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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 (see instructions below)	Begin tracking
Radical hysterectomy or radical trachelectomy (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) (see instructions below)	15
Pelvic sentinel lymph node (SLN) (see instructions below)	50
Para-aortic	
Para-aortic lymph node dissection	15
Inguinal	
Inguinal lymphadenectomy*	5
Inguinal sentinel lymph node biopsy*	10
Debulking	
Upper abdominal debulking (including diaphragm, spleen, stomach, etc. – see instructions below)	20
Total debulking	40
Gastrointestinal Procedures	
Large bowel (including low anterior resection (LAR))	10
Total bowel resections	20
Ostomies	5
Chemotherapy/Targeted	100 cycles

*Can include *Assistant* cases

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.

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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 must direct and oversee 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.

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Questions

When are the gynecologic oncology procedural minimums effective and when might programs be cited for not meeting the required procedural minimums?
These minimum number categories became effective beginning August 1, 2025. AFIs may be issued for the 2027 graduation cohort. Programs not meeting the minimums may be subject to citations for the 2028 graduation cohort.

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.

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: case ID (typically an MRN), case date, case year (i.e., PGY in which the case was performed), role (e.g., Surgeon, Teaching Assistant, Assistant), site, and attending.
- Add the disease category from the drop-down menu.
- Select the Area/Type/Keyword tab.
- Under Area: Select “Medical Management or Surgical Procedure.”

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    - Under Type: Enter a selection from this drop-down menu to narrow the search. This step is not required.
    - Click on the "Search" button that is denoted by the magnifying glass icon.
    - Scroll to find the applicable Case Log that is to be added.
    - Select any appropriate checkbox for that Case Log entry (e.g., complex for hysterectomy or upper abdominal for debulking).
        - Select "Add" on the right had side. Fellows will see a blue alert banner that states "Code added to this case" and the blue "Selected" button in the upper right hand will indicate "1."
    - Additional log entries can be added for the same patient or other patients at this time.
        - The number by the "Selected" button will increase appropriately with each log entry.
- Codes can be viewed or edited by selecting them from the right-hand column.
- Once all codes have been added, click the green "Submit" button.
- Case Log entries will NOT be recorded in the system unless you click the "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 there are certain circumstances when it is appropriate to allow two fellows to log the same procedure according to the roles that they performed. These situations are exenterations, conduits, brachytherapy, vulvectomy (for invasive cancer), inguinal lymphadenectomy, and inguinal sentinel lymph node biopsy. If two fellows participate in one of these procedures, one fellow should log the case as "Assistant" and the other as "Surgeon" or "Teaching Assistant." Correctly logging these cases will help the Review Committee establish appropriate minimums in the future. The Review Committee may determine that for rare cases, credit toward the required minimum will be given for both the "Assistant" and "Surgeon" or "Teaching Assistant" roles.

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What counts as a complex hysterectomy and 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. Radical hysterectomy for cervical cancer should not be logged using the “Complex” checkbox in this category, but rather logged as radical hysterectomy.

Complex hysterectomies can be performed by a minimally invasive or open approach. Examples include, but are not limited to: i) en bloc resection of uterus and recto-sigmoid 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 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 to be counted as complex.

How do fellows log a complex hysterectomy?
In the list of Case Log procedures, the hysterectomy options will show a checkbox with the word “Complex” below the procedure name. The fellow must select the “Complex” checkbox prior to selecting to “Add” the procedure. See the figure below.

	Abdominal hysterectomy ☐ Complex	Surgical procedure	Hysterectomy (total or supracervical +/- BSO)	★	Add

If a fellow performs an operation that includes several procedure types in the Case Log System, does the fellow need to enter a log for each of those procedures?
Yes, the Case Log System can only track procedures if they have a separate log entry.

For certain 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 log the component procedures they 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, hysterectomy and select the “Complex” checkbox, bowel resection, and ostomy).

When should a radical hysterectomy or radical trachelectomy be logged?
These procedure categories should only be logged when the procedure is being performed for an indication of cervical cancer.

A radical hysterectomy for any other indication should be logged as either laparoscopic hysterectomy, robotic hysterectomy, or abdominal hysterectomy – depending on the route performed – and mark the corresponding box that says “Complex” in the Case Log System.

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A radical hysterectomy for cervical cancer should NOT be logged using the “Complex” checkbox.

How should fellows record an exenteration?
Fellows should record the portion of exenterations 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, vulvar, 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 hysterectomy selecting the “Complex” checkbox along with a bowel resection. If this is performed as part of a debulking, then the fellow would also select the appropriate debulking category.

Should fellows log debulking if the case is limited to staging?
No. Fellows should only log debulking if they performed a debulking surgery. For example, if a surgery includes an exploratory laparotomy, total abdominal hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic and paraaortic lymphadenectomies, omentectomy and peritoneal biopsies for an apparent early-stage ovarian cancer, then the fellow would select the appropriate codes to log the pelvic and paraaortic lymphadenectomies. If the hysterectomy met the description of being complex as described above, then the fellow would also select abdominal hysterectomy and select the “Complex” checkbox.

How should the fellow enter procedure logs for pelvic sentinel lymph node biopsies if both sides map?
Pelvic sentinel lymph node (SLN) biopsy is typically required bilaterally for the staging of cervical and endometrial cancers. In the most common scenario, when the sentinel lymph nodes map on both sides of the pelvis, the fellow should log only one pelvic sentinel lymph node biopsy in the Case Log System even though sentinel lymph nodes on both sides are removed.

