

## **Pathway Gynaecology Cancer & Diagnostic Protocol for Inter Trust transfer**

Timed schedules to enable the proactive management of the patient from point of receipt of referral to first definitive treatment were drafted.

### **Document history**

Version 1 - June 2003.

Version 2 – February 2007 distributed for consultation (closing 12<sup>th</sup> March 2007).

Version 3 – March 2007

Version 4 – Version 3 amended to include timed schedules; distributed for consultation closing 29<sup>th</sup> November 2007.

Version 5 Care Pathway – December 2007

<b>Gynaecological Cancer Care Pathway: Typical Presentation, Diagnosis and Treatment (TIME 0 DAYS)</b>				
<b>Referral Guidance</b>	Refer patients with symptoms suggestive of gynaecological cancer to an appropriate specialist team. <ul style="list-style-type: none"> <li>Lesions suspicious of cervical or vaginal cancer on speculum examination (smear not needed)</li> <li>Unexplained vulval lump</li> <li>Vulval bleeding due to ulceration</li> <li>Postmenopausal bleeding with no HRT</li> <li>Postmenopausal bleeding on tamoxifen</li> <li>Postmenopausal bleeding persisting for 6 weeks after stopping HRT</li> </ul>		Ovarian cancer is difficult to diagnose. In patients with vague unexplained abdominal symptoms carry out an abdominal palpation. Consider pelvic examination and Ca125 blood test.  Refer for urgent USS with palpable abdominal or pelvic mass (not obvious fibroid uterus) where direct access USS is available otherwise make urgent referral.  Consider referral if persistent intermenstrual bleeding with normal pelvic examination	
<b>REFER TO CONSULTANT GYNAECOLOGIST FOR INVESTIGATION/DIAGNOSIS</b>				
	<b>Ovary</b>	<b>Cervix</b>	<b>Vulva/Vagina</b>	<b>Uterus</b>
<b>Investigation and Diagnosis</b>	USS/CT/Ca 125/CEA/C19.9 Risk of Malignancy Index (RMI) calculated	Cervical Biopsy MRI	Biopsy CT	Hysteroscopy/Biopsy MRI
<b>MULTIDISCIPLINARY TEAM MANAGEMENT</b> (ALL PATIENTS SHOULD BE DISCUSSED AT AN MDT MEETING PRE-MANAGEMENT WHERE POSSIBLE) (I.E;STAGING OF DISEASE; NATURE & LOCATION OF TREATMENT)				
<b>DECISION TO TREAT</b> (DATE PATIENT INFORMED OF TREATMENT AND AGREES TO TREATMENT PLAN)				
<b>PRIMARY TREATMENT</b>				<b>(TIME 31 DAYS)</b> <b>(TIME 62 DAYS)</b>
<b>Primary Treatment</b>	<b>Cancer Unit</b> Surgery <b>Cancer Centre</b> Radical Surgery / Chemotherapy	<b>Cancer Centre Only</b> Radical Hysterectomy or Chemo-radiation	<b>Cancer Centre Only</b> Radical Vulvectomy	<b>Cancer Unit</b> Hysterectomy+ BSO (early stage low risk disease) <b>Cancer Centre</b> Hysterectomy+BSO+/-Radiotherapy
<b>CONTINUING CARE AND FOLLOW-UP SHOULD BE AGREED BY THE CANCER CENTRE / CANCER UNITS MDTs</b>				
	<b>SPECIALIST PALLIATIVE CARE</b>			<b>PSYCHOSEXUAL COUNSELLING</b>
<b>Continuing Care</b>	All patients should receive information and literature on community based support. Most palliative care provided by primary care team. Refer as appropriate at any stage for psychosexual counselling or specialist palliative care.	<ul style="list-style-type: none"> <li>Physical: uncontrolled pain; intestinal obstruction; lymphoedema; drug side effects</li> <li>Psychological: complex emotional issues</li> <li>Rehabilitation</li> </ul>	<ul style="list-style-type: none"> <li>Social: complex family issues</li> <li>Spiritual: loss of hope; cultural or religious issues</li> <li>Respite Care</li> <li>Terminal Care</li> </ul>	<ul style="list-style-type: none"> <li>Severe adjustment reaction to the diagnosis of cancer or the effect of treatment</li> <li>Physical complications affect normal sexual function</li> <li>Psychosexual difficulties directly or indirectly related to disease.</li> </ul>

