

THE MANAGEMENT OF GYNAECOLOGICAL CANCER	POLICY Register no: 09068 Status: Public
--	---

Developed in response to:	NHS Cancer Plan Improving Outcomes Guidance (IOG) RCOG
CQC Fundamental Standard:	9,10,11,14

Consulted With:	Individual/Body:	Date:
Anita Rao/ Alison Cuthbertson	Clinical Director for Women's, Children's Division	May 2018
Alsin Garnham	Clinical Nurse Specialist	May 2018
Jannabel Said	Oncologist	May 2018
Barnaby Rufford	Gynaecologist	May 2018
Wendy McNabb	Gynaecology /Oncologist	May 2018
Krishnaswamy Madhavan	Oncologist	May 2018
Naveed Sarwar	Medical Oncologist	May 2018
Jonathan Evan-Jones	Gynaecology Surgeon	May 2018
Dr Alan Lamont	Oncologist	May 2018
Rosemary Thompson	Clinical Nurse Specialist	May 2018
Sasha Badzek	Medical Oncologist	May 2018
Eimear Walker	Clinical Nurse Specialist	May 2018
Abby Cyriac	Clinical Oncologist	May 2018
Madhu Joshi	Consultant Obstetrics & Gynaecology	May 2018
Anne Powell	Matron Gynaecology	May 2018
Laura Clover	Senior Nurse Gynaecology	May 2018
	Members of the Essex and East Suffolk Supra-Network Site Specific Group	April 2018

Professionally Approved By:	
Anita Rao; Consultant Obstetrics & Gynaecology	May 2018

Version Number	3.0
Issuing Directorate	Women's and Children's Division
Ratified by	Document Ratification Group
Ratified on	18 th June 2018
Trust Executive Board Date	July 2018
Implementation Date:	18 th July 2018
Next Review Date	May 2021
Author/ Contact for Information	Mr Partington, Lead Consultant for Colposcopy and Gynaecological Oncology
Policy to be followed by	Nurses, Doctors, Consultant Gynaecologists
Distribution Method	Intranet & Website Notification in Staff Focus
Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene

Document History:

Review No:	Authored/Reviewed by:	Issue Date:
1.0	Jane Torble	23 July 2009
1.1	Jane Torble	2009
2.0	Members of the Essex & East Suffolk Supra-Network Site Specific Group	23 October 2014
3.0	Mr Partington – Full review	18 th July 2018

INDEX

- 1.0 Purpose**
- 2.0 Background**
- 3.0 Scope**
- 4.0 MEHT Care Pathways for each Cancer**
- 5.0 Follow Up**
- 6.0 Staff Training**
- 7.0 Clinical/Administrative Breaches**
- 8.0 Audit and Monitoring**
- 9.0 Communication**
- 10.0 References**
- 11.0 Addendum – Referral: Diagnosis and Management Guidelines (Index on page 6)**

Appendices to Addendum

- Appendix 1 - National guidance relating to recall status of women having vault cytology page 41
- Appendix 2 - Follow-up protocol for patients undergoing radical trachelectomy for early stage carcinoma of the cervix page 42
- Appendix 3 - Network agreed chemotherapy algorithms page 43
- Appendix 4 - Terms of reference and membership page 44
- Appendix 5 - Sarcoma pathways page 50
- Appendix 6 - Rehabilitation pathways page 51
- Appendix 7 -TYA pathways page 52
- Appendix 8- Cervical Cancer Care Pathway page 55
- Appendix 9 - Uterine Cancer Care Pathway page 56
- Appendix 10 -Ovarian Cancer Care Pathway page 57
- Appendix 11 -Vulval and Vaginal Cancer Care Pathway page 58

1.0 Purpose

- 1.1 This guideline covers the Referral, Diagnosis and Management of Gynaecological Cancers within the guidelines and policies determined by the Essex and East Suffolk Gynaecological Cancer Supra-Network (EESC), to provide uniformity of care across the Network.

