature search on this organizational topic was not undertaken for the following pragmatic reasons: 1. To make efficient use of guideline resources (clinical experts, guideline methodologists); 2. The original consensus recommendations remain valid and useful.

The consensus recommendations in the original 2013 document were informed by a systematic review of existing guidance documents and primary literature found in electronic databases. Overall, the evidence base was determined to be of lower quality based on study design, conflicting findings, and the lack of generalizability of results due to heterogeneity of comparison groups and outcome measures. In 2013, the GDG, which included expertise in gynecologic oncology, radiation oncology, medical oncology, methodology, and representation from CCO's Surgical Oncology Program, used an informal consensus-based approach to develop a consensus-based guideline, relying on trends found in the evidence, recommendations from other jurisdictions, and personal opinion informed by knowledge of the current situation in the province. In 2025, the original 2013 recommendations were reviewed by a newly convened

Working Group and an Expert Panel (see Appendix 1 for members and affiliations) with expertise in gynecologic oncology, medical oncology, radiation oncology, pathology, and radiology. The document was also disseminated to professionals from relevant specialties across Ontario for their review and feedback, which was incorporated into the guideline draft.

GUIDELINE DEVELOPERS

This guideline was developed by the Organizational Guideline for Gynecologic Oncology Services in Ontario GDG (Appendix 1), which was convened at the request of the OH (CCO) Gynecologic Cancers Advisory Committee and the OH (CCO) Surgical Oncology Program.

The project was led by a small Working Group of the Organizational Guideline for Gynecologic Oncology Services in Ontario GDG, which was responsible for reviewing the original recommendations, drafting revisions to the guideline recommendations, and responding to comments received during the document review process. The Working Group had expertise in gynecologic oncology, surgical and radiation oncology, pathology, radiology, and health research methodology. Other members of the GDG served as the Expert Panel and were responsible for the review and approval of the draft document produced by the Working Group. Conflict of interest declarations for all GDG members are summarized in Appendix 1, and were managed in accordance with the [PEBC Conflict of Interest Policy](#).

GUIDELINE DEVELOPMENT METHODS

The PEBC produces evidence-based and evidence-informed guidance documents using the methods of the Practice Guidelines Development Cycle [4,5].

The PEBC uses the AGREE II framework [6] as a methodological strategy for guideline development. AGREE II is a 23-item validated tool that is designed to assess the methodological rigour and transparency of guideline development and to improve the completeness and transparency of reporting in practice guidelines.

The currency of each document is ensured through periodic review and evaluation of the scientific literature and, where appropriate, the addition of newer literature to the original evidence-base. This is described in the [PEBC Document Assessment and Review Protocol](#). A list of any implementation considerations (e.g., costs, human resources, and unique requirements for special or disadvantaged populations, dissemination issues, etc.) is provided along with the recommendations for information purposes. PEBC guideline development methods are described in more detail in the [PEBC Handbook](#) and the [PEBC Methods Handbook](#).

GUIDELINE REVIEW AND APPROVAL

Internal Review

For the guideline document to be approved, 75% of the content experts who comprise the GDG Expert Panel must cast a vote indicating whether they approve the document, or abstain from voting for a specified reason, and of those that vote, 75% must approve the document. In addition, the PEBC Report Approval Panel (RAP), must unanimously approve the document. The Expert Panel and RAP members may specify that approval is conditional, and that changes to the document are required. If substantial changes are subsequently made to the recommendations during external review, then the revised draft must be resubmitted for approval by RAP and the GDG Expert Panel.

External Review

Feedback on the approved draft guideline is obtained from content experts and the target users. Through Professional Consultation, relevant care providers and other potential

users of the guideline are contacted and asked to provide feedback on the guideline recommendations through a brief online survey.

DISSEMINATION AND IMPLEMENTATION

The guideline will be published on the OH (CCO) website. The Professional Consultation of the External Review is intended to facilitate the dissemination of the guideline to Ontario practitioners. OH (CCO)-PEBC guidelines are routinely included in several international guideline databases including the CPAC Cancer Guidelines Database, the CMA/Joule CPG Infobase database, NICE Evidence Search (UK), and the Guidelines International Network (GIN) Library.

Similar to the original implementation of Organizational Guideline for Gynecologic Oncology Services in Ontario, there will be a multifaceted implementation strategy that includes regional planning, quality indicator development and ongoing performance management.

ACKNOWLEDGEMENTS

The Organizational Guideline for Gynecologic Oncology Services in Ontario GDG would like to thank the following individuals for their assistance in developing this report:

- Dr. Jonathan Sussman, for providing feedback on draft versions.
- Sara Miller for copy editing.
- CI-DAP staff at OH-CCO

Organizational Guideline for Gynecologic Oncology Services in Ontario

Section 3: Internal and External Review

INTERNAL REVIEW

The guideline was evaluated by the GDG Expert Panel and the PEBC Report Approval Panel (RAP) (Appendix 1). The results of these evaluations and the Working Group’s responses are described below.

