ESGO Guidelines and Quality Indicators

QUALITY INDICATORS

CERVICAL
OVARIAN
VULVAR
CANCERS

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The European Voice of Gynaecological Oncology

European Society of Gynaecological Oncology

QUALITY INDICATORS

CERVICAL, OVARIAN, VULVAR CANCERS

- SURGICAL MANAGEMENT OF GYNAECOLOGICAL CANCERS -

The European Society of Gynaecological Oncology has developed a list of quality indicators (QIs) for the surgical treatment of cervical cancer, ovarian cancer (advanced stages), and vulvar cancer that can be used to audit and improve the clinical practice in an easy and practical way. These QIs give practitioners and health administrators a quantitative basis for improving care and organisational processes. They also facilitate the documentation of quality of care, the comparison of performance structures, and the establishment of organisational priorities as a basis for accreditation in European countries. The QIs and proposed targets are based on the standards of practice determined from available scientific evidence and/or expert consensus.

The philosophy behind the project is to improve the standard of surgical care by providing a set of quality criteria which can be used for self-assessment, for institutional quality assurance programs, for governmental quality assessment, and eventually to build a network of certified centres for gynaecological cancer surgery. The mindset is incentive, not punitive.

Each QI is categorised as a structural indicator, process indicator, or outcome indicator[1] and has a description which specifies what the indicator is measuring. The measurability specifications are then detailed. The latter highlight how the indicator will actually be measured in practice to allow audits. In this regard, the timeframe for assessment of criteria is the last calendar year (unless otherwise indicated).

Further to measurement of the indicator, a target is indicated. This specifies the level which each unit/centre should be aiming to achieve. When appropriate, two or three targets were defined: an optimal target, expressing the best possible option for patients, a minimal target, expressing the minimal requirement when practical feasibility factors are taken into account, and an intermediate target if necessary. Targets were based on evidence whenever available, or database analysis of the international development group members, and on expert consensus. They can absolutely not be used to penalise or litigate doctors or institutions. They may have to be modified in the future.

ESGO would like to thank the international development groups for their constant availability, work, and for making possible the development of these QIs for surgical treatment of cervical cancer, ovarian cancer (advanced stages), and vulvar cancer. The list of the international development groups is available in the Appendix.

[1] Mainz, J. Defining and classifying clinical indicators for quality improvement. Int J Qual Health Care 15, 523-530 (2003)

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CERVICAL CANCER – CENTRE CASE LOAD, TRAINING, AND EXPERIENCE OF THE SURGEON

QI 1 Number of radical procedures (parametrectomies) in cervical cancer performed per centre per year

TYPE	Structural indicator
DESCRIPTION	A radical procedure is defined as one that includes parametrectomy (e.g., radical hysterectomy, radical trachelectomy, parametrectomy).
SPECIFICATIONS	*Numerator:* Number of radical procedures as defined above performed per centre per year. *Denominator:* not applicable.
TARGETS	*Optimal target:* ≥30 *Minimum required target:* ≥15

QI 2 Surgery performed or supervised by a certified gynaecologic oncologist or a trained surgeon dedicated to gynaecological cancer

TYPE	Process Indicator
DESCRIPTION	Surgery is performed or supervised by a certified gynaecologic oncologist or by a trained surgeon dedicated to gynaecological cancer (accounting for over 80% of his or her practice) or having completed an ESGO-accredited fellowship.
SPECIFICATIONS	*Numerator:* number of patients with cervical cancer operated by a surgical specialist (as defined above). *Denominator:* number of patients undergoing surgery for cervical cancer.
TARGETS	100%

CERVICAL CANCER – OVERALL MANAGEMENT

QI 3 Centre participating in ongoing clinical trials in gynaecological cancer

TYPE	Structural indicator
DESCRIPTION	The centre actively accrues patients in ongoing clinical trials (not restricted to surgery) in gynaecological cancer.
SPECIFICATIONS	*Numerator:* number of ongoing clinical trials in gynaecological cancer (not restricted to surgery only). *Denominator:* not applicable.
TARGETS	≥1