## GYNAE CANCER - SECONDARY TO TERTIARY REFERRAL

### *Diagnostics Protocol For Inter Trust Transfer*

#### **INTRODUCTION**

Priorities for Action 2007/08 targets introduced this year aim to improve the timeliness of access to services for cancer patients.

- By March 2008, at least 98% of patients diagnosed with cancer should commence treatment within 31 days of the decision to treat.
- By March 2008 at least 75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days (increasing to 95% by March 2009).

Central to the delivery on this target will be effective and timely transfer of those patients that require a tertiary referral. This will be supported through effective Regional MDTs; by avoiding delay and duplication of diagnostic and staging tests; ensuring that there are no gaps or conflicting pathways operating in organisations along the patient pathway; and proactive patient tracking.

It has been agreed with the DHSS&PS Service Delivery Unit that all referrals to tertiary care for treatment should be made within 28 days of receipt of referral as a suspect cancer. This should be possible for the majority of patients.

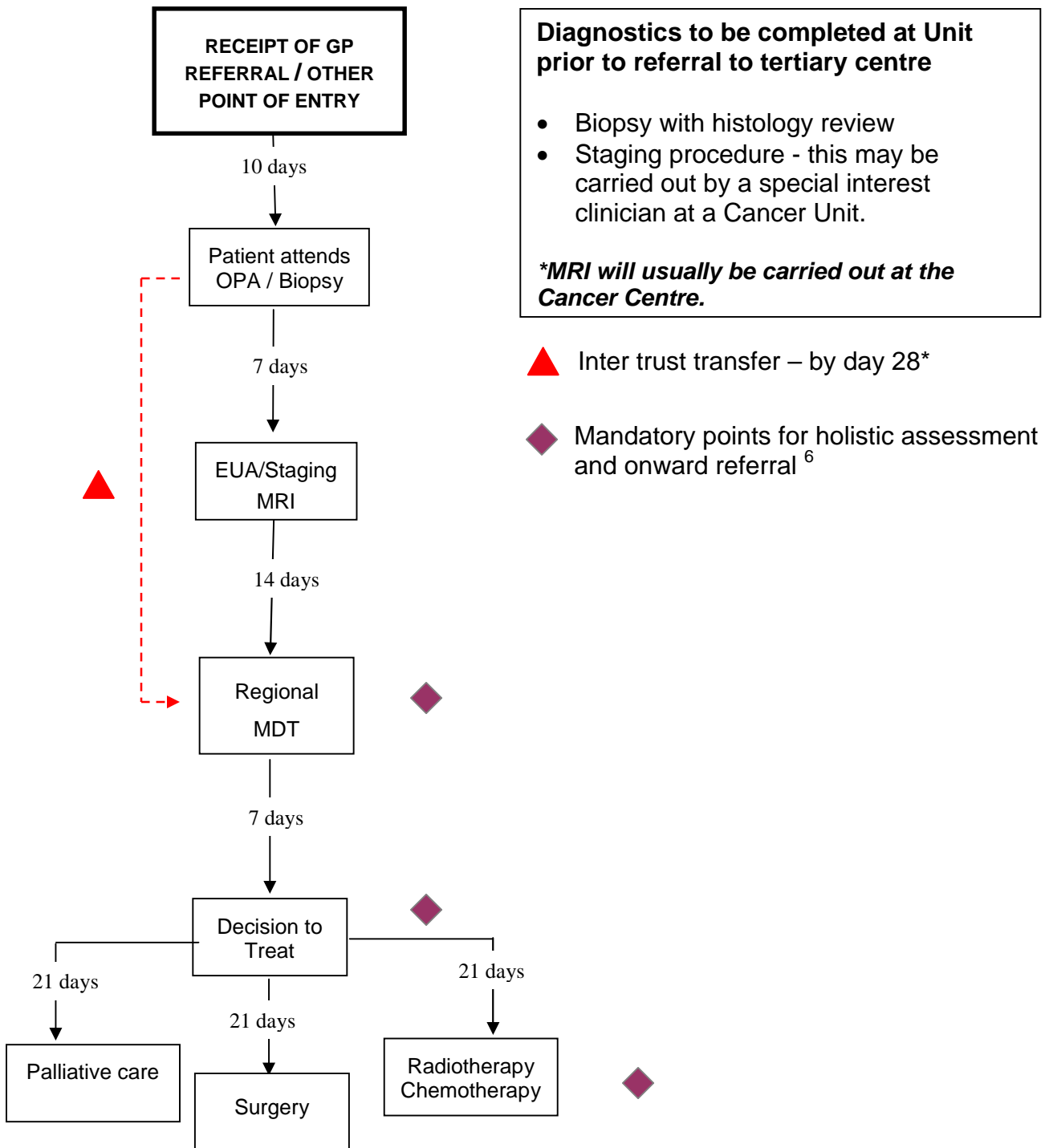
The protocol outlines the clinical investigations that need to be completed before transfer to the tertiary centre in order to enable the service to meet the targets and to ensure that patients have a quality, timely and effective experience at all stages of their pathway.

