

Suspicion of Cancer, What Next?

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Learning Objectives

The approved learning objectives for this program are:

1. Explain how to complete a suspicion of cancer workup from symptoms to investigations, biopsy and referral.
2. Describe when to order a myeloma workup and how to manage the results (including MGUS and benign results).

Disclosures

- Dr. Geordie Linford
 - Janssen Oncology – Speaker honoraria (June 2022); Consultancy (January 2021)
 - Bayer – Speaker honoraria (December 2022)
- Dr. Guy Desmarais
 - None
- Dr. Lacey Pitre FRCP(C)
 - Merck Oncology – Speaker honoraria (January 2021)
 - Astra Zeneca – Speaker honoraria (April 2021)
 - Roche – Grant Funding
 - Local Principal Investigator:
 - Boehringer Ingelheim Canada Ltd., Bristol Myers Squibb, Amgen Canada Inc., Galera Therapeutics Inc., F. Hoffmann-La Roche Ltd., Astra Zeneca, Roche, GlaxoSmithKline

Presentation Outline:

- Why is pathology important (prior to referral)?
- Suspicion of cancer – approach by disease site:
 - Hepatobiliary / pancreatic mass
 - Unknown primary – bone only metastases
 - Multiple myeloma / MGUS
 - Lymphoma
 - Gyne / ovarian
- When to be cautious about ordering a biopsy
- Is pathology always needed?
- Questions

Case #1

71F presenting to the ER with a several month history of small caliber stools, nausea, and 25 lb weight loss. Rectal mass on examination. CEA is elevated.

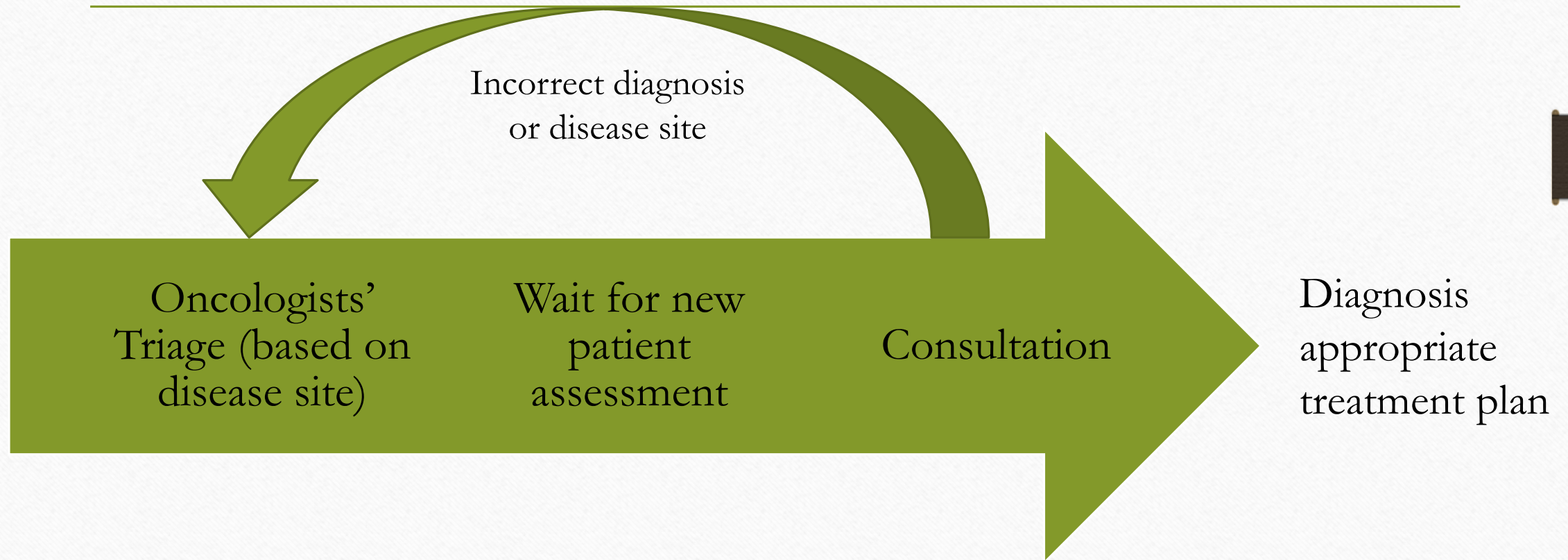
CT A/P → diffusely thickened rectum, suspected peritoneal carcinomatosis

General surgery resident consult → metastatic colon cancer, Prognosis “weeks”. Oncology inpatient consultation requested...

Case #1

- On further review:
 - Past medical history is significant for lobular breast cancer many years prior. Completed adjuvant therapy 5 years ago.
 - Patient underwent sigmoidoscopy. Biopsy taken – final pathology consistent with recurrent breast cancer.
 - Referral placed to breast medical oncologist; ongoing response to hormone therapy.

Cancer Center Triage Process



Pancreatic / Hepatobiliary

- Pancreatic cancer –obstructive jaundice, abdominal or midback pain, significant weight loss. May not have jaundice if tail lesion.
- Almost always adenocarcinoma but can sometimes show neuroendocrine tumors or lymphoma. Can be site of metastasis (esp renal).
 - Biopsy is usually needed for treatment plan.