Expert Panel Review and Approval

Of the 16 members of the GDG Expert Panel, 14 members voted and 2 abstained, for a total of 81% response in November 2025. Of those who voted, 14 approved the document (100%). The main comments from the Expert Panel and the Working Group’s responses are summarized in Table 5-1.

Table 5-1. Summary of the Working Group’s responses to comments from the Expert Panel.

| Comments | Responses |
|--|--|
| 1. Target Population: Suggest change in wording to “High Risk equivalent” instead of “Intermediate or High Risk of malignancy score. | Target population wording was revised. |
| 2. Rec 1.1: Remove mention of myometrial invasion and pre-operative MRI in this organizational guidance document but refer to the clinical direction in the Endometrial Biomarkers document. | Wording was revised accordingly. |
| 3. Rec 1.3: Clarify the specific example of appropriate indications for robotic surgery, and make clear that robotic surgery is an option, not required. | Wording was revised accordingly. |
| 4. Rec 1.4: Remove “high volume”. GTD is rare so not high volume anywhere. Align with new GTD guidance in development. Add in review by a gynecologic pathologist with GTD expertise. | Wording was revised accordingly. |
| 5. Rec 3.1: Additional support through digital pathology and consultation should be added, along with access to IR. | Wording was revised accordingly. |
| 6. Rec 3.2: Clarify on site resources versus “access to” resources. Add access to lymphedema care, this is an unmet need at present. | Wording was revised accordingly. |
| 7. Rec 4.1: Pathology services should include high-quality digital pathology and support for clinical trials. | Wording was revised accordingly. |

RAP Review and Approval

The Scientific Director of the PEBC reviewed this document in November 2025 and approved the document. The recommendations were derived through a process of endorsement and consensus. The main comments from the review and the Working Group’s responses are summarized in Table 5-2.

Table 5-2. Summary of the Working Group’s responses to comments from RAP.

| Comments | Responses |
|---|---------------------|
| 1. The document reads clearly and well with good documentation of changes made from previous versions. No concerns or issues. | No response needed. |

EXTERNAL REVIEW

External Review by Ontario Clinicians and Other Experts

Professional Consultation

Feedback was obtained through a brief online survey of healthcare professionals and other stakeholders who are the intended users of the guideline. Contacted professionals included oncologists within the PEBC contact database with an interest in gynecologic cancers, members of the OH-CCO Gynecological Cancers Advisory Committee, members of the Gynecological Oncologists Group of Ontario (GOGO), the Ontario Regional Surgical Oncology Leads, and OH-CCO Regional Vice Presidents and Regional Directors. One hundred and fifty-five professionals were contacted. Of these, 47 (31%) responses were received of which 3 stated that they did not have interest in this area or were unavailable to review this guideline in the allotted time. The results of the feedback survey from 47 people are summarized in Table 5-5. The main comments from the consultation and the Working Group’s responses are summarized in Table 5-6.

Table 5-5. Responses to four items on the professional consultation survey.

| General Questions: Overall Guideline Assessment | Number 47 (31%) | | | | |
|--|-----------------------|-----|-----|-----|---------------------|
| | Lowest Quality (1) | (2) | (3) | (4) | Highest Quality (5) |
| 1. Rate the overall quality of the guideline report. | 0 | 1 | 3 | 22 | 21 |
| | Strongly Disagree (1) | (2) | (3) | (4) | Strongly Agree (5) |
| 2. I would make use of this guideline in my professional decisions. | 0 | 1 | 7 | 15 | 24 |
| 3. I would recommend this guideline for use in practice. | 0 | 1 | 3 | 17 | 26 |
| 4. What are the barriers or enablers to the implementation of this guideline report? | | | | | |
| Barriers | | | | | |
| Resources: Lack of availability of resources (human and physical) for: gynecological oncology, pathology (e.g., reliable access to digital pathology, capacity for endometrial biopsies), diagnostic | | | | | |

imaging (e.g., MR, application of ORADs), operating room resources, supportive services (sexual health, dietician, lymphedema care). Variability of resources from region to region.

Collaboration: Limited ability for GOC to impact practice at ACs

System Support: funding for positions and equipment (new and replacement), HHR/gyne oncology program planning for GOCs and ACs, institutional support (protected time/realistic scheduling, coordination of nursing, pharmacy and care, administrative and nurse navigation support). Establishing competency in ACs for robotic surgery performed for gynecologic malignancy.

Geographic distance is a significant travel burden for patients going outside their region.

Enablers

Dissemination to treating physicians and referring family physicians.

System Support to build capacity for collaboration between GOCs and ACs for training and skills development, building a strong quality-assurance relationship, ensure consistency for MCCs.

Flexibility to accommodate regional, networked models of care and formal referral pathways to GOCs. Legacy of prior systems work that supports care closer to home, access to an MCC, an appropriately skilled team, and a range of multidisciplinary resources.

