Referral and Management Guidelines for Gynaecological Cancers within North Trent

Final Version 3.0 August 2011

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Produced by the
North Trent Cancer Network Gynaecology NSSG
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Appendix 1  Sheffield Gynae-Oncology Multidisciplinary Team Operational Policy

Appendix 2  Referral proforma
1.0 Network Teams

North Trent Cancer Network underwent a reconfiguration in April 2010 to one Central Specialist MDT in Sheffield plus for local diagnostic teams providing an enhanced diagnostic service function.

1.1 Central Specialist MDT

MDT Lead Miss Fiona Kew
Held in Sheffield the Central Specialist MDT serves Sheffield, Barnsley, Bassetlaw, Chesterfield, Doncaster and Rotherham. It also provides a local MDT function for the local Sheffield population.

1.2 Local Diagnostic Teams

Barnsley Service/Team Lead Mr Khalid Farag
Chesterfield Service/Team Lead Ms Darly Mathew
Doncaster Service/Team Lead Mr Purvis Iqbal
Rotherham Service/Team Lead Mr Clive Ramsden
Sheffield Local MDT Lead Miss Fiona Kew

The local diagnostic team is comprised in each locality of:
- Named surgeons authorised to operate on low risk endometrial carcinoma in the host hospital
- Clinical Nurse Specialist
- Pathologist
- Radiologist
- MDT Co-ordinator

The function of the local diagnostic team is to provide a stand alone diagnostic service and in addition will act as a triage to identify those patients that can be presented by the Unit to the central MDT(with local imaging and pathology) for discussion from those that require review and presentation in Sheffield as outlined within the Sheffield Gynae-Oncology Multidisciplinary Team Operational Policy (Appendix One).

Where appropriate according to protocol, named surgeons within the diagnostic team undertake surgery for low risk endometrial cancer cases (see section 1.4)
1.3 Guidelines for Onward Referral (08-1C-111e)

Figure 1 outlines the referral pathway for onward referral for patients diagnosed with gynaecology malignancy from the local diagnostic MDTs.

Figure 1.
1.4 Authorised Surgeons (08-1A-210e)

The following table identifies the named surgeons authorised to operate on low risk endometrial cancer in the host hospital of the diagnostic service, their host hospital and the MDT which they attend as a core member.

<table>
<thead>
<tr>
<th>Surgeon</th>
<th>Host Hospital</th>
<th>MDT attended as core member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr M Alloub</td>
<td>Doncaster</td>
<td>Specialist and Local Diagnostic</td>
</tr>
<tr>
<td>Mr P Iqbal</td>
<td>Doncaster</td>
<td>Specialist and Local Diagnostic</td>
</tr>
<tr>
<td>Mr K Farag</td>
<td>Barnsley</td>
<td>Specialist and Local Diagnostic</td>
</tr>
<tr>
<td>Mr C Ramsden</td>
<td>Rotherham</td>
<td>Specialist and Local Diagnostic</td>
</tr>
<tr>
<td>Mr H Loftallah</td>
<td>Rotherham</td>
<td>Specialist and Local Diagnostic</td>
</tr>
<tr>
<td>Mrs R Gosarkan</td>
<td>Rotherham</td>
<td>Specialist and Local Diagnostic</td>
</tr>
<tr>
<td>Ms D Mathew</td>
<td>Chesterfield</td>
<td>Specialist and Local Diagnostic</td>
</tr>
<tr>
<td>TBA</td>
<td>Chesterfield</td>
<td>Specialist and Local Diagnostic</td>
</tr>
</tbody>
</table>
2.0 GP Referral Guidelines

Where a Primary Care Practitioner suspects malignancy the NICE referral guidelines for suspected cancer which have been agreed and adopted by the North Trent Cancer Network will be followed. An urgent referral will be made using the electronic Choose and Book Two-Week wait referral form for patients with suspected cancer. A copy of this form is attached as an appendix to these guidelines.

2.1 Referral of patients from primary care should be to their Local Diagnostic Team according to the national guidelines published by NICE and reproduced here:

**Gynaecological cancer**

**General recommendations**

A patient who presents with symptoms suggesting gynaecological cancer should be referred to a team specialising in the management of gynaecological cancer, depending on local arrangements.

**Specific recommendations**

The first symptoms of gynaecological cancer may be alterations in the menstrual cycle, intermenstrual bleeding, postcoital bleeding, postmenopausal bleeding or vaginal discharge. When a patient presents with any of these symptoms, the primary healthcare professional should undertake a full pelvic examination, including speculum examination of the cervix.

In patients found on examination of the cervix to have clinical features that raise the suspicion of cervical cancer, an urgent referral should be made. A cervical smear test is not required before referral, and a previous negative cervical smear result is not a reason to delay referral.

Ovarian cancer is particularly difficult to diagnose on clinical grounds as the presentation may be with vague, non-specific abdominal symptoms alone.
bloating, constipation, abdominal or back pain, urinary symptoms). In a woman presenting with any unexplained abdominal or urinary symptoms, abdominal palpation should be carried out. If there is significant concern, a pelvic examination should be considered if appropriate and acceptable to the patient. D

Any woman with a palpable abdominal or pelvic mass on examination that is not obviously uterine fibroids or not of gastrointestinal or urological origin should have an urgent ultrasound scan. If the scan is suggestive of cancer, or if ultrasound is not available, an urgent referral should be made. C

When a woman who is not on hormone replacement therapy presents with postmenopausal bleeding, an urgent referral should be made. C

When a woman on hormone replacement therapy presents with persistent or unexplained postmenopausal bleeding after cessation of hormone replacement therapy for 6 weeks, an urgent referral should be made. C

Tamoxifen can increase the risk of endometrial cancer. When a woman taking tamoxifen presents with postmenopausal bleeding, an urgent referral should be made. C

An urgent referral should be considered in a patient with persistent intermenstrual bleeding and a negative pelvic examination. D

**Vulval cancer**

When a woman presents with vulval symptoms, a vulval examination should be offered. If an unexplained vulval lump is found, an urgent referral should be made. C

Vulval cancer can also present with vulval bleeding due to ulceration. A patient with these features should be referred urgently. D

Vulval cancer may also present with pruritus or pain. For a patient who presents with these symptoms, it is reasonable to use a period of ‘treat, watch and wait’ as a method of management. But this should include active follow-up until symptoms resolve or a diagnosis is confirmed. If symptoms persist, the referral
may be urgent or non-urgent, depending on the symptoms and the degree of concern about cancer. 

These guidelines can be found on the NICE website at: http://www.nice.org.uk/page.aspx?o=cg027niceguidelineword

Recent Guidance (March 2010) is available for general practitioners regarding the assessment of Young Women aged 20-24 with Abnormal Vaginal Bleeding These guidelines can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113478
3.0 Guidelines for the Management of Cervical Cancer

3.1 Background

There were 2221 cases of cervical cancer in England in 2004. The Cervical Screening programme has resulted in an overall reduction of the incidence of the disease, but has also altered the pattern of the disease so that the diagnosis is made at a much earlier stage. The introduction of HPV vaccination with the bivalent vaccine (against HPV 16 and 18) for all girls aged 12-13 should result in a further reduction in incidence of disease, but this will take decades to show effect. For the meantime, the cervical screening programme will continue unchanged.

Careful histological examination of biopsies is essential, as this has a major impact on management decisions. In the treatment of high grade pre-invasive disease the lesion should be removed in one piece if at all possible. In the unfortunate event of the lesion containing invasive disease the piecemeal removal of the area makes histological staging difficult if not impossible.

3.2 Criteria for referral via two week wait

Lesion suspicious of cancer of the cervix on speculum examination

Cervical smear suggestive of invasive disease or glandular neoplasia if direct referral is not in place.

3.3 Criteria for referral to the Cancer Centre

All patients with a diagnosis of cervical cancer must be discussed at the central MDM, and the pathology reviewed. Cases confirmed as pathological stage 1a1 can be managed locally. All other cases must be referred to the cancer centre.

3.4 Management Guidelines

3.4.1 Investigations

In very early disease a loop excision can be both diagnostic and therapeutic. Wherever possible an adequate margin should be removed to ensure the lesion has been removed.
If the lesion has not been adequately removed a cone biopsy is more likely to show that residual disease has been removed and is preferable in glandular lesions. However there are higher morbidity and fertility problems with cone biopsy when compared to loop excision.
In larger lesions the diagnosis can be made with a diagnostic biopsy or a small loop. The biopsy must be of sufficient size to include stroma in order to prove invasive disease.

A chest X-ray should be performed apart from Stage 1A disease
A MRI should be performed in all cases apart from early stage disease when the disease has been completely excised.

FBC and U & E, apart from Stage 1A.

3.4.2 Treatment

Stage 1A1
This can be managed at the cancer Units following Pathology review in Sheffield. A loop excision or Cone biopsy is appropriate.

Stage 1A2
A Cone biopsy or Hysterectomy is appropriate. There is a significant risk of lymph node involvement and the risk increases with depth of invasion and a lymphadenectomy should be considered on an individual basis. If the patients wishes to retain her fertility a Cone biopsy with or without a lymphadenectomy is appropriate.

Stage 1B
Radical surgery or Chemo-radiotherapy produce similar survival rates. A discussion should take place regarding both treatments with the patient before a decision is made and an opportunity to discuss the options with a surgeon and a clinical oncologist offered. Surgery is usually better at preserving ovarian and sexual function but Chemo-radiotherapy is less morbid in the short term, but may have more long-term morbidity. It is important to try and avoid the combination of surgery followed by radiotherapy as this increases morbidity with no survival benefit.