Pancreatic Mass: Diagnosis

ERCP – surgery or gastroenterology

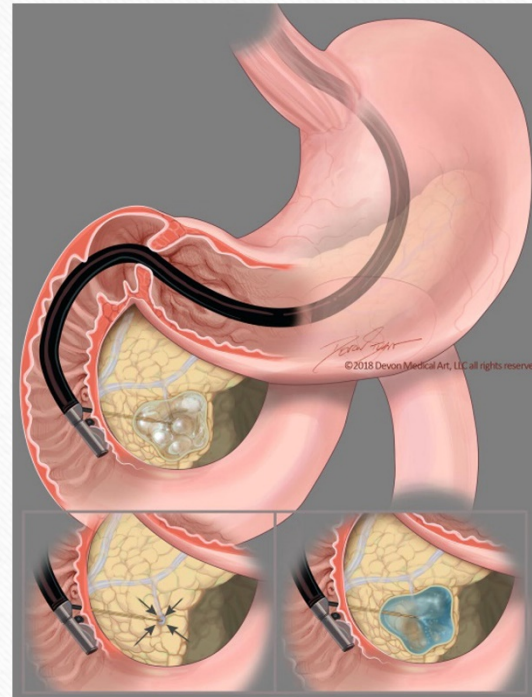
- therapeutic intervention (stent for obstructive jaundice)
- Usually not diagnostic for pancreatic

Imaging guided biopsy

- Available at more centres in the north
- Usually returns with diagnostic results

Endoscopic Ultrasound (EUS) *

- Dr. Al Mazrou'i & Dr. Hartford
- Can allow for better staging if considered possibly operative



Moyer, M.T., Maranki, J.L. & DeWitt, J.M. EUS-Guided Pancreatic Cyst Ablation: a Clinical and Technical Review. *Curr Gastroenterol Rep* **21**, 19 (2019). <https://doi.org/10.1007/s11894-019-0686-5>

Liver mass diagnosis

- HCC
 - 90% will have cirrhosis; increasingly seen in obese patients with NASH
 - Classic hypervascularity and washout pattern on CT can be diagnostic without biopsy!
 - Elevation in AFP tumor marker in 75%; level is prognostic
- Cholangiocarcinoma
 - 20% intrahepatic; jaundice less likely
 - RUQ pain, weight loss, elevated CA 19-9
 - Refer to hepatobiliary surgery for biopsy
- Metastatic deposit – very common site. Interventional radiology is safe and high yield.

Tumor Markers

- Problems with sensitivity and specificity
- Rarely useful alone in diagnosis; more helpful in disease response or recurrence on follow up.
 - CA-19-9 (pancreatic, biliary) → not produced in 5-10% of population. Can be VERY elevated in obstructive jaundice of any cause
 - CEA (colon, upper GI) → Many false negatives. Helpful to follow if elevated
 - CA 125 (ovarian) → Can be elevated in any peritoneal pathology (infection, endometriosis)
 - PSA → Produced by most prostate cancers at initial diagnosis; Higher number (>100) predicts likelihood of metastasis.
 - Alpha fetal protein → Abnormal in male patients; suggestive of germ cell tumor or HCC.

Metastatic bone lesions

Lytic lesions	Sclerotic Lesions
Renal cell	Breast
Myeloma	Prostate
Lung	Lung (less commonly)
Thyroid	
Breast (less commonly)	
Diagnosis: Plain film Xray, CT NOTE: bone scan can be negative	Diagnosis: Bone scan, CT

Unknown Primary – Bone-only Lesions

- **Sclerotic:**

- Men with history of prostate cancer, elevated PSA - refer to cancer center
- Women, any history of breast cancer (even if distant) – refer to cancer center
- Difficult to biopsy / lower yield but may be needed if diagnosis uncertain

- **Lytic:**

- Complete work up for myeloma
- CT C/A/P with contrast; upper and lower endoscopy, lymph node exam
- Can usually get CT guided biopsy if soft tissue component

When to refer without a biopsy?

- **Clinically unstable** / difficulty getting pathology (**call MD on call**)
- **Imaging / labs diagnostic:**
 - Hepatocellular carcinoma → Classic CT contrast pattern, +/- elevated AFP (refer to surgery)
 - Suspicion of hematological malignancies needing bone marrow bx...
- **Biopsy potentially dangerous** (tumor seeding?)
 - Testicular Germ cell – testicular mass and elevated b-HCG and/or Alpha fetal protein (AFP)

Dr. Guy Desmarais

Mrs. X

- 74 female, Caucasian, lives independently with husband in outside of Sudbury
- Presents with fatigue and mild SOB on exertion, no bleeding
- PMHx HTN, Gout, Obesity, DLPD
- Meds: allopurinol, irbesartan, rosuvastatin, niacin, fenofibrate
- No alcohol use
- Hb 100, MCV 90, WBC 6.6, platelets 200, Retic 30, creatinine 150, GFR 50, ferritin 200, TSH normal, LE normal, B12 normal, albumin 30

What is the appropriate screen for
Myeloma in the setting of unexplained
anemia?