How should the fellow enter procedure logs if one side maps a pelvic sentinel lymph node and a paraaortic sentinel lymph node maps on the other side?
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: 1) a pelvic sentinel lymph node biopsy for the one side; and, 2) a paraaortic lymphadenectomy for the other side, as there is no category for paraaortic sentinel lymph node biopsy.

How should the fellow enter procedure logs if both sides map to paraaortic sentinel lymph nodes?
In this scenario, similar to when two pelvic lymph nodes map, the fellow will enter only one paraaortic lymphadenectomy even though paraaortic lymph nodes are removed from both sides.

How should the fellow enter procedure logs if one side maps for a pelvic sentinel lymph node biopsy and the other side does not map at all?
In cases of non-mapping on one side, a full lymphadenectomy would be required. In this case, the fellow would log: 1) a pelvic SLN biopsy for the side on which an SLN biopsy was performed; and, 2) a pelvic lymphadenectomy for the side on which a full pelvic lymphadenectomy was performed. If it is determined that a paraaortic lymphadenectomy is also required on the side that does not map, then the fellow would enter a third Case Log for paraaortic lymphadenectomy.

How should the fellow enter procedure logs if neither side maps in a planned pelvic sentinel lymph node procedure?
If neither side maps for pelvic sentinel lymph nodes, and the fellow completes a full pelvic

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lymphadenectomy bilaterally, then the fellow would log one pelvic lymphadenectomy even though lymph nodes are removed on both sides. If it is determined that a paraaortic lymphadenectomy is also required on one or both sides when neither side maps, then the fellow would also enter one log entry for paraaortic lymphadenectomy even when both sides of a paraaortic lymphadenectomy are performed.

How should the fellow enter procedure logs for lymphadenectomy for ovarian cancer staging or lymph node debulkings?
When pelvic or paraaortic lymphadenectomy is performed as a bilateral procedure for the staging of an ovarian cancer, or if there are enlarged lymph nodes bilaterally that require debulking, this would be logged as a single procedure under either pelvic lymphadenectomy or paraaortic lymphadenectomy, as appropriate. If both bilateral pelvic and bilateral paraaortic lymphadenectomies are performed, then the fellow would log two procedures: 1) pelvic lymphadenectomy; and 2) paraaortic lymphadenectomy. In cases where only a single side of a pelvic or paraaortic lymphadenectomy is performed (e.g., unilaterally enlarged pelvic or paraaortic node at the time of ovarian cancer debulking) then a pelvic or paraaortic lymphadenectomy may also be logged as applicable

How should fellows log inguinal lymph node procedures?
As noted in the Minimum Numbers table, a fellow functioning in any capacity as defined above (Surgeon, Teaching Assistant, or Assistant) should enter a log for an inguinal lymph node procedure. This could include a procedure in which one fellow functions in the role of Surgeon or Teaching Assistant and another fellow in the role of Assistant in the same case.

For procedures that involve either a unilateral or bilateral inguinal sentinel lymph node biopsy, the fellow will create only one log entry. If two fellows are present for a unilateral inguinal sentinel lymph node biopsy and one functions as the Surgeon or Teaching Assistant and the other as the Assistant, then each will create a single log entry for inguinal sentinel lymph node biopsy according to their role.

If two fellows are present for a bilateral inguinal sentinel lymph node biopsy where one functions as the Surgeon or Teaching Assistant and the other Assistant (and/or they alternate roles for each side), then each fellow will still only create a single log entry under inguinal sentinel lymph node biopsy.

For planned unilateral inguinal sentinel lymph node procedures that do not map and a full inguinal lymphadenectomy is performed, the fellow will log one inguinal lymphadenectomy. If there are two fellows, then one fellow may log the inguinal lymphadenectomy as the Surgeon or Teaching Assistant and the other as Assistant.

For planned bilateral inguinal sentinel lymph node procedures in which one side maps and the other side does not map and results in a full inguinal lymphadenectomy, then the fellow (or fellows) will create two log entries: 1) one inguinal sentinel lymph node biopsy for the side on which a sentinel lymph node mapped; and, 2) one inguinal lymphadenectomy for the side that did not map. Again, if two fellows are present, then each fellow will log the inguinal sentinel lymph node biopsy and the inguinal lymphadenectomy according to their role in each.

For planned bilateral inguinal sentinel lymph node procedure in which neither side maps, or in planned bilateral full inguinal lymphadenectomy procedures (either systematic or debulking), the fellows may create a log entry for each side of the procedure. For example, if the fellow functions as the Surgeon or Teaching Assistant for both the right and a left inguinal lymphadenectomy,

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then that fellow would create two log entries – both for inguinal lymphadenectomy. In another example, if a fellow functions as the Surgeon or Teaching Assistant for a right inguinal lymphadenectomy and the Assistant for a left inguinal lymphadenectomy with the same patient, the fellow will create two log entries – one for their role in each side of the full inguinal lymphadenectomies. If two fellows are participating in the full inguinal lymphadenectomies, they should each create log entries applicable to the role they performed on each side. If both fellows participated in both sides, the two fellows may create two log entries each – one for each side of the lymphadenectomy.

How do fellows log medical management of chemotherapy and targeted therapeutics?
There are three options available in the Case Log System: chemotherapy, targeted therapeutic, and chemotherapy/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 role for medical management of cancer therapeutics?
Yes. The system requires a role to be chosen. Fellows should choose Surgeon.

If a fellow administers a cancer 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 to recognize 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 and they have entered a log for the same patient previously. 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 enter another medical management log in the Case Log System?
Similar to above, whether there is an existing or a new regimen, each cycle should be logged.

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.

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