Recurrences in gynaecologic cancers

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Introduction

Going through gynaecological cancer treatment is an uneasy journey and when the battle seems to be won no one wants to think of possible recurrences. However, recurrences in gynaecological cancers may happen and are more or less frequent depending on the type of cancer. This brochure is intended as a guide to lead you through the process of possible recurrences, the importance of regular check-ups and to offer you compassion during times of anxiety.

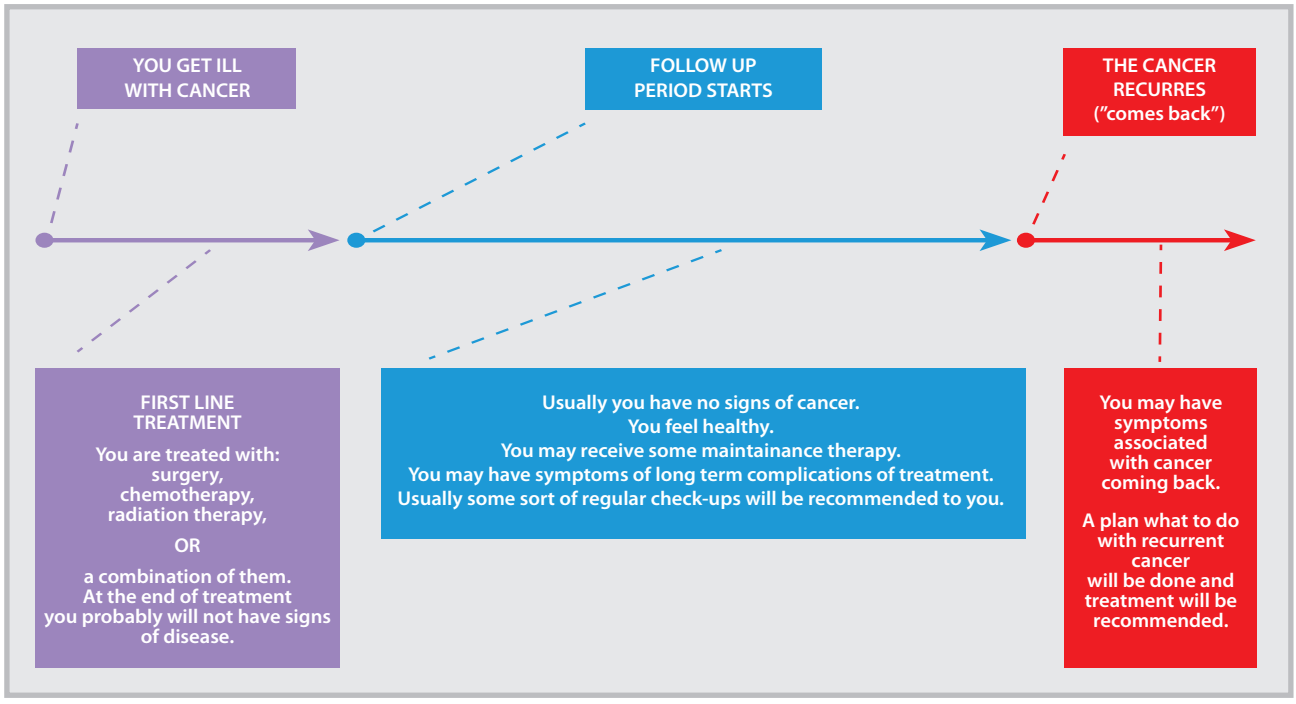
First-line treatment

When you get ill with gynaecological cancer, you start first-line treatment of the cancer. You may have surgery, get chemotherapy or radiation therapy, or most often, a combination of the three. For the majority of patients, first-line treatment is planned to radically treat the disease. This means that the aim of cancer therapy is to make the cancer ''disappear''.

At the end of first-line treatment, you will likely have no signs of cancer; tumours will disappear, and radiological examinations (such as CT scan, PET CT, MRI, or ultrasound) will no longer show a tumour. At that point, the "follow-up" period starts.