Figure 1 outlines the diagnostic procedures that should be undertaken by Cancer Units prior to referral to the tertiary centre. ***Immediately the diagnosis has been confirmed histologically Cancer Units should make arrangements for the results of these investigations to be presented at next Regional MDT (Wednesdays at 8.30am) and to be forwarded with the tertiary referral.***

**FIGURE 1. INVESTIGATIONS TO BE COMPLETED AT CANCER UNIT TO BE FORWARDED WITH TERTIARY REFERRAL**

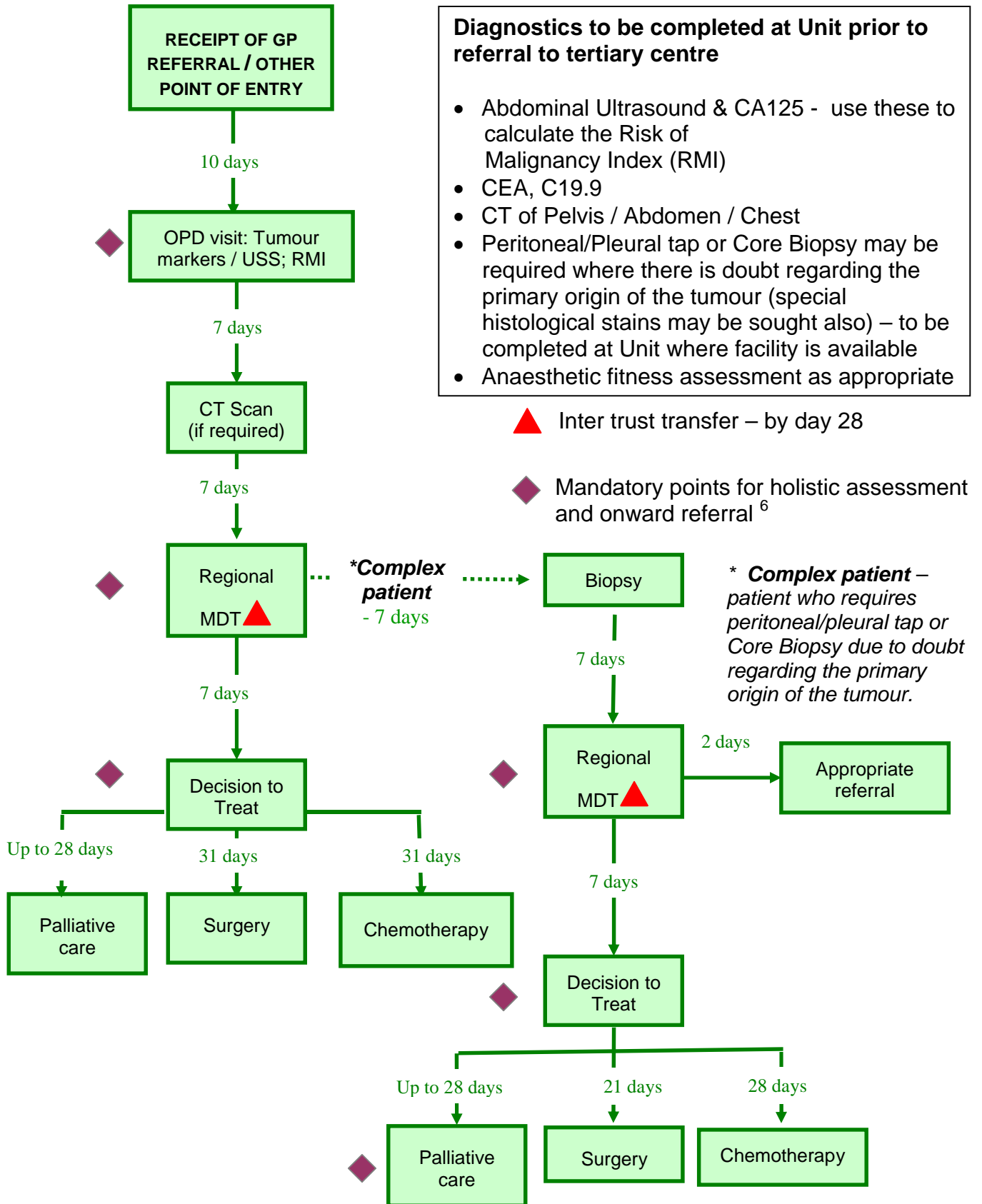
Cervical	Vulval	Endometrial	Ovarian
<ul style="list-style-type: none"> <li>• Biopsy with histology review.</li> <li>• Staging procedure - this may be carried out by a special interest clinician at a Cancer Unit.</li> </ul> <p><b><i>*MRI will usually be carried out at the Cancer Centre.</i></b></p>	<ul style="list-style-type: none"> <li>• Biopsy with histology results.</li> <li>• Anaesthetic assessment as appropriate</li> <li>• CT Scan of Pelvis/Abdomen/Chest - may be done at Cancer Unit or at Centre.</li> <li>• MRI of pelvis if suspicion of pelvic node involvement – may be completed at Unit (following appropriate protocols) or at Centre.</li> </ul>	<ul style="list-style-type: none"> <li>• Hysteroscopy/ biopsy with histology results.</li> <li>• MRI (following appropriate protocols).</li> <li>• Anaesthetic Assessment as appropriate</li> </ul>	<ul style="list-style-type: none"> <li>• Abdominal Ultrasound &amp; CA125 - use these to calculate the Risk of Malignancy Index (RMI)</li> <li>• CEA, C19.9</li> <li>• CT of Pelvis / Abdomen / Chest</li> <li>• Peritoneal/Pleural tap or Core Biopsy with histology results - may be required where there is doubt regarding the primary origin of the tumour (special histological stains may be sought also). <i>To be completed at Unit where facility is available</i></li> <li>• Anaesthetic fitness assessment as appropriate</li> </ul>