2.0 Background

- 2.1 The five hospitals Essex and East Suffolk Gynaecological Cancer Supra-Network are Basildon Hospital, Southend Hospital, Mid Essex Hospital Trust (MEHT) Chelmsford, Colchester Hospital and Ipswich Hospital. The designated specialist gynaecological cancer service centres are Southend Hospital and Ipswich Hospital. Patients from MEHT receive their specialist cancer care from Ipswich cancer centre. The two centres host a specialist multidisciplinary team (SMDT) that aims to provide total cancer care for women with gynaecological cancers. This arrangement will ensure uniformly high quality in primary, secondary and tertiary centres for all its patients.
- 2.2 Patients are seen in the gynaecological clinics at MEHT (refer to appendices B, C, D, E) and will receive preliminary investigations to aid the diagnosis of cancer.
- 2.3 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Scope

- 3.1 This guideline applies to all clinical staff caring for women with gynaecological cancer.
- 3.2 This MEHT guideline will continually link to the Essex and East Suffolk Gynaecological Cancer Supra-Network guidelines. The numbered references in the text relate to **Appendix E, The Essex and East Suffolk Gynaecological Cancer Supra-Network Guideline.**
- 3.3 Referral and diagnostic pathways 4.0
- 3.4 The cancers treatments covered by this guideline and the Essex and East Suffolk Gynaecological Cancer Supra-Network guidelines are:
- Cervical Cancer 5.1
 - Endometrial (uterine) Cancer 5.2
 - Ovarian Cancer 5.3
 - Vulval Cancer 5.4
 - Vaginal Cancer 5.5
- 3.5 Chemotherapy guideline 6.0
- 3.6 Radiotherapy guideline 7.0

4.0 MEHT Care Pathways for each Cancer

- Cervical Cancer 5.1
- Endometrial (uterine) Cancer 5.2
- Ovarian Cancer 5.3

- Vulval Cancer 5.4
- Vaginal Cancer 5.5

5.0 Follow Up

- 5.1 Patients follow up will be agreed by the multidisciplinary team, and take place at either the Cancer centre or the Unit depending on clinical need and patient preference.
- 5.2 Follow up schedule for patients treated for gynaecological cancers at Mid Essex Hospitals Trust

6.0 Staff Training

- 6.1 All medical and nursing staff are to ensure that their knowledge, competencies and skills are up-to-date in order to complete their portfolio for appraisal.
- 6.2 At case presentations and junior doctor teaching will discuss cancer cases and learn from the outcomes.
- 6.3 On-going teaching and training by Cancer Multi-disciplinary team.

7.0 Clinical/Administrative Breaches:

- 7.1 When there has been a breach in clinical or administrative competencies or actions in the management of patients with gynaecological cancer, the matter should be reported by the Datix system. An appropriate level of investigation would be determined in such instances and suitable recommendations be made including system rectification, further training or retraining or in the case of a serious incident possible implementation of Trust Disciplinary proceedings.

8.0 Audit and Monitoring

- 8.1 An audit of compliance with this policy will be undertaken at least 2 yearly. Where deficiencies are identified, an action plan will be developed to address these issues and findings will be fed back to relevant staff at departmental meetings.
- 8.2 The matron for Gynaecological services will review all risk event report forms that relate to the care of women admitted with gynaecological cancers to identify any training issues.
- 8.3 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the trust's intranet site.
- 8.4 Where a patient's notes have demonstrated that the appropriate action has not been taken a 'risk event form' is to be completed. This may result in additional training as required in the event that a risk event form indicates a shortfall .
- 8.5 Annual audit of patient satisfaction to include all patients diagnosed with cancer treated within Mid Essex or referred to Ipswich Cancer centre. Results will be fed back to the Multidisciplinary Team and Gynaecological Staff.
- 8.6 Annual audit of patient notes to audit that patients have a named Keyworker (this is usually the Clinical Nurse Specialist). Results will be fed back to the multidisciplinary

team. This will also be included in the patient satisfaction survey.

- 8.7 Annual audit whereby after a patient is given a diagnosis of cancer the GP is informed by the end of the next working day. Results will be fed back to the Multidisciplinary team.