GLOSSARY

First-line treatment: the first treatment given for a disease. It is often part of a standard set of treatments, such as surgery followed by chemotherapy and radiation. When used by itself, first-line therapy is the one accepted as the best treatment. If it doesn't cure the disease or it causes severe side effects, other treatments may be added or used instead. Also called induction therapy, primary therapy, and primary treatment.



Follow-up period

GLOSSARY

Follow up: Care given to a patient over time after finishing treatment for a disease. Follow-up care involves regular medical check-ups, which may include a physical exam, blood tests, and imaging tests. Follow-up care checks for health problems that may occur months or years after treatment ends, including the development of other types of cancers. Follow-up care is given after positive screening test results, such as a positive Pap test result. In cancer patients, one purpose of follow-up care is checking to see if the cancer has come back or has spread to other parts of the body.

Maintenance therapy: treatment that is given to help keep cancer from coming back after it has disappeared following the initial therapy. It may include treatment with drugs, vaccines, or antibodies that kill cancer cells, and it may be given for a long time. Examples for gynaecologic cancers: bevacizumab for ovarian cancer, PARP inhibitors for ovarian cancer.

As you may experience yourself, the period immediately after first-line treatment is a special time of a woman's life: It is the time when there are no signs of cancer apart from possible side effects of cancer treatment influencing the quality of life for every woman. But a psychological burden might still exist and can highly influence quality of life. Being scared of the disease recurring, being scared of returning to ''normal'' life, being scared of rejections at work or home, or being scared of not feeling like a woman anymore are the most frequent concerns during this time.

Thus, there are several reasons for performing follow-up after first-line treatment. They are:

- to find the long-term complications of oncologic treatment and to treat them (for instance lymphoedema, which you can read about in our special leaflet or triple loss of function - urination, defecation, sexual problems),
- to perform long term rehabilitation, and to help you return to your ordinary life in physical, psychological, and social aspects,
- to see if the cancer has come back or has spread to other parts of the body; and if it has, to treat it.

What can I do during the follow-up period?

Generally, it is highly recommended to follow a healthy lifestyle during this period. It means that you are physically active as much as possible, eat healthy food, stop smoking and drinking excessive amount of alcohol. This is important for several reasons. One very important is that you stay healthy and in good shape in case of cancer comes back and you will need to start another cancer treatment. Healthy lifestyle also makes better control of other illness that you may have (arterial hypertension, diabetes, osteoporosis) and prevents them from occurring.

You are encouraged to take care of your:

a) physical wellbeing

- With regular physical activity and healthy food. See the ENGAGe nutrition brochure for more information.

b) emotional wellbeing

- The stress associated with the diagnosis of cancer persists for much longer than the treatment of cancer. It may persist your whole life even if cancer does not come back.
- It is important that you admit to yourself if you have anxiety, fears, lack of energy, and so on; these are completely normal for cancer patients. When you admit it, you can start looking for help.
- You can always ask for help from your general physician, gynaecologist, oncologist, nurses, and can get a referral to a psychologist or psychiatrist,
- Every country has some sort of support groups for cancer patients. See our leaflet.

During the follow-up period, you will likely receive a suggested schedule of regular check-ups. Different countries and cancer centres may have different check-up schedules, so you might not have the same schedule as other patients with the same cancer. This also applies to the person performing your check-ups. Follow-up visits may be done by specialized nurses, gynaecologists, oncologists, radiation oncologists, or general practitioners. This is because we do not have good scientific evidence for which strategy is the best, and because countries have different health system structures.

However, please be reassured that different strategies are generally equivalent and none is better than any other when we talk about oncologic outcomes (like overall survival).

GLOSSARY

Overall survival: The length of time from either the date of diagnosis or the start of treatment for a disease, such as cancer, that patients diagnosed with the disease are still alive. In a clinical trial, measuring the overall survival is one way to see how well a new treatment works. Also called OS.

Progression free survival: The length of time during and after treatment without cancer progression. Also called PFS.

How regular should check-ups be?

There are several drawbacks to undergoing high numbers of check-ups and examinations (like laboratory tests, CT scans, PET CT, MRI, ultrasounds, etc). As said, this is a period of life when you will not feel sick anymore, and you will have no signs of cancer. That is why every examination represents a psychological burden: because you will feel some amount of stress prior to, and while waiting for, the results. There might also be logistic or financial burdens involved with visiting the cancer centre so often. It is important to ask ourselves how frequently we want to undergo check-ups to ensure that they are associated with better oncologic outcomes.