For patients with small 1b lesions who want to preserve fertility more conservative management can be considered including a large cone biopsy plus pelvic lymphadenectomy or a radical trachelectomy.

If the MRI suggests that the tumour has spread outside the cervix or there is lymph node involvement there should be careful discussion at the Centre MDT as to the role of surgery or chemo-radiotherapy.

Stage 2B or higher stage
Chemo-radiotherapy is the treatment of choice. If the patient is not fit, radiotherapy alone may be used.

3.4.3 Adjuvant treatment

Radiotherapy should be considered if there are 2 or more positive lymph nodes or if the disease free margins are less than or equal to 1mm. The role of the addition of chemotherapy in the adjuvant setting is not clear. A salvage hysterectomy should be considered if there is residual tumour following chemo-radiotherapy.

3.4.4 Management of Recurrent Disease

This should be individualised and managed in the centre. Chemo-radiotherapy is usually more appropriate if the recurrence is after surgery. Extensive imaging is necessary before definitive treatment. Patients suitable for cytoreductive (surgical or non-surgical) treatment for recurrent cancer should be referred to the Specialist MDT, Sheffield.

3.4.5 Palliative care

Radiotherapy may be appropriate to relieve pain but treatment must be individualised. Palliative chemotherapy may be indicated for systemic disease or recurrence after prior radiotherapy. The palliative care and Pain teams may need to be involved.

3.5 Follow up

Patients should be seen every three months for the first year, four monthly for the second year, six monthly for the third year and then annually until five years. The follow up of stage 1 disease, where there is retention of part of the cervix, should be in the colposcopy clinic. Patients treated in the Cancer Centre may be offered follow-up after 2 years, at their Locality hospital performed by the Lead or Deputy Lead MDT Clinician.

3.6 Staging

Staging of carcinoma of the cervix is based on clinical examination.
### Stage I – Carcinoma confined to the cervix.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Ia</td>
<td>Invasive carcinoma diagnosed only by microscopy; all macroscopically visible lesions, even with superficial invasion, are stage Ib</td>
</tr>
<tr>
<td></td>
<td>Ia₁ Invasion ≤ 3mm depth of invasion from parent epithelial base, horizontal spread ≤ 7mm</td>
</tr>
<tr>
<td></td>
<td>Ia₂ Invasion &gt; 3mm depth of invasion not greater than 5mm from parent epithelial base, the horizontal spread ≤ 7mm</td>
</tr>
<tr>
<td>Ib</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ib₁ Carcinoma confined to cervix &gt; 7mm wide or 5mm deep but ≤ 4cm in size</td>
</tr>
<tr>
<td></td>
<td>Ib₂ Carcinoma &gt; 4cm diameter</td>
</tr>
</tbody>
</table>

### Stage II – Carcinoma extending beyond the cervix but not extending to the pelvic sidewall or to the lower third of the vagina.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIa</td>
<td>Without parametrial invasion</td>
</tr>
<tr>
<td>IIa₁</td>
<td>Clinical visible lesion ≤ 4.0cm in greatest dimension</td>
</tr>
<tr>
<td>IIa₂</td>
<td>Clinical visible lesion ≥ 4.0cm in greatest dimension</td>
</tr>
<tr>
<td>IIb</td>
<td>With obvious parametrial invasion</td>
</tr>
</tbody>
</table>

### Stage III – Tumour extends to the pelvic sidewall and/or involves the lower third of vagina and/or causes hydronephrosis or non-functioning kidney

On rectal examination there is no tumour free space between the tumour and pelvic sidewall. All cases of hydronephrosis with non functioning kidney should be included unless it is known to be from another cause.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIIa</td>
<td>Tumour involves lower third of vagina, with no extension to pelvic sidewall</td>
</tr>
<tr>
<td>IIIb</td>
<td>Extension to sidewall or non functioning kidney</td>
</tr>
</tbody>
</table>

### Stage IV - Extension beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. A bullous oedema is not sufficient to tumour as stage IV

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVa</td>
<td>Spread of growth to adjacent organs</td>
</tr>
<tr>
<td>IVb</td>
<td>Spread to distant organs</td>
</tr>
</tbody>
</table>
Other patients with significant medical problems can be referred to the Cancer Centre for discussions with the Sheffield Consultants.

Cervical Pathway
24/8/11

Time in Days

Referral to Trust → First Seen in Colposcopy or One Stop Clinic Colposcopy +/- Biopsy / Diagnostic/Staging Tests / Bloods → Clinical Review with Results + FBC / U&E → Central MDT Review and recommendation → Staging greater than 1A1 refer to Centre All other cases treat locally Patient informed of appropriate Outcome → STH OPD Joint Decision to Treat with Patient → First Treatment

Ideal Two Week Wait (62 Day Pathway)
4.0 Protocol for the management of Ovarian Cancer

4.1 Background

Ovarian cancer is the fourth most frequently diagnosed cancer in women. In 2005 6806 women were diagnosed with ovarian cancer in the UK, and in 2006 4407 women died of the disease. The lifetime risk of developing ovarian cancer is approximately 1 in 48 for women in England and Wales. Ovarian cancer occurs as either epithelial or non-epithelial tumour, with the former accounting for over 90% of all ovarian cancers. This guideline deals with the management of epithelial ovarian cancer only. The disease is rare in women under the age of 30 years, with the incidence increasing with age, reaching its maximum in the eighth decade. It is more common in nulliparous women; however there is 50% reduction in incidence after 5 or more years usage of the combined oral contraceptive pill. Most cases occur sporadically in women with no family history. An important group of women are those with genetic predisposition, but this only accounts for 5% of cases.

4.2 Initial Assessment

4.2.1 Signs and symptoms

Symptoms are often insidious in onset and difficult to diagnose as they are often non-specific. However pelvic and abdominal pain, increased abdominal size/bloating and difficulty eating and feeling full have been shown to be the most reliable symptoms when suspecting ovarian cancer. Most women with ovarian cancer present with disease outside the ovary.

4.2.2 Imaging

Ultrasound scan (pelvic and abdominal) is the most appropriate investigation for identifying pelvic masses. It may also give an indication of the presence of ascites and/or upper abdominal metastases.

4.2.3 Tumour Markers

CA125 is a glycoprotein antigen. All women presenting with an ovarian mass should have their CA125 level determined. Elevated concentration of CA125
is associated with malignant tumours of the pancreas, breast, lung, colon and ovary. CA125 can also be raised in the following benign conditions: menstruation, endometriosis, PID, liver diseases, ascites and recent laparotomy.

Women under the age of 40 with suspicious features on ultrasound scan should also have AFP, HCG and LDL concentrations checked in case of germ cell tumours. CEA and CA19.9 may be useful in distinguishing between primary ovarian cancer and metastases from the GI tract.

**4.3 Ovarian and Other Non-Testicular Germ Cell Tumours**

Fax or phone to Professor Rob Coleman or Dr Matthew Hatton at Weston Park Hospital on confirmation of diagnosis, with a view to arranging admission to ward 3 or for review at next clinic whichever can be arranged sooner.

Proposed surgery should be discussed with the Oncologists if diagnosis made prior to planned resection though surgery is likely to remain an important part of the multi-disciplinary management.

All patients referred by letter, fax or phone will be discussed at the next germ cell MDT meeting.

**Contact Details:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof R E Coleman:</td>
<td>via secretary – Norma Smith</td>
<td>phone: 0114 226 5279</td>
</tr>
<tr>
<td>Dr M Q Hatton:</td>
<td>via secretary – Kelly Bishop</td>
<td>phone: 0114 226 5080</td>
</tr>
<tr>
<td></td>
<td>MDT Facilitator – Norma Smith</td>
<td>phone: 0114 226 5079</td>
</tr>
</tbody>
</table>

**4.3.1 Histopathology**

Ovarian germ cell tumours requiring chemotherapy: initial diagnostic review should be undertaken by the Gynaecological Tumour Panel, according to their NSSG guidelines. However the cases should then be made available to the Urological Tumour Panel as clinical management will be via the Germ Cell Tumour MDT.

The Sheffield Urological Tumour Panel is also willing to accept referral of cases for consultation.

**4.4 Referral Guidelines**

RMI = USS score x menopausal score x CA125 level in U/ml
<table>
<thead>
<tr>
<th>Feature</th>
<th>RMI Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound features:</td>
<td>0 = none</td>
</tr>
<tr>
<td>- multilocular cyst</td>
<td>1 = one abnormality</td>
</tr>
<tr>
<td>- solid areas</td>
<td>3 = two or more abnormalities</td>
</tr>
<tr>
<td>- bilateral lesions</td>
<td></td>
</tr>
<tr>
<td>- ascites</td>
<td></td>
</tr>
<tr>
<td>- intra-abdominal metastasis</td>
<td></td>
</tr>
<tr>
<td>Premenopausal</td>
<td>1</td>
</tr>
<tr>
<td>Postmenopausal</td>
<td>3</td>
</tr>
<tr>
<td>CA125</td>
<td>U/ml</td>
</tr>
</tbody>
</table>

- Women with RMI > 250 should be referred to Sheffield Gynae Cancer Centre.
- Women with significant medical co-morbidity and / or morbid obesity can be referred to the cancer centre.
- All results of investigations (tumour markers, USS and CT report if done) should be included.
- All women with suspected or confirmed non-epithelial ovarian cancer should be referred to Sheffield Gynae Cancer Centre.