9.0 Communication

- 9.1 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.
- 9.2 Approved guidelines will be disseminated to appropriate staff via email after ratification of guideline.

10.0 Reference

Department of Health Guidance on Commissioning Cancer Services: Improving Outcomes in Gynaecological Cancer (1999).

Addendum

Essex & East Suffolk Gynae Cancer Supra-Network

Gynaecological Cancers - Referral, Diagnosis and Management Guidelines

Version Number	10.0
Author	Members of the NSSG
Date Written	April 2018
Next Review Date	March 2021
Constitution agreed by Group on	April 2018

Authors: Members of the Essex & East Suffolk Supra-Network Site Specific Group

Document Owner:

Essex Cancer Network
Kestrel House
Hedgerows Business Park
Chelmsford
Essex
CM2 5PF

This constitution document has been revised in April 2012. The main changes are the incorporation of Guidelines for the management of premenopausal Ovarian cysts following guidance published by the RCOG in December 2011, the inclusion of approved chemotherapy algorithms for Ovary, Cervix, endometrial, vulva, uterine and mixed tumours and Sarcoma guidelines from the centre.

INDEX

1. **The Gynaecological Cancer Supra-Network for Essex and East Suffolk**
2. **Local MDT and Specialist MDT Referral Arrangements**
3. **Suspected Gynae Cancer Referrals**
4. **Referral and Diagnostic Pathways**
5. **Guidelines for the Treatment of Gynaecological Cancer**
6. **Chemotherapy Guidelines**
7. **Radiotherapy Guidelines**
8. **Follow Up Schedules and Investigations**
9. **Clinical and Molecular Trials Supra Network**
10. **Collection of the Minimum Data Set Across Supra Network**
11. **Network Audit Projects Across the Supra Network**

1.0 THE GYNAECOLOGICAL CANCER SUPRA NETWORK FOR ESSEX AND EAST SUFFOLK

- 1.1 The 5 hospitals in the Gynae cancer supra network are Basildon Hospitals, Southend Hospital, Mid Essex Hospital (Chelmsford), Colchester Hospital and Ipswich Hospital. The designated Gynae specialist cancer centres are Southend Hospital and Ipswich Hospital. Both centres host a specialist multidisciplinary team (SMDT) that aims to provide total cancer care for women with gynaecological cancers. Ipswich Hospital is part of the Anglia Cancer Network but receives two thirds of its referral catchment population from ECN localities. In view of this there is network support to establish a supra-network arrangement linking the two specialist centres serving the ECN population. This arrangement will ensure uniformly high quality in primary, secondary and tertiary centres for all its patients.

This constitution document has been revised in April 2018. The main changes are the incorporation of the revised (2009) FIGO staging system into the guidelines, adding the MDS (Minimum Data Set), updating of trials and audits and updating names of members.

- 1.2 The function of the Supra-network is coordinated through a Network Site-Specific Group (NSSG). **Appendix 4** sets out the agreed Terms of Reference and Membership of the NSSG.

2.0 LOCAL MDT AND SPECIALIST MDT REFERRAL ARRANGEMENTS

- 2.1 The supra-network has 4 local Gynae cancer MDTs:-
- Colchester serving North East Essex locality
 - Chelmsford serving Mid Essex locality
 - Southend/Basildon serving South East and South West Essex locality (combined LMDT/SMDT)
 - Ipswich serving East Suffolk locality
- 2.2 The supra-network has two specialist Gynae SMDTs (a) Hosted by Southend (serving South East and South West localities) and (b) Hosted by Ipswich (serving the North-east/Mid Essex/east Suffolk localities)
- 2.3 The implementation of the Improving Outcomes Guidance for Gynae cancer in South Essex and Mid Anglia Cancer Networks saw the formal designation of two specialist surgical centres for gynae cancer surgery, these are:-
- Ipswich Hospital
 - Southend Hospital
- 2.4 The respective multidisciplinary teams, comprises of gynaecological oncology surgeons, clinical and medical oncologists, specialist nursing staff, radiology and histopathology specialists, and specialists in palliative care. Box 1 below identifies the criteria for referral to the SMDTs. For more information see the individual SMDT Operational Policy.