IMWG Criteria for Diagnosis of Myeloma

MGUS	Smoldering Myeloma	Active Multiple Myeloma
▪ M-protein < 3 g/dL ▪ Clonal plasma cells in BM < 10% ▪ No myeloma-defining events	▪ M-protein ≥ 3 g/dL (serum) or ≥ 500 mg/24 hrs (urine) ▪ Clonal plasma cells in BM $\geq 10\%$ to 60% ▪ No myeloma-defining events	▪ Underlying plasma cell proliferative disorder ▪ AND ≥ 1 SLiM-CRAB* feature

***S**: $\geq 60\%$ clonal bone marrow plasma cells

Li: Serum free light chain ratio ≥ 100 (involved kappa) or ≤ 0.01 (involved lambda)

M: MRI studies with > 1 focal lesion (> 5 mm in size)

C: Calcium elevation (> 11 mg/dL or > 1 mg/dL higher than ULN)

R: Renal insufficiency (CrCl < 40 mL/min or serum creatinine > 2 mg/dL)

A: Anemia (Hb < 10 g/dL or 2 g/dL $<$ normal)

B: Bone disease (≥ 1 lytic lesions on skeletal radiography, CT, or PET/CT)

ORIGINAL ARTICLE

Prevalence of Monoclonal Gammopathy of Undetermined Significance

Robert A. Kyle, M.D., Terry M. Therneau, Ph.D., S. Vincent Rajkumar, M.D., Dirk R. Larson, M.S., Matthew F. Plevak, B.S., Janice R. Offord, B.S., Angela Dispenzieri, M.D., Jerry A. Katzmann, Ph.D., and L. Joseph Melton, III, M.D.

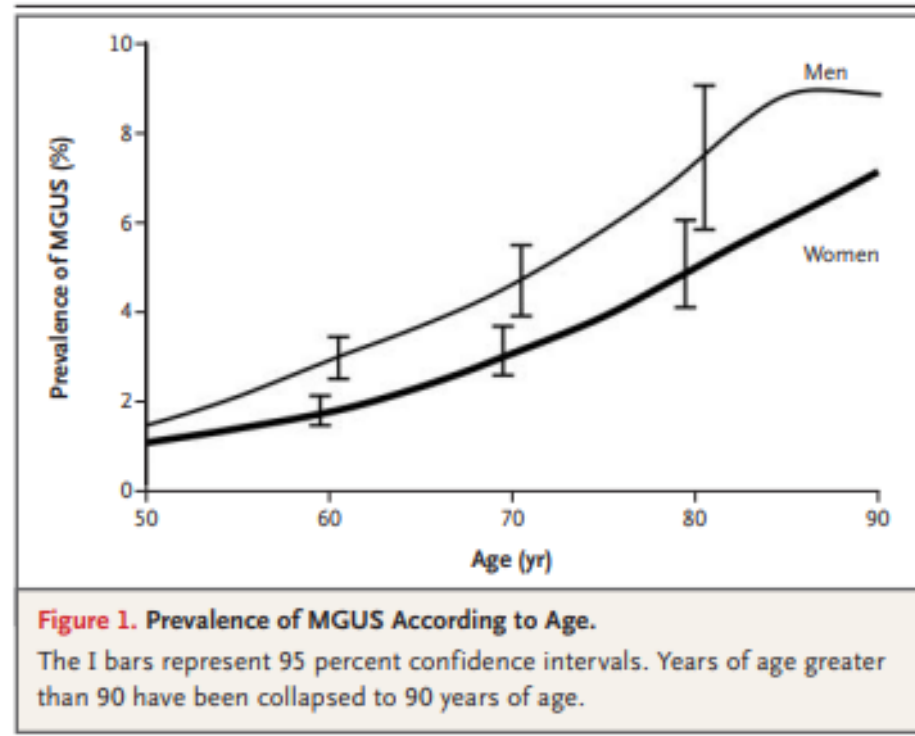
[Article](#) [Figures/Media](#)

March 30, 2006

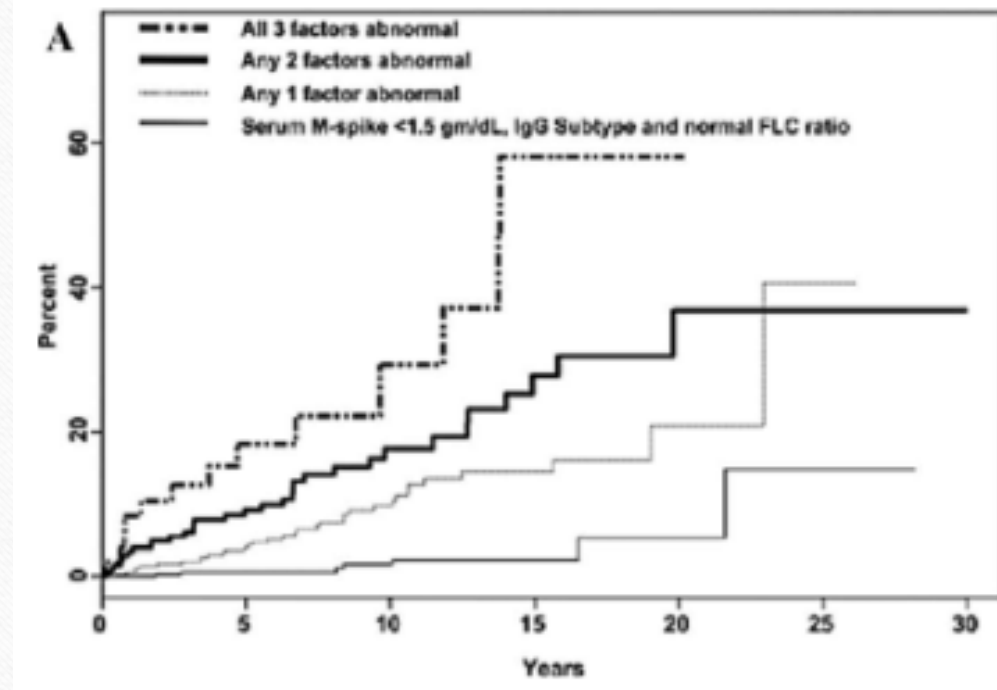
N Engl J Med 2006; 354:1362-1369

DOI: 10.1056/NEJMoa054494

[21 References](#) [898 Citing Articles](#) [Letters](#)