4.5 Pre-treatment Investigations

CT:
It may be useful to obtain more information on the extent of metastatic disease. CT is better than USS for retroperitoneal assessment, and detection of omental and peritoneal disease. CT is preferred to MRI.

Chest X-ray:
Should be taken to identify pulmonary metastasis and/or pleural effusion.

Biopsy
If a patient is to receive neoadjuvant chemotherapy a tissue diagnosis should be obtained prior to commencement of treatment. This may be under ultrasound or laparoscopic guidance. In exceptional circumstances, if this is not possible then evidence of a gynaecological cancer on cytological examination of pleural or ascitic fluid is acceptable.

4.6 Primary treatment of ovarian cancer
The long term survival for women with advanced ovarian cancer appears to be the same whether they are first treated with surgery ('up front') followed by chemotherapy or by neoadjuvant chemotherapy followed by interval debulking surgery. The morbidity associated with interval debulking surgical procedures is lower when compared with ‘up front’ surgery and the percentage of women with optimally debulked tumours also appears to higher. Prior to commencing treatment all women with suspected ovarian cancer should be considered for either ‘up front’ surgery followed by chemotherapy or neoadjuvant chemotherapy followed by interval debulking surgery.
4.7 Surgical treatment

‘Up front’ surgery should be considered for women with suspected ovarian cancer and significant symptoms that might be relieved by surgery rather than neoadjuvant chemotherapy. Patients may also elect to have ‘up front’ surgery rather than neoadjuvant chemotherapy following informed discussion.

4.7.1 Preparation for surgery

- Patients with suspected bowel involvement should be assessed for the likelihood of bowel surgery.
- Serum CA 125 levels are useful in predicting disease bulk and should be assayed preoperatively in women with pelvic mass.
- FBC, U+E’S, LFT, G+S and cross match
- Thromboprophylaxis
- Antibiotic prophylaxis

4.7.2 Operative procedures

All patients should have a midline incision to allow palpation of all peritoneal surfaces. The largest diameter of the presenting tumour and the largest diameter of residual disease at the end of surgery must be recorded.

The minimum surgery to be undertaken includes peritoneal cytology, hysterectomy, removal of both tubes and ovaries and omentectomy. Further debulking is undertaken to reduce disease bulk, preferably to no residual disease.

Young women with apparent stage 1A disease are eligible for conservative surgery comprising salpingo-oophorectomy, inspection +/- biopsy of the other ovary, representative omental biopsy, peritoneal washings, sub-diaphragmatic scrapes, inspection of the whole peritoneal cavity, selective biopsies of palpable pelvic or para-aortic nodes. Further ‘completion’ surgery may be undertaken once the diagnosis and risk have been established.

In low risk patients, it is considered good practice to take an omental biopsy and peritoneal washings in all women with an adnexal mass with a low index of suspicion of cancer. In peri and post menopausal women it is advisable to perform bilateral rather than unilateral salpingo-oophorectomy.

Bowel resection will be reserved for patients in which obstruction is imminent or the surgeon believes that these procedures are necessary for optimal/complete cytoreduction.

4.7.3 Interval debulking surgery
If the patient has received neoadjuvant chemotherapy the option for interval debulking surgery should be reviewed after 3 cycles of treatment. CT imaging should be organised and the case discussed at the MDT meeting..

4.8 Chemotherapy

4.8.1 Neoadjuvant chemotherapy
Neoadjuvant chemotherapy should be offered to all women as primary treatment of advanced ovarian cancer as part of the informed decision making process. It should also be considered for women at high peri-operative risk.

4.8.2 Adjuvant chemotherapy
All patients with stage 1C-IV should be considered for chemotherapy. Patients with stage 1A/B with adverse features (i.e. clear cell or grade 3 histology) should also be considered for chemotherapy (ICON1). The standard treatment is platinum based chemotherapy, with or without paclitaxel. Chemotherapy should be started no later than eight weeks after surgery.

Patients should be considered for trials where eligible.

Where gynaecological oncology services are available in the locality hospitals, then approved chemotherapy regimes may be administered there under the care of the visiting gynaecological Clinical Oncologist.

4.9 Treatment of Recurrent Disease

Second line and subsequent line chemotherapy

Treatment following relapse is palliative. In patients who are platinum sensitive (relapse > 6 months) platinum can be repeated. In patients who are platinum resistant (relapse < 6 months) options include chemotherapy or radiotherapy and supportive care. In patients who relapse more than 1 year after completion of chemotherapy further debulking surgery may be of value (central multidisciplinary team to decide).

Tamoxifen 40mg daily should be considered in patients for whom chemotherapy is not appropriate.

4.10 Follow up

There is no evidence to guide follow up protocols. The aim of follow up is to identify and treat recurrence, identify and treat treatment related physical and psychological sequelae and to provide reassurance.

Follow up should be offered for patients with stage 2 or greater borderline tumours and all malignant tumours.
Patients should be seen every three months for the first year, four monthly for the second year, six monthly for the third year and then annually until five years. Discharge back to the referring unit will be considered/offered after two years from surgery. Where gynaecological oncology services are available in the Locality hospitals, then all follow-up may be conducted locally.

Each follow-up visit should include:
- History
- Clinical examination including assessment of lymphadenopathy and examination for abdominal and pelvic masses.
- CA125 and imaging should not be routinely offered.

<table>
<thead>
<tr>
<th>Stage I – Growth limited to the ovaries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ia</strong></td>
</tr>
<tr>
<td><strong>Ib</strong></td>
</tr>
<tr>
<td><strong>Ic</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage II – Growth involving one or both ovaries with pelvic extension</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IIa</strong></td>
</tr>
<tr>
<td><strong>IIb</strong></td>
</tr>
<tr>
<td><strong>IIc</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage III – Tumour involving one or both ovaries with histologically confirmed peritoneal metastasis outside the pelvis and/or positive retroperitoneal or inguinal nodes. Superficial liver metastasis equals stage III. Tumour is limited to the true pelvis, but with histologically proven malignant extension to small bowel or omentum.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IIla</strong></td>
</tr>
<tr>
<td>IIIb</td>
</tr>
<tr>
<td>IIIc</td>
</tr>
</tbody>
</table>

**Stage IV**

Growth involving one or both ovaries with distant metastasis. If pleural effusion is present there must be positive cytology to allot a case to stage IV. Parenchymal liver metastasis equals stage IV.

**4.11 Unexpected Findings of a gynaecological malignancy at laparotomy**

If at laparotomy for presumed benign gynaecological pathology or for suspected bowel obstruction, findings are suspicious of either ovarian or advanced endometrial malignancy, then the advice of the Lead or the Deputy Lead Clinician, Gynae MDT should be sort as a matter of urgency. The extent of the disease should be assessed and appropriate biopsy specimens obtained of the suspicious tumour within the pelvis, omental biopsy as well as a sample of any ascitic fluid for cytology. Any evidence of bowel obstruction should be corrected by appropriate surgical team before closure of the abdominal cavity. De-bulking surgery should be avoided unless it is deemed necessary as part of a bowel resection procedure.

The results of Histological review should be discussed with the patient and carers by the locality Gynae MDT and appropriate arrangements made for review following a period of convalescence at the Central MDT, followed by clinical review with a Cancer Pathway Plan.

**4.12 Management of acutely unwell patients with suspectated metastatic ovarian cancer or primary peritoneal cancer (PPC) who have not undergone laparotomy**

Patients with metastatic ovarian cancer or PPC may present to other clinical specialities. If investigations suggest ovarian cancer or PPC then review by the diagnostic team should taken place as soon as possible. A management review of these cases may be undertaken by the visiting clinical oncologist to the locality site if this can be achieved without undue delay. Alternatively arrangements can be made to transfer the patient to the gynaecology ward at the Royal Hallamshire Hospital or to the clinical oncology ward at Weston Park Hospital. To arrange transfer the locality MDT should contact the surgical
or clinical oncologist, via the relevant secretaries or central MDT co-ordinator listed below.

Miss F Kew 01142268570
Miss J Palmer 01142268569
Mr J Tidy 01142268570
Mr A Gillespie 01142268569
Dr J Martin 01142265070
Dr S Pledge 01142265070
MDT co-ordinator 01142268573

All cases should referred to the central MDT for discussion at the next MDT meeting.
Time in Days

0  < 7  7  < 14  21  7  28  4  32  < 17  ** 52

Referral to Trust

First Seen - Clinical Review
Diagnostic/Staging Tests
Bloods CA125 – TVSTAS requested *
Consider CEA and CA19.9 especially in bilateral tumours

RMI less than 250
Patient reviewed by Lead/Deputy MDT
Clinician and Treat Locally

RMI greater than 250 refer to the Centre
OPA Results – Telephone contact to STH Gynaecologist
by Cancer Unit Gynaecologist and patient discussed
Decision to treat discussed with patient. Unit CT

SAME DAY
STH access OPA diary and give Cancer
Unit Gynaecologist the appt date.
Patient informed Tertiary ref Fax & Letter to STH

Out Patient Appointment at STH
Central MDT discussion

Local MDT recommendation (no need for
discussion at network MDT)

CT Scan if not already performed

First Treatment
First Treatment

Ideal Two Week Wait (62 Day Pathway)

* CT Scan agreed not appropriate for these patients as first line Imaging investigation

** Cannot go beyond 52 days or a 31 day breach will occur.

Other patients with significant medical problems can be referred to the Cancer Centre for discussions with the Sheffield Consultants.
5.0 Protocol for the management of Fallopian Tube Cancer

5.1 Background

Carcinoma of the fallopian tube accounts for 0.3% of all cancers of the female genital tract. It is very similar to ovarian cancer in both its histological features and behaviour and is therefore managed in essentially the same way.