Box 1: Criteria for referrals to SMDT

Suspected cancers should be referred to local gynae cancer diagnostic teams based in individual acute hospitals. All gynae cancers should be discussed at SMDT. The following cancers will be referred to the SMDT for central management:

- a) Stage IA2 and above cervical carcinoma
- b) Stage IC and above, all grade 3 *endometrial cell carcinoma* and other high risk

- | | |
|----|--|
| | pathologies (MMT, clear cell, sarcoma) |
| c) | All invasive vulval carcinoma / vaginal carcinoma |
| d) | Clinically predicted ovarian carcinoma (see pg 10) |
| e) | Other rare tumours e.g. fallopian tube, primary peritoneal carcinoma |

MDT Referral Arrangements:

- 2.5 Referrals can be made to any of the clinicians in the multidisciplinary team using dedicated referral form via fax or email to the centre. (See individual MDT Operational Policy)

3.0 SUSPECTED GYNAE CANCER REFERRALS

- 3.1 The Supra-network supports the NICE Referral Guidelines for Suspected Cancer which is detailed in Box 2 below.

Box 2: Referral Guidelines for Suspected Gynae Cancer (NICE 2017)

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, post coital 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, a 2ww 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.
- 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.
- When a woman who is not on hormone replacement therapy presents with postmenopausal bleeding, an urgent referral should be made.
- 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.
- Tamoxifen can increase the risk of endometrial cancer. When a woman taking tamoxifen presents with postmenopausal bleeding, an urgent 2ww referral should be made.
- An urgent referral should be considered in a patient with persistent intermenstrual bleeding and a negative pelvic examination.

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

2 week Referral for Suspected cancer

- 3.2 All patients will be given the earliest 2 week wait referral and imaging appointment but will be offered another date of their choice (if available) if the initial date is not suitable. Similarly, all patients will be normally offered the earliest treatment dates for surgery/chemotherapy/radiotherapy but will be given the choice to alter these start dates subject to availability and meeting targets and guidelines for treatment.
- 3.3 Referring GPs and PCTs will be given information/feedback on appropriateness and timeliness of urgent referrals periodically.

4.0 REFERRAL AND DIAGNOSTIC PATHWAYS

All histology from local units where management is going to take place at the centre should be reviewed by the centre SMDT

4.1 Pathway for referral of Cervical Cancer

- 4.1.1 Clinically obvious cancer:
- 4.1.2 An EUA performed by the gynaecological oncologist (and clinical oncologist if required) to determine appropriate treatment will be performed at the cancer centre.
- 4.1.3 Invasive carcinoma diagnosed on cone biopsy/LLETZ:
- 4.1.4 In these cases, referral direct to the gynaecological oncologist is appropriate for case discussion at the SMDT. The pathology *slides* should be presented for review at SMDT.

4.2 Pathway for referral of Endometrial cancer

- 4.2.1 Endometrial cancer will be diagnosed on the basis of an endometrial biopsy either obtained by a sampler (pipelle) in the clinic or by biopsy at hysteroscopy.
- 4.2.2 MRI should be performed at diagnosis to estimate the stage of the tumour (myometrial invasion, cervical involvement and status of lymph nodes).

4.2.3 Women who on endometrial biopsy are found to have carcinoma must be referred immediately to the SMDT for discussion as to further management.

4.2.4 The management of complex atypical hyperplasia should be discussed at SMDT.

4.3 Pathway of referral for Ovarian Cancer

4.3.1 Any women with clinical or imaging evidence suspicious of malignancy should be discussed at SMDT.

4.3.2 A Risk of Malignancy Index (RMI) should be calculated on these women (See Box 2 below).

Box 3: Calculating RMI

Menopausal Status

Premenopausal = score of 1

Postmenopausal = score of 3

Ultrasound status:

One abnormal feature = score of 1.

