Question 1:
In evaluating the risk of lymph node metastasis in endometrial cancer a tumor size greater than ___ has been associated with a greater risk of lymph node metastasis in grade 2 and 3 cancers.
   a. 1 cm
   b. 2 cm
   c. 3 cm
   d. 5 cm

Answer: B

Feedback:
Especially in patients that do not undergo lymph node dissection, the decision regarding pelvic radiation is often made in relationship to the risk of lymph node metastasis. In evaluating this risk it is important to also consider the size of the tumor.

References: Schink Cancer 67:279;1991

Question 2:
PORTEC 1 randomized intermediate risk endometrial cancer patients between:
   a) Pelvic Radiation and Observation
   b) Vaginal Cuff Radiation and Observation
   c) Vaginal Cuff Radiation and Pelvic Radiation
   d) Chemotherapy and Radiation

Answer: A

Feedback:
Knowledge of PORTEC 1 is critical in the decision for treatment for intermediate risk endometrial cancer.

Reference: Creutzberg, Lancet 2000; Scholten, IJROBP 2005

Question 3:
A 61 year old female undergoes total abdominal hysterectomy, oophorectomy and pelvic and para-aortic lymphadenectomy. Final pathology reveals a Grade 2 endometroid adenocarcinoma invading 8 of 12 mm of myometrial thickness. The most correct answer regarding her recurrence risk without therapy is:
   a) Of the loco-regional recurrences, approximately 75% are at the vaginal apex.
   b) The loco-regional recurrence risk is 35%.
   c) Survival is expected to be 50%.
   d) The risk of loco-regional recurrence is less than 2%.

Answer: A

Feedback:
Knowledge of patters of recurrence in endometrial cancer is critical is treatment decisions.

Question 4:
In prognostic nomograms for cervical cancer published in 2015 based on the prospective GOG trials, which of the following is not listed as a prognostic factor?

A) Lymph node involvement
B) Grade
C) Race/Ethnicity
D) Lymphovascular invasion
E) Chemotherapy utilization

Answer: D.
Feedback: LVI is not listed as a prognostic factor in the nomograms. Factors listed include: histology, negative para-aortic nodes, presence of pelvic node involvement, race/ethnicity, performance status, tumor size, FIGO stage, grade, and treatment (RT +/- chemotherapy) administered.


Question 5:
When utilizing CT imaging to optimize treatment planning to the cervix, one will notice the following about reporting point A:

a) point A lies outside of the contoured cervix when the cervix is greater than 5 cm
b) point A lies outside of the contoured cervix when the cervix is less than 3 cm
c) point A lies inside the contoured cervix when the cervix is less than 3 cm wide
d) the dose to point A remains a constant regardless of where the prescription line surrounding the cervix lies
e) the dose to point A will vary based on the number of days between fractions

Answer: B
Feedback: When contouring, the physician will delineate the cervix based on its visualized dimensions. If the cervix is greater than 4 cm, point A will lie inside the contours. If the cervix is less than 4 cm, point A will lie outside of the contours. If one utilizes the D90, the prescription line will cover the cervical contour, and the dose to point A will vary. The dose to point A will not vary based on the number of days between fractions. Over a course of 5 fractions, the dose to point A will be higher than a dose to a CT contoured volume by @4%.

Reference
Cho LP, Manuel M, Catalano P, Lee L, Damato AL, Cormack RA, Buzurovic I, Bhagwat M, O'Farrell D, Devlin PM, Viswanathan AN.
Outcomes with volume-based dose specification in CT-planned high-dose-rate brachytherapy for stage I-II cervical carcinoma: A 10-year institutional experience.
Gynecol Oncol. 2016 Dec;143(3):545-551
Question 6.
A prospective trial from France (STIC trial) has shown that CT-based contouring and treatment planning, when compared to plain radiographic film imaging for cervical cancer, has:

a) Worse survival rates
b) Increased the normal tissue doses surrounding the applicator
c) Shorter time requirements for contouring and planning
d) Broader lateral width dimensions of the cervix on MR compared to CT cervical contours
e) Reduced normal tissue toxicity

Answer: E

Feedback: T2 weighted MR provides good visualization of the gross tumor, whereas CT dose not. CT contours are wider than MR contours. The STIC trial, in patients that received chemoradiation, showed a reduction in normal tissue toxicity from 22% to 2.7%.

References: