Sentara® Health Plans

SENTARA HEALTH PLANS CLINICAL PRACTICE GUIDELINE:

OB/GYN SUBSPECIALTY REFERRAL

Guideline History

Date Approved	09/00
Date Revised	06/01, 06/03, 07/05, 12/07, 01/08, 11/08,11/10,11/12,11/24,11/16, 11/18,11/20
Date Reviewed	01/23
Next Review Date	01/25

OB/GYN
Subspecialty Referral Criteria

DEFINITIONS OF GYNECOLOGIC ONCOLOGY SERVICES

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

1. Vulvar CA -Invasive

2. Vaginal CA -Invasive

3. Cervical CA -Microinvasive and Invasive

4. Endometrial CA -All Grades

5. Ovarian CA
   a) Documented malignancy
   b) High pre-op clinical suspicion by:

   - Evidence of abdominal or distant metastasis or ascites.
   - A clinically suspicious pelvic mass [>10 cm, complex, fixed, nodular, bilateral] is diagnosed.
   - Premenarchal girls requiring surgical treatment for pelvic mass & young patients who have a pelvic mass and elevated tumor markers (CA-125, OVA1, AFP, hCG).
   - Postmenopausal women who have suspicious ovarian masses or elevated tumor markers, not to include simple cyst < 5 cm.
   - Perimenopausal women who have ovarian masses, particularly when associated with elevated CA-125. Elevation between 35 and 65 U/ml are associated with cancer risk of 50 to 60%. A CA-125 > 65 U/ml in a 50 year old or older women is virtually diagnostic of malignancy with a specificity of 98%.
   - Suspicious findings are present on imaging studies. The risk of malignancy in a postmenopausal woman with a unilocular mass without solid components is <1%, increasing to 8% in a multilocular mass and 70% in a mass with solid components.
   - Complex masses with solid components or excrescences or otherwise suspicious for cancer are present.
   - Suspicious pelvic masses are found in women with a significant family or personal history of ovarian, breast, or other cancers (one or more first-degree relative).

6. Intraoperatively encountered CA and borderline tumors.

7. PCP may directly refer to GYN Oncology if member is receiving ongoing treatment or has an established diagnosis.

OB/GYN
Subspecialty Referral Criteria

DEFINITIONS OF REPRODUCTIVE ENDOCRINOLOGY SERVICES

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

1. Hyperprolactinemia with macroadenoma or failed medical therapy (serum prolactin, MRI + medical therapy by generalist)
2. Ovulation induction when clomiphene or letrozole resistance exists (clomiphene dose >150 mg qd). Clomiphene or letrozole should not be used indefinitely. Once ovulation is achieved the clomiphene or letrozole should only be used for 3 months.
3. Severe hyperandrogenism
4. Ambiguous genitalia
5. Precocious puberty
6. Infertility with more than 1 year of unsuccessful therapy in women <35 years old and infertility greater than six months for women >35.
7. Bilateral hydrosalpinx
8. Primary amenorrhea (excluding PCO and pregnancy)
9. Ovulation induction with insulin sensitizers.

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

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

C. Procedures limited to Reproductive Endocrinologists

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

Indications and timing of the infertility evaluation

Infertility evaluation is indicated for couples who seek help because they have not been able to conceive.
1. Initiate evaluation after 12 months of unprotected and frequent intercourse:
Women under age 35 years without risk factors for infertility
2. Initiate evaluation after six months of unprotected and frequent intercourse:
Women age 35 to 40 years
3. Initiate evaluation upon presentation despite less than six months of unprotected and frequent intercourse:
Women over age 40 years
Women with oligomenorrhea/amenorrhea
Women with a history of chemotherapy, radiation therapy, or advanced stage endometriosis
Women with known or suspected uterine/tubal disease
Women whose male partner has a history of groin or testicular surgery, adult mumps, impotence or other sexual dysfunction, chemotherapy and/or radiation, or a history of subfertility with another partner

Graphic 70415 Version 5.0

- Women older than 35 years should receive an expedited evaluation and undergo treatment after 6 months of failed attempts to become pregnant or earlier, if clinically indicated. In women older than 40 years, more immediate evaluation and treatment are warranted. If a woman has a condition known to cause infertility, the obstetrician–gynecologist should offer immediate evaluation.

- A comprehensive medical history, including items relevant to the potential etiologies of infertility, should be obtained from the patient and partner, should one exist.

- A targeted physical examination of the female partner should be performed with a focus on vital signs and include a thyroid, breast, and pelvic examination.

- For the female partner, tests will focus on ovarian reserve, ovulatory function, and structural abnormalities.

- Imaging of the reproductive organs provides valuable information on conditions that affect fertility. Imaging modalities can detect tubal patency and pelvic pathology and assess ovarian reserve.

- A women's health specialist may reasonably obtain the male partner's medical history and order the semen analysis. Alternatively, it is also reasonable to refer all male infertility patients to a health care specialist with expertise in male reproductive medicine.

Background

REFERENCES
Obstetrics and Gynecology

Pelvic Mass

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Dr. Holly Puritz (January 2023)

Referral & Management

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