Two or more abnormal features = 3

Abnormal features: solid areas
 bilateral lesions
 septae
 ascites
 distant metastases

CA-125

Score is actual level

RMI Calculation = Menopausal Score x Ultrasound Score x CA-125

4.3.3 Women suitable for surgical treatment with RMI score greater than 250 should be operated on by the SMDT gynae-oncologist at the centre. Women with a score less than 250 suitable for surgical treatment may be managed by the unit gynaecologist following discussion at SMDT.

4.3.4 It is inevitable that some surgery will be performed at local hospitals on women with unsuspected ovarian cancer. The number of cases should be recorded for audit as outlined in the COG guidelines. Once histology of cancer is confirmed, the case should be discussed at the next SMDT meeting to determine the need for further evaluation and treatment.

4.3.5 Prior to transfer to Specialist Centre with a presumed diagnosis of metastatic ovarian cancer, the following should be considered:

- Ca125, CEA, CA 19.9
- CT abdo/pelvis, CXR, breast examination
- + Discussion with local core member for gynaecological cancers

4.3.6 If there is any doubt raised by the unit lead or after discussion with the cancer centre, the following may be required before transfer:

- Cytokeratin studies on the malignant cells in the ascites

- Guided biopsy + cytokeratin studies
- Upper / lower GI endoscopy
- Mammogram

Management of Premenopausal Ovarian Cysts

- 4.3.7 The RCOG has published a Green Top Guideline in December 2011 looking at the issue of ovarian cysts in the premenopausal women. The guideline acknowledges the limitations of both the CA 125 and transvaginal ultrasound scan in this age group but ultimately, these are the only available investigations at present and should be utilized judiciously. If there is any suspicions on these investigations, the patients should be discussed at the Gynae-oncology MDT or with a gynaecological oncologist.
- 4.3.8 The RMI has not been proven to be as valuable in the premenopausal age group compared to menopausal women. The Guideline mentions the use of the IOTA group of ultrasound rules but this has not been widely used in the UK.
- 4.3.9 The addition of beta hCG and alpha feto-protein in women with ovarian cysts under the age of 40 has been advocated.
- 4.3.10 Simple ovarian cysts up to 5cm in diameter can be left alone and monitored unless the patient is symptomatic or if there is a progressive increase in size, in which case, consideration for removal would be expected (please refer to RCOG GTG 62 for further information).

4.4 Pathway for referral of Vulval cancer

- 4.4.1 Women with biopsy positive vulval carcinoma should be referred to SMDT for management.
- 4.4.2 In patients with a clinically obvious cancer, referral may be made prior to histological diagnosis.

4.5 Pathway for referral of Vaginal cancer:

- 4.5.1 A direct referral to SMDT of women with biopsy positive vaginal carcinoma. An EUA will usually be organized with the SMDT.
- 4.5.2 In patients with a clinically obvious cancer, referral may be made prior to histological diagnosis.

4.6 Pathway for referral of Recurrent Cancer:

- 4.6.1 Cases of recurrent or suspected recurrent cancer should be discussed with the SMDT for further management.

4.7 Pathways for Chemotherapy

- 4.7.1 Chemotherapy is given at Southend Hospital, Mid Essex Hospital, Colchester hospital or Ipswich hospital under supervision of core member oncologist of SMDT.
- 4.7.2 The chemotherapy for gynaecological cancer will be provided under the care of the oncology team who are core members of SMDT.
- 4.7.3 Active consideration for clinical trials should be made if appropriate.

4.8 Pathways for Radiotherapy

4.8.1 Radiotherapy is given at Southend, Colchester or Ipswich Hospital

4.9 Histological Datasets and Tissue Pathway

4.9.1 The minimum data set for gynaecological cancers should be recorded by all histopathology departments. It is envisaged that this will be put onto a central database in the future.

4.9.2 Second opinions may be sought for difficult specimens. Second opinions may be requested from a selection of experts who may have special interests in individual tumours.