QI 4 Treatment discussed at a multidisciplinary team meeting

TYPE	Process indicator
DESCRIPTION	The decision for any therapeutic intervention (excluding any diagnostic procedure, i.e., biopsies or conisation performed with a diagnostic intent) has been taken by a multidisciplinary team including at least a gynaecologic oncologist or a trained surgeon specifically dedicated to gynaecological cancer as defined above (QI 2), a radiologist, a radiation oncologist, a medical or clinical oncologist, and a pathologist.
SPECIFICATIONS	*Numerator:* number of patients with cervical cancer for whom the decision for any therapeutic intervention has been made by a multidisciplinary team. *Denominator:* all patients presenting with cervical cancer.
TARGETS	100%

CERVICAL CANCER

QI 5 Required pre-operative workup

TYPE	Process indicator
DESCRIPTION	The required pre-operative workup is defined according to the ESGO-ESTRO-ESP Guidelines.
SPECIFICATIONS	*Numerator:* number of patients with cervical cancer planned for surgery who received a pre-operative workup according to the ESGO-ESTRO-ESP Guidelines. *Denominator:* all patients with cervical cancer planned for surgery.
TARGETS	100%(1)

(1) need to specify if the required pre-operative workup, defined according to the ESGO-ESTRO-ESP Guidelines, is not followed.

CERVICAL CANCER – RECORDING PERTINENT INFORMATION FOR IMPROVING QUALITY

QI 6 Minimum required elements in surgical reports

TYPE	Process indicator
DESCRIPTION	The required surgical report, based on the ESGO-ESTRO-ESP Guidelines, includes at least the elements mentioned above.
SPECIFICATIONS	*Numerator:* number of patients with cervical cancer undergoing surgery who have a complete surgical report that contains all required elements as defined above. *Denominator:* all patients with cervical cancer undergoing surgery.
TARGETS	100%

QI 7 Minimum required elements in pathology and pathology reports

TYPE	Process indicator
DESCRIPTION	The minimum required elements in pathology and pathology reports, based on the ESGO-ESTRO-ESP Guidelines, includes at least the elements mentioned in the Table 1.
SPECIFICATIONS	*Numerator:* number of patients with cervical cancer undergoing surgery for whom all minimum required elements as defined above are reported. *Denominator:* all patients with cervical cancer undergoing surgery.
TARGETS	≥90%(1)

(1) the tolerance with this target reflects situations where it is not possible to report all components due to poor quality of specimen.

QI 8 Structured prospective reporting of the follow-up and 30-day post-operative morbidity

TYPE	Outcome indicator
DESCRIPTION	Structured prospective reporting of the follow-up and 30-day post-operative morbidity using a validated surgical complications scoring system.
SPECIFICATIONS	*Numerator:* number of patients with cervical cancer who have undergone a surgery and for whom a structured prospective reporting of the follow-up and 30-day post-operative morbidity is available. *Denominator:* all patients with cervical cancer undergoing surgery.
TARGETS	*Optimal target:* ≥90%. *Minimum required target:* selected cases are discussed at morbidity and mortality conferences.

Table 1.
Minimum requirements for pathology report for cervical cancer

Description of the specimen(s) submitted for histological evaluation
Macroscopic description of specimen(s) (biopsy, loop/cone, trachelectomy, hysterectomy) including specimen dimensions (3 dimensions), number of tissue pieces for loop/cones, and maximum and minimum length of vaginal cuff and the parametria in 2 dimensions
Macroscopic tumour site(s), if the tumour is visible grossly, in trachelectomy and hysterectomy specimens
Tumour dimensions including 2 measurements of horizontal extent and depth of invasion or thickness (tumour dimension should be based on a correlation of the gross and histological features). When multifocal separate tumours are present, each should be described and measured separately, and the largest used for tumour staging. Specimens from prior conisation and subsequent conisation, trachelectomy, or hysterectomy should be correlated for estimation of the tumour size. This is important because different specimens may have been reported at different institutions. It should also be recognised that simply adding up the maximum tumour sizes in separate specimens may significantly overestimate the maximum tumour dimension.
Histological tumour type and tumour grade
The presence or absence of lymphovascular space involvement
Coexisting pathology (squamous intraepithelial lesion/cervical intraepithelial neoplasia, adenocarcinoma in situ, stratified mucin-producing intraepithelial lesion)
Minimum distance of uninvolved cervical stroma
Margin status (invasive and preinvasive disease, specify the margin(s))
Lymph node status including sentinel lymph node status, the total number of nodes found, the number and location of positive lymph nodes, and the presence of extranodal extension. Micrometastasis (>0.2 mm and up to 2 mm) are reported as pN1 (mi). Isolated tumour cells no greater than 0.2 mm in regional nodes should be reported as pN0 (i+). The number of positive lymph nodes per anatomical group should be reported separately.
Pathologically confirmed distant metastases
Provisional pathological staging (TNM, eighth edition(1)); a pathological FIGO stage(2) may also be provided if local protocols dictate this
The results of any frozen section specimen evaluation
(1) UICC. Union for International Cancer Control. 8th edition of the UICC TNM classification of malignant tumours. (2016). (2) Bhatla, N., et al. Revised FIGO staging for carcinoma of the cervix uteri. Int J Gynaecol Obstet 145, 129-135 (2019)