There is clearly a need to establish a system of regular check-ups that feels right for you. This is why it is important to talk to your care provider (e.g., a doctor or nurse) about regular check-ups, which you can do any time during the follow-up period.

What should I ask the doctor?

To prepare yourself for a discussion with your care provider (e.g., a doctor or nurse), you can ask yourself some important questions while you're still at home. There is a detailed guideline at your disposal in another ENGAGe brochure called What Should You Ask the Doctor? that is available for download on engage.esgo.org in several languages.

Some questions might be:

- How do I feel about having regular check-ups if I have no problems or symptoms? (Does it make me feel safe, or does it make me feel stressed?)
- Do I like to actively plan check-ups with my doctor/nurse, or do I like to leave that to him/her?
- Do I want to know all the statistical data regarding my cancer and what is to be expected?
- Do I want to do tests and examinations that can tell me if the cancer will come back in advance, even if it is not possible to prevent it from coming back?
- Do I want my family members or friends to be actively involved with regular check-ups?

Once you answer these questions for yourself, you can discuss them with your doctor/nurse.

These are some questions you can prepare in advance:

- What follow-up strategy is recommended for me?
- How often will I have regular check-ups?
- Can I choose to have regular check-ups, or can I schedule the check-up by myself when new symptoms occur?
- Which long-term complications of oncologic treatment can I expect, and what can I do about them?
- Which symptoms suggest the cancer has come back, and which symptoms are associated with long-term complications of the treatment?
- Who is performing follow-up, and how can I make a contact with the care provider (e.g., phone call, email, patient's reported outcome applications, virtual check-ups, etc.)?
- Where can I receive psychological and social support?

Recurrences – General aspects

GLOSSARY

Recurrence: cancer that has recurred (come back), usually after a period of time during which the cancer could not be detected.

In general, the cancer can come back locally—where it started—or can spread to other organs (like the lungs, liver, or brain). Local recurrences in gynaecological cancers are localized in the pelvis and external genitalia. They may present with symptoms such as local pain, bleeding, discharge from the vagina, bladder, or bowel, or new problems with urination or defecation. On the other hand, distant metastasis occurs most often in the abdominal cavity as disseminated carcinomatosis. It can also occur as metastasis in the liver, or as metastasis in the chest or central nervous system. Other locations are very rare. The symptoms are associated with the organ that is involved. Abdominal recurrences are often associated with lack of appetite, nausea, vomiting, weight-loss, or abdominal stretching with ascites. Metastasis in the chest (pleural and pulmonary) may be associated with shortness of breath, cough, chest pain, or cough with blood. Metastasis in the central nervous system may be associated with headaches, nausea, vomiting or general neurological impairment, such as not being able to move or feel a certain part of the body.

Most women suspect the cancer has come back by themselves because they feel something has changed, or a new symptom has emerged. Other women do not feel or notice anything, but a doctor discovers a tumour during a regular check-up. New cancer could also be seen when regular imaging (such as CT, MRI, PET CT, or US scans) or laboratory tests (such as a rise in CA125) are performed. When a recurrence is suspected, it is best to confirm it with a biopsy,when possible. When the cancer comes back, examinations are performed to see all possible locations of recurrence, which is important for planning new treatments.

Anxiety following recurrence

At this point you may feel sadness, anxiety, anger, lack of will, or stress. Psychological support at this time is crucial, especially to enable you to think clearly, understand your doctor, and take part in the decision about what to do next.

Again, it is wise to prepare some questions in advance, such as:

1. What kind of treatment is planned?

When cancer comes back, there are usually more options on how to treat it. Sometimes it is possible to remove or destroy all tumours again, but sometimes it isn't. In this case, treatment is planned to slow the progression of the disease and to treat the symptoms associated with the cancer (like pain, vomiting, and bleeding).

