Case Log Information: Gynecologic Oncology
Review Committee for Obstetrics and Gynecology

The Review Committee has defined index categories required for fellow education in gynecologic oncology. The Review Committee uses ACGME Case Logs to assess the breadth and depth of a program's procedural training as well as the individual fellow experience. This document provides information about the index categories, the minimum number of cases fellows are required to perform and properly logging procedural experiences.

The index categories and minimums became effective in the Accreditation Data System (ADS) for the 2026 graduates. The Review Committee will review 2026 graduate data, but programs will not receive an Area for Improvement (AFI) or citation for missed procedural minimums for these graduates. Upon review of 2027 graduate data, the Review Committee may issue AFIs to programs for missed procedural minimums. Beginning with the review of the 2028 graduate data, programs may be subject to a citation for missed procedural minimums.

Program directors are expected to monitor fellows' Case Logs to ensure that they are logging consistently and accurately. A list of gynecologic oncology tracked procedures can be found in the Accreditation Data System (ADS) > Case Log Tab > Reports > Tracked Codes Report. The "Min Cat" column indicates whether a procedure counts toward a minimum subcategory(ies). If a minimum subcategory is listed, credit is also given to the corresponding index category.

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Gynecologic Oncology Minimum Numbers

Category	Minimum
Hysterectomy	
Complex (en bloc ovca, post-radiation, percreta, etc.)	Begin tracking
Radical hysterectomy or radical trachelectomy (for cervical cancer only)	10
Total radical + complex hysterectomy	40
Other	
Exenteration*	2
Conduit*	2
Brachytherapy*	3
Vulvectomy (for invasive cancer)*	10
Diaphragm/liver mobilization	Begin tracking
Splenectomy	Begin tracking
Lymph Nodes	
Pelvic	
Pelvic lymph node dissection (LND) (count sides)	15
Pelvic sentinel lymph node (SLN) (count patients)	50
Para-aortic	
Para-aortic lymph node dissection	15
Inguinal	
Inguinal lymph node dissection (LND) (count sides)*	5
Inguinal sentinel lymph node (SND) (count patients)*	10
Debulking	
Complex/upper abdominal debulking (including diaphragm, spleen, stomach)	20
Total debulking (including complex)	40
Gastrointestinal Procedures	
Large bowel (including Low Anterior Resection (LAR))	10
Total – bowel resections	20
Ostomies	5
Chemotherapy/Targeted	100 cycles

*Includes Assistant

Notes:

- For some procedures, how the procedure was performed will be logged (i.e., minimally invasive surgery (MIS) or open).
- For each procedure or therapy entered, fellows must identify a disease type, including:
  - Benign disease
  - Cervical cancer
  - Non-gynecologic cancer
  - Ovarian/fallopian tube cancer
  - Uterine cancer
  - Vulvar-vaginal cancer

Minimum numbers represent what the Review Committee believes to be an acceptable minimal experience. Minimum numbers are not a final target number and achievement does not signify competence. Program directors must ensure that fellows continue to report their procedures in the Case Log System after minimums are achieved.

Surgeon, Assistant, and Teaching Assistant Roles

Surgeon
To be recorded as **Surgeon**, a fellow must perform at least 50 percent of the procedure, including a significant number of key portions. Two fellows may enter Surgeon for a bilateral procedure provided that they each complete one side, each is involved in 50 percent of the procedure, and each equally participates in key portions of the procedure.

Assistant
To be recorded as **Assistant**, a fellow must perform less than 50 percent of the procedure and/or not perform the key portions of the procedure.

Teaching Assistant
To be recorded as **Teaching Assistant**, a fellow directs and oversees major portions of the procedure being performed by a more junior fellow or a resident. The attending surgeon must function as an Assistant or Observer.

Questions

When are the gynecologic oncology procedural minimums effective?
The minimums are effective with the 2026 graduate cohort, i.e., fellows who complete fellowship on June 30, 2026, or soon thereafter. The new minimum procedural requirements will not be enforced until 2027 graduate data is available.

How were the minimums determined?
Identification of minimums is a data-driven exercise based on graduate Case Log data. A subcommittee including members from the Review Committee for Obstetrics and Gynecology reviewed all available graduate Case Log data from gynecologic oncology programs. Discussion of the minimum for each category/subcategory started with the tenth percentile of graduate experience representing a minimum threshold. This baseline is consistent with other (sub)specialties. To arrive at a final minimum number, subcommittee members reviewed the data in all programs and considered their knowledge and experience as subject matter experts.

When will programs start to be cited for not meeting the required procedural minimums?
The Committee recognizes that it may take time for programs to acclimate to the new required minimums. Citations related to meeting the required procedural minimums will not be issued at least through the 2027 graduates. Programs may receive citations for missed procedural minimums starting with the 2028 graduate data.