Table 5-6. Summary of the Working Group’s responses to comments from professional consultants.

| Comments | Responses |
|---|---|
| <p>There is currently an application to OH to remove the BMI 35 rider for robotic management of endometrial cancer. There are published benefits of the technique that go beyond those with high BMI. The high BMI qualifier should be removed, and GOC centres should have access to robotics for various indications in line with other gynecologic oncology centres internationally.</p> | <p>This organizational guideline does not state a BMI qualifier, but reference is made to another OH document (Robotic-Assisted Hysterectomy for Endometrial Cancer in People with Obesity)</p> |
| <p>With the reduced incidence of ovarian cancer, the guideline should include minimum numbers for the management of advanced ovarian cancer as a centre of high expertise. This has been done internationally (https://www.esgo.org/ovarian-cancer-surgery-accreditation/)</p> | <p>The Surgical Oncology Program will be monitoring the number of ovarian cancer and overall gynecologic cancer surgeries</p> |
| <p>The only service that specified a patient volume was for new surgical cases at a GOC, with a minimum of 150 per GOC. This number seemed very low for four full-time gynecologic oncologists and was not supported by any references that that provided sufficient volume for maintenance and development of skills. Including that would be helpful.</p> | <p>This rec was carried forward and endorsed from GL 4-11 V1, stated as: 5.1 A minimum annual volume of 150 new surgical cases is recommended for each GOC.</p> |

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| <p>The HR requirement for a GOC was four FTEs, but would this be appropriate for a new centre just starting? is that consistent with the minimum surgical volume of 150 new survival cases? Might the HR complement be smaller in a smaller centre with lower volumes?</p> | <p>If a new centre was initiated, a comprehensive plan would be developed including a volumes analysis and a phased approach of increasing of gynecologic oncologic surgeons and cases per year is expected until the goal is met.</p> |
| <p>There remains for me some confusion of the organization of general gynecologists (who do not have specialized training for FIGO1) and Affiliated Centres, and whether generalists should seek affiliation.</p> <p>1.3 - It is confusing as to whether a general gynecologist with robotics can perform FIGO</p> <p>1.4 - should all cases be reviewed by a gynecological pathologist, or just high-risk individuals</p> <p>3.1 - How do we account for HHR issues related to parental leaves, attrition, and low levels of available providers? What is only 3 Gynecological Oncologists are available? How do we mitigate in these situations?</p> <p>3.2 - I am not aware of any centres that have psychosexual therapists - McMaster was the last unit and it closed. I would broaden to psychosocial oncology and dilator training.</p> <p>3.3 - does this have to be in a GOC, or somewhere in the province - and if this is a cancer program, what are the resources to support this - general gynecologists have no capacity</p> <p>7.1 - This is a big change in practice to designate general gynecologists as having an interest in cancer and MIS - I assume you mean the ability to do a TLH? That's most grads. Is there evidence to support limiting generalists or surgical volumes for FIGO 1?</p> <p>Recommendation 11 - I don't understand why you would not have an MCC for any patient, even if you see the patient off-site. Should this not be an RCP responsibility to ensure all cancers in the region receive an MCC discussion? I understand this is "current practice" but the cart shouldn't drive the horse - the evidence drives the recommendations and MCCs are typically an important benchmark in the cancer system.</p> | <p>1.3 Specifically for robotics cases, a general gynecologist, at either a GOC or AC, can treat low risk stage 1, grade 1 endometrial cancer (not MMR deficient and no p53 mutation).</p> <p>1.4 As stated in the recommendation: Very high-risk GTD cases (FIGO 2000 score 12 and greater) should be reviewed by a pathologist with GTD expertise.</p> <p>3.1 Four gynecological oncologists is minimum, with the intent that this is sufficient to mitigate absences.</p> <p>3.2 The recommendation states that they "should be on site". These specialists should be advocated for if not available now.</p> <p>3.3 Patients should have access to these resources; they may be located elsewhere.</p> <p>7.1 The recommendation is not substantively changed from the original recommendation, see below. 2026: "A minimum of one gynecologist with a special/dedicated interest in gynecologic oncology and skills to perform minimally invasive surgery." 2013: "A minimum of one gynecologist with a commitment to gynecologic oncology and skills to perform minimally invasive surgery."</p> <p>Recs 11.1 and 11.2 outline a practice of collaborative care intended to ensure appropriate patient access and follow-up. As well, it also states that all cases can be discussed at an MCC.</p> |
| <p>Please clarify ORADS 3-4 (in report as being able to be managed by gen GYN). Is this ORADS rads score on ultrasound (vs MRI).</p> | <p>ORADS 2, 3 patients are to be assessed and managed by primary care or general gynecologists. Some ORADS 4 patients can also be surgically managed by general gynecologic surgeons although a discussion</p> |

