Appendix 1

Laparoscopic/Robotic Hysterectomy, Bilateral Salpingo-Oophorectomy Surgeon Protocol

- The patient is under general anaesthetic and ventilated;
- Allan stirrups or equivalent are used to rest the patient's legs;
- Preoperative antibiotic is given at least 15 minutes before skin incision;
- Positioning in the lower lithotomy position with the arms parallel to the patient or the arms resting on the patient's chest;
- One (peri-)umbilical port, which carries the telescope plus multiple other 5 mm ports are inserted;
- Pelvic washings are collected for cytology;
- Division of the round ligament in order to enter the retroperitoneum;
- The ovarian pedicle is secured and divided; in selected patients, the preservation of ovaries is accepted;
- The peritoneum of the broad ligament, both the anterior and the posterior leaves are divided;
- The incision is carried anteriorly, and the bladder peritoneum is incised at the cervico-uterine junction and the bladder is reflected;
- A vaginal device (e.g., tube) is inserted transvaginally;
- Bladder reflection is completed, and the bladder pillars are lateralised over the edge of the tube;
- The uterine artery is identified, secured and divided at the level of the rim of the tube; alternatively, the uterine vessels can be secured at their origin at the level of the internal iliac vessels;
- The vagina is circumcised over the vaginal tube and the specimen is removed through the vaginal tube;
- Morcellation of the specimen is prohibited. If the specimen is too large to be extracted transvaginally, an abdominal incision will be made to retrieve the specimen;
- Enlarged, suspicious lymph nodes or any other suspicious tissues will be removed through the transvaginal tube or a port (through an endobag); these tissues will need to be labelled by providing location of nodes (aortic, caval, common iliac, external iliac, obturator, presacral) and side (right, left);
- Laparoscopic/Robotic suture of the vault is performed while the CO2 pneumoperitoneum is maintained; suturing the vagina through a vaginal approach is unwarranted.

Appendix 2	
Follow-up Procedures	
Day 1 – after surgery	Record the postoperative Haemoglobin level taken on the day after surgery (if done)
Postoperative Week 1 ± 3 days (Visit 3)	• Provide participant with questionnaire booklet • Review ECOG performance score • Weight if available • Assess participants for their individual pain level using Numeric Pain Rating Scale • Record full blood count, urea and electrolytes and liver function tests if available • Physical examination – not a requirement at this time point, however record done/not done • Collect all adverse events. Assess using Common Terminology Criteria for Adverse Events (CTCAE) v5.0 • Update all concomitant medications • Update illnesses/morbidities • Electronic case report form completed
Postoperative Week 6 ± 7 days (Visit 4)	• Provide participant with questionnaire booklet • Lymphoedema assessments via bioimpedance spectroscopy and/or self-report questionnaire • Review ECOG performance score • Weight if available • Assess participants for their individual pain level using Numeric Pain Rating Scale • Record full blood count, urea and electrolytes and liver function tests if available • Physical examination – not a requirement at this time point, however record done/not done • Collect all adverse events. Assess using Common Terminology Criteria for Adverse Events (CTCAE) v5.0 • Update all concomitant medications • Update illnesses/morbidities • Electronic case report form completed
Postoperative Month 3 ± 14 days (Visit 5)	• Provide participant with questionnaire booklet • Lymphoedema assessments via bioimpedance spectroscopy and/or self-report questionnaire • Review ECOG performance score • Weight if available • Assess participants for their individual pain level Numeric Pain Rating Scale • Record full blood count, urea and electrolytes and liver function tests if available • Physical examination –must be done every 3-6 months, record if done/not done • Queensland Centre for Gynaecological Cancer (QCGC) symptom checklist

	• Collect all adverse events. Assess using Common Terminology Criteria for Adverse Events (CTCAE) v5.0 • Update all concomitant medications • Update illnesses/morbidities • Electronic case report form completed
Postoperative Month 6 ± 30 days (Visit 6)	• Provide participant with questionnaire booklet • Lymphoedema assessments via bioimpedance spectroscopy, leg circumference measurements (QLD only) and/or self-report questionnaire • Review ECOG performance score • Weight if available • Assess participants for their individual pain level using Numeric Pain Rating Scale • Record full blood count, urea and electrolytes and liver function tests if available • Physical examination- must be done every 3-6 months, record if done/not done • QCGC symptom checklist • Collect all adverse events. Assess using Common Terminology Criteria for Adverse Events (CTCAE) v5.0 • Update all concomitant medications • Update illnesses/morbidities • Electronic case report form completed
Postoperative Month 9 (Visit 7)	**Must be collected any time after the date of last visit and up to 2 weeks after the due date of this visit.** • Provide participant with questionnaire booklet • Lymphoedema assessments via bioimpedance spectroscopy and/or self-report questionnaire • Weight if available • Physical examination- must be done every 3-6 months, record if done/not done • QCGC symptom checklist • Collect all adverse events. Assess using Common Terminology Criteria for Adverse Events (CTCAE) v5.0 • Update all concomitant medications • Update illnesses/morbidities • Electronic case report form completed
Postoperative Month 12 (Visit 8)	**Must be collected any time after the date of last visit and up to 2 weeks after the due date of this visit.** • Provide participant with questionnaire booklet • Lymphoedema assessments via bioimpedance spectroscopy, leg circumference measurements (QLD only) and/or self-report questionnaire • Weight must be recorded at this visit • Physical examination- must be done every 3-6 months, record if done/not done • QCGC symptom checklist

	• Collect all adverse events. Assess using Common Terminology Criteria for Adverse Events (CTCAE) v5.0 • Update all concomitant medications • Update illnesses/morbidities • Electronic case report form completed
Postoperative Month 18 - 54 (Visit 9-18)	**Must be collected any time after the date of last visit and up to 2 weeks after the due date of this visit.** • Clinic visit and/or QCGC symptom checklist • Bloods, pathology, results/scans etc to establish participant status if required/available • Electronic case report form completed • Physical examination record at each visit if it has been done. Must be done every 3-6 months up to 2 years post operatively and then 6monthly up to 4.5 years, record if done/not done