Is it possible that the minimums may change in the near future?
There are no plans to update the minimum procedural requirements for at least a few years. Case Log data will be regularly reviewed. The Committee may consider revising the minimums once additional years of graduate Case Log data are available.

How do fellows get an ID and password to access the Case Log System?
Fellows will have an ID and password assigned and emailed to them when their information is first entered into ADS by the program director or coordinator. Fellows will be required to change their passwords the first time they log into the system.

Do fellows need to enter a Case ID?
Case ID is optional.

Do fellows log cases differently than when they were obstetrics and gynecology residents?
Yes. The Case Log System for obstetrics and gynecology is based on CPT codes. To ease the burden of logging, the Case Log System for gynecologic oncology instead asks fellows to identify the disease category (e.g., cervical cancer) and type of medical and/or surgical management.

How do fellows log cases?
Two types of information are needed: disease category and intervention (e.g., specific procedure or chemotherapy). To log:

- Add general case information at the top of the log.
- Add the disease category:
    - Under Area: Select “Disease Category.”

    - Under Type: Select the disease (e.g., cervical cancer, vulvar-vaginal cancer).
    - Click “Search.”
    - Click “Add.”
    - **Note:** Fellows will see a blue row that states “Code added to this Case” and the blue “Selected Codes” button will indicate “1.”
- Add the medical management or surgical procedure.
    - Under Area: Select “Medical Management or Surgical Procedure.”
    - Under Type: Select the specific medical management or procedure; there are several ways to do this:
        - Select “All” > “Search” > “Add.”
        - Narrow the category under “Type” by choosing the type of medical management or procedure.
        - Click “Search” > “Add.”
    - Note: Fellows will see a blue row that states “Code added to this Case” and the blue “Selected Codes” button will indicate “2.”
    - Repeat for additional medical management or surgical procedure(s).
- To view or remove selected codes, click the blue “Selected Codes” button.
- Once all codes have been added, click the green “Submit” button.

Can fellows log procedures that are not being tracked in the Case Log System?
Yes, though not required by the ACGME, fellows may wish to use the system to track other procedures for their own purposes. Fellows should follow the instructions above and choose “Other (non-tracked procedure).” Specific information about the procedure(s) can be entered by pressing “+ Add Comments” and entering the procedure(s).

How do fellows create a report for procedures that are not tracked in the Case Log System?
Use the **Case Detail Report** because it includes comments. See above for instructions on logging non-tracked procedures.

Can attending physicians not included in the program’s Faculty Roster in ADS be included in the Attending list?
Yes. Program directors and coordinators can add an attending physician to the Case Log System: **Manage > Attendings > Add**. Only a name and email address are needed. The Case Log System will verify whether the attending is already in the database.

Can the program director and coordinator access the Case Log System?
Yes. Program directors and coordinators can access the system in a “view only” mode. Go to **Case Log System > Cases > Entry (View Only)**. Information can be entered but not saved.

Can two fellows choose the role of Surgeon for the same case?
No. Two fellows can log the same case, but they must choose different roles (e.g., Assistant and Surgeon or Surgeon and Teaching Assistant).

The Review Committee recognizes that exenteration, conduit, and bilateral inguinal femoral lymphadenectomy are rare cases. If two fellows participate in one of these procedures, one fellow should log the case as “Assistant” and the other as “Surgeon.” Correctly logging these cases will help the Review Committee establish appropriate minimums. The Review Committee may determine that for rare cases, credit will be given for both the “Assistant” and “Surgeon” roles. For information regarding the establishment of minimums, see the last question below.

If a fellow performs a complex procedure that by its nature includes several other procedures, should the fellow only enter the complex procedure into the Case Log System?
Given the breadth of surgical procedures and the individualization during any case, it is important to capture experience in specialty-defining activities. Therefore, for several operations, fellows should log both the general operation (e.g., exenteration or debulking) and any specific tracked procedures done during the operation. For example, if a fellow is the Surgeon for a total exenteration, the fellow should log an exenteration and also log the component procedures performed with that exenteration (e.g., bowel resection, ostomy, conduit) as applicable. Similarly, for a debulking procedure with a bowel resection, the fellow should log debulking and the type of bowel resection. As another example, for a debulking procedure that requires an en bloc resection of the uterus and rectosigmoid with ostomy creation, the fellow would log a procedure in all applicable categories (debulking, complex hysterectomy, bowel resection, and ostomy).