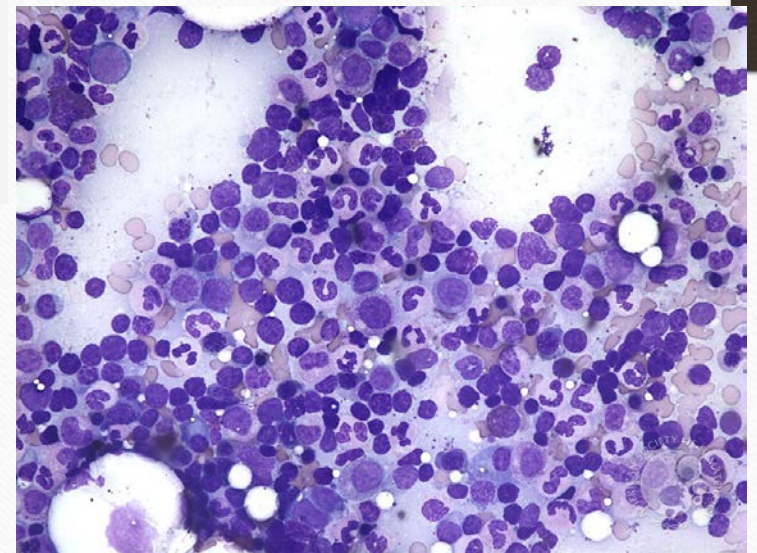
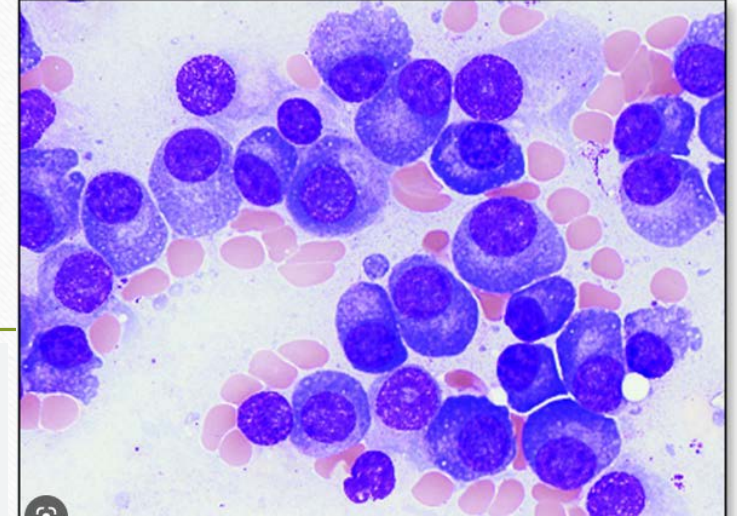
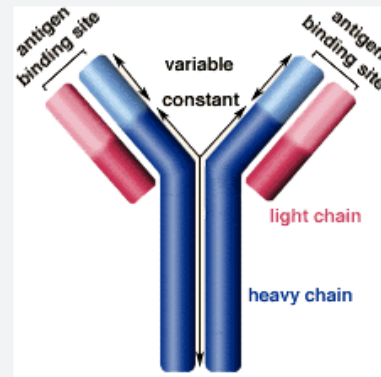