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| | <p>with a gynecologic oncologist can be considered.</p> <p>ORADS in this province is based on US imaging. Tools for ORADS calculations include the ORADS app. Recommendation and use of MRI should be limited and recommended as per ORADS document. MRI should not be used routinely to supplement every pelvic US report. See: Standardized Ultrasound Reporting for Ovarian-Adnexal Masses in Ontario (Explanatory Notes Version January 2025)</p> |
| <p>How would Thunder Bay be assessed in this document as there is 1 gynecological oncologist who attends and sometimes operates there and sometimes brings patients to Hamilton.</p> <p>I believe it would be helpful to comment on Secretarial support, clinic resources and access to colposcopy. Some GOC sites offload a not insignificant volume of cervical and vulvar cancer cases for ongoing follow-up to colposcopy.</p> <p>Is there any literature on maintenance of surgical skills for a gynecologist (annual individual volumes) i.e., splenectomy, PA node dissection, Robotics. May be helpful to comment on benefits of regular QI assessments on specific topics.</p> <p>Pathology - comments on time to reporting - any data on this</p> <p>Gynecological oncologist - any data on time from referral to time for definitive treatment in terms of outcomes, psychosocial QOL, etc.</p> | <p>This is a provincial organizational guideline and is not specific to a centre or specific resource implementation for a centre.</p> <p>The intent of this guideline is to provide high level recommendations for the organization of care, more specific details regarding resources and specific centres are out of scope.</p> <p>The guideline did not include a literature review on these specific surgical skills.</p> <p>Hospitals that have implemented robotic programs for patients with cancer should have a quality committee in place (as per Surgical Oncology Program recommendations).</p> <p>Various performance indicators (wait times, pathology turnaround times) are monitored by Ontario Health (Cancer Care Ontario)</p> |
| <p>Guideline is worded too strongly for the evidence that is presented</p> <p>The evidence presented is quite poor/low Association in the studies is confused with causation</p> <p>Regionalization of Gynecological Oncology has occurred not just due to policy but also naturally as many OBGYN's are not capable or interested in managing these cancers</p> <p>Similarly, survival for this cancer has improved with time</p> <p>Bradford Hill criteria for causation are not discussed or accounted for</p> | <p>Following the implementation of the original version of this guideline, nine GOCs (3 new) have been established in Ontario, and ACs were created. Using Ontario-based research utilizing administrative data, in 2021 a publication showed that the policy led to an increase in the proportion of high-grade endometrial cancer surgeries performed by gynecologic oncologists, and improvement in patient survival. A 2022 study of epithelial ovarian cancer showed improved survival. Administrative data show that access to care has improved, with 77% of patients being treated within target for 24/25-Q4. (see references in the guideline Introduction).</p> <p>For this guideline, the 2013 consensus recommendations, which were based on consensus informed by a systematic review with low certainty evidence, were endorsed with some modifications. A new literature</p> |

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| | <p>search on this organizational topic was not undertaken for the following pragmatic reasons: 1. To make efficient use of guideline resources (clinical experts, guideline methodologists); and 2. the original consensus recommendations remain valid and useful.</p> |
| <p>My comments are coming from the perspective of an administrator: It would be helpful to clarify what does access to lymphoedema care mean? Is it expected that it be provided in-house or is access to community services sufficient to meet the recommendation? If expectation is to provide in house, will QBP funding be reviewed to ensure it is included in funding model?</p> <p>There is no mention of the role of the GOC is facilitating access to appropriate clinical trials. Does this belong in a document like this?</p> | <p>Lymphoedema care for many disease sites is available at some hospital sites and are typically nurse led. Some of this work can be done virtually after initial visit.</p> <p>Some financial support is available through ADP or other insurance. QBP funding is out of scope for this guideline.</p> <p>Rec 4.1 indicates “support for clinical trials” at an organization level.</p> |
| <p>This guideline, in the way that it is written, does not allow for Gynecologic Oncologists (GOs), who work within GOCs, to perform operations at an Affiliated Centre (AC). There is data to demonstrate that a model where GOs perform gynecologic oncology surgery at ACs decrease wait times for surgery. The overall purpose of this document is to ensure that patients with gynecologic malignancies receive care by gynecologic oncologists who have the expertise and infrastructure such that the patients receive optimal care for optimal outcomes. If a gynecologic oncologist is overseeing the care of a patient through a GOC but performs their operation at an AC that has the necessary equipment and supports available, this is the same as a gynecologic oncologist performing their operation at a GOC; it is only the physical location that is different, not the quality of care. Keeping this in mind, the following statements should be edited to reflect this:</p> <p>1.2 "...definitive surgical management of all in-scope gynecologic malignancies not listed in Recommendation 1.1, should be performed by a gynecologic oncologist at a GOC" Please edit to "...should be performed by a gynecologic oncologist at a GOC or performed by a gynecologic oncologist at an AC."</p> | <p>1.2: The Working group disagrees. We are not currently advocating that GOs should provide care at an AC on a wide scale across Ontario. The guideline specifies that definitive surgical management occur <i>at a GOC</i> because GOCs are the provincial sites formally designated, governed, and resourced to provide comprehensive gynecologic oncology surgery. This includes standardized infrastructure, multidisciplinary support, quality oversight, and accountability mechanisms that ACs are not currently required to meet. As such, the difference between a GOC and an AC is not solely geographic or the presence of a GO—it</p> |