Because there are different options for treatment of recurred cancer, different cancer centres may offer different therapies. There is no single "correct" course of treatment, so it is important to ask your doctors about all possible options, as well as options that are available worldwide. Almost all countries and cancer centres are available for a second opinion. It is important that you know second opinions exist for you, and your doctor should be able to help you obtain one. It is recommended that the treatment of recurrent cancer takes place in a high-volume cancer centre and not in a small local hospital, where there might be a lack of knowledge or equipment for optimal treatment. We recommend that you locate the nearest ESGO-accredited cancer centres for gynaecologic oncology in your country or region.

Another important aspect of treatment of recurrent cancer is being included in clinical trials. Clinical trials offer you the possibility of being treated with new drugs or other methods. You can read more about that in our separate brochure.

2. What short- and long-term complications of treatment may I expect?

3. What quality of life may I expect?

- Will I be able to continue my ordinary life and career?
- Will I need help with ordinary tasks?

4. Where can I get psycho-oncological help and support?

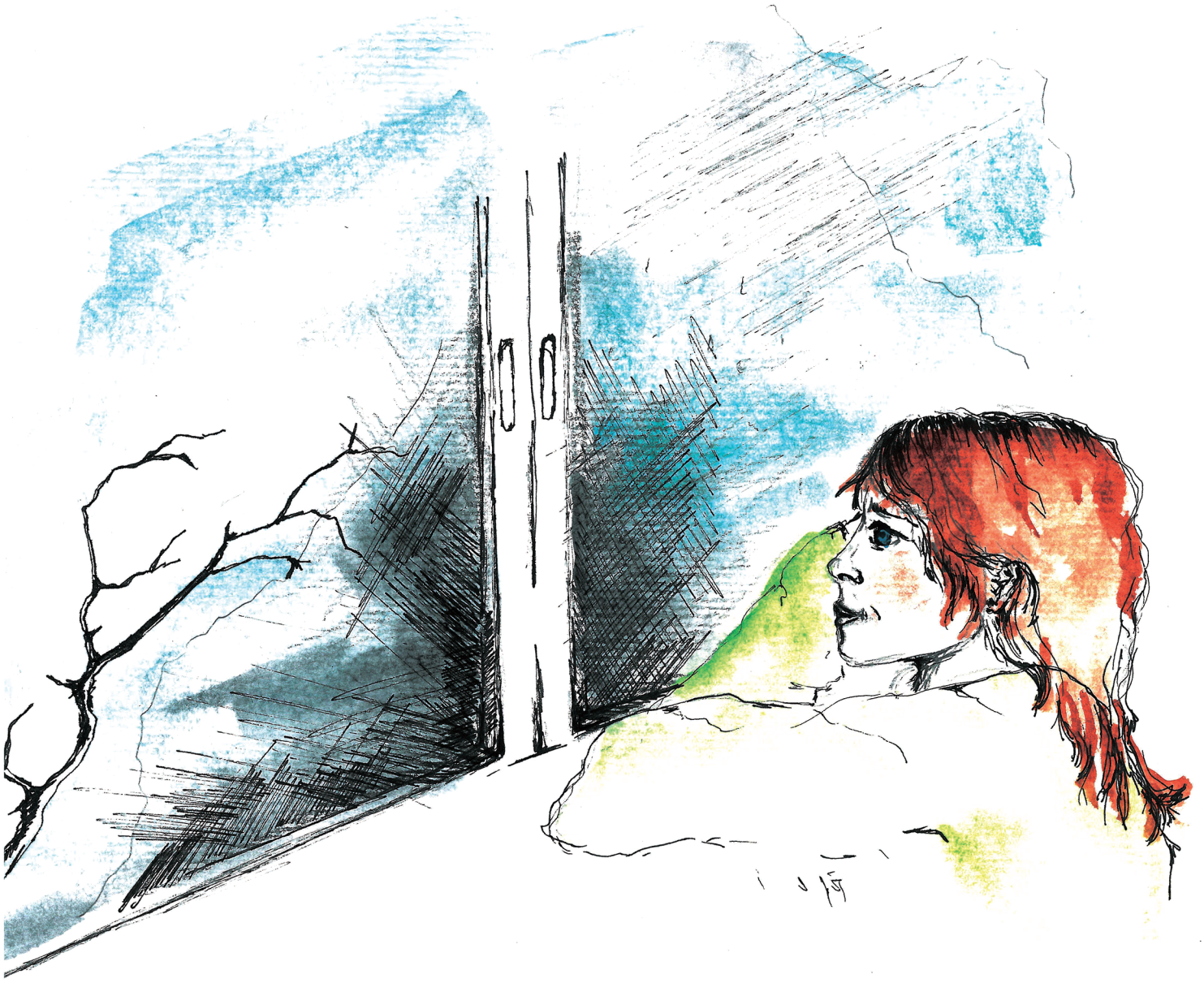
- Are there any institutions that can help me with social support?
- How do I include my family and friends?