4.9.3 All cancers will be recorded according to RCPATH Guidelines for a minimum data set. (Links below)

4.9.4 The designated pathologist will attend SMDT to consult on patient's treatment plan.

4.9.5 Facilities will be available for the storage of histology slides for a minimum of ten years and tissue blocks for specimens indefinitely. Pathology labs will have appropriate external accreditation

4.9.6 Facilities will be available for storage of fresh tumour tissue for research (provided ethics approval is given).

4.9.7 The following are the links to the RCPATH agreed dataset for histological reporting of gynaecological cancers:

CERVICAL - <http://www.rcpath.org/index.asp?PageID=1152>

ENDOMETRIUM - <http://www.rcpath.org/index.asp?PageID=1156>

OVARY – <http://www.rcpath.org/resources/pdf/g079ovariandatasetfinal.pdf>

VULVA - <http://www.rcpath.org/index.asp?PageID=1166>

4.10 Teenagers and Young Adults

4.10.1 Any Teenage and Young Adult (TYA) in the age range 16-18 (up to 19th birthday) suspected of a gynaecological Cancer must be referred to the TYA Primary Treatment Centre (PTC) Multidisciplinary Team (MDT) for treatment.

4.10.2 The PTC for the **Essex Cancer Network is University College London Hospitals NHS Foundation Trust.**

4.10.3 Any TYA in the age range 19-24 (up to 25th Birthday) must be discussed with the TYA PTC MDT but can choose either to follow the adult pathway or be treated at the PTC. If treated locally their treatment plans must be discussed with the PTC MDT

5.0 GUIDELINES FOR THE TREATMENT OF GYNAECOLOGICAL CANCERS

The following guidelines are evidence based and have been agreed by the Gynaecological Supra-network NSSG. Chemotherapy guidelines are in section 6.

All tumours must have pathological review *please see comment page 8* of slides and appropriate staging investigations to determine FIGO staging. All new cases must be discussed at the SMDT before optimal therapy is decided upon.

5.1 CERVICAL CANCER

5.1.1 FIGO Staging

Carcinoma of the Cervix FIGO staging (updated version 2009)

Stage I	The carcinoma is strictly confined to the cervix (extension to the corpus would be disregarded)
Stage IA	Invasive carcinoma which can be diagnosed only by microscopy, with deepest invasion $\leq 5.0\text{mm}$ and largest extension $\leq 7.0\text{mm}$
Stage IA1	Measured stromal invasion of $\leq 3.0\text{mm}$ in depth and horizontal extension of $\leq 7.0\text{mm}$
Stage IA2	Measured stromal invasion of $>3.0\text{mm}$ and not $>5.0\text{mm}$ with an extension of not $>7.0\text{mm}$
Stage IB	Clinically visible lesions limited to the cervix uteri or pre-clinical cancers greater than stage IA
Stage IB1	Clinically visible lesion $\leq 4.0\text{cm}$ in greatest dimension
Stage IB2	Clinically visible lesion $>4.0\text{cm}$ in greatest dimension
Stage II	Cervical carcinoma invades beyond the uterus, but not to the pelvic wall or to the lower third of the vagina
Stage IIA	Without parametrial invasion
Stage IIA1	Clinically visible lesion $\leq 4.0\text{cm}$ in greatest dimension
Stage IIA2	Clinically visible lesion $>4.0\text{cm}$ in greatest dimension
Stage IIB	With obvious parametrial invasion
Stage III	The tumor extends to the pelvic wall and/or involves lower third of the vagina and/or causes hydronephrosis or non-functioning kidney
Stage IIIA	Tumor involves lower third of the vagina, with no extension to the pelvic wall

- Stage IIIB** Extension to the pelvic wall and/or hydronephrosis or non-functioning kidney
- Stage IV** The carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. A bullous edema, as such, does not permit a case to be allotted to Stage IV
- Stage IVA** Spread of the growth to adjacent organs
- Stage IVB** Spread to distant organs

All macroscopically visible lesions—even with superficial Invasion—are allotted to stage IB carcinomas. Invasion is limited to a measured stromal invasion with a maximal depth of 5.0mm and a horizontal extension of not >7.0mm. Depth of invasion should not be >5.0mm taken from the base of the epithelium of the original tissue—superficial or glandular. The depth of invasion should always be reported in mm, even in those cases with “early (minimal) stromal invasion” (~1.0mm). The involvement of vascular/lymphatic spaces should not change the stage allotment.