As with ovarian cancer, women who have BRCA1 and BRCA2 gene mutations are at substantially increased risk of developing carcinoma of the fallopian tube, hence salpingectomy should be performed along with oophorectomy at prophylactic surgery.

5.2 Presentation

The classic triad of signs are

1. profuse watery vaginal discharge
2. pelvic pain
3. pelvic mass

However this triad is only present in 15% of cases. The most common symptoms is vaginal discharge or bleeding. Pelvic mass is present in about 60% of cases. Endometrial biopsy is usually negative, but about 10% may have abnormal or adenocarcinomatous cells on cervical cytology.

Cases are often discovered incidentally at hysterectomy. Presentation with advanced disease is less common than with ovarian cancer, perhaps because of a propensity for the disease to produce symptoms at an earlier stage.

5.3 Referral

All cases or suspected cases of fallopian tube cancer should be referred to the cancer centre for management, in view of the rarity of these cases.

5.4 Management

Fallopian tube carcinoma is managed in the same way as epithelial ovarian cancer. For full details, please refer to the ovarian cancer guidelines.

5.5 Follow up

As for ovarian cancer.
### Stage I – Growth limited to the fallopian tube(s)

| Ia | Growth limited to one tube, without penetrating the serosal surface |
| Ia | Growth limited to both tubes, without penetrating the serosal surface |
| Ic | Tumour limited to one or both tube(s) with extension onto or through the tubal serosa, or with malignant cells in ascites or peritoneal washings. |

### Stage II – Growth involving one or both fallopian tubes with pelvic extension

| IIa | Extension and/or metastasis to the uterus and/or ovaries. |
| IIb | Extension to other pelvic tissue. |
| IIc | Tumour either stage IIa or IIb, with ascites present containing malignant cells or with positive peritoneal washings. |

### Stage III – Tumour involves one or both fallopian tube(s) with peritoneal implants outside the pelvis and/or positive regional lymph nodes

| IIIa | Tumour grossly limited to the true pelvis, with negative nodes, but with histologically confirmed microscopic seeding of abdominal peritoneal surface. |
| IIIb | Tumour of one or both ovaries with histologically confirmed implants, peritoneal metastasis of abdominal peritoneal surfaces, none exceeding > 2cm in diameter, nodes are negative. |
| IIIc | Peritoneal metastasis beyond the pelvis > 2cm in diameter and/or positive retroperitoneal or inguinal nodes. |

### Stage IV

Growth involving one or both ovaries with distant metastasis. If pleural effusion is present there must be positive cytology to allot a case to stage IV. Parenchymal liver metastasis equals stage IV.
6.0 Protocol for the management of Endometrial Cancer

6.1 Referral Guidelines

Women with presumed Stage 1A/B, G1 or G2, based on locality pathological assessment, locality ultrasound and or MRI, if appropriate, should undergo treatment at their local District General Hospital. Surgery should be performed by the Lead or Deputy Lead Clinician of the locality MDT. A register of approved surgeons is recorded in the Gynaecology NSSG Terms of Reference and reviewed by the Chairman of the NSSG annually. Recommended treatment is peritoneal washings for staging cytology, followed by a total hysterectomy and bilateral salpingo-oophorectomy. Omental biopsy is at the discretion of the surgeon if there is unexpected evidence of advanced disease. Surgery may be performed by laparoscopy or open procedure. Women should be offered the opportunity of referral for laparoscopic surgery if it is not available locally, in keeping with NICE guidelines.

Women with presumed Stage 1C or any woman with a G3 endometrial carcinoma at preoperative diagnosis, based on pathology, hysteroscopy, ultrasound and or MRI, if appropriate, should be referred to the cancer centre. All women with the pre-operative diagnosis of papillary serous adenocarcinoma, clear cell or carcinosarcoma should be referred to the Cancer Centre. Women with significant medical co-morbidity and/or morbid obesity can be referred to the Cancer Centre for management irrespective of the suspected stage or grade of tumour. A register of approved gynaecological oncology surgeons is recorded in the NSSG Terms of Reference and reviewed by the Chairman annually.

Women with presumed or biopsy proven, after central MDT review, leiomyosarcomas, endometrial stromal sarcomas, adenosarcomas, and carcinosarcomas should be referred to the cancer centre.

6.2 Recommended Investigations

1. Transvaginal ultrasound scan. (An endometrial thickness of 5mm or more should be further investigated by means of a biopsy taken at time of hysteroscopy. Local guidance set at a lower cut off is acceptable).
2. Endometrial biopsy.
3. Hysteroscopy - this may help in staging of cervical involvement
5. MRI could be a problem solving technique to assess the primary tumour and pelvic lymph glands if there is a problem in assessment with other investigations.

6. CT scan of thorax should be performed pre-operatively in patients with leiomyosarcomas, endometrial stromal sarcomas, adenosarcomas, and carcinosarcomas as this investigation is more sensitive than chest X-ray in detecting pulmonary metastases.

6.3 Primary Treatment Guidelines

Stage 1 disease

Surgery is the treatment of choice for this cancer. The surgery of choice is total hysterectomy (laparoscopic or open) with bilateral salpingo-oophorectomy and peritoneal washings. In women with papillary serous or clear cell carcinoma an omentectomy should be performed as well. The role of lymphadenectomy in suspected stage 1 disease remains the subject of debate. The ASTEC trial has now concluded and the results of the surgery randomisation are available. The trial does not support the routine use of lymphadenectomy in all patients. The use of this surgical intervention may give additional prognostic information. Lymphadenectomy (laparoscopic or open) may be employed at the Cancer Centre in selected patients.

Stage 2 disease

Women with suspected Stage 2 disease should be considered for a radical hysterectomy with pelvic lymphadenectomy.

Stage 3 and 4 disease

Women should undergo total abdominal hysterectomy, peritoneal washings and tumour debulking where appropriate. In patients considered unsuitable for surgery the treatment may consist of a combination of brachytherapy and external beam radiotherapy or hormone therapy or chemotherapy or best supportive care.

6.4 Adjuvant Treatment Guidelines

Brachytherapy should be offered to stage 1c all grades, and 1b G3 (Portec 2 study) in addition to the current situation whereby all stage 2 cases are considered for brachytherapy, and stage 3 for external beam. Vaginal brachytherapy is effective in preventing vaginal recurrence. There is a slight but significantly increased pelvic failure rate with vaginal brachytherapy compared to external beam radiotherapy but rates of distant metastases, overall survival are similar. However, quality of life after vaginal brachytherapy is better than after external beam. Therefore vaginal brachytherapy should be the treatment of choice for patients with high-intermediate risk endometrial carcinoma.
Adjuvant radiotherapy for carcinosarcoma should be considered on an individual basis. Adjuvant chemotherapy should be considered for cases of papillary serous adenocarcinoma.

6.5 Guidelines for the management of disease recurrence

Management of disease recurrence should be individualised and it is difficult to generalise. Each case should be assessed on its merits. All cases of disease recurrence should be managed at the Cancer Centre.

Patients suitable for cytoreductive (surgical or non-surgical) treatment for recurrent cancer should be referred to the Specialist MDT, Sheffield

6.6 Recommendations For Follow Up

Patients should be seen every three months for the first year, four monthly in the second year, six monthly in third year and annually until five years. Patients treated locally should have their follow-up locally. Patients who have been treated at the Cancer Centre should be offered follow-up locally after 2 years.

6.7 Staging

<table>
<thead>
<tr>
<th>Stage I – Carcinoma confined to the corpus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ia</td>
</tr>
<tr>
<td>Ib</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage II – Tumour invades cervical stroma, but does not extend beyond the uterus</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Stage III – Local and/or regional spread of the tumour</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIIa</td>
</tr>
<tr>
<td>IIIb</td>
</tr>
<tr>
<td>IIIc</td>
</tr>
<tr>
<td>IIIc1</td>
</tr>
<tr>
<td>IIIc2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage IV – Tumour invades bladder and/or bowel mucosa, and/or distant</th>
</tr>
</thead>
</table>
### Staging for uterine sarcomas (leiomyosarcomas, endometrial stromal sarcomas, adenosarcomas, and carcinosarcomas)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Tumour limited to uterus</td>
</tr>
<tr>
<td>Ia</td>
<td>(\leq 5) cm</td>
</tr>
<tr>
<td>Ib</td>
<td>(&gt; 5) cm</td>
</tr>
<tr>
<td>II</td>
<td>Tumour extends beyond the uterus, within the pelvis</td>
</tr>
<tr>
<td>IIa</td>
<td>Adnexal involvement</td>
</tr>
<tr>
<td>IIb</td>
<td>Involvement of other pelvic tissues</td>
</tr>
<tr>
<td>III</td>
<td>Tumour invades abdominal tissue (not just protruding into the abdomen)</td>
</tr>
<tr>
<td>IIIa</td>
<td>One site</td>
</tr>
<tr>
<td>IIIb</td>
<td>(&gt;) one site</td>
</tr>
<tr>
<td>IIIc</td>
<td>Metastasis to pelvic and or para-aortic lymph nodes</td>
</tr>
<tr>
<td>IV</td>
<td>Tumour invades the bladder and/or rectum</td>
</tr>
<tr>
<td>IVA</td>
<td>Distant metastasis, including intra-abdominal metastases and/or</td>
</tr>
<tr>
<td></td>
<td>inguinal lymph nodes</td>
</tr>
<tr>
<td>IVB</td>
<td>Distant metastasis</td>
</tr>
</tbody>
</table>

2 Adenosarcomas
<table>
<thead>
<tr>
<th>Stage I – Tumour limited to uterus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ia</td>
</tr>
<tr>
<td>Ib</td>
</tr>
<tr>
<td>Ic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage II – Tumour extends beyond the uterus, within the pelvis</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIA</td>
</tr>
<tr>
<td>IIB</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage III – Tumour invades abdominal tissue</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIIA</td>
</tr>
<tr>
<td>IIIB</td>
</tr>
<tr>
<td>IIIc</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVa</td>
</tr>
<tr>
<td>IVb</td>
</tr>
</tbody>
</table>

(3) Carcinosarcomas
Carcinosarcomas should be staged as carcinomas of the endometrium.