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| <p>2.1 "Care by gynecologic oncologists should be delivered within designated GOCs." Please edit to add "Gynecologic oncologists who are part of designated GOCs can deliver surgical care at an AC if operative resources are available such that the equivalent surgery can be completed at an AC."</p> <p>6.1: "ACs that develop a formal affiliation with GOCs may provide, in collaboration, any or all of the following services:" Please add: "Surgery not listed in Recommendation 1.1 can be completed at an AC by a gynecologic oncologist who is part of a designated GOC"</p> | <p>reflects provincial standards and system-level governance.</p> <p>2.1 The surgical services that general gynecologists can provide at ACs is specifically stated in Recommendation 1.1. All other services should be provided by GOs at GOCs. In practice, there are some GOs that perform services at ACs under conditions that ensure the best patient care, but these are exceptions that provide flexibility for high quality patient care in unusual circumstances and not the general rule. No change has been made.</p> <p>6.1 Specific details related to affiliations between GOCs and ACs would be determined through the implementation of this guidance as these will vary across the province.</p> |
| <p>3.1 currently states that a multidisciplinary team at a GOC should include a minimum of 2 specialists in medical oncology. Gynecologic Oncologists are also trained to give systemic therapy for gynecologic malignancies, similar to medical oncology. The statement should be edited to allow gynecologic oncologists who oversee and prescribe systemic therapy to be recognized as a systemic therapy specialist. The way that it is currently written it implies that there must be 2 medical oncologists in addition to gynecologic oncologists.</p> | <p>The Working group disagrees. Recommendation 3.1 is written in the way it was intended. The two medical oncologists are in addition to a gynecological oncologist who give systemic therapy. There needs to be these additional resources in GOC. The gynecological oncologist should not be considered as part of the two medical oncologists. Patient populations for systemic treatment may be different. Therapeutics are growing and needs of patients becoming very medically complex.</p> |
| <p>For MRI-guided intracavitary or brachytherapy procedures, the document should read such that these techniques should be available by referral (i.e. does not have to be present within a GOC for a GOC to exist). This would be similar to HIPEC, where as long as the GOC has ability to refer for HIPEC, that is acceptable.</p> | <p>For MRI-guided intracavity or brachytherapy procedures, the Working Group feels that Recommendations 3.1 and 6.1 completely explain any referral issues. Recommendation 3.1: The two radiation oncologists should be experienced in the use of MR-guided intracavitary and interstitial brachytherapy or refer patients to another GOC for MR-guided intracavitary and interstitial brachytherapy when needed. Recommendation 6.1: Patients requiring MR-guided intracavitary or interstitial brachytherapy should be referred to a GOC.</p> |
| <p>One of the items I was looking for was number of cases related to competency in brachytherapy. This was not detailed in the document. Guidelines endorsed by OH(CCO) are useful for supporting arguments for resources or structures required for a program.</p> | <p>See Recommendation 5.1, qualifying statements re: radiation therapy and reference: GL 21-2 v2 Three-Dimensional MR-Guided Intracavitary and Interstitial Brachytherapy for Cervical Cancer.</p> |
| <p>The guideline objective mentions that it focuses on patients diagnosed with gynecologic malignancy, but the</p> | <p>The reference to a diagnosed malignancy in the objective was deleted to keep it broad</p> |

Guideline 4-11 Version 2

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| <p>target population includes patients both suspected and diagnosed. I would suggest being consistent throughout.</p> | <p>and therefore consistent with the specified target population.</p> |
| <p>The guideline does a very good job clearly describing the role of the general gynecologist vs gynecologic oncologist in the surgical management of gynecologic malignancies. For patients requiring systemic therapy, this can be administered by both gynecologic oncologists and medical oncologists. With the growing number of systemic treatments for advanced gynecologic malignancies, which types of cases would benefit from the expertise of medical oncologist vs gynecologic oncologist would be a very useful addition to the guideline.</p> | <p>It is out of scope in this document to recommend which patients should be managed by a gynecological oncologist or medical oncologist. There are no criteria for this, and this should be decided by each cancer program internally. Either a gynecological oncologist or a medical oncologist could prescribe systemic treatment, but distribution and collaboration of patient management can be decided via consensus between gynecological/medical oncologist groups locally.</p> |
| <p>In various areas, there is mention of "training" (i.e. robotic procedures) - is there another document that defines what "trained" means.</p> | <p>The surgical oncology program has recommended that the site have a robotic committee that oversees quality. Sites should demonstrate a commitment to developing a high-quality cancer surgery robotics program, including implementation of a Steering Committee for Robotic Surgery of appropriate staff (surgeons, anesthesia, surgical administration, quality leads, data analysts, etc.) which will monitor the safe implementation or utilization of robotic surgery.</p> |
| <p>What do you mean by "formal" partnership in the Section on Relationship between GOCs and ACs - who is accountable for the ultimate care of patients treated at ACs?</p> | <p>As part of the implementation of the organizational guideline regions will be asked to develop plans which includes demonstrating of partnership between GOCs and ACs.</p> |
| <p>Clearly define "low grade endometrial cancer": Grade 1? 2? or both</p> | <p>It is defined in Rec 1-1 as Grade 1 endometrioid adenocarcinoma that are estrogen receptor positive, MMRi and p53 normal.</p> |
| <p>The scope of this guidance document does NOT include the following non-invasive conditions: Does this mean the management of these conditions no longer under gynecological oncology?</p> | <p>Yes. these include cervical dysplasia, stage Ia1 cervical cancer (after consultation with GO), hyperplasia, hyperplasia with atypia, vulvar dysplasia (VIN 2-3).</p> |
| <p>Treatment of EIN/Atypical hyperplasia - should this be performed by gynecologic oncologist or gynecologist?</p> | <p>The treatment of EIN/Atypical hyperplasia could be done by either. These patients may be surgically treated in an AC as any other Grade I endometrial cancers that are estrogen receptor positive, MMRi and p53 normal. Gynecologic Oncology opinion may be requested if clinical scenario requires it.</p> |