GLOSSARY

Progression: In medicine, the course of a disease, such as cancer, as it becomes worse or spreads in the body.

Second opinion: In medicine, the opinion of a doctor other than the patient's current doctor. The second doctor reviews the patient's medical records and gives an opinion about the patient's health problem and how it should be treated. A second opinion may confirm or question the first doctor's diagnosis and treatment plan, give more information about the patient's disease or condition, and offer other treatment options.

Clinical trial: A type of research study that tests how well new medical approaches work in people. These studies test new methods of screening, prevention, diagnosis, or treatment of a disease. Also called a clinical study.



Recurrent gynaecological cancer types

1. High grade serous ovarian/tubal/peritoneal carcinomas

Most cancers that start on the fallopian tubes, ovaries, and peritoneum are high-grade serous carcinomas. At the time of the first diagnosis, these cancers are usually already advanced and have spread around the abdominal cavity on the peritoneum. The first-line treatment is composed of surgery and chemotherapy. Surgery may be very demanding for you because it may be necessary to remove parts of bowel, liver, peritoneum, or spleen, and sometimes stomas are formed. There are usually no signs of disease at the end of treatment, if the cancer is sensitive to chemotherapy, and if it is possible to remove all visible tumours in the abdomen. However, this type of cancer likes to come back, most often in the abdominal cavity, including the liver, or in the chest (on the pleura and lungs).

Follow-up period:

There are some drugs available for maintenance therapy that prolong the time for cancer to come back. These are bevacizumab and a group of drugs called PARP inhibitors. Your oncologist will give you more information as to whether these drugs are available in your country, and if they are safe and efficient for you.

During this period, you may feel some long-term complications or effects of treatment. These may be associated with surgery or with chemotherapy.

The most common long-term complications are:

- Lymphoedema (you may read about it in our special brochure), if the lymph nodes were removed,
- Lack of appetite, nausea, or fatigue (these usually improve over time),
- Hair loss, though it usually grows back,
- Paraesthesia of hands and legs, which may persist for several months.

During the follow-up period, you will be offered regular check-ups. Some centres perform clinical examination only, but others include laboratory tests like CA125; some also do regular imaging (like CT scans, MRI, PET CT, or ultrasounds).

What is specific for this type of cancer, is that it is possible to foresee the recurrence of the cancer with CA125 if the tumour marker was high before the start of first-line treatment. Levels of CA125 go up about 3 to 6 months before symptoms arise or we can see it with imaging. However, although we know that cancer will come back after a few months, it is not smart to immediately start treatment if a rise in CA125 is your only symptom. If you decide to start chemotherapy just because your CA125 has gone up, it will cause side effects, but do nothing to prolong overall survival. So, it is important to discuss with your doctor whether you want to have your CA125 checked regularly, or only when you have new symptoms. In the future, it might happen that new drugs will be developed that would be efficient also in case of CA125 going up.

You should be offered genetic testing for BRCA mutations. Genetic testing is important for you personally, because some drugs from the group of PARP inhibitors are registered only for patients with this mutation. Genetic testing is also important for your close relatives. BRCA mutations are associated with an increased probability of developing breast cancer, even in men, as well as ovarian cancer, and we have efficient strategies to prevent them both.

Symptoms of recurrence:

Symptoms that suggest recurrence of this cancer are associated with tumours growing on the peritoneum and bowel surface, abdominal bloating, worsening of nausea, vomiting, lack of appetite, losing weight, and pain. Or, if the tumours grow in the chest (in the lungs or pleura), there might be symptoms like shortness of breath, coughing, or coughing with blood. Individual symptoms do not mean the cancer is back, but if you have multiple symptoms at the same time, if symptoms persist for more than a few weeks, or if they are getting worse, then it is very possible that the cancer has come back.