*Note
Simultaneous endometrial stromal sarcomas of the uterine corpus and ovary / pelvis in association with ovarian / pelvic endometriosis should be classified as independent primary tumours (FIGO staging 2009)
Other patients with significant medical problems can be referred to the Cancer Centre for discussions with the Sheffield Consultants.

Endometrial Pathway

24.08.11

Time in Days

0 → < 11 → 11 → < 14 → 25 → 7 → 32 → < 21 → 53

Referral to Trust → First Seen - One Stop Diagnostic Staging Tests
TVS Endometrial thickness >4mm proceed to Hysteroscopy +/- Endometrial Biopsies

Network MDT review. If high risk for central pathology review

Grade 1 & 2 adenocarcinoma treated locally

Decision to Treat discussed with Patient in Cancer Unit

First Treatment

All Grade 3 & Papillary Clear Cell Adenocarcinomas
Any other malignancy (carcinosarcomas)
All Stages over 1B
Any other suspicious features

Referral to Cancer Centre. Decision to treat in cancer centre

First Treatment

Ideal Two Week Wait (62 Day Pathway)
7.0 Guidelines for the Management of Vulval Cancer

7.1 Background

Vulval cancer is rare with between 750 and 1000 cases presenting in England and Wales each year. Women with pre-existing lichen sclerosus are at increased risk of developing vulval cancer, however the risk is low, about 4% and so does not warrant the routine follow women with this condition. Women who develop differentiated vulval intra-epithelial neoplasia (VIN) within lichen sclerosus are at significant risk of developing vulval cancer and requiring routine follow up in specialist clinics. Because of the rarity of differentiated VIN it remains difficult to quantify the absolute risk. Women with high grade undifferentiated VIN (VIN2/3) are at increased risk of developing vulval cancer. This risk for women who undergo surgical excision is between 6-8% whereas the risk in untreated VIN may be as high at 87%. Careful follow up of women with undifferentiated VIN, particularly in the first five years after diagnosis, is recommended.

7.2 Referral Guidelines

The criterion for referral via the two week wait pathway is any lesion suspicious of vulval cancer on clinical examination.

All cases of vulval cancer should be referred to the cancer centre for clinical review and further management.

7.3 Management guidelines

7.3.1 Investigations

A biopsy should be taken from the edge of the cancer. The biopsy should be of sufficient size to assess depth of invasion. Ideally the lesion should not be completely excised to help with planning of definitive treatment. Women should have a cervical smear taken where appropriate. A chest X-ray should be performed. MRI or CT should be performed when there is clinical suspicion of nodal involvement. Ultrasound scan should be performed if there is any evidence of a pelvic mass.

All histopathology from the referring centre should be reviewed prior to treatment.
7.3.2 Surgery

Patients who are fit for anaesthesia should be offered radical surgery as the treatment of choice for early stage disease. The nature and extent of the surgery under taken should be influenced by the stage of the disease, the location of the tumour and the patient. All tumours must under go at least wide radical local excision, larger lesions may require a radical vulvectomy. The disease free margin must be at least 1cm. To achieve an adequate deep margin the skin must be excised to the fascia covering the pubic bone and muscles. Non malignant vulval dystrophic skin may be excised at the same time, particularly if symptomatic, but excision of this area need only be superficial.

Where groin node dissection is required (see below) a triple incision technique should be used in order to reduce morbidity. The incidence of skin bridge recurrence in early disease treated by this method is very low.

**Early stage vulval cancer**

**Stage 1a**
Wide radical excision of the lesion with 1cm disease free margin where possible.

**Stage 1b**
Wide radical excision of the lesion with 1cm disease free margin where possible. Inguinal dissection should include the superficial and deep medial lymph nodes. A unilateral, i.e. ipsi-lateral, inguinal dissection should be considered in cases when the medial disease free margin is 1cm lateral to the midline of the vulva.

**Stage 2**
Wide radical excision of the lesion with 1cm disease free margin where possible. Inguinal dissection to include the superficial and deep medial lymph nodes.

**Advanced stage vulval cancer**

**Stage 3**
Wide radical excision of the lesion with 1cm disease free margin where possible. Inguinal dissection should include the superficial and deep medial lymph nodes.

**Stage 4**
Wide radical excision of the lesion with 1cm disease free margin where possible. Inguinal dissection should include the superficial and deep medial lymph nodes. If there is evidence of gross lymphatic vessel involvement
between the primary and the inguinal lymph glands an ‘en bloc’ radical vulvectomy should be considered.

7.3.3 Radiotherapy

Neo-adjuvant and primary treatment

Radiotherapy or concurrent chemoradiotherapy should be considered in cases when patients are too unfit for surgery. Radiotherapy should be considered prior to surgery in cases of extensive disease to allow for a less destructive surgical procedure or in cases when patients are too unfit for extensive surgery. This is particularly true for lesions close to or involving the urethra or anal margin. Pre-operative radiotherapy should be employed to reduce tumour volume and so reduce the need for surgery which may damage the anal sphincter or require a colostomy. Radiotherapy given with curative intent will include the primary vulval lesion and the regional inguinal lymph nodes.

Adjuvant

Radiotherapy to the regional inguinal and pelvic lymph nodes should be offered when two or more regional inguinal nodes are involved with metastatic, disease or there is evidence of extra capsular spread or metastatic disease in any lymph node. Adjuvant radiotherapy to the primary tumour site may be considered if there is incomplete excision of the primary lesion and further surgery is not feasible or there is an intention to give adjuvant radiotherapy to the regional and pelvic lymph glands.

7.3.4 Special cases

Basal cell carcinoma
Wide superficial excision with a 1cm disease free margin is recommended. If surgery is not feasible radiotherapy should be offered.

Melanoma
Wide radical excision with a 1cm disease free margin is recommended. CT imaging of the thorax, abdomen and pelvis should be performed. Adjuvant treatment would be offered after referral to and discussion with the melanoma MDT. SSMDT review of management is recommended for all patients with vulval melanoma.

7.4 Follow up

Patients should be seen every three months for the first year, four monthly for the second year, six monthly for the third year and then annually until five years.
7.5 Management of recurrent disease

All recurrences should be confirmed by biopsy where possible. Localised recurrences in the vulva can be managed by repeat wide radical local excision or radiotherapy. Recurrence within the groin or pelvic lymph nodes should be treated with radiotherapy if not previously used. In cases where there are no suitable active treatment options available then best supportive care will be arranged.

Patients suitable for cytoreductive (surgical or non-surgical ) treatment for recurrent cancer should be referred to the Specialist MDT, Sheffield.

7.6 Trials

None currently open.

7.7 Staging (FIGO 2009)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Clinical/pathological findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td>carcinoma in situ, intraepithelial carcinoma</td>
</tr>
<tr>
<td>Stage 1</td>
<td>Tumour confined to the vulva</td>
</tr>
<tr>
<td>1a</td>
<td>Tumour confined to the vulva or perineum ≤ 2cm diameter, stromal invasion &lt; 1mm, negative nodes</td>
</tr>
<tr>
<td>1b</td>
<td>Tumour confined to the vulva or perineum ≤ 2cm diameter, depth &gt; 1mm, negative nodes</td>
</tr>
<tr>
<td>Stage II</td>
<td>Tumour of any size with extension to adjacent perineal structures (1/3 lower urethra, 1/3 lower vagina, anus), negative nodes</td>
</tr>
<tr>
<td>Stage III</td>
<td>Tumour of any size with extension to adjacent perineal structures (1/3 lower urethra, 1/3 lower vagina, anus), with positive inguino-femoral nodes</td>
</tr>
<tr>
<td>IIIa</td>
<td>(i) with 1 lymph node metastasis (≥5mm) or (ii) 1-2 lymph nodes metastasis(es) (≤5mm)</td>
</tr>
<tr>
<td>IIIb</td>
<td>(i) with 2 or more lymph node metastasis (≥5mm) or (ii) with 3 or more lymph nodes metastases (≤5mm)</td>
</tr>
<tr>
<td>IIIc</td>
<td>With positive nodes with extracapsular spread</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Tumour invades other regional (2/3 lower urethra, 2/3 lower vagina) or distant structures</td>
</tr>
<tr>
<td>IVa</td>
<td>Tumour invades any of the following (i)upper urethra and/or vaginal mucosa, bladder mucosa, rectal mucosa, or fixed topelvic bone, or (ii) fixed or ulcerated inguino-femoral lymph nodes</td>
</tr>
<tr>
<td>IVb</td>
<td>Aany distant metastases, including pelvic lymph nodes</td>
</tr>
</tbody>
</table>
Ideal Two Week Wait (62 Day Pathway)
8.0 Guidelines for the Management of Vaginal Cancer

8.1 Background

Primary vaginal cancer is rare. It constitutes about 2% of malignant neoplasms of the female genital tract. Squamous cell carcinoma is the commonest type. Most vaginal tumours are metastases, and most of these tumours have originated elsewhere in the pelvis.

