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, 01/23
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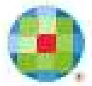
Next Review Date	11/26

These Guidelines are promulgated by Sentara Health as recommendations for the clinical Management of specific conditions. Clinical data in a particular case may necessitate or permit deviation from these Guidelines. The Sentara Health Guidelines are institutionally endorsed recommendations and are not intended as a substitute for clinical judgment.

GYN SUBSPECIALTY REFERRALS

GYNECOLOGY ONCOLOGY



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Referral of women with a pelvic mass to a gynecologic oncologist: ACOG guidelines

Premenopausal women (refer if any are present)
Very elevated CA 125 level*
Ascites
Evidence of abdominal or distant metastases
Postmenopausal women (refer if any are present)
Elevated CA 125 level*
Ascites
Nodular or fixed pelvic mass
Evidence of abdominal or distant metastases

ACOG: American College of Obstetricians and Gynecologists; CA 125: cancer antigen 125.

* These guidelines do not provide a specific value for an elevated (or very elevated) CA 125 level. While the 2002 version used a value of >200 units/mL, this was removed in 2011. Studies evaluating the performance of the 2002 guidelines showed that 70 to 79% of premenopausal and 93 to 94% of postmenopausal patients with ovarian cancer will be captured by this threshold (specificity 70 and 60%, respectively).

References:

1. *American College of Obstetricians and Gynecologists. Cancer Diagnosis and Management. In: Guidelines for Women's Health Care, 4th ed, 2014.*
2. *Committee Opinion No. 477: the role of the obstetrician-gynecologist in the early detection of epithelial ovarian cancer. Obstet Gynecol 2011; 117:742.*
3. *Im SS, Gordon AN, Buttin BM, et al. Validation of referral guidelines for women with pelvic masses. Obstet Gynecol 2005; 105:35.*
4. *Dearking AC, Aletti GD, McGree ME, et al. How relevant are ACOG and SGO guidelines for referral of adnexal mass? Obstet Gynecol 2007; 110:841.*

Graphic 55063 Version 9.0

REPRODUCTIVE ENDOCRINOLOGY:

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

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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

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- 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.

REFERENCES
Obstetrics and Gynecology

Pelvic Mass

American College of Obstetricians and Gynecologists Practice Bulletin 140 (2013), Management of Abnormal Cervical Cancer Screening Test Results and Cervical Cancer Precursors (Obstetrics and Gynecology 2013; 122:1338–67). (Reaffirmed 2016)

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Referral & Management

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