A Guide to Gynaecological Oncology: What GPs need to know

Dr Nim Cabraal

Gynaecological Oncologist
Gynaecological Surgeon

Introducing Dr Nim Cabraal

Sub-Specialist in Gynaecological Oncology and Complex Gynaecological Surgery

Dr Nim Cabraal

Gynaecological Oncologist & Gynaecological Surgeon

BHB, MBChB, MSc, FRANZCOG, CGO

Mater Private Hospital, South Brisbane, St Andrew's Ipswich Private Hospital

Dr Nim Cabraal is an experienced Gynaecological Oncologist and Gynaecological Surgeon with expertise in the management of gynaecological cancers and complex benign conditions.

Dr Cabraal is a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (FRANZCOG) and holds sub-speciality Certification in Gynaecological Oncology, following training in gynaecological cancers and complex pelvic surgery.

Dr Cabraal's research interests include fertility-preserving treatments in young women with endometrial cancer, and the use of molecular testing to personalise endometrial cancer care. She holds a Master's degree in International Health Policy and Health Economics from the London School of Economics and is actively involved in quality improvement initiatives, including developing statewide guidelines for surveillance of gynaecological malignancies.

Dr Cabraal blends expert surgical care with a genuine commitment to supporting her patients. She is passionate about helping women feel informed, empowered, and cared for – always with kindness, clarity, and compassion.

She is sincerely appreciative of the trust placed in her through your referrals.

Specialist in:

Confirmed malignancy

- Vulvar cancer
- Ovarian cancer
- Cervical cancer
- Endometrial (uterine) cancer
- Vaginal cancer

Suspected malignancy

- Ovarian mass on CT/ultrasound or raised tumour markers
- Complex or persistent pelvic mass
- Suspicious vulval or vaginal lesion
- Abnormal endometrium or uterus on imaging
- Unexplained postmenopausal bleeding

Risk-reduction surgery

- BRCA1/2 mutations
- Lynch syndrome
- Other high-risk cancer mutations (e.g. PALB2, RAD51C/D)

Benign conditions

- Complex endometriosis
- Large or symptomatic fibroids
- Ovarian cysts or adnexal masses requiring assessment or surgery
- Abnormal uterine bleeding or heavy periods

Colposcopy indications

- High-risk HPV positive or persistent HPV other
- pHSIL, HSIL or suspected cancer on cervical screening

Comparing Gynaecologists with Gynaecological Oncologists

What's the difference between a gynaecologist and a gynaecological oncologist?

Gynaecologists manage a broad range of women's health needs – from contraception, menstrual disorders and pelvic pain to cervical screening, endometriosis and sexual health.

Gynaecological oncologists are subspecialists in cancers of the female reproductive system – including ovarian, cervical, uterine (endometrial), vulvar and vaginal cancers. This field requires additional years of intensive surgical training beyond general gynaecology, and a deep understanding of cancer biology, genetics and complex pelvic surgery.

Gynaecological oncologists are often called in by general gynaecologists to assist with difficult procedures and for second opinions.

With fewer than 60 practicing gynaecological oncologists across Australia and New Zealand, it's a highly specialised field – but one that plays an essential role in ensuring women with suspected or confirmed gynaecological cancer receive timely, expert care.

Does Dr Cabraal only treat women with cancer?

No – while cancer care is a key part of what Dr Cabraal does, she also treats a wide range of complex benign gynaecological conditions. These include advanced endometriosis, fibroids, adnexal masses, abnormal uterine bleeding, and colposcopy for cervical abnormalities.

Her aim is always to provide the same level of specialist, patient-centred care to all women – whether their condition is malignant or not.

Postmenopausal Bleeding & Endometrial Cancer

Early recognition and timely referral make all the difference.

Key Information

- Postmenopausal bleeding (PMB) is defined as any vaginal bleeding ≥12 months after the last menstrual period. PMB should never be considered ‘normal’.
- 1 in 5 women with PMB will have endometrial cancer or precancerous changes.
- The most common cause is benign (e.g. atrophy), but cancer must always be excluded.
- Endometrial cancer is the most common gynaecological cancer in Australia and is often curable with early treatment.
- Obesity is a significant risk factor for development of endometrial cancer. Women with a BMI >40 have a 10-15% lifetime risk of developing endometrial cancer.
- Timely referral is essential for improved outcomes.