Treatment of recurrence:

Generally, treatment is planned to prolong the progression of disease and to treat the symptoms. Chemotherapy is usually recommended. If bevacizumab or PARP inhibitors were not used after first-line treatment, they can be started after second-line chemotherapy. Symptom relief can be achieved with different drugs, and sometimes removal of ascites and pleural effusion is necessary. Some patients are candidates for surgical treatment, as well. That is why it is recommended that you are treated in a centre where both chemotherapy and surgery are available, and patients are presented at multidisciplinary tumour boards.

For this kind of ovarian/tubal/peritoneal cancer, it is especially important that you ask for information about clinical trials.

GLOSSARY

Peritoneum: The tissue that lines the abdominal wall and covers most of the organs in the abdomen.

Stoma: A surgically created opening from an area inside the body to the outside (for instance between large bowel and abdominal wall—colostomy).

Pleura: A thin layer of tissue that covers the lungs and lines the interior wall of the chest cavity. It protects and cushions the lungs. This tissue secretes a small amount of fluid that acts as a lubricant, allowing the lungs to move smoothly in the chest cavity while breathing.

Abdomen: The area of the body that contains the pancreas, stomach, intestines, liver, gallbladder, and other organs.

Paraesthesia: An abnormal touch sensation, such as burning or prickling, that occurs without an outside stimulus.

Nausea: A feeling of sickness or discomfort in the stomach that may come with an urge to vomit. Nausea is a side effect of some types of cancer therapy.

Fatigue: A condition marked by extreme tiredness and inability to function due to lack of energy. Fatigue may be acute or chronic.

Ascites: Abnormal build-up of fluid in the abdomen that may cause swelling. In late-stage cancer, tumour cells may be found in the fluid in the abdomen. Ascites also occurs in patients with liver disease.

Pleural effusion: An abnormal collection of fluid between the thin layers of tissue (pleura) lining the lung and the wall of the chest cavity.

Multidisciplinary tumour board or opinion: A treatment planning approach in which a number of doctors who are experts in different specialties (disciplines) review and discuss the medical condition and treatment options of a patient. In cancer treatment, a multidisciplinary opinion may include that of a medical oncologist (who provides cancer treatment with drugs), a surgical oncologist (who provides cancer treatment with surgery), and a radiation oncologist (who provides cancer treatment with radiation). Also called tumour board review.

2. Endometrial cancer

The majority of endometrial cancers are usually detected in the early stages. Most often, they are surgically treated with the removal of the uterus, ovaries, or lymph nodes (though only the sentinel lymph node might be removed). Sometimes radiation therapy to the pelvis and/or chemotherapy is recommended, but chemotherapy is rarely needed. At the end of the treatment, there are usually no signs of disease. The majority of patients with endometrial cancers have an excellent prognosis. Endometrial cancers do not often recur.

Follow-up period:

Most centres perform follow-up for patients with endometrial cancer with regular check-ups at the gynaecologist. The patient is asked about new symptoms and a clinical gynaecologic examination is done. Some centres recommend imaging.

During this period, you may feel some long-term complications of treatment. These may be associated with surgery, radiation therapy or chemotherapy. The most common long-term complications are:

- Lymphoedema (you may read about this in our special brochure), if the lymph nodes were removed, or
- Chronic inflammation of the bladder or large bowel, in the case of r radiation therapy.

Risk factors for the most common type of endometrial cancer are obesity, diabetes, and arterial hypertension. It is therefore important to lead a healthy lifestyle; losing weight and controlling diabetes and hypertension may be associated with a better prognosis and better quality of life.

Symptoms of recurrence:

Endometrial cancer may recur locally, meaning on top of the remaining vagina. Thus, bleeding from the vagina is often the first symptom.

In rare cases, it can spread to other organs, like the abdomen, liver, or chest (lungs and pleura). In that case, symptoms are similar to those described above.