On rectal examination, there is no cancer-free space between the tumor and the pelvic wall. All cases with hydronephrosis or non-functioning kidney are included, unless they are known to be due to another cause.

Refer: International federation of Gynaecology and Obstetrics, Int Journal of Gyn and Obstetrics 105 (2009) 103-104

5.1.2 Pre-treatment investigations in cancer more than Stage 1A1

- MRI – Pelvis and Abdomen (according to agreed guidelines)
- Chest X-ray
- Thoracic CT (only if suspicious of metastatic disease)
- PET or surgical staging for evaluation of nodal involvement should be considered

5.1.3 Early stage cancer

Figo stage 1A1, no LVSI

If fertility preservation

- cone biopsy if not already performed
- repeat cone biopsy if margins not clear
- colposcopy follow up if cone biopsy margins clear

Follow-up: Colposcopy at 6/12, then at clinician’s discretion. Continue clinical follow up for 5 years.

If family complete

- simple total hysterectomy

Figo stage 1A1, LVSI present

As for 1.A.1 but consider pelvic node dissection at centre

Figo stage 1A2

- Surgery is the standard.
- Trachelectomy in patients who wish to retain fertility
- Simple or radical hysterectomy in other patients
- Pelvic lymphadenectomy is required
- In patients with pelvic node involvement: chemoradiation

Figo stage 1B1

- Options consist of surgery or external irradiation plus brachytherapy (with or without chemotherapy).
- Standard surgery consists of radical hysterectomy, bilateral oophorectomy (optional) and pelvic lymphadenectomy.
- In patients treated with upfront surgery who are found to have pelvic node involvement: consider post-operative concomitant chemoradiation cisplatin-containing (i.e. cisplatin alone or cisplatin and 5-fluorouracil).
- Small Stage 1B1 or less, desiring fertility, consider laparoscopic pelvic lymphadenectomy and radical trachelectomy.

Post-Operative adjuvant RT

Parametrial involvement
 Resection margins positive
 Positive pelvic lymph nodes as above

Para-aortic glands involved
 - Consider extended field external beam RT

5.1.4 Locally advanced cancer

Figo Stage 1B2 – IVA

- Selected patients stages 1B2 and 2A may be considered for radical surgery
- Concomitant cisplatin-containing chemoradiation is standard.
- Patients with advanced stage III and IVA may benefit less than patients with stage 1B2–IIA/B.
- .
- External irradiation is combined with brachytherapy and the total treatment duration should remain <55 days
- Neoadjuvant chemotherapy is currently under investigation.

Stage 4B

- Platinum-based combination chemotherapy has a potential benefit
- Palliative radiotherapy could also be considered
- Palliative care support should be offered to all patients

5.1.5 Recurrent cancer

Treatment options should be discussed at SMDT. The following options could be considered.

No previous radiotherapy

- Consider surgical resection, if feasible

- pelvic radiotherapy +/- chemotherapy

Previous radiotherapy, no hysterectomy - central recurrence/persistent disease

- radical hysterectomy, exenteration or palliative surgical procedures.

Previous radiotherapy, previous hysterectomy – central recurrence

- pelvic exenteration (if appropriate)

Previous radiotherapy – side wall disease

- Side wall resection and/or CORT

Previous radiotherapy – incurable disease

- palliative chemotherapy
- palliative radiotherapy
- palliative care team

5.1.6 Special situations

Neuro endocrine or small cell tumours of the cervix

- These women should be reviewed for neo-adjuvant chemotherapy (usually Cisplatin and Etoposide for 6 cycles);
- Following chemotherapy, consideration would be given for performing either a radical hysterectomy with node dissection or radical chemo-radiation.