Common causes of PMB

Cause	Note
Endometrial atrophy	Most common; fragile lining bleeds easily
Endometrial hyperplasia	Overgrowth of the endometrium; precancerous in nature
Endometrial cancer	Must be ruled out in all cases of PMB
HRT (esp. unopposed oestrogen)	Always investigate bleeding, even on HRT
Polyps or cervical pathology	Consider visual/cytology assessment

What you need to know when referring

Initial assessment in general practice

- Take a focused history: bleeding pattern, HRT use, systemic symptoms (weight loss, fatigue), cancer history.
- Perform a pelvic exam (if tolerated): inspect cervix/vulva, check for lesions or discharge.

Arrange a transvaginal ultrasound

- <4 mm endometrial thickness: manage conservatively if only a single bleeding episode.
- ≥4 mm or abnormal findings: refer for biopsy or specialist assessment

Consider cervical screening if overdue

Do not rely on CA125 – not useful for endometrial cancer

When to refer for specialist assessment

- Endometrial thickness ≥4 mm or abnormal findings on ultrasound
- Biopsy showing hyperplasia with atypia or carcinoma
- Recurrent or unexplained PMB
- Co-existing risk factors (obesity, PCOS, Lynch syndrome, tamoxifen)

What you need to know to support your patient’s ongoing care (if cancer is confirmed)

Treatment Overview

- Surgery is first-line: hysterectomy + BSO ± sentinel lymph node dissection
- Most procedures are minimally invasive
- Adjuvant radiotherapy or chemotherapy guided by staging and risk factors
- Fertility-sparing options may be possible for some young women

After treatment, your role is vital.

Early stage patients are often discharged to GP care 6 months post-treatment.

For these patients, offer:

- Annual symptom review
- Pelvic exam if indicated
- Support for menopausal symptoms and psychosocial wellbeing

Be alert to symptoms of recurrence, including:

- Vaginal bleeding or discharge
- Pelvic or abdominal pain
- Bloating, weight loss, fatigue

Support includes:

- Ongoing care for comorbidities (e.g. obesity, diabetes, hypertension)
- Fertility discussions in younger patients
- Psychosocial support and reassurance
- Management of treatment side effects (e.g. vaginal dryness, lymphoedema)

FIGO 2018 Staging for Endometrial Cancer

Stage I	Tumour confined to the uterus
IA	Tumour limited to endometrium or <50% myometrial invasion
IB	≥50% myometrial invasion
Stage II	Tumour invades cervical stroma but not beyond uterus
Stage III	Local and/or regional spread of tumour
IIIA	Tumour invades serosa and/or adnexa
IIIB	Vaginal and/or parametrial involvement
IIIC1	Pelvic lymph node metastasis
IIIC12	Para-aortic lymph node metastasis ± pelvic nodes
Stage IV	Tumour invades bladder, bowel, or distant metastases

Adnexal Masses & Ovarian Cancer

Accurate triage and timely referral lead to better outcomes.

Key Information

- Adnexal (pelvic) masses are common and mostly benign, especially in premenopausal women.
- GPs play a vital role in the early and accurate triage of adnexal masses.
- Risk of malignancy increases with age – particularly post-menopause.
- Appropriate imaging, judicious use of tumour markers, and awareness of age-related malignancy risks ensures patients receive the right care at the right time.
- Early referral to gynaecological oncology improves survival in ovarian cancer.
- CA125 has limited specificity – always interpret in context.

Types of Adnexal Masses

Benign ovarian	Functional cysts/Luteal cysts Endometrioma Serous cystadenoma Serous cystadenoma Mucinous cystadenoma Mature teratoma (Dermoid)
Benign gynaecological, non-ovarian	Para tubal cyst Ectopic pregnancy Tubo-ovarian abscess Hydrosalpinx/Haematosalpinx Leiomyoma
Non-gynaecological	Diverticular disease Peritoneal inclusion cysts Colorectal cancers
Malignant primary ovarian	Germ Cell cancer Epithelial cancers Sex-cord stromal cancers
Malignant non primary ovarian	Krukenburg tumours – Commonly breast and GI tumours Metastatic gynaecological – commonly endometrial Retroperitoneal sarcomas