Guideline 4-11 Version 2

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| <p>Human resource: “A minimum of two specialists in Medical Oncology, with a special/dedicated interest in gynecologic malignancies” - special/dedicated medical oncologist need to be explicitly defined what does this mean? Workload? Research commitment? Teaching?</p> | <p>A special/dedicated interest is a clinical interest in that they are interested in taking care of patients with gynecologic malignancies</p> |
| <p>Should dedicated surgical oncology and pharmacy be included in human resource planning for GOC?</p> | <p>The Working group agrees that pharmacy should be added in the human resources section. However, they think that general surgery would be sufficient.</p> |
| <p>For AC - “sufficient patient volume at the location to maintain competency and skills of professional healthcare providers to address the acuity and complexity of the treatment modalities and/or to provide cost-effective use of resources and drugs” - sufficient volume needs to be defined explicitly despite lack of data to ensure quality care is delivered everywhere in Ontario.</p> | <p>There is no basis for setting a volume number in this document.</p> |
| <p>There is little mention of early screening, detection, and role of genetics in this process. Expanding the guidelines to a full patient journey including wait time zero (while under investigation in primary care) would make it more comprehensive and ensure a high accountability across the cancer journey for patients. Many gynecologic cancers are picked up late, and better early id is needed which includes shared care pathways between primary care and gynecology and oncology.</p> | <p>Screening, detection and the role of genetics are out of scope for this document which is focused on organization of treatment of patients. There are other guidelines that provide information on these important issues: OH-CCO Screening Guidelines</p> |
| <p>Might there be a definition of what constitutes "GTD expertise"? The number of cases per year, perhaps?</p> | <p>Unfortunately, there is no definition due to extremely low volumes. Complex cases should be discussed at a multidisciplinary cancer conference (MCC) with GTD expertise or at a GTD Tumour Board.</p> |
| <p>1.1 needs to be clarified with respect to ORADS4 - Can we specify the subset of ORADS 4 that we want referred to gynecologic oncologist? We need to decide if the pathway is that they all should be referred for consideration but may be operated on by general gynecologist if deemed appropriate for gynecologic oncologist. Or do we want to provide criterion for referral within the ORADS 4 category? I think this recommendation leaves it very vague and seems like general gynecologist can do ORADS 4 all the time and consult if they would like. I don't think that's a clear approach.</p> | <p>Ontario Health (Cancer Care Ontario) will continue the education and implementation strategy for ORADS including increasing knowledge and use of ORADS within the imaging community and patient evaluation and follow up guidance for primary care, gynaecologists. Further refinement of ORADS 4 is currently being developed as well as a clinical companion to the ORADS document referenced in the main document. (Standardized Ultrasound Reporting for Ovarian-Adnexal Masses in Ontario (Explanatory Notes Version January 2025))</p> |