8.2 Referral Guidelines

Any suspicious lesion in the vagina should be biopsied and any malignant pathology reviewed at the central MDT. All vaginal cancers must be referred to the Cancer Centre for management.

8.3 Recommended Pre-Treatment Investigations

Chest x-ray
MRI is much better than CT for assessing the primary cancer. MRI and CT are equal for lymph node assessment.

8.4 Primary Treatment Guidelines

Vaginal cancer is rare. Treatment needs to be individualised. Most patients will receive intra-cavity radiation therapy, with or without external beam radiotherapy, with or without concurrent chemotherapy (depending on the extent of the disease). However radical vaginectomy, with or without vaginal reconstruction, may be an option in a small number of women with apparently stage 1 disease, along with pelvic or inguinal lymphadenectomy, depending on the location of the tumour.

8.5 Adjuvant Treatment Guidelines

Adjuvant radiotherapy should be considered for women who have been treated by primary surgery and have close or involved margins. Exenteration may be an option for women with persistent but resectable disease at the end of radiotherapy.

8.6 Guidelines For The Management Of Disease Recurrence

Management of disease recurrence should be individualised and it is difficult to generalise. Each case should be assessed on its merits. All cases of disease recurrence should be managed at the Cancer Centre.
Patients suitable for cytoreductive (surgical or non-surgical) treatment for recurrent cancer should be referred to the Specialist MDT, Sheffield.

8.7 Recommendations for Follow Up

Patients should be seen every three months for the first year, four monthly for the second year, six monthly for the third year and then annually until five years.

8.8 Staging of Vaginal Cancer

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 0</strong></td>
<td>Carcinoma in situ, intraepithelial neoplasia Grade III</td>
</tr>
<tr>
<td><strong>Stage I</strong></td>
<td>The carcinoma is limited to the vaginal wall</td>
</tr>
<tr>
<td><strong>Stage II</strong></td>
<td>The carcinoma has involved the subvaginal tissue but has not extended to the pelvic wall</td>
</tr>
<tr>
<td><strong>Stage III</strong></td>
<td>The carcinoma has extended to the pelvic wall</td>
</tr>
<tr>
<td><strong>Stage IV</strong></td>
<td>The carcinoma has extended beyond the true pelvis or has involved the mucosa of the bladder or rectum; bullous oedema as such does not permit a case to be allotted to Stage IV</td>
</tr>
<tr>
<td>IVa</td>
<td>Tumour invades bladder and/or rectal mucosa and/or direct extension beyond the true pelvis</td>
</tr>
<tr>
<td>IVb</td>
<td>Stage spread to distant organs</td>
</tr>
</tbody>
</table>
Other patients with significant medical problems can be referred to the Cancer Centre for discussions with the Sheffield Consultants

Time in Days

Referral to Trust → First Seen in Colposcopy or One Stop Clinic Colposcopy +/- Biopsy / Diagnostic Staging Tests / Bloods → Clinical Review with Results + FBC / USG → Central MDT All Cancer Histology to be reviewed centrally → STH OPD Joint Decision to Treat with Patient → First Treatment

Ideal Two Week Wait (62 Day Pathway)
9.0 Pathology Guidelines

Pathologists follow the Royal College of Pathologists guidance on gynaecological cancer. Please follow the weblink in the following page.
# Tissue pathways for gynaecological pathology

**July 2008**

<table>
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<th>G073</th>
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<td>Document name</td>
<td>Tissue pathways for gynaecological pathology</td>
</tr>
<tr>
<td>Version number</td>
<td>1</td>
</tr>
<tr>
<td>Produced by</td>
<td>Dr Laurence Brown (Writing Group Lead), Dr Alison Andrew, Dr Lynn Hirschowitz and Dr David Millan, on behalf of the College's Specialty Advisory Committee on Histopathology and the Cancer Services Working Group</td>
</tr>
<tr>
<td>Date active</td>
<td>July 2008</td>
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<tr>
<td>Date for review</td>
<td>July 2010</td>
</tr>
<tr>
<td>Comments</td>
<td>In accordance with the College's pre-publications policy, this document was put on The Royal College of Pathologists' website for consultation from 21 May – 20 June 2008. Seventeen pieces of feedback were received and the authors considered them and amended the document accordingly. Please email <a href="mailto:publications@rcpath.org">publications@rcpath.org</a> if you wish to see the responses and comments. Professor Carrock Sewell Director of Publications</td>
</tr>
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Fax: 020 7451 6701
Web: www.rcpath.org

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The data sets used for reporting of gynaecological cancer which can be accessed on the Royal College of Pathologists website at:

http://www.rcpath.org/resources/pdf/g079ovariandatasetfinal.pdf
10.0 Chemotherapy Guidelines

Chemotherapy in the North Trent Cancer Network is principally focused within the Weston Park Hospital, Sheffield. Appropriate guidelines are set out in the Anticancer Drug Therapy Handbook which as a live, iterative document is accessed via the Sheffield intranet which can viewed from all hospital sites (link to this site given below) Development of local chemotherapy is ongoing and a position statement as at the 1st January 2009 prepared for the Chemotherapy Peer Review (edited to show only gynaecological cancers) is set out below.

Chemotherapy Within North Trent For Solid Cancers

Within Weston Park Hospital, in-patient. Short stay, ambulatory and out-patient chemotherapy for Solid tumours is administered, in addition to chemotherapy for lymphoma patients up to, and including, level II (previously level III until November 2008).

Within North Trent, there are four units where out-patient chemotherapy for solid tumour malignancies is undertaken:

- Doncaster Royal Infirmary;
- Rotherham district General;
- Barnsley District General;
- Chesterfield Royal.

Development of local chemotherapy is ongoing. Currently, therefore, individual units are currently administering different chemotherapy regimens.

Thus, on the 1st January 2009 the following regimens are standard regimens for each unit:

**Doncaster**

*Ovary*
- Carboplatin.
- Paclitaxel
- Carboplatin/Paclitaxel

*Endometrial*
- Carboplatin.
- Paclitaxel
- Carboplatin/Paclitaxel

**N.B.** “Any regimen not on this list must be treated at Weston Park Hospital. If they are not protocol regimens at Weston Park, the doctor must follow the appropriate guidelines, found in the Anticancer Drug Therapy Handbook”

http://nwww.sth.nhs.uk/NHS/ClinicalGuidelines/CGP_byFolder_ACTHb.asp
11.0 Supportive and Palliative Care Guidelines

Supportive and palliative care are cross-cutting issues that affect all cancer patients, at all stages from pre-diagnosis to survivorship, or death. The NICE guidance on supportive and palliative care for adults with cancer (2004) gives definitions of these two terms and tries to explain their distinctions and overlaps. However, there is still considerable confusion and unclear thinking about these concepts, with the important consequence that many patients are being referred inappropriately, too late or not at all to specialist services.

The Sheffield Model for Supportive Care clarifies this area and should be seen as the model which applies to North Trent Cancer Network (Ahmedzai, Walsh, *Seminars in Oncology*, 2001.)

In essence, supportive care is a wide range of specialist services which work as a ‘virtual team’ to help the patient (and family) cope with the effects of disease, of treatment-related side-effects (acute and long-term) and with the psychosocial and rehabilitation needs for both long-term survivors with cancer and those who are progressing.

Palliative care is a somewhat more restricted range of services, often configured as an actual team, which focuses on symptoms, psychological, social and spiritual issues for patients and their families, when the disease is progressive and will likely lead to death within 6-12 months.

In many acute settings, palliative care teams provide both supportive and end of life care; in community and hospices, they concentrate almost exclusively on end of life care. Specialists who contribute to supportive care for cancer patients, e.g. dieticians, SALT, other AHPs, pain clinic staff, are scattered across a hospital and are often not coordinated. They provide only limited input in community and hospices. It is ideal for cancer MDTs to have their own dedicated supportive care professionals, or at least dedicated sessions from a trust service.

All patients, regardless of the stage of disease or estimated prognosis, are candidates for supportive care and all those who are nearing the end of life are candidates for palliative care. The difficulty arises in identifying which patients need the different specialists inputs of supportive care at which stage. In North Trent we have developed a screening questionnaire – SPARC, which provides a ‘holistic’ assessment of a patient’s needs for symptom control, psychological, social and spiritual issues as well as needs for information, help with daily living, making plans, and other areas. It is recommended that this instrument is used by clinics and wards to identify patients who need supportive and palliative care. An alternative tool is the ‘Distress Thermometer’ – the North Trent Supportive and Palliative Care Group is producing guidelines to advise MDTs to choose one or other of these tools, as
well as other more specific questionnaires for complex pain, psychological distress, etc.

Most acute settings in North Trent have a team of palliative care nurse specialists. Only 4 out of the 5 localities have consultant-level input into these teams. Furthermore, only 3 of out 5 localities have consultants with regular sessions in hospices.

The Sheffield/Chesterfield/Rotherham localities have a 24/7 medical on-call service with first-on registrars (covering Sheffield and Chesterfield) and second-on consultants (covering all three localities). The consultants also provide an informal second-on call service for the specialist palliative care teams in Barnsley and Doncaster/Bassetlaw.