What you need to know when referring

Initial assessment in general practice

Take a targeted history:

- Pelvic or abdominal pain
- Bloating or increased girth
- Urinary frequency or early satiety
- Menstrual irregularities
- Family history of breast, ovarian or bowel cancer

Examine:

- Abdominal exam for masses or ascites
- Pelvic exam (if appropriate) to detect adnexal fullness, tenderness or nodularity

First-line investigations

Transvaginal ultrasound is preferred:

- Simple cysts <5 cm in premenopausal women are likely physiological
- Complex features (solid areas, septations, papillary projections, bilateral masses, ascites) warrant referral

CA125:

- Useful in postmenopausal women with complex masses
- May be raised in benign conditions (e.g. endometriosis, fibroids)
- Can be normal in early-stage ovarian cancers

Additional markers:

- AFP, hCG, LDH for women <40
- CEA, CA19-9 if GI source is suspected
- HE4/ROMA - use if Ca 125 is elevated but endometriosis is the suspected cause of an adnexal mass (should be normal)

Treatment in General Practice

- Simple ovarian cyst <5 cm (premenopausal): likely physiological. Repeat ultrasound in 6–12 weeks.

When to refer to for specialist assessment

Refer to general gynaecology for:

- Persistent cysts >5–7 cm
- Benign-appearing ‘named’ cysts on imaging (e.g. dermoid, endometrioma)
- Borderline/unclear findings in asymptomatic premenopausal patients

Urgent referral to gynaecological oncology for:

- Suspicious or symptomatic masses
- Elevated CA125 in postmenopausal women
- Ascites or signs of metastatic disease
- Complex benign pathology (e.g. severe endometriosis, large masses)

What you need to know to support your patient’s ongoing care

Ovarian Cancer Management

Early referral to a gynaecological oncologist improves outcomes.

Management is tailored to:

- Cancer type and stage
- Fertility wishes
- Overall health

Surgery:

- Mainstay of treatment – aim is full removal of visible disease (cytoreduction).
- Procedures may include hysterectomy, BSO, omentectomy, and tumour debulking.
- Timing of surgery depends on disease burden and may occur before, or after chemotherapy.

Chemotherapy:

- Used after surgery or as neoadjuvant treatment to shrink tumour burden before surgery.
- Common in advanced-stage disease.

After surgery or cancer treatment

- Ongoing specialist follow-up is required for most patients with ovarian cancer (often up to 5 years)
- GPs are critical in monitoring general health and wellbeing

Monitor for recurrence symptoms:

- Pelvic or abdominal pain or pressure
- Abdominal bloating or distension
- Unexplained weight loss or fatigue
- Changes in bowel or urinary habits
- Shortness of breath (if pleural involvement)

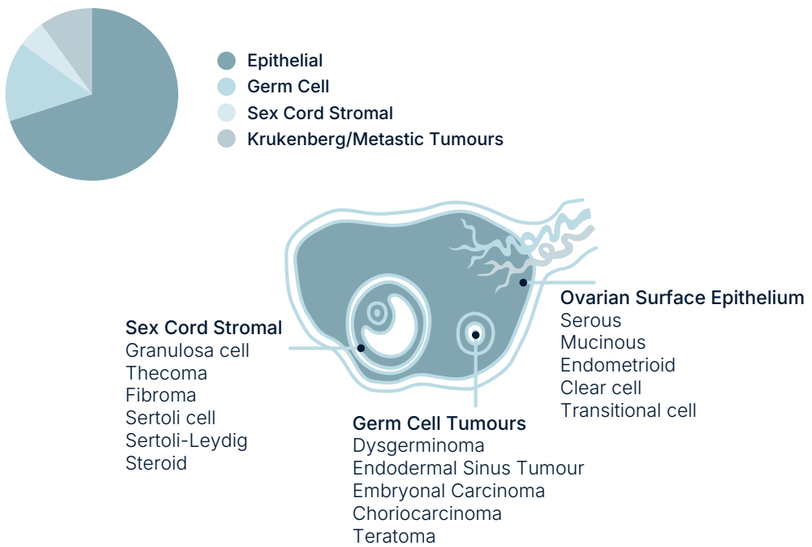
Provide support for:

- Psychosocial needs and cancer survivorship concerns
- Managing treatment-related symptoms (fatigue, lymphoedema, early menopause)
- Coordination of care with oncology team
- Monitoring of comorbidities (hypertension, diabetes, mental health)

Important to note:

- Recurrent ovarian cancer can be subtle – early symptoms are often vague
- Your role in listening and acting on concern is vital.