Treatment of recurrence:

Local tumours in the pelvis, above the vagina, may be treated with radiation, surgery, or a combination of them.

If the cancer has spread to other organs, chemotherapy is usually recommended. A lot of patients with endometrial cancer have cancer that is hormone-dependent, which means that hormonal therapy may also be available.

Again, it is recommended that you are treated in a centre where all cancer therapies (surgery, radiation therapy, and chemotherapy) are available, and where patients are presented at multidisciplinary tumour boards.

3. Other ovarian malignancies

(other epithelial ovarian cancers, sex cord stromal tumours, germ cell tumours)

There are many types of malignant diseases that differ in terms of the cells/tissues that first become malignant. In the case of ovarian tumours, 90% originate in the ovarian epithelium, i.e., the outer layer of ovarian cells. As previously stated, the most common form of ovarian cancer is high-grade serous cancer, which is a type of epithelial ovarian tumour. Other epithelial tumours are not as common and are listed in Table 1. Besides epithelial ovarian tumours, other rare ovarian tumours can grow from germ cells, which are cells that produce eggs, or special stromal cells, which are cells laying in the centre of the ovary. Whereas epithelial ovarian tumours are the most common ovarian tumour among adult and postmenopausal women, germ cell ovarian tumours are the most common ovarian tumour among children.

All tumours listed in Table 1 have special biology and behaviour, so they require different approaches to treatment and follow-up. Because there is no uniform structure for follow-up visits, different centres may have different strategies. It is important to talk to your care provider and make a plan.

It is not possible to present details for each tumour type. It is, however, important to talk to your care provider about what is to be expected, how often tumours can recur, what symptoms usually appear, and what kind of treatment is available at that time. In general, ovarian tumours that are not high-grade serous cancers, with some exceptions, have a much better prognosis.

Table 1: Classification of rare ovarian tumours

Epithelial ovarian tumours	Mucinous adenocarcinoma Clear cell adenocarcinoma Low-grade serous carcinoma Other carcinomas
Sex cord-stromal ovarian tumours	Adult granulosa cell tumour Juvenile granulosa cell tumour Sertoli-Leydig cell tumour Steroid cell tumour
Mixed ovarian tumours	Adenosarcoma
Germ cell ovarian tumours	Dysgerminoma/Seminoma Mixed germ cell tumour Embryonal carcinoma Choriocarcinoma, Immature teratoma Gonadoblastoma

4. Vulvar, vaginal, cervical cancer

The majority of cervical, vaginal, and vulvar cancers are detected in the early stages if women attend screening programs regularly. Of these, cervical cancers are the most common, while vaginal cancers are extremely rare. The majority of vulvar cancers, almost all vaginal cancers, and cervical cancers, are HPV-related diseases. It is expected that with vaccination against high-risk HPV and attending screening programs, cervical cancers might be almost eliminated in the future. If cervical and vulvar cancers are diagnosed at an early stage or confined to the organ of origin, they are treated surgically. Sometimes, radiation and chemotherapy are also recommended. At the end of early-stage treatment, there are usually no signs of disease. Women with early stages of disease usually have good prognoses. If cervical cancer is diagnosed in young women who would like to have children, there are treatments that can also preserve fertility. Vaginal cancers are so rare that treatment should only take place at a large gynaecological oncology centre.

Follow-up period:

Most centres perform follow-up for patients with cervical, vaginal, and vulvar cancer with regular check--ups at the gynaecologist. The patient is asked about new symptoms and a clinical gynaecologic examination is done. Some centres recommend imaging.

During this period, you may feel some long-term complications of treatment. These may be associated with surgery, radiation therapy or chemotherapy. The most common long-term complications are:

- Lymphoedema (you may read about this in our special brochure), if the lymph nodes were removed,
- Chronic inflammation of the bladder or large bowel, in the case of radiation therapy,
- Problems with emptying the bladder after radical hysterectomy surgery.

Symptoms of recurrence:

Cervical cancer may recur locally, meaning on top of the remaining vagina. The first symptom is therefore bleeding from the vagina.

It can also spread to other organs, like the abdomen, liver, or chest (lungs and pleura). In these cases, symptoms are similar to those above.