Ideally a member of each trust palliative care team should attend the Gynaecological cancer MDT. However there are currently insufficient staff to support this. Moreover, MDTs are not always configured to pick up and discuss supportive and palliative care issues within the normal agenda. It is recommended that an alternative arrangement is made to cover this by:

a. Routine use of a supportive care screening tool, e.g. SPARC or Distress Thermometer by all clinicians in both in-patient and out-patient settings.
b. Clearly identified routes of referral between the Gynaecology MDT, usually via the CNS but also via medical staff, to a named person in the local palliative care MDT.
c. The ability to timetable discussion of complex supportive or palliative care issues for specific patients in the MDT meeting, e.g. to discuss palliative surgery, difficult pain or respiratory management, transfer to hospice or other settings.

It is recommended that advance care planning for all patients is started as soon as feasible after the diagnosis of an incurable cancer, including the patient’s preferences for place of care in the terminal stage and the use or rejection of interventional medical support, e.g. artificial hydration, CPR.
12.0 Teenagers and Young Adults

In January 2009 specific referral pathways were developed for teenagers (16-18 years) and young adults (19 -24 years) into the TYA MDT. The Gynaecology NSSG has agreed age appropriate referral into these pathways Set out below:-

The North Trent Children and Young Peoples IOG (CYPIOG) Implementation Summary has been approved by the Specialist Commissioning Group and was submitted to the Cancer Action Team on September the 30th. This paper addresses referral to the Teenage and Young Adult (TYA) MDT, which is based at Weston Park Hospital.

“The model for referral to the TYA MDT, has been agreed with the Cancer Network Chairs and MDT leads within the network and it is anticipated that all young people diagnosed with cancer within the network will be referred to the TYA MDT from April 2009. All patients in this age range will be flagged by the MDT co-ordinator and supported by IT systems to monitor that all appropriate patients are being referred to the TYA MDT.” (North Trent CYPIOG Action Plan).

“Referral to the TYA MDT will be made by the site specific Consultant at their weekly MDT as per operational policy and communication will be two way, electronic and by way of video-conferencing where available to enhance clinical decision-making.” (North Trent CYPIOG Action Plan).

It is clear that in order to implement the above actions there will be a requirement for NSSGs to incorporate the new Teenage and Young Adult Referral Guidelines into their existing Operational Policies. Illustrations are provided below on how these guidelines may look. Within the examples provided, there is some scope for local interpretation.

16 – 18 YR OLDS

GP 2WW REFERRAL

1. Referral straight to STHFT Site Specific MDT

ROUTINE REFERRAL/HOSPITAL ADMISSION TO LOCAL TRUST

1. Diagnostic tests as appropriate. Positive Diagnosis/Strong suspicion of Cancer. Referral by local Consultant to STHFT for treatment via NHS.net electronic referral form.

2. Patient seen by STHFT Site Specific Consultant
3. Diagnostic tests as appropriate

4. **A joint Site Specific/TYA MDT discussion around the treatment plan must take place.** The means by which this will be achieved is to be locally determined but could include phone conversations/video conferencing/TYA attendance at Site Specific MDT/e-mail correspondence. Whatever the means it must be documented and auditable.

**Discussion at Site Specific MDT. Treatment plan generated.** TYA representative may or may not be in attendance depending on agreed joint discussion procedure.

**Referral by Site Specific MDT coordinator to TYA MDT coordinator** via electronic referral form, using NHS.net, outlining diagnosis, treatment plan and any additional relevant information. May happen before or after SSMDT depending on agreed joint discussion procedure.

**Clinical referral to TYA MDT by Site Specific Lead** outlining diagnosis, treatment plan and any additional relevant information. May happen before or after SSMDT meeting depending on agreed joint discussion procedure.

*(Bold statements outline the “Must do’s”)*

5. Discussion with patient around treatment options to include TYA representation. This will most probably be the TYA Nurse Specialist/Key Worker.

6. Patient discussed at weekly TYA MDT with Site Specific input where appropriate.

   Clinical Psychologist to produce supportive care plan for Site Specific referring clinician.

   TYA consultant to provide electronic outcome to Site Specific MDT coordinator within 48hrs, using NHS.net.

7. Patient treatment. TYA key worker input in coordination of support services.

8. Review and follow up care coordinated by TYA Key Worker involving community, secondary site, tertiary site and TYA MDT as appropriate and locally wherever possible

   Patient referred to TYA Late Effects MDT by TYA MDT via electronic referral form.
19 - 24 YR OLDS

GP 2WW REFERRAL

1. Referral to Local Trust. Patient Seen by Site Specific Consultant. Diagnostic tests as appropriate. Positive Diagnosis

ROUTINE REFERRAL/HOSPITAL ADMISSION TO LOCAL TRUST

1. Diagnostic tests as appropriate. Positive Diagnosis/Strong suspicion of Cancer. Patient Seen by Site Specific Consultant

2. **A joint Site Specific/TYA MDT discussion around the treatment plan must take place.** The means by which this will be achieved is to be locally determined but could include phone conversations/video conferencing/TYA attendance at Site Specific MDT/e-mail correspondence. Whatever the means it must be documented and auditable.

**Discussion at Site Specific MDT. Treatment plan generated.** TYA representative may or may not be in attendance depending on agreed joint discussion procedure.

**Referral by Site Specific MDT coordinator to TYA MDT coordinator** via electronic referral form, using NHS.net, outlining diagnosis, treatment plan and any additional relevant information. May happen before or after SSMDT depending on agreed joint discussion procedure.

**Clinical referral to TYA MDT by Site Specific Lead** outlining diagnosis, treatment plan and any additional relevant information. May happen before or after SSMDT meeting depending on agreed joint discussion procedure.

**Bold statements outline the “Must do’s”.**

3. Discussion with patient around treatment options to include TYA representation. This will most probably be the TYA Nurse Specialist/Key Worker. Patient has option of treatment in SCG designated adult services.

4. Patient discussed at weekly TYA MDT with Site Specific input where appropriate.

Clinical Psychologist to produce supportive care plan for Site Specific referring clinician.
TYA consultant to provide electronic outcome to Site Specific MDT coordinator within 48hrs, using NHS.net.

5. Patient treatment. TYA key worker input in coordination of support services.

6. Review and follow up care coordinated by TYA Key Worker involving community, secondary site, tertiary site and TYA MDT as appropriate and locally wherever possible

Patient referred to TYA Late Effects MDT by TYA MDT via electronic referral form.
North Trent Cancer Network Teenage and Young Adult Pathway (16-24 years)

Referral to Trust via GP 2WW or direct admission

First seen by site specific Consultant

If patient is aged 16-18yrs and there is a high suspicion of cancer, refer to STHFT site specific MDT

Diagnostic tests performed as appropriate

Patient discussed at site specific MDT meeting and treatment plan devised

Referral to TYA MDT via electronic referral form

The TYA MDT should be involved in local discussion and an appropriate representative should be invited to attend the meeting either in person or via V/C link

Decision to treat with patient

If patient is 16-18yrs, refer to STHFT for treatment

If the patient is 19-24yrs a choice of treatment site should be offered

Review and follow up care coordinated by secondary site, tertiary site and TYA MDT as appropriate and locally wherever possible

Patient referred to TYA Late Effects MDT via electronic referral form

Consultant Oncologist completes WPH green form to initiate treatment OR Consultant Haematologist initiates treatment

In cases where excision surgery is performed at diagnostic level and is classified as first definitive treatment, any subsequent treatment and follow-up care can be carried out either locally or at STHFT dependent on the patient’s wishes

Patient discussed at a weekly TYA MDT meeting with locality input where appropriate

TYA Consultant to provide electronic outcome to site specific MDT Coordinator within 48 hours

Clinical Psychologist to produce supportive care plan for site specific referring clinician

Register and follow up care coordinated by secondary site, tertiary site and TYA MDT as appropriate and locally wherever possible

Patient referred to TYA Late Effects MDT via electronic referral form

Decision to treat with patient

If patient is 16-18yrs, refer to STHFT for treatment

If the patient is 19-24yrs a choice of treatment site should be offered
### 13.0 Rehabilitation Pathway

#### CANCER REHABILITATION PATHWAY – GYNAECOLOGICAL

## Diagnosis and Care Planning

<table>
<thead>
<tr>
<th>Clinical Indication</th>
<th>Intervention Required</th>
<th>Contact Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dietetics</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Malnutrition or risk of malnutrition | • Undertake nutritional screening, assess level of malnutrition/nutritional risk & refer to Dietitian for nutritional assessment if required  
• Undertake full nutritional assessment  
• Assess potential impact of disease and/or treatment on patient’s nutritional status  
• Develop nutrition support care plan to achieve optimal nutritional status  
• Offer practical dietary advice & give written dietary information to patient/carers  
• Liaise with MDT & other health professionals as appropriate | Key Worker |
| **Physiotherapy**   |                       |                |
| Presence of 2 or more of the following risk factors  
Full midline laparotomy/very low or high BMI/smoker/respiratory condition/previous ITU or SHDU admission/admission for chest problems/70years + | • Full pre-operative assessment  
• Respiratory assessment  
• Role of physiotherapy in recovery  
• Establish levels of current mobility and post operative mobility  
• Assessment of any issues that may impact on discharge | Key worker/medical team |
<p>| <strong>Speech &amp; Language Therapy</strong> | N/A | N/A |</p>
<table>
<thead>
<tr>
<th>Occupational Therapy</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>
| Lymphoedema          | Any patient at risk of lymphoedema or those with lymphoedema | • Advise and inform patient of potential risk factors for developing lymphoedema  
• Offer appropriate advice, and written information | Key worker/medical team |