Types of ovarian cancer

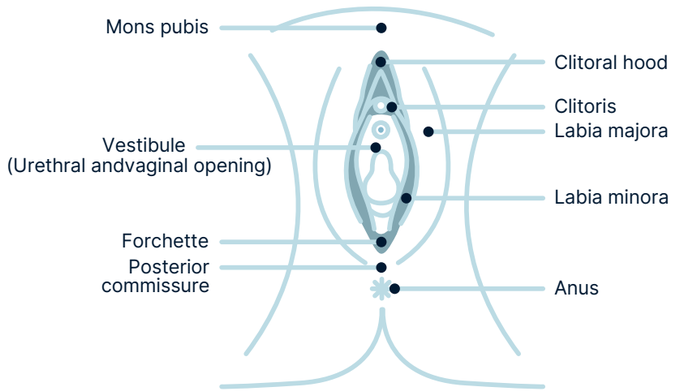


Vulvar Dysplasia & Vulvar Cancer

Persistent symptoms deserve a closer look.

Key Information

- Vulvar dysplasia (VIN) and vulvar cancer are uncommon but important causes of morbidity in women, particularly postmenopausal.
- Persistent itching, lesions, or vulvar changes should never be dismissed.
- Always inspect the vulva in women with persistent genital symptoms.
- Vulvar cancers are often diagnosed late due to delayed recognition or under-examination. Biopsy/refer any lesion that is new, persistent, or abnormal.



Common histological types

- Usual-type VIN (HSIL/uVIN): HPV-related, younger patients
- Differentiated VIN (dVIN): Non-HPV related, older women, often linked to lichen sclerosis
- The risk of malignant transformation into squamous cell carcinoma is much higher in lichen sclerosis related dVIN around 80% vs 20% for HPV related uVIN
- Early biopsy and specialist referral can significantly improve outcomes.
- GPs are vital in ongoing care, surveillance, and patient education.

What you need to know when referring

Initial assessment in general practice

Take a focused history:

- Duration of symptoms: itching, pain, bleeding, skin cracking
- Previous treatments or topical steroids
- Sexual or dermatological history

Perform a careful vulvar inspection

- Look for white plaques, erosions, hyperkeratosis, colour changes, ulceration or thickening

When to biopsy or refer:

Any vulvar lesion that is:

- Persistent or recurring
- Unresponsive to topical corticosteroids
- Shows architectural distortion (e.g. labial fusion, clitoral burying, ulceration)
- Associated with lichen sclerosis
- Suspicious for malignancy

When to refer to gynaecological oncology:

- Biopsy-confirmed vulvar dysplasia (HSIL/uVIN or dVIN)
- Suspicious lesions (e.g. ulcerated, bleeding, nodular)
- Known or suspected vulvar cancer

What you need to know to support your patient's ongoing care

Management of Vulvar Dysplasia

Usual-Type VIN (uVIN)

- Wide local excision is the standard, aiming for 2–3 mm clear margins
- Laser ablation
- Topical imiquimod 5% cream for 16 weeks

Differentiated VIN (dVIN)

- Always managed surgically due to high risk of malignant transformation
- Requires wide local excision or skinning vulvectomy

Management of Vulvar Cancer

Gynaecological oncologists lead the care of vulvar cancer, coordinating surgery, staging, and ongoing multidisciplinary support. Early referral is key to achieving optimal outcomes.

Surgical management:

- Radical wide local excision is standard, aiming for clear margins while preserving vulvar function and appearance.
- Reconstructive flaps may be used for larger or central lesions to support healing and maintain anatomy.