Vulvar cancer usually recurs locally, meaning on the vulva or in the inguinal region, and can spread locally to the bladder, rectum, or pelvis. It rarely spreads to other organs. Again, symptoms are related to the site of recurrence.

Treatment of recurrence:

Local tumours in the pelvis, vulva, or above the vagina may be treated with radiation, surgery, or a combination of both, if feasible and not yet attempted.

If the cancer has spread to other organs, chemotherapy is usually recommended. Target therapy, like bevacizumab, may be used for recurrent cervical cancer. Immunotherapy is also available or under investigation to be used for cervical and vulvar cancer.

Again, it is recommended that you are treated in a centre where all cancer therapies (surgery, radiation therapy, and chemotherapy) are available, and where patients are presented at multidisciplinary tumour boards. Since these cancers are relatively rare, it is also very important that the centre has the ability to participate in new studies, so that new drugs and new methods of treatment may be available to you.

5. Other gynaecologic cancers

There are a high number of different malignant diseases that can occur in gynaecologic organs and tissues. Most of those not listed above are rare tumours when we look at the general population of women. They can originate in different types of cells, including epithelial (cancers), mesenchymal (sarcomas), as well as other special types of cells (such as tumours originating from the placenta, called gestational trophoblastic disease).

When diagnosed with these types of tumours, it is again crucial for treatment and follow-up to take place at a centre that is familiar with these types of tumours. It is also important to talk to the provider about the nature of the disease and ask the above listed questions. All malignant diseases have their own biological characteristics, and they all behave differently. The best method of treatment is also dependent on your general health, physical condition, and personal preferences. Again, a multidisciplinary approach and thorough talk with your provider is the most important thing.

Leiomyosarcoma uteri:

These tumours grow from the muscular layer of the womb. They are, fortunately, quite rare. They usually appear in women who are 50 to 60 years old. One of the complications of these tumours is that they resemble benign leiomyomas. Leiomyomas are the most common tumours in the womb and occur at a younger age. Usually, they do not cause any problems, but can be associated with heavy menstrual bleeding or cramps. Conversely, they can be so big that they compress other organs (like the bladder or bowel). It is almost impossible to say for sure whether a tumour in the womb is a benign leiomyoma or malignant leiomyosarcoma with only ultrasound, CT scan, RI, or other imaging. It is, however, more common for a leiomyosarcoma to cause troubles, grow quickly, and cause bleeding and pain, especially if these symptoms appear after menopause.

It is therefore important that women obtain information about the probability of a malignant tumour diagnosis before treatment of solid tumours in the womb. It is also important for women to discuss the best way to remove a malignant tumour with their surgeon, as most leiomyomas are removed with a laparoscopic approach and cut into small pieces inside the abdomen.

Gestational trophoblastic diseases

These tumours occur in the placenta and are therefore associated with pregnancy. This category includes several types of tumours with different biological characteristics and behaviour. Usually, but not always, they are associated with very high levels of the pregnancy hormone betaHCG, which can be used as a tumour marker afterwards. Additionally, they are often very sensitive to chemotherapy, which is the most important method of treatment, although surgery and radiation are also combined in certain circumstances.

The most common of these is called molar pregnancy. It usually has an excellent prognosis, is a relatively benign disease, and is treated with the surgical removal of tissue with curettage. Other malignant forms are choriocarcinoma, placental site trophoblastic tumours, and epithelioid trophoblastic tumours. All forms of gestational trophoblastic disease need prolonged follow-up, as they can recur long after primary treatment. During follow-up, the pregnancy hormone betaHCG is usually checked to see if the disease has occurred. It may recur locally in the womb if it was not surgically removed or with distant metastasis to other organs. These are most common to the liver, lungs, and brain. Symptoms are usually associated with the organ that is involved.

The primary tumour and metastasis may be very fragile and can bleed very quickly and heavily. During the follow-up period, it is very important that you have very reliable contraception if the womb was not removed, so that we can determine whether a rise in pregnancy hormone is associated with tumour recurrence. Oral combined contraceptives may be safely used. The safest time to get pregnant should be discussed with your care provider at your gynaecologic oncology centre.

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ENGAGe recommends contacting your local patient association!

Notes

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