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| <p>3.1 How is a subspecialist in gynecologic radiation oncologist determined? Regarding med oncologist- we already have sites that do not have medical oncologist who do gynecological oncology...how will we address this? Is this mandatory? How would it be enforced?</p> | <p>Medical oncologist and gynecologic radiation oncologist identification will go into implementation piece.</p> |
| <p>1.1 - I think the intent is that patients with adnexal masses ORADS 4 or less can be operated at AC - not just 3 and 4. A statement that ORADS 5 should be operated on at GOCs would be helpful.</p> | <p>As above. Ontario Health (Cancer Care Ontario) will continue the education and implementation strategy for ORADS to support a standardized approach throughout Ontario. A specific statement that ORADS 5 patients should be cared for at GOC has been added to recommendation 1.1.</p> |
| <p>5.1 - volumes at GOCs. This is always a tricky area for commentary. There is little high-quality evidence informing volume designations for the various modalities of treatment. One can accept the consensus of 150 cases for surgery if this is an historical figure. The comments on systemic treatment (no consensus) and radiation (e.g., MRI-IC/IS is a paradigm shift - major improvements in patient outcomes - but don't know needed volumes and many centres do not have this) are likely to create some cognitive dissonance. This guideline cannot answer all potential concerns/questions. It may be more helpful to simply comment - for example - that 'minimum volumes to maintain competency in these areas are not known, but that GOCs are expected to take regional leadership roles in the provision of complex systemic and radiation treatment plans. For the latter this should include MRI-guided IC/IS brachytherapy or pathways to ensure appropriate patients can receive such treatments. Competency requires ongoing evaluation of local treatment standards. Such a statement better parallels dispassionate comments already made in section 4.1.</p> | <p>The surgical volume is from the original guideline. The Surgical Oncology Program uses quality indicators to address quality monitoring. The comment "GOCs are expected to take regional leadership roles in the provision of complex systemic and radiation treatment plans." has been added to Recommendation 5.1</p> |
| <p>10.1 - formal partnerships between GOCs and ACs to ensure accountability. I am not sure without more detail how such a partnership can be operationalized. Much of the interactions among centres/clinicians/administrators with varying resource intensities relies on good will and professionalism. If this guideline calls for a formal partnership and accountability (i.e., responsibility for quality), to maintain credibility and clarity, more details should be provided.</p> | <p>This document is not intended to be prescriptive. There will implementation plans made after the release of the guideline by the SOP including requests regarding details of partnerships.</p> |

CONCLUSION

The final guideline recommendations contained in Section 1 reflect the integration of feedback obtained through the external review processes with the document as drafted by the GDG Working Group and approved by the GDG Expert Panel and the PEBC RAP.

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Appendix 1: Affiliations and Conflict of Interest Declarations

Table 1. Members of the Organizational Guideline for Gynecologic Oncology Services in Ontario Working Group.

| Name | Affiliation | Declarations of interest |
|--------------------------|--|--|
| Rachel Kupets, Co-Chair | Ontario Cancer Lead, OH (CCO) Gynecological Oncology Advisory Committee; Sunnybrook Health Sciences, Toronto, Ontario | None declared |
| Frances Wright, Co-Chair | Clinical Lead, OH (CCO) Surgical Oncology Program; Sunnybrook Health Sciences Toronto, Ontario | CME talk on melanoma-received honorarium from COMET which is funded by a consortium of pharma companies |
| Sarah Ferguson | Gynecologic Oncologist, Princess Margaret Cancer Centre & University Health Network, Toronto, Ontario | None declared |
| Anjelica Hodgson | Pathologist, Toronto General Hospital & University Health Network, Toronto, Ontario | Honoraria from Merck, AstraZeneca, AbbVie for advisory board and speaking events related to biomarkers in gynecologic pathology/oncology |
| Zahra Kassam | Radiologist, St. Joseph's Health Care London, London, Ontario | Consulting speaker fees - Bayer Inc |
| Michael Milosevic | Radiation Oncologist, Princess Margaret Cancer Centre & University Health Network, Toronto, Ontario | Qurcan Therapeutics, Merck Medical Systems - Exp Advisor; Varian Medical Systems - laboratory research, Research Director. Special Advisor, NCI (US) Gynecologic Cancer Steering Committee |
| Clare Reade | Gynecologic Oncologist, Juravinski Cancer Centre, McMaster University, Hamilton, Ontario | None declared |
| Peter Stotland | Quality and Knowledge Transfer Lead, OH (CCO) Surgical Oncology Program; North York General Hospital, Toronto, Ontario | None declared |
| Amber Hunter | Manager, OH (CCO) Surgical Oncology Program | None declared |
| Spencer MacDonald | Senior Specialist, OH (CCO) Surgical Oncology Program | None declared |
| Sheila McNair | PEBC, McMaster University, Hamilton, Ontario | None declared |
| Caroline Zwaal | PEBC, McMaster University, Hamilton, Ontario | None declared |

Table 2. Members of the Organizational Guideline for Gynecologic Oncology Services in Ontario Expert Panel.