CERVICAL CANCER

CERVICAL CANCER – QUALITY OF SURGICAL PROCEDURES

QI 9 Urological fistula rate within 30 post-operative days after a radical parametrectomy

TYPE	Outcome indicator
DESCRIPTION	Any bladder or ureteral fistula diagnosed after a procedure including radical parametrectomy. The fistula rate should be calculated on the basis of data of the preceding three years. Radical parametrectomies include radical hysterectomies, radical trachelectomies and parametrectomies.
SPECIFICATIONS	*Numerator:* number of patients treated in the preceding three years who develop ureteral or bladder fistulas within 30 post-operative days. *Denominator:* all patients with cervical cancer undergoing a procedure including radical parametrectomy in the preceding three years.
TARGETS	≤3%

QI 10 Proportion of patients after primary surgical treatment who have clear vaginal (invasive disease) and parametrial margins

TYPE	Outcome indicator
DESCRIPTION	Clear surgical margins apply for both the vaginal margins and parametrial margins. Using adequate clinical staging with modern imaging and careful pre-operative vaginal assessment as defined in the ESGO-ESTRO-ESP Guidelines, positive surgical margins after a radical hysterectomy or trachelectomy should be avoided.
SPECIFICATIONS	*Numerator:* number of patients after primary surgical treatment who have clear surgical margins for invasive disease in the time period of three preceding years. *Denominator:* all patients who have undergone primary surgical treatment in the preceding three years.
TARGETS	≥97

QI 11 Proportion of patients with a stage T1b disease T-upstaged after surgery

TYPE	Outcome indicator
DESCRIPTION	T-upstaging refers to detection of any involvement of parametria or vagina found on pathology which was unknown before surgery, or a stage shift from T1b1 to T1b2 or higher, from pre-operative assessment to post-operative pathology. Detection of positive lymph nodes is not included.
SPECIFICATIONS	*Numerator:* number of patients with stage T1b disease T-upstaged after surgery, as defined above. *Denominator:* all patients with a stage T1b who have undergone a surgery.
TARGETS	<10%

QI 12 Recurrence rate at two years in patients with a stage pT1b1 with negative lymph nodes after primary surgical treatment

TYPE	Outcome indicator
DESCRIPTION	This quality indicator applies to the common tumour types (squamous cell and usual types adenocarcinoma) and both local or distant recurrences, irrespective of adjuvant treatment strategy.
SPECIFICATIONS	*Numerator:* lymph node-negative pT1b1 patients who have recurred within two years after primary surgical treatment, irrespective of adjuvant treatment strategy, with a minimum of two years follow-up. *Denominator:* All lymph node-negative pT1b1 patients after primary surgical treatment, irrespective of adjuvant treatment strategy, with a minimum of two years follow-up.
TARGETS	<10%

CERVICAL CANCER – COMPLIANCE OF MANAGEMENT WITH THE STANDARDS OF CARE

QI 13 Proportion of patients with a stage T1 disease treated by primary surgery who have undergone lymph node staging according to the ESGO-ESTRO-ESP Guidelines

TYPE	Outcome indicator
DESCRIPTION	Lymph node staging is defined according to the ESGO-ESTRO-ESP Guidelines.
SPECIFICATIONS	*Numerator:* number of patients with a stage T1 disease who have undergone lymph node staging according to the ESGO-ESTRO-ESP Guidelines. *Denominator:* all patients with a stage T1 disease who were treated by primary surgery.
TARGETS	≥98%