Groin lymph node assessment:

- Required when tumour invasion is >1.1 mm — nodal status impacts prognosis and treatment planning.
- Sentinel lymph node biopsy is used in eligible early-stage cases (<4 cm, unifocal, no nodal involvement) to reduce the risk of lymphoedema.
- Inguinal-femoral lymphadenectomy is indicated for larger or multifocal tumours, sentinel node positivity, or mapping failure — carries a higher risk of lower limb lymphoedema.

Adjuvant therapy:

- Radiation and/or chemotherapy may be required based on stage, nodal involvement, or incomplete resection.

After treatment for dysplasia or cancer

Monitor for recurrence:

- VIN has a high recurrence rate – regular follow-up is essential
- Cancer recurrence often presents as new or changing vulvar lesions

Manage underlying conditions:

- Long-term topical corticosteroids are needed for lichen sclerosus (e.g. clobetasol proprionate 0.05%)
- Educate patients about self-monitoring and symptom awareness (itch, recurrent lumps, bleeding, pain)

Support includes:

- Psychosexual health (dyspareunia, body image, intimacy concerns)
- Wound care after surgery, especially if reconstruction is involved
- Referral to lymphoedema services if lymph node dissection performed
- Ongoing emotional support – vulvar conditions can significantly impact quality of life/sexual function

Follow-up schedule varies depending on pathology and treatment:

- VIN: specialist review for 6–12 monthly for 3 years if no recurrence
- Vulvar cancer: regular specialist-led surveillance for at least 5 years

FIGO Vulvar Cancer Staging (2021)

Stage I – Tumour confined to vulva/perineumIA: ≤2 cm, ≤1 mm stromal invasion, node-negative

- IB: >2 cm or >1 mm invasion, node-negative

Stage II – Any size tumour with adjacent spread (lower urethra, vagina, anus), node-negative

Stage III – Any tumour size, inguino-femoral lymph node positive

- IIIA: 1 node ≥5 mm or 1–2 nodes <5 mm
- IIIB: ≥2 nodes ≥5 mm or ≥3 nodes <5 mm
- IIIC: Node(s) with extracapsular spread

Stage IV – Advanced local or distant disease

- IVA: Tumour invades upper urethra/vagina, bladder, rectum, or fixation to bone
- IVB: Distant metastases, including pelvic nodes

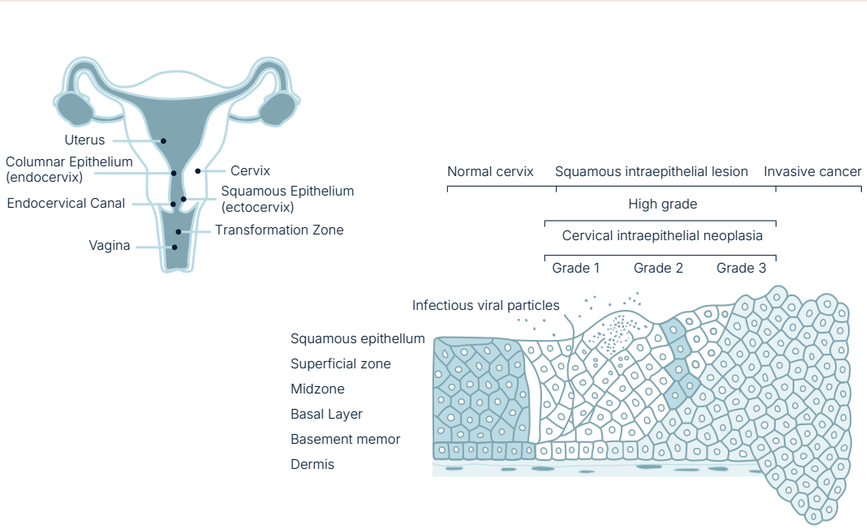
Cervical Dysplasia & Cervical Cancer

Screening saves lives – GPs play a crucial role.

Key Information

- Cervical cancer is largely preventable with HPV vaccination and regular cervical screening.
- Most cases develop from persistent high-risk HPV infection in the transformation zone of the cervix.
- Most cervical cancers are squamous cell carcinomas; adenocarcinomas are less common and can be harder to detect.
- GPs are central to early detection, referral, and long-term care following treatment. Always assess the cervix in women with abnormal genital tract bleeding.
- Self-collected HPV testing is now available and can improve screening uptake.
- Abnormal screening results should be managed with colposcopy referral.