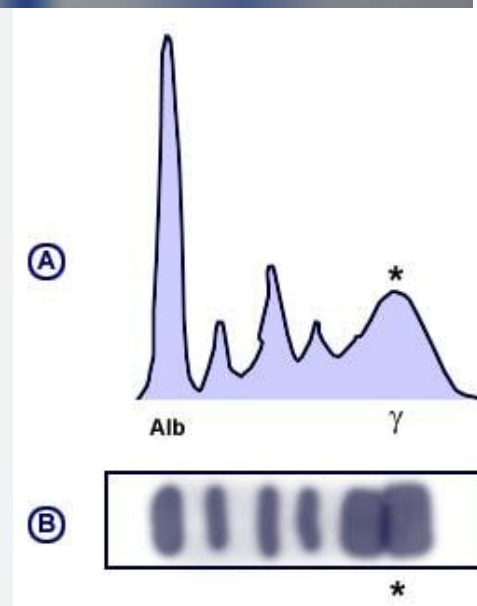
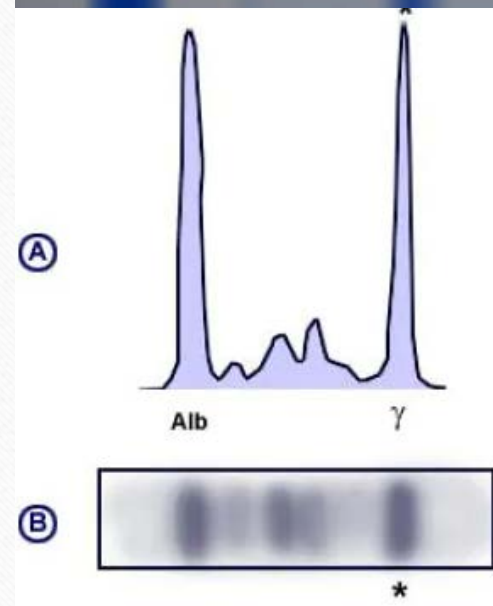
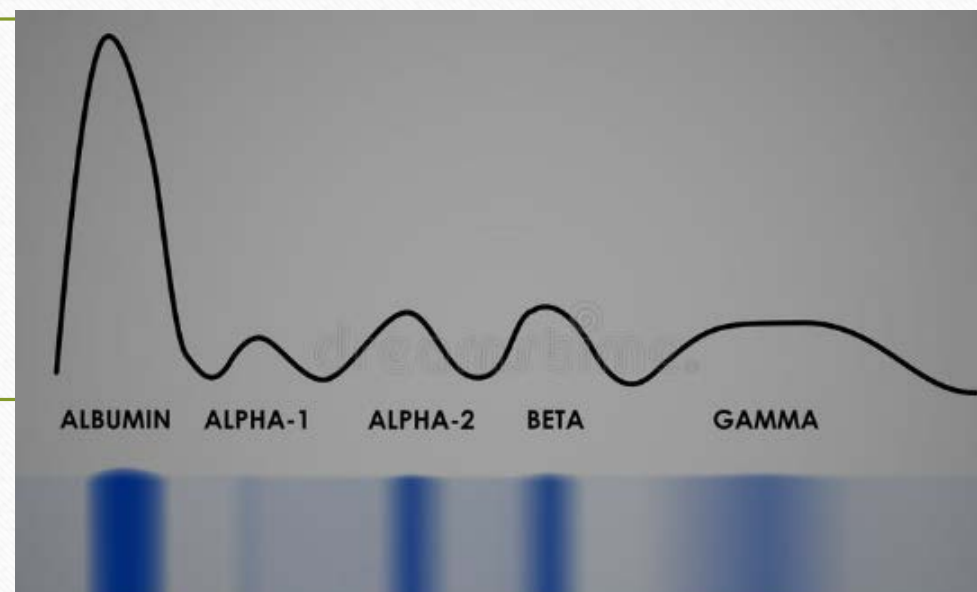
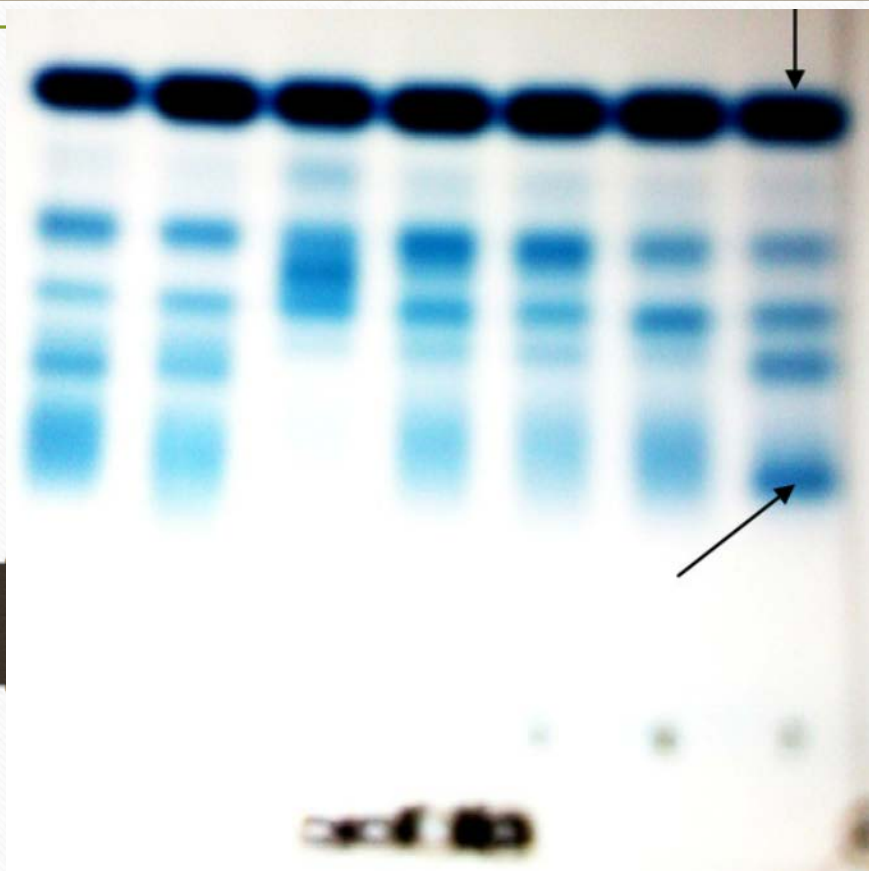
Not all MGUS created equal



Myeloma

- Neoplasm of Plasma cells
 - 70ish% produce heavy chain +/- light chain
 - 25ish% produce light chain only
 - 2ish% non-secretory
-
- So: if ordered only SPEP would miss 25% of cases!
 - Need UPEP or FLC





Mrs. X's SPEP shows 6 g/L M protein,
immunofixation is IgG Lambda, UPEP
positive for Bence-Jones protein

My patient has an M protein... now what?

- Look for CRAB!
- Bone Scan?
- Skeletal Survey?
- MRI, CT?
- **Refer to cancer center!**

Criterion	Definition
Sixty percent	Plasma cell infiltration in bone marrow
Light chains	Quotient involved: uninvolved > 100
MRI	> focal bone lesion
Calcium	Hypercalcemia > 2.75 mmol/l or > 0.25 mmol/l above ULN
Renal insufficiency	Creatinine > 173 µmol/l or CCl < 40 ml/min
Anemia	Hb < 100.0 g/dl or > 20 g/dl below LLN
Bone lesions	≥1 osteolysis on skeletal radiography, CT or PET/CT

Table 1. Overview of the SLiM-CRAB criteria.³

LLN, lower limit of normal; ULN, upper limit of normal.