# CARE PATHWAY CERVICAL CANCER

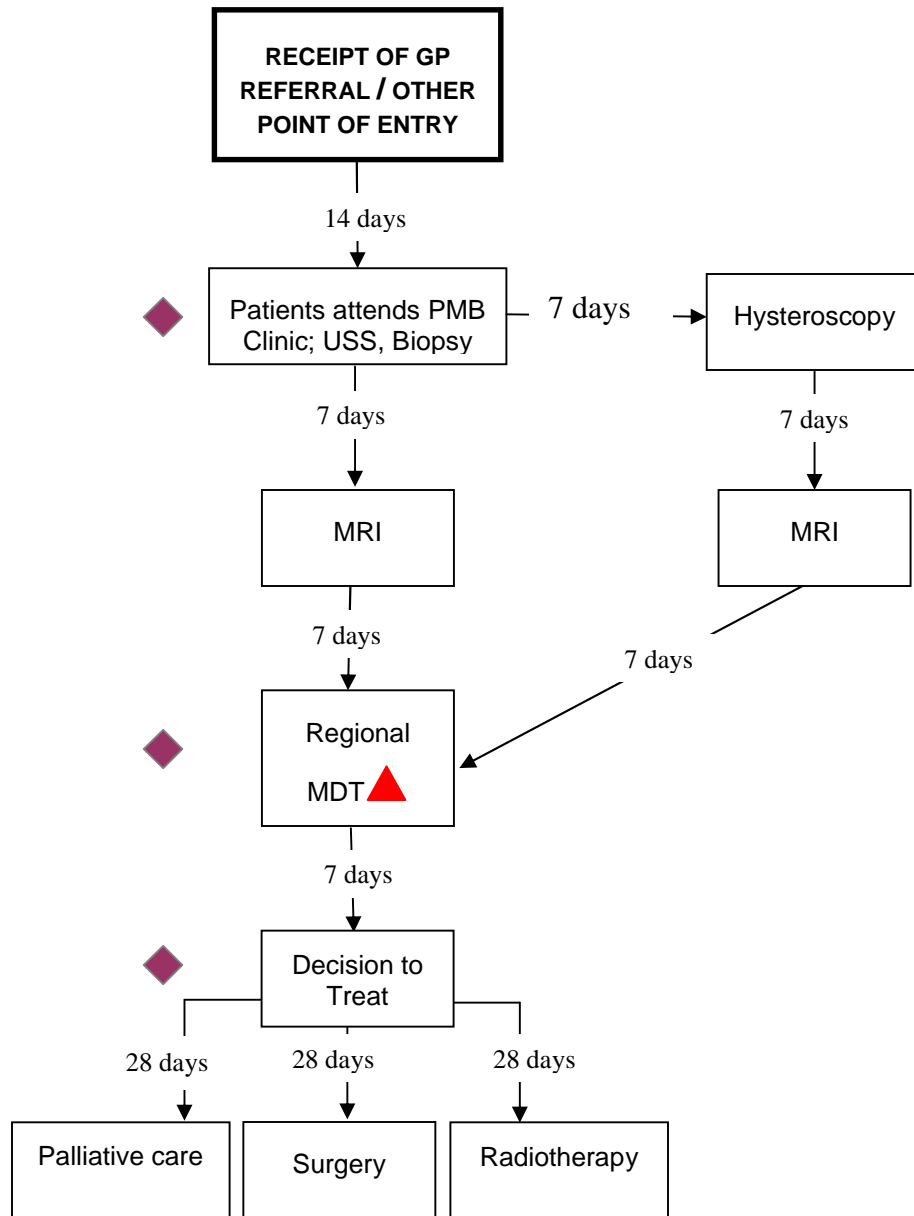


*\* Referral to centre is not dependent upon completion of other investigations*

# CARE PATHWAY OVARIAN CANCER



# CARE PATHWAY ENDOMETRIAL CANCER



## Diagnostics to be completed at Unit prior to referral to tertiary centre

- Hysteroscopy/ biopsy
- MRI (following appropriate protocols).
- Anaesthetic Assessment as appropriate

▲ Inter trust transfer – by day 28

◆ Mandatory points for holistic assessment and onward referral<sup>6</sup>

# CARE PATHWAY VULVAL CANCER