Cervical dysplasia to cancer



What you need to know when referring

Initial assessment in general practice

Symptoms to ask about:

- Postcoital or intermenstrual bleeding
- Persistent abnormal vaginal discharge
- Pelvic pain or dyspareunia

Perform a speculum examination:

- Look for visible cervical lesions, bleeding on contact, or friable tissue
- Ensure cervical screening is up to date

Cervical screening and follow-up:

- HPV 16/18 positive → refer for colposcopy regardless of cytology result
- Other high-risk HPV types with abnormal cytology → colposcopy within 6 weeks
- Suspicious lesions (e.g. visible tumour, persistent bleeding) → urgent gynaecology/gynae-oncology referral
- Always refer patients with biopsy-confirmed high-grade abnormalities (HSIL/CIN2/3, AIS, carcinoma)

What you need to know to support your patient's ongoing care

Treatment overview (if cancer is confirmed)

- Early-stage cancer (FIGO IA–IB2): often managed with simple or radical hysterectomy ± lymph node assessment
- Locally advanced disease (IB3–IVA): typically treated with chemoradiation
- Fertility-sparing procedures (e.g. cone biopsy or radical trachelectomy) may be appropriate for selected early-stage cases

After treatment for dysplasia

- Patients need 'test of cure' cervical screening co-tests at 12 and 24 months post treatment as per the National Screening Guidelines

After treatment for cancer

Patients need ongoing surveillance to monitor for recurrence of symptoms:

- Regular pelvic exams
- Monitoring for recurrence (bleeding, discharge, pelvic pain, weight loss)
- Screening of the vaginal vault (only if hysterectomy alone was performed, not recommended in patients treated with radiation)

Psychosocial care is essential:

- Address anxiety, fertility concerns, sexual function and body image
- Support patients through early menopause if radiation/surgically induced

FIGO 2018 Cervical Cancer Staging

Stage I – Confined to cervix

- IA: Microscopic
- IA1: ≤3 mm depth
- IA2: >3–5 mm depth
- IB: Visible or >5 mm depth
- IB1: ≤2 cm
- IB2: >2–4 cm
- IB3: >4 cm

Stage II – Beyond uterus, not to pelvic wall

- IIA: Upper 2/3 vagina, no parametrial invasion
- IIA1: ≤4 cm
- IIA2: >4 cm
- IIB: Parametrial invasion

Stage III – Lower vagina/pelvic wall or lymph nodes

- IIIA: Lower 1/3 vagina
- IIIB: Pelvic wall and/or hydronephrosis
- IIIC1: Pelvic nodes
- IIIC2: Para-aortic nodes

Stage IV – Beyond pelvis or adjacent organs

- IVA: Bladder/rectum involvement
- IVB: Distant metastases

Notes

Contact

How to refer

Referrals are accepted via:

- Medical Objects

  Dr Nimithri (Nim) Cabraal
  289857QT (South Brisbane)
  289857PF (Ipswich)

- F: 07 3112 1801
- P: 07 3844 9932
- E: welcome@gyon.com.au

Urgent referrals

For urgent or complex cases,
please feel free to contact
Dr Cabraal directly: **0449 761 773**

Referral categories

Urgent (Seen in 1–2 weeks):

- Suspected or confirmed gynaecological malignancy
- Abnormal imaging or tumour markers
- Unexplained postmenopausal bleeding

Routine (Seen in 3–6 weeks):

- Complex benign conditions (e.g. fibroids, endometriosis, adnexal masses)
- Colposcopy or dysplasia
- Risk-reducing surgery

Locations

Consults at:

Mater Private Clinic
Suite 5.07, Level 5
550 Stanley St,
South Brisbane QLD 4101

Lower Cameron House
St Andrew's Ipswich Private Hospital
12 Roderick St,
Ipswich QLD 4305

Performs procedures at:

Mater Private Hospital Brisbane
301 Vulture Street,
South Brisbane QLD 4101

St Andrew's Ipswich Private Hospital
12 Roderick St,
Ipswich QLD 4305

P: 07 3844 9932
F: 07 3112 1801
E: welcome@gyon.com.au

www.gyon.com.au

GYON
Gynaecology & Oncology Group