QI 14 Counselling about the possibility of fertility-sparing treatment

TYPE	Structural indicator
DESCRIPTION	The counselling of patients with stage T1b1 ≤2 cm disease, potential candidates for fertility-sparing treatment, is described in the ESGO-ESTRO-ESP Guidelines. All eligible patients should be appropriately counselled about a possibility of fertility-sparing treatment. Fertility-sparing treatment should exclusively be undertaken in centres with comprehensive expertise in this management.
SPECIFICATIONS	*Numerator:* number of patients with stage T1b1 ≤2 cm disease, potential candidates for fertility-sparing treatment, counselled according to the ESGO-ESTRO-ESP guidelines. *Denominator:* all patients with stage T1b1 ≤2 cm disease, potential candidates for fertility-sparing treatment.
TARGETS	100%

QI 15 Proportion of patients receiving adjuvant chemoradiotherapy after a primary surgical treatment for a stage pT1b1 pN0 disease

TYPE	Structural indicator
DESCRIPTION	Management of patients after a surgical treatment for a stage pT1b1 pN0 disease is defined according to the ESGO-ESTRO-ESP Guidelines.
SPECIFICATIONS	*Numerator:* number of patients receiving adjuvant chemoradiotherapy after primary surgical treatment for stage pT1b1 pN0 disease, according to the ESGO-ESTRO-ESP Guidelines. *Denominator:* all patients with primary surgical treatment for stage pT1b1 pN0 disease.
TARGETS	<15%

OVARIAN CANCER – CENTRE CASE LOAD, TRAINING, AND EXPERIENCE OF THE SURGEON

QI 1 Rate of complete surgical resection

TYPE	Outcome indicator
DESCRIPTION	Complete abdominal surgical resection is defined by the absence of remaining macroscopic lesions after careful exploration of the abdomen. Whenever feasible, localised thoracic disease is resected. Surgery can be decided upfront or planned after neoadjuvant chemotherapy. However, the quality assurance programme must take into account that patients who can be operated upfront with a reasonable complication rate benefit most from primary debulking surgery.
SPECIFICATIONS	*Numerator:* (i) number of cytoreductive surgeries as defined above performed per centre per year. (ii) number of cytoreductive surgeries as defined above performed per surgeon per year. Secondary and tertiary procedures are accepted. *Denominator:* not applicable.
TARGETS	(i) complete resection rate: • *Optimal target:* ≥65% • *Minimum required target:* ≥50% (ii) proportion of primary debulking surgeries: ≥50%

QI 2 Number of cytoreductive surgeries performed per centre and per surgeon per year

TYPE	Structural indicator(1) Process indicator (2)
DESCRIPTION	Only surgeries with an initial objective of complete cytoreduction are recorded. Exploratory endoscopies, exploratory laparotomies, or surgeries limited to tissue biopsy that do not include at least a bilateral salpingo-oophorectomy (if applicable) hysterectomy (if applicable), and a comprehensive peritoneal staging including omentectomy are not included.
SPECIFICATIONS	*Numerator:* (i) number of cytoreductive surgeries as defined above performed per centre per year; (ii) number of cytoreductive surgeries as defined above performed per surgeon per year. Secondary and tertiary procedures are accepted. *Denominator:* not applicable.
TARGETS	(i) number of surgeries performed per centre per year: • *Optimal target:* N ≥100 • *Intermediate target:* N ≥50 • *Minimum required target:* N ≥20 (ii) ≥95% of surgeries are performed or supervised by surgeons operating at least 10 patients a year.

(1) number of upfront or interval cytoreductive surgeries performed per centre
(2) number of surgeries per surgeon per year

OVARIAN CANCER – CENTRE CASE LOAD, TRAINING, AND EXPERIENCE OF THE SURGEON *(continued)*

QI 3 Surgery performed by a gynaecologic oncologist or a trained surgeon specifically dedicated to gynaecological cancer management

TYPE	Process indicator
DESCRIPTION	Surgery is performed by a certified gynaecologic oncologist or, in countries where certification is not organised, by a trained surgeon dedicated to the management of gynaecologic cancer (accounting for over 50% of his/her practice) or having completed an ESGO-accredited fellowship. Skills to successfully complete abdominal and pelvic surgery procedures necessary to achieve complete cytoreduction must be available.
SPECIFICATIONS	*Numerator:* number of patients with advanced ovarian cancer operated by a specialist (as defined above). *Denominator:* all patients undergoing surgery for advanced ovarian cancer.
TARGETS	≥90%

OVARIAN CANCER – OVERALL MANAGEMENT

QI 4 Centre participating in clinical trials in gynaecologic oncology

TYPE	Structural indicator
DESCRIPTION	The centre actively accrues patients in clinical trials in gynaecologic oncology.
SPECIFICATIONS	*Numerator:* not applicable. *Denominator:* not applicable.
TARGETS	Not applicable