When should fellows log a complex hysterectomy?
This category is for hysterectomies that require some degree of radical or atypical dissection of pelvic urinary or vascular structures or other radical dissection in the pelvis at the time of the hysterectomy. It can be performed by a minimally invasive or open approach. Examples include, but are not limited to: i) en bloc resection of uterus and rectosigmoid colon during a debulking; ii) modified radical hysterectomy or similar dissection required for a cancer other than cervix; iii) a benign condition such as endometriosis; iv) hysterectomy done urgently for abnormal placentation at time of cesarean section or in the immediate post-partum period; and v) hysterectomy in conjunction with an abdominal-perineal resection for rectal cancer when requiring urinary, vascular, or other radical pelvic dissection. Fellows should consult with their program director if there are questions regarding whether a specific case fulfills the criteria for this category.

When should a radical hysterectomy or radical trachelectomy be logged?
These procedure categories should only be used when the procedure is being performed for an indication of cervical cancer. A radical hysterectomy for any other indication should be logged as a “complex hysterectomy.”

A radical hysterectomy for cervical cancer should not also be logged as a complex hysterectomy.

How should fellows record an exenteration?
Fellows should record the portion of exenteration they perform—anterior, posterior, or total. In addition, fellows should log procedures such as conduit and ostomy if performed. Posterior exenteration should be reserved for cervical or endometrial cancer recurrences in general. In contrast, en bloc resection of uterus/ovaries with rectosigmoid colon should not be considered posterior exenteration. It should instead be logged as a complex hysterectomy and bowel resection.

Should fellows log debulking if the case is limited to staging?
No. Fellows should only log debulking if they performed a debulking. If a case is limited to staging, fellows would only log the specific lymphadenectomy procedures.

Should fellows log bilateral lymphadenectomies as one procedure or two procedures?
Changes have occurred to this section. Pelvic SLN biopsy is typically required bilaterally for staging of cervical and endometrial cancers, and therefore fellows should log this as one procedure when SLN biopsies are performed on both sides. However, in cases of non-mapping

on one side, a lymphadenectomy would be required. In this case, the fellow would log a pelvic SLN for the side on which an SLN procedure was performed and a pelvic lymph node dissection for the side on which a full pelvic lymph node dissection was performed. To capture this, fellows are instructed to count each side of a lymphadenectomy when performed. When a sentinel lymph node procedure results in one pelvic lymph node mapped and one paraaortic lymph node mapped on the other side, then the fellow should log two procedures: a pelvic sentinel lymph node for the one side, and a paraaortic lymph node dissection for the other side.

When paraaortic lymphadenectomy is performed as a planned bilateral procedure as is the case for the staging of an ovarian cancer, this situation would be logged as a single procedure under paraaortic lymph node dissection. In cases where only a single side of a paraaortic lymph node dissection is performed (e.g., enlarged paraaortic node at the time of ovarian cancer debulking, unmapped sentinel lymph node in an endometrial cancer surgery when the surgeon determines that a paraaortic lymphadenectomy should be performed), then a paraaortic lymph node dissection may also be logged.

Cases in which a unilateral lymphadenectomy is the typical practice (e.g., groin nodes for a lateral vulvar cancer), each side should be counted.

How do fellows log the administration of chemotherapeutic drugs, radiation, and targeted therapeutics?
There are four options available in the Case Log System for therapies: chemotherapy, chemoradiation, chemotherapy/targeted therapeutic, and targeted therapeutic. A fellow should only log administration of a cancer therapeutic if they evaluated the patient, assessed the suitability to receive the medication(s), and participated in the decision-making regarding management of side effects, dosing, and administration of the medication(s).

Do fellows need to log a "Resident Role" for the administration of chemotherapeutic drugs, radiation, and targeted therapeutics?
Yes. The system requires a role be chosen. Fellows should choose "Surgeon."

If a fellow administers chemotherapy, chemoradiation, chemotherapy/targeted therapeutic, or targeted therapeutic to an individual patient several times, how many times does the fellow need to enter the same therapy given to the patient in the Case Log System?
The Committee will now be tracking cycles administered, recognizing the value of seeing sufficient cycles to identify rare side effects, dose reductions, and to assess response. Therefore, fellows should log each cycle they administer even if the regimen has not changed. Regimens with multi-day dosing should be logged as only one cycle.

If a patient has a recurrence of cancer and requires a new treatment regimen, should the fellow log the new therapy in the Case Log System?
Similar to above, whether an existing or a new regimen, each cycle should be counted.

What therapies should be logged as a targeted therapeutic?
Antiangiogenics, poly adenosine diphosphate ribose polymerase (PARP) inhibitors, immuno-oncology agents, hormonal agents, and other pathway-specific therapies should be logged as targeted therapeutic. When chemotherapy and targeted therapies are used together, this should be logged as chemotherapy/targeted therapeutic.