Guy's Myeloma No-No's

- DO NOT

- Forget to screen for myeloma in anemia
- Forget to screen for myeloma in CRF
- Forget the FLC or UPEP
- Order a Bone scan to look for lytic lesions

- DO

- Add SPEP and FLC or UPEP to standard workup for anemia and CRF
- Order a skeletal survey or CT/MRI
- Refer to cancer center when SPEP shows monoclonal protein

Lymphoma

Mr. Y

- Mr Y, a healthy 50 yr old male non-smoker has noticed the appearance of lymph nodes in his neck for the past 2 months. He comes to your office to discuss
 - Takes no medications
 - No recent infections or illnesses
 - No recent travel
 - No joint pains, vision loss, ulcers in mouth, rash
 - No weight loss, night sweats or fevers
- Your examination shows a well appearing male with two palpable lymph nodes, 2cm in size on the right cervical chain, no other Lymphadenopathy is palpated, no organomegaly, rest of exam is non-contributory
- What now?!?

Lymphoma facts!

- A neoplasm of mature lymphoid cells originating from lymphoid tissues (nodes, spleen)
- Present with lymphadenopathy, organomegaly, B symptoms, Extranodal involvement, Bone marrow failure
- Hodgkins/ Non-Hodgkins, B cell/ T cell, Indolent / Aggressive, Curable / Non-Curable

Blastic plasmacytoid dendritic cell neoplasm	9727/3	Alpha heavy chain disease	9762/3
Acute leukaemias of ambiguous lineage		Plasma cell neoplasms	
Acute undifferentiated leukaemia	9801/3	Non-IgM monoclonal gammopathy of undetermined significance	9765/1
Mixed-phenotype acute leukaemia with t(9;22)(q34.1;q11.2); <i>BCR-ABL1</i>	9806/3	Plasma cell myeloma	9732/3
Mixed-phenotype acute leukaemia with t(v;11q23.3); <i>KMT2A</i> -rearranged	9807/3	Solitary plasmacytoma of bone	9731/3
Mixed-phenotype acute leukaemia, B/myeloid, NOS	9808/3	Extraosseous plasmacytoma	9734/3
Mixed-phenotype acute leukaemia, T/myeloid, NOS	9809/3	Monoclonal immunoglobulin deposition diseases	
Mixed-phenotype acute leukaemia, NOS, rare types		Primary amyloidosis	9769/1
Acute leukaemias of ambiguous lineage, NOS		Light chain and heavy chain deposition diseases	9769/1
Precursor lymphoid neoplasms		Extranodal marginal zone lymphoma of mucosa-associated lymphoid tissue (MALT lymphoma)	9699/3
B-lymphoblastic leukaemia/lymphoma, NOS	9811/3	Nodal marginal zone lymphoma	9699/3
B-lymphoblastic leukaemia/lymphoma with t(9;22)(q34.1;q11.2); <i>BCR-ABL1</i>	9812/3	<i>Paediatric nodal marginal zone lymphoma</i>	9699/3
B-lymphoblastic leukaemia/lymphoma with t(v;11q23.3); <i>KMT2A</i> -rearranged	9813/3	Follicular lymphoma	9690/3
B-lymphoblastic leukaemia/lymphoma with t(12;21)(p13.2;q22.1); <i>ETV6-RUNX1</i>	9814/3	In situ follicular neoplasia	9695/1*
B-lymphoblastic leukaemia/lymphoma with hyperdiploidy	9815/3	Duodenal-type follicular lymphoma	9695/3
B-lymphoblastic leukaemia/lymphoma with hypodiploidy (hypodiploid ALL)	9816/3	Testicular follicular lymphoma	9690/3
B-lymphoblastic leukaemia/lymphoma with t(5;14)(q31.1;q32.1); <i>IGH/IL3</i>	9817/3	<i>Paediatric-type follicular lymphoma</i>	9690/3
B-lymphoblastic leukaemia/lymphoma with t(1;19)(q23;p13.3); <i>TCF3-PBX1</i>	9818/3	<i>Large B-cell lymphoma with IRF4 rearrangement</i>	9698/3
B-lymphoblastic leukaemia/lymphoma, <i>BCR-ABL1</i> -like	9819/3*	Primary cutaneous follicle centre lymphoma	9597/3
B-lymphoblastic leukaemia/lymphoma with <i>iAMP21</i>	9811/3	Mantle cell lymphoma	9673/3
T-lymphoblastic leukaemia/lymphoma	9837/3	In situ mantle cell neoplasia	9673/1*
Early T-cell precursor lymphoblastic leukaemia	9837/3	Diffuse large B-cell lymphoma (DLBCL), NOS	9680/3
<i>NK-lymphoblastic leukaemia/lymphoma</i>		Germinal centre B-cell subtype	9680/3
Mature B-cell neoplasms		Activated B-cell subtype	9680/3
Chronic lymphocytic leukaemia (CLL)/small lymphocytic lymphoma	9823/3	T-cell/histiocyte-rich large B-cell lymphoma	9688/3
Monoclonal B-cell lymphocytosis, CLL-type	9823/1*	Primary DLBCL of the CNS	9680/3
Monoclonal B-cell lymphocytosis, non-CLL-type	9591/1*	Primary cutaneous DLBCL, leg type	9680/3
B-cell prolymphocytic leukaemia	9833/3	EBV-positive DLBCL, NOS	9680/3
Splenic marginal zone lymphoma	9689/3	<i>EBV-positive mucocutaneous ulcer</i>	9680/1*
Hairy cell leukaemia	9940/3	DLBCL associated with chronic inflammation	9680/3
<i>Splenic B-cell lymphoma/leukaemia, unclassifiable</i>	9591/3	Fibrin-associated diffuse large B-cell lymphoma	
<i>Splenic diffuse red pulp small B-cell lymphoma</i>	9591/3	Lymphomatoid granulomatosis, grade 1, 2	9766/1
<i>Hairy cell leukaemia variant</i>	9591/3	Lymphomatoid granulomatosis, grade 3	9766/3*
Lymphoplasmacytic lymphoma	9671/3	Primary mediastinal (thymic) large B-cell lymphoma	9679/3
Waldenström macroglobulinemia	9761/3	Intravascular large B-cell lymphoma	9712/3
IgM monoclonal gammopathy of undetermined significance	9761/1*	ALK-positive large B-cell lymphoma	9737/3
Heavy chain diseases		Plasmablastic lymphoma	9735/3
Mu heavy chain disease	9762/3	Primary effusion lymphoma	9678/3
Gamma heavy chain disease	9762/3	Multicentric Castleman disease	

Mature T- and NK-cell neoplasms		Hodgkin lymphomas	
T-cell prolymphocytic leukaemia	9834/3	Nodular lymphocyte predominant Hodgkin lymphoma	9659/3
T-cell large granular lymphocytic leukaemia	9831/3	Classic Hodgkin lymphoma	9650/3
<i>Chronic lymphoproliferative disorder of NK cells</i>	9831/3	Nodular sclerosis classic Hodgkin lymphoma	9663/3
Aggressive NK-cell leukaemia	9948/3	Lymphocyte-rich classic Hodgkin lymphoma	9651/3
Systemic EBV-positive T-cell lymphoma of childhood	9724/3	Mixed cellularity classic Hodgkin lymphoma	9652/3
Chronic active EBV infection of T- and NK-cell type, systemic form		Lymphocyte-depleted classic Hodgkin lymphoma	9653/3
Hydroa vacciniforme-like lymphoproliferative disorder	9725/1*	Immunodeficiency-associated lymphoproliferative disorders	
Severe mosquito bite allergy		Post-transplant lymphoproliferative disorders (PTLD)	
Adult T-cell leukaemia/lymphoma	9827/3	Non-destructive PTLD	
Extranodal NK/T-cell lymphoma, nasal type	9719/3	Plasmacytic hyperplasia PTLD	
Enteropathy-associated T-cell lymphoma	9717/3	Infectious mononucleosis PTLD	
Monomorphic epitheliotropic intestinal T-cell lymphoma	9717/3	Florid follicular hyperplasia	
Intestinal T-cell lymphoma, NOS	9717/3	Polymorphic PTLD	9971/1
<i>Indolent T-cell lymphoproliferative disorder of the gastrointestinal tract</i>	9702/1*	Monomorphic PTLD	**
Hepatosplenic T-cell lymphoma	9716/3	Classic Hodgkin Lymphoma PTLD	9650/3
Subcutaneous panniculitis-like T-cell lymphoma	9708/3	Other iatrogenic immunodeficiency-associated lymphoproliferative disorders	
Mycosis fungoides	9700/3		
Sézary syndrome	9701/3	Histiocytic and dendritic cell neoplasms	
Primary cutaneous CD30-positive T-cell lymphoproliferative disorders		Histiocytic sarcoma	9755/3
Lymphomatoid papulosis	9718/1*	Langerhans cell histiocytosis, NOS	9751/1
Primary cutaneous anaplastic large cell lymphoma	9718/3	Langerhans cell histiocytosis, monostotic	9751/1
Primary cutaneous gamma delta T-cell lymphoma	9726/3	Langerhans cell histiocytosis, polystotic	9751/1
<i>Primary cutaneous CD8-positive aggressive epidermotropic cytotoxic T-cell lymphoma</i>	9709/3	Langerhans cell histiocytosis, disseminated	9751/3
<i>Primary cutaneous acral CD8-positive T-cell lymphoma</i>	9709/3*	Langerhans cell sarcoma	9756/3
<i>Primary cutaneous CD4-positive small/medium T-cell lymphoproliferative disorder</i>	9709/1	Indeterminate dendritic cell tumour	9757/3
Peripheral T-cell lymphoma, NOS	9702/3	Interdigitating dendritic cell sarcoma	9757/3
Angioimmunoblastic T-cell lymphoma	9705/3	Follicular dendritic cell sarcoma	9758/3
Follicular T-cell lymphoma	9702/3	Fibroblastic reticular cell tumour	9759/3
Nodal peripheral T-cell lymphoma with T follicular helper phenotype	9702/3	Disseminated juvenile xanthogranuloma	
Anaplastic large cell lymphoma, ALK-positive	9714/3	Erdheim-Chester disease	9749/3
Anaplastic large cell lymphoma, ALK-negative	9715/3*		
<i>Breast implant-associated anaplastic large cell lymphoma</i>	9715/3*		

The morphology codes are from the International Classification of Diseases for Oncology (ICD-O) [1257A]. Behaviour is coded /0 for benign tumours; /1 for unspecified, borderline, or uncertain behaviour; /2 for carcinoma in situ and grade III intraepithelial neoplasia; and /3 for malignant tumours. The classification is modified from the previous WHO classification, taking into account changes in our understanding of these lesions.