QI 5 Treatment planned and reviewed at a multidisciplinary team meeting

TYPE	Process indicator
DESCRIPTION	The decision for any major therapeutic intervention has been taken by a multidisciplinary team including at least a surgical specialist as defined above (QI 2 and QI 3), a radiologist, a pathologist (if a biopsy is available), and a physician certified to deliver chemotherapy (a gynaecologic oncologist in countries where the subspecialty is structured and/or a medical oncologist with special interest in gynaecologic oncology).
SPECIFICATIONS	*Numerator:* number of patients with advanced ovarian cancer for whom the decision for therapeutic intervention(s) has been taken by a multidisciplinary team. *Denominator:* all patients with advanced ovarian cancer undergoing therapeutic intervention(s).
TARGETS	≥95%

QI 6 Required preoperative work-up

TYPE	Process indicator
DESCRIPTION	Unresectable parenchymal metastases have been ruled out by imaging. Ovarian and peritoneal malignancy secondary to gastrointestinal cancer has been ruled out by suitable methods, e.g., plasma CA-125 and CEA levels, and/or by biopsy under radiologic or laparoscopic guidance.
SPECIFICATIONS	*Numerator:* number of patients with advanced ovarian cancer who had undergone cytoreductive surgery and who were offered minimum preoperative work-up as defined above. *Denominator:* all patients with advanced ovarian cancer who underwent cytoreductive surgery.
TARGETS	≥95%

OVARIAN CANCER (advanced stages)

OVARIAN CANCER – PERIOPERATIVE CARE

QI 7 Pre-, intra-, and post-operative management

TYPE	Structural indicator
DESCRIPTION	The minimal requirements are: (1) intermediate care facility and access to an intensive care unit in the centre are available; (2) an active perioperative management programme is established(1).
SPECIFICATIONS	*Numerator:* not applicable. *Denominator:* not applicable.
TARGETS	Not applicable

(1) details of perioperative management include (non-exhaustive list): preoperative haemoglobin optimisation and iron deficit correction; correction of denutrition and immunonutrition according to the current guidelines; fluid management, involving a goal-directed therapy policy rather than liberal fluid therapy without hemodynamic goals (However, the superiority of goal direct therapy compared to restrictive fluid strategy remains unclear. There is no recognised standard method of monitoring); pain management, including in the absence of contra-indication the use of epidural analgesia in order to avoid opioids; while routine premedication is no longer recommended, prevention of postoperative nausea and vomiting should be systematic.

OVARIAN CANCER – RECORDING PERTINENT INFORMATION FOR IMPROVING QUALITY

QI 8 Minimum required elements in operative reports

TYPE	Process indicator
DESCRIPTION	Operative report is structured. Size and location of disease at the beginning of the operation must be described. All the areas of the abdominal cavity(1) must be described. If applicable, the size and location of residual disease at the end of the operation, and the reasons for not achieving complete cytoreduction must be reported.
SPECIFICATIONS	*Numerator:* number of patients with advanced ovarian cancer undergoing cytoreductive surgery who have a complete operative report that contains all required elements as defined above. *Denominator:* all patients with advanced ovarian cancer undergoing cytoreductive surgery
TARGETS	90%

QI 9 Minimum required elements in pathology reports

TYPE	Process indicator
DESCRIPTION	Pathology report contains all the required elements listed in the international collaboration on cancer reporting (ICCR) histopathology reporting guide(2)(3).
SPECIFICATIONS	*Numerator:* number of patients with advanced ovarian cancer undergoing cytoreductive surgery who have a complete pathology report that contains all required elements as defined in ICCR histopathology reporting guide. *Denominator:* all patients with advanced ovarian cancer undergoing cytoreductive surgery.
TARGETS	≥90%. The tolerance within this target reflects situations where it is not possible to report all components of the data set due to poor quality of specimen.

(1) ovaries, tubes, uterus, pelvic peritoneum, paracolic gutters, anterior parietal peritoneum, mesentery, peritoneal surface of the colon and bowel, liver, spleen, greater and lesser omentum, porta hepatis, stomach, Morrison pouch, lesser sac, undersurface of both hemidiaphragms, pelvic and aortic nodes, and, if applicable, pleural cavity.

(2) https://www.rcpa.edu.au/Library/Practising-Pathology/ICCR/Cancer-Datasets.