| Name | Affiliation | Declarations of interest |
|-------------------|---|---|
| Allison Ball | Gynecologic Oncologist, Royal Victoria Hospital, Barrie, Ontario | None declared |
| Matthew Cesari | Pathologist, Credit Valley/Trillium Health Partners | None declared |
| Tanya Chawla | Radiologist, Joint Department of Medical Imaging, University of Toronto | Author of publication on imaging for adnexal masses |
| Andrew Chung | Radiologist, Kingston Health Sciences Centre | Professional income may be affected by changes in imaging volumes |
| Bojana Djordjevic | Pathologist, London Health Sciences Centre | None declared. |
| David D'Souza | Radiation Oncologist, London Health Sciences Centre | GSK, Tersera, Abbvie - consulting; Tersera - travel |
| Josee-Lyne Ethier | Medical Oncologist, Sunnybrook Health Sciences Centre | AstraZeneca, Abbvie Speaker fees: AstraZeneca, Merck, GSK Advisory Board Participation: AstraZeneca, Merck, GSK, Eisai - consulting; Local PI for trials for AstraZeneca and Merck. |
| Wylam Faught | Gynecologic Oncologist, The Ottawa Hospital | None declared |
| Julie Francis | Gynecologic Oncologist, Lakeridge Health | None declared |
| Orit Freedman | Medical Oncologist, Lakeridge Health | None declared |
| Adam Gladwish | Radiation Oncologist, Royal Victoria Hospital, Barrie, Ontario | Abbvie, Tersera, Knight Pharmaceuticals - all in relation to LHRH agonists relating to prostate cancer therapy. |
| Kathy Han | Radiation Oncologist, University Health Network | Merck - consulting; CIHR - grants; PI on CCTG EN10 |
| Felice Lackman | Gynecologist, Markham Stouffville | Bayer - advisory board for neurokinin B inhibitor; |
| David McConnell | Regional Cancer Care Northwest | None declared. |
| Jake McGee | Gynecologic Oncologist, London Health Sciences Centre | AstraZeneca, GSK - research consultancy; Abbvie, AstraZeneca, GSK - advisory boards; AstraZeneca grant for methylation testing in ovarian cancer. |
| Julie Nguyen | Gynecologic Oncologist, Juravinski Cancer Centre, Hamilton, Ontario | GSK and Stryker sponsored educational activity and fundraising at our institution; Research support from academic entities. |

Table 3: Report Approval Panel

| Name | Declaration of Interest |
|---|--------------------------------|
| Dr. Jonathan Sussman, Scientific Director, PEBC | None declared. |

Appendix 2: 2015 Systematic Review

The systematic review from the original 2013 Guideline was updated to 9 Jan 2015 (the original search included up to Dec 2011). In the journal publication of the systematic review, 1 additional article met inclusion criteria and was added. <https://doi.org/10.3747/co.22.2482>



REVIEW ARTICLE

The optimal organization of gynecologic oncology services: a systematic review

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ABSTRACT

Background A system-level organizational guideline for gynecologic oncology was identified by a provincial cancer agency as a key priority based on input from stakeholders, data showing more limited availability of multidisciplinary or specialist care in lower-volume than in higher-volume hospitals in the relevant jurisdiction, and variable rates of staging for ovarian and endometrial cancer patients.

Methods A systematic review assessed the relationship of the organization of gynecologic oncology services with patient survival and surgical outcomes. The electronic databases MEDLINE and EMBASE (OVID: 1996 through 9 January 2015) were searched using terms related to gynecologic malignancies combined with organization of services, patterns of care, and various facility and physician characteristics. Outcomes of interest included overall or disease-specific survival, short-term survival, adequate staging, and degree of cytoreduction or optimal cytoreduction (or both) for ovarian cancer patients by hospital or physician type, and rate of discrepancy in initial diagnoses and intraoperative consultation between non-specialist pathologists and gynecologic oncology-specialist pathologists.

Results One systematic review and sixteen additional primary studies met the inclusion criteria. The evidence base as a whole was judged to be of lower quality; however, a trend toward improved outcomes with centralization of gynecologic oncology was found, particularly with respect to the gynecologic oncology care of patients with advanced-stage ovarian cancer.

Conclusions Improvements in outcomes with centralization of gynecologic oncology services can be attributed to a number of factors, including access to specialist care and multidisciplinary team management. Findings of this systematic review should be used with caution because of the limitations of the evidence base; however, an expert consensus process made it possible to create recommendations for implementation.

Key Words Organization, gynecologic oncology, systematic reviews

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INTRODUCTION

The annual incidence of gynecologic cancers exceeds a million cases worldwide, with half a million deaths annually¹. In some jurisdictions, gynecologic oncology services have been centralized² in one or more centres with higher patient volumes and interdisciplinary collaboration³. Those centres receive referrals from less-specialized hospitals within a network, region, or defined catchment area. The effectiveness of that model of service delivery has been shown for other cancer disease sites⁴, but its benefits have historically not been as clear for gynecologic oncology⁵⁻⁷.

The present systematic review was designed to assess the relationship of the organization of gynecologic oncology services with patient survival, surgical outcomes, the delivery of chemotherapy, and some aspects of the role of specialist pathologists in gynecologic oncology. This choice of topic was based on perceived issues, including the absence of a health care system-wide network of care and a lack of collaboration, even in a setting in which most gynecologic oncologists are practicing in major centres with teaching hospitals and using a multidisciplinary team approach. Specific areas of potential concern for patient care included low rates of appropriate disease staging^{8,9}, geographic variations in treatment⁸, and variations in

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e282

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Appendix 3: Guideline Document History

| GUIDELINE VERSION | SYSTEMATIC REVIEW | | PUBLICATIONS | NOTES and KEY CHANGES |
|---------------------------------------|-----------------------------|-------------|---|---------------------------------------|
| | Search Dates | Data | | |
| Original June 2013 | 1995 to December 2011 | Full Report | Peer review publication. Web publication. | N.A. |
| Current Version 2 March 2026 | NA | NA | Updated web publication. | Updated consensus recommendations. |