### Treatment

<table>
<thead>
<tr>
<th>Clinical Indication</th>
<th>Intervention Required</th>
<th>Contact Points</th>
</tr>
</thead>
</table>
| Dietetics Malnutrition or risk of malnutrition | • Identify nutrition related symptoms – weight loss/anorexia/cachexia  
• Develop nutrition support care plan to achieve optimal nutritional status  
• Implement plan appropriate to patient need, including nutritional supplements/enteral feeding if indicated  
• Offer dietary advice as appropriate & give written dietary information to patients/carers  
• Review nutrition support care plan at appropriate intervals  
• Provide ongoing support to patients/carers  
• Identify signs of anxiety/depression  
• Liaise with MDT & other health professionals as appropriate | Key Worker |

| Physiotherapy Respiratory issues Mobility issues Vulvectomy patients Extenteration Below midline insertion Identified issues that could affect discharge | • Stairs assessment for vulvectomy patients  
• Assessment of mobility  
• Assessment of respiratory function  
• Liaison with discharge liaison nurse and social worker | Ward staff |

<table>
<thead>
<tr>
<th>Speech &amp; Language Therapy</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy Identified social issues on</td>
<td>• Assess mobility/ ADL if required</td>
<td>Key Worker Consultant/</td>
</tr>
<tr>
<td>Admission that could affect discharge</td>
<td>Liaise with social services</td>
<td>Medical Treatment Centre/AHP</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Any co morbidities that may affect Activities of Daily Living</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Lymphoedema**

<table>
<thead>
<tr>
<th>Any patient at risk of lymphoedema or those with lymphoedema</th>
<th>Assess patient status especially noting the presence of oedema</th>
<th>Macmillan Clinical Nurse Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Advise patient regarding potential risk factors</td>
<td>GP or Community Health Care Professional</td>
</tr>
<tr>
<td></td>
<td>Inform patient and carer of lymphoedema pathway available if needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer to Specialist Lymphoedema Service lymphoedema for ongoing advice, support to both patient and their carer and appropriate treatment for a patient undergoing medical and surgical interventions</td>
<td></td>
</tr>
</tbody>
</table>

### Post Treatment

<table>
<thead>
<tr>
<th>Clinical Indication</th>
<th>Intervention Required</th>
<th>Contact Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dietetics</strong></td>
<td>Malnutrition or risk of malnutrition</td>
<td>Review nutrition support care plan at appropriate intervals if re referred</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide ongoing support to patients/carers as required</td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
<td>Mobility issues Requirements affecting discharge</td>
<td>May be seen for bladder problems after radiotherapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treat as normal continence patient</td>
</tr>
<tr>
<td><strong>Speech &amp; Language Therapy</strong></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td>Any co morbidities that may affect Activities of Daily Living</td>
<td>Assess mobility/ADL if required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liaise with social services</td>
</tr>
<tr>
<td><strong>Lymphoedema</strong></td>
<td>Any patient at risk of lymphoedema or those with lymphoedema</td>
<td>Assess patient for Lymphoedema</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If mild and uncomplicated, provide ongoing advice, support and treatment to both patient and their carer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If moderate to severe or complicated refer to</td>
</tr>
</tbody>
</table>
Lymphoedema specialist service to provide ongoing advice, support and treatment to both patient and their carer
- Specialist Service assess Lymphoedema treatment options and implement appropriate intervention, liaise with other Health care professionals involved in their care and maintain and monitor patients’ ongoing progress

**Monitoring and Survivorship**

<table>
<thead>
<tr>
<th>Clinical Indication</th>
<th>Intervention Required</th>
<th>Contact Points</th>
</tr>
</thead>
</table>
| **Dietetics**       | Malnutrition or risk of malnutrition | • Assess dietetic treatment options  
• Review nutritional status  
• Review nutritional care plan accordingly  
• Offer dietary advice as appropriate & give written dietary information to patients/carers  
• Provide ongoing support to patient/carers  
• Continue to identify symptoms of anxiety/depression  
• Liaise with MDT & other health professionals as appropriate | Key Worker |
| **Physiotherapy**   | Respiratory issues  
Mobility issues | • Advise patient on impact of treatment and provide information regarding respiratory care, exercise progression, provision of mobility aids as needed  
• Referral onto community rehabilitation services as required  
• Review as an out-patient if required and more appropriate | |
| **Speech & Language Therapy** | N/A | N/A |
| **Occupational Therapy** | Any co morbidities that may affect Activities of Daily Living | • Assess mobility/ ADL if required  
• Liaise with social services | Key worker/ GP or Community Health Care Professional |
<p>| <strong>Lymphoedema</strong>     | Any patient at risk | • Assess patient for ongoing | Key Worker |</p>
<table>
<thead>
<tr>
<th>Clinical Indication</th>
<th>Intervention Required</th>
<th>Contact Points</th>
</tr>
</thead>
</table>
| Dietetics Malnutrition or risk of malnutrition | • Agree appropriate nutrition care plan with patient/carers to manage nutrition related symptoms to aid optimum nutritional quality of life for patient  
• Liaise with MDT & other health care professionals as appropriate  
• Refer patient to Specialist Palliative Care Team (including Dietitian) as appropriate | Key Worker  
Any medical/AHP/palliative care Team.  
GP |
| Physiotherapy | • Be available to provide specialist advice if required, i.e. breathlessness management, fatigue management, advice on positioning to patient and carers, exercise regimes, handling and passive movements training to carers, pain management using various modalities, lymphoedema management, mobility, including provision and training in using walking aids and transfers, management of spinal cord compression  
• Liaise with MDT/Palliative care team | Any medical/AHP/palliative care Team.  
GP  
Specialist palliative Physiotherapist |
| Speech & Language Therapy Communication problems Dysphagia | • Assess patient’s speech, communication and swallowing function | Key Worker /Any medical/AHP/palliative care Team.  
GP |
and liaise with palliative care team & Specialist SLT, as required
- Provide suitable forms of assisting communication where necessary to patients / carers e.g. AAC
- Provide information and advice regarding quality of life and ethical issues and contribute to consent and capacity assessments as necessary
- Continued liaison with MDT regarding above

| Occupational Therapy | Identified problems that affect Activities of Daily Living | Functional and psychological assessment.  
Facilitating informed choice.  
Enabling choice of where to be cared for/die.  
Advising and supporting carers /providing information.  
Home visit/Environmental assessment.  
Equipment provision.  
Fatigue management.  
Self esteem and life review work i.e. memory boxes, creative work.  
Positioning and comfort  
Pressure relief  
Realistic patient goal setting  
Exploring psychological/emotional issues through activities to work towards closure  
Act as patient advocate | Any medical/AHP/palliative care Team.  
GP  
Specialist Palliative OT |
| Lymphoedema | Any patient at | Contact specialist | GP, Community |
| risk of lymphoedema or those with lymphoedema | lymphoedema team when advice and intervention is required  
• Refer to physiotherapy service at Hospice or refer on to the Specialist Service where appropriate | Health Care Professional, Hospital Staff, Palliative Care Team |
Appendix 1 – Sheffield MDT Operational Policy

Final SGCC MDT Operational Policy 2011 (on Cquins).doc

This document is available to download from Cquins. Please see your local cancer manager if you require access. http://www.cquins.nhs.uk/
Appendix 2 – Referral Proforma
Dear Colleague

I would be grateful for your opinion on the patient named above who presents with clinical findings I consider suspicious of malignancy.

I have discussed the possibility of cancer with this patient.

Has the patient confirmed that they can be available to attend an appointment within the next two weeks?  Yes ( ) No ( )

Refer urgently if your patient has any of these presentations:

1. **Urgent Referral for 2ww appointment**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Tick if chosen</th>
<th>Tick if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speculum exam shows lesion on cervix or in vagina suggestive of cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-coital bleeding in women over 35 years that has persisted for more than four weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-menopausal bleeding in women 55 years or more</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[12 months or more since last menses]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent PMB 6 weeks or more after stopping HRT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent Intermenstrual bleeding with normal pelvic and speculum examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal or pelvic mass [not fibroids, not of GI or urological origin]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please order URGENT CA125 at time of referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vulval lesion suspicious of cancer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Menopausal Status**

<table>
<thead>
<tr>
<th>Status</th>
<th>Tick if chosen</th>
<th>Tick if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-menopausal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peri-menopausal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-menopausal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has had hysterectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is on HRT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HRT stopped for the past 6 weeks</td>
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<td></td>
</tr>
</tbody>
</table>

**Other Features**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Tick if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking tamoxifen</td>
<td></td>
</tr>
<tr>
<td>NOT taking tamoxifen</td>
<td></td>
</tr>
<tr>
<td>Pelvic ultrasound done?</td>
<td></td>
</tr>
<tr>
<td>Please give date of any ultrasound exam</td>
<td></td>
</tr>
</tbody>
</table>
### Contributory comments:


### Clinical Information

**Is there a family history?**  
[ ] Y  ( )  [ ] N  ( )

Please provide details.

### Medical History

**Active problems:**

**Consultations:**

**Investigations:**

(FBC, U&E, IFT, INR, TFT, triple swabs, including Chlamydia, Ca 125)

### Current Medications

Medication Table

### Known Allergies

Allergy Table

### Patient information & support needs

Please provide details

---

### To be completed by the Data Team

| Date of decision to refer |  |
| Date of appointment |  |
| Date of earliest offered appointment (if different to above) |  |
| Specify reason if not seen at earliest offered appointment |  |
| Periods of unavailability |  |
| Booking number (UBRN) |  |

### Final diagnosis:

[ ] Malignant  [ ] Benign

### Referral Information

[ ] Initial referral appropriate

[ ] Initial referral not appropriate. Reason: 

Re-referred to:  

---

60