(3) McCluggage, W.G. et al. Data set for reporting of ovary, fallopian tube and primary peritoneal carcinoma: recommendations from the international collaboration on cancer reporting (ICCR). Mod Pathol (2015).

OVARIAN CANCER – RECORDING PERTINENT INFORMATION FOR IMPROVING QUALITY *(continued)*

QI 10 Existence of a structured prospective reporting of postoperative complications

TYPE	Outcome indicator
DESCRIPTION	Data to be recorded are reoperations, interventional radiology, readmissions, secondary transfers to intermediate or intensive care units, and deaths.
SPECIFICATIONS	*Numerator:* number of recorded serious postoperative complications or deaths occurred among patients with advanced ovarian cancer who have undergone cytoreduction. *Denominator:* all complications occurred among patients with advanced ovarian cancer who have undergone cytoreduction.
TARGETS	*Optimal target:* 100% of complications are prospectively recorded. *Minimum required target:* selected cases are discussed at morbidity and mortality conferences.

VULVAR CANCER – CENTRE CASE LOAD, TRAINING, AND EXPERIENCE OF THE SURGEON

QI 1 Number of new vulvar cancer patients per year per institute

TYPE	Structural indicator
DESCRIPTION	Number of new vulvar cancer patients per year per institute
SPECIFICATIONS	*Numerator:* number of new vulvar cancer patients per year per institute. *Denominator:* not applicable.
TARGETS	*Optimal target:* N ≥50 *Minimum required target:* N ≥20

QI 2 Number of sentinel node procedures per surgeon per year

TYPE	Structural indicator
DESCRIPTION	Number of sentinel node procedures per surgeon per year
SPECIFICATIONS	*Numerator:* number of sentinel node procedures per surgeon per year. *Denominator:* not applicable.
TARGETS	*Optimal target:* N ≥20 *Minimum required target:* N ≥10

QI 3 Proportion of patients with surgery performed by a gynaecologic oncologist within the centre

TYPE	Process indicator
DESCRIPTION	Proportion of patients with surgery performed by a gynaecological oncologist within the centre
SPECIFICATIONS	*Numerator:* number of women with vulvar cancer operated by a gynaecological oncologist. *Denominator:* total number of women with vulvar cancer who had surgery that year.
TARGETS	*Optimal target:* 100% *Minimum required target:* >90%

QI 4 Proportion of patients with successful sentinel node procedure

TYPE	Outcome indicator
DESCRIPTION	Proportion of patients with successful sentinel node procedure.
SPECIFICATIONS	*Numerator:* number of women with vulvar cancer and successful sentinel node procedure. *Denominator:* total number of women with vulvar cancer in whom sentinel node procedure was performed.
TARGETS	*Optimal target:* >99% *Minimum required target:* >95%

VULVAR CANCER – OVERALL MANAGEMENT

QI 5 Completeness of preoperative work-up for patients with sentinel node procedure

TYPE	Process indicator
DESCRIPTION	Complete work-up for sentinel node detection includes biopsy showing macroinvasive small cell carcinoma of the vulva, and preoperative imaging of the groins to rule out gross nodal involvement.
SPECIFICATIONS	*Numerator:* number of women with complete work-up in one year. *Denominator:* number of women in whom sentinel node procedure was performed in one year.
TARGETS	*Optimal target:* 100% *Minimum required target:* 95%

QI 6 Proportion of patients discussed within the multidisciplinary team

TYPE	Process indicator
DESCRIPTION	Proportion of patients discussed within the multidisciplinary team
SPECIFICATIONS	*Numerator:* number of women with vulvar cancer discussed in multidisciplinary team. *Denominator:* total number of women with vulvar cancer that year.
TARGETS	*Optimal target:* 100% *Minimum required target:* >90%

VULVAR CANCER – QUALITY OF SURGICAL PROCEDURES

QI 7 Groin recurrence rate over five years after a negative sentinel node procedure

TYPE	Outcome indicator
DESCRIPTION	Groin recurrence rate over five years after a negative sentinel node procedure
SPECIFICATIONS	*Numerator:* number of women with groin recurrence over five years after a negative sentinel node procedure. *Denominator:* total number of women with a negative sentinel node.
TARGETS	*Optimal target:* <3% *Minimum required target:* <5 %

CERVICAL CANCER

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VULVAR CANCER

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NOTES

Access the full ESGO Guidelines

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