* These new codes were approved by the IARC/WHO Committee for ICD-O.

** These lesions are classified according to the lymphoma to which they correspond, and are assigned the respective ICD-O code.

italics: Provisional tumour entities.

Mr. Y gets referred to ENT for an excisional biopsy of the cervical node. What workup should you order while awaiting the pathological diagnosis?

Lymphoma workup:

- Get a biopsy, the bigger the better
- CBC
- Lytes, Cr, Urea, **Urate**, **Ca**, albumin, **LDH**
- CT Neck/chest/abdo/pelvis
- Hepatitis B surface Ag, surface Ab, Core Ab, Hep C, HIV
- Echo
- Watch out for: febrile neutropenia, tumor lysis syndrome, hypercalcemia

Table 2: Criteria for laboratory and clinical tumour lysis syndrome as defined by Cairo-Bishop⁹

Cairo-Bishop criteria		
Laboratory TLS	≥ 2 among	Clinical TLS
Uric acid	≥ 476 µmol/L	Laboratory TLS and ≥ 1 among: • Acute kidney injury • Seizure • Arrhythmia • Sudden death
Potassium	≥ 6 mmol/L	
Phosphorus	≥ 2.1 mmol/L (children) ≥ 1.5 mmol/L (adults)	
Calcium	≤ 1.75 mmol/L	

Laboratory alterations should be measured within the same 24 hours and must occur within 3 days before and 7 days after therapy. TLS = tumour lysis syndrome.

Guy's Lymphoma No-No's

- DO NOT

- Get a fine needle biopsy
- Start prednisone prior to obtaining diagnosis/ without talking to Oncology
- Forget to screen for hypercalcemia/TLS

- DO

- Obtain Core or Excisional biopsy (the bigger the better)
- Discuss with oncology prior to considering prednisone
- Update patient's vaccinations
- Refer to cancer center

Dr. Lacey Pitre

Case - GYNE

- 50F with new onset abdominal cramping, discomfort

CONCLUSION:

Large 15 cm multilocular right ovarian cyst. Mostly 1 large cavity, posterior either septation or locule seen dependently, difficult to be sure. There are at least 2 mural projections, papillary posterior measuring 8 mm and adjacent a sessile area measuring 6 mm thick and about 2 cm in length. These may be all part of 1 lobulated plaque. There is peripheral vascularity in the wall, color score 2-3.

Cancer Antigen 125

Name	Result	Flag	Ref Range	Units
Cancer Antigen 125	42	H	< 36	kU/L
Test method: Roche Cobas immulite 1000				

Most Common Patient Presentations

Ascites/Peritoneal disease



☐ Ca125, CEA

☐ CT (AP +/- C)

☐ Referral for BIOPSY

☐ Referral to CANCER CENTRE

Large complex Ovarian mass



☐ Ca125, CEA. If less than 40 (AFP, BHCG, LDH)

☐ CT (AP +/- C)

☐ Referral to GYNECOLOGY

☐ Referral to Gynecologic Oncology

GYN MULTIDISCIPLINARY ONCOLOGY INTAKE FORM

Request for Gyn Oncology Program Consultation

Fax: 705-739-5636 Tel: 705-728-9090 ext 43155

Date of Referral (DD/MM/YYYY): _____

Consultation Requested:
(check all that apply)

☐ Medical

☐ Radiation

☐ Surgical

Referring Physician Information

Referring Physician

()

OHIP Billing #

()

Phone #

Fax #

Primary Care Physician Information

☐ Same as Referring Physician

Primary Physician

()

OHIP Billing #

()

Phone #

Fax #

Patient Information (please fill in as much as possible)

Patient Name

Date of Birth (DD / MM / YYYY)

()

()

Street Address

Home Phone #

Business/Other Phone #

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City, Province

Postal Code

Health Card #

Version

Expiry date

Reason for Referral

Date of Referral(DD/MM/YYYY): _____

Referral Reason (Diagnosis): _____

☐ New Diagnosis

☐ Follow-Up

☐ 2nd Opinion

☐ Recurrent /Progressive Disease

RVH Gynecologic Oncology Referral - Recommended Staging Investigations

The following investigations should be ordered concurrently with a referral to the Gynecologic Oncology program to expedite patient care.

Please use this document as a guideline only, if you have questions or require clarification, please contact the Gynecologic Oncologist on call at **705-986-0126**.

Endometrial Cancer

Grade 1

- Pelvic US
- If suspicion of extrauterine or locally advanced disease – CT Chest Abdomen Pelvis

Grade 2

- CT Abdomen Pelvis
- Consider CT Chest if abnormal findings on abdominal or pelvic imaging

Grade 3

(Includes serous, clear cell, carcinosarcoma)

- CT Chest Abdomen Pelvis

Cervical cancer

- CT Abdomen Pelvis
- CT Chest if stage 1B or greater
- MRI pelvis

Ovarian cancer or Suspicious pelvic mass

- CT Abdomen Pelvis
- CT Chest if confirmed or highly suspicious for cancer
- Ca125
- If < 40 years old, AFP, HCG, LDH

Extra PEARLS

- LDAP
- Breast Cases

Questions?