5.1.7 Cervical Cancer chemotherapy

(Refer to section 6 plus agreed list of network harmonised chemotherapy schedules)

5.2 UTERINE CANCER

5.2.1 FIGO Staging Carcinoma of the Endometrium, includes carcinosarcoma (revised version 2009)

The treatments outlined below concern endometrial cancer. Regarding other uterine cancers, refer to the following below:

Stage I	Tumour confined to the corpus uteri. Endocervical glandular involvement is included.
Stage IA	Tumour confined to the uterus, no or < ½ myometrial invasion
Stage IB	Tumour confined to the uterus, > ½ myometrial invasion
Stage II	Cervical stromal invasion, but not beyond uterus
Stage III	Local and/or regional spread of the tumour. Positive cytology to be reported separately and does not influence the stage.
Stage IIIA	Tumour invades serosa or adnexa
Stage IIIB	Vaginal and/or parametrial involvement
Stage IIIC1	Pelvic node involvement

Stage IIIC2 Para-aortic involvement

Stage IV Tumour invades bladder and/or bowel mucosa, and/or distant metastases

Stage IVA Tumour invasion bladder and/or bowel mucosa

Stage IVB Distant metastases including abdominal metastases and/or inguinal lymph nodes

5.2.2 Uterine sarcomas were staged previously as endometrial cancers, which did not reflect clinical behaviour. Therefore, a new corpus sarcoma staging system was developed based on the criteria used in other soft tissue sarcomas. This is described as a best guess staging system, so data will need to be collected and evaluated for further revision.

5.2.3 Staging for Uterine Sarcomas (Leiomyosarcoma, endometrial stromal sarcomas, adenosarcomas and carcinosarcoma). Please see below.

Refer: International federation of Gynaecology and Obstetrics, Int Journal of Gyn and Obstetrics 105 (2009) 103-104

5.2.4 Endometrial cancer can be grouped with regard to the degree of differentiation of the adenocarcinoma, as follows:

G1 = 5% or less of a nonsquamous or nonmorular solid growth pattern
G2 = 6%-50% of a nonsquamous or nonmorular solid growth pattern
G3 = more than 50% of a nonsquamous or nonmorular solid growth pattern

Ref: International Federation of Gynaecology and Obstetrics 1989; International Journal of Gynaecology Obstetrician, 28, 189-190

5.2.5 Investigations Before Definitive Treatment

- Chest X-ray and transvaginal ultrasound.
- Contrast-enhanced dynamic MRI should be performed to assess the uterine and locoregional pelvic extension of the disease
- A CT scan of the abdomen and retroperitoneal nodes **may** be helpful to determine extra-uterine spread if there is any doubt following the previous investigations as determined by the MDT.

5.2.6 Treatment

- Endometrial carcinoma is a surgically staged disease.
- The minimal procedure should include peritoneal fluid or washings, a thorough exploration of the abdominal cavity and pelvic and para-aortic nodal areas, and a total hysterectomy with bilateral salpingo-oophorectomy.
- In high risk cases omentectomy and retroperitoneal lymph node dissection may be considered.
- If patient unfit or refuse surgery radiotherapy could be considered.

5.2.7 Post-operative Therapy

Consider according to risk

- (i) low risk
 - stage Ia/Ib, grade 1 or 2, endometrioid histology
 - Low risk group: no adjuvant therapy
- (ii) intermediate risk
 - stage Ic, grade 1 or 2, endometrioid histology
 - stage Ia/Ib, grade 3, endometrioid histology
 - Adjuvant pelvic radiotherapy significantly reduces the risk of pelvic/vaginal relapses, but has no impact on overall survival
- (iii) high risk
 - stage Ic, grade 3, endometrioid histology
 - stage Ia or Ib or Ic, serous, clear cell, small cell or undifferentiated histology.
 - LVSI plus one other risk factor (1C or Grade 3)
 - Consider pelvic lymphadenectomy if identified as high risk pre-operatively
 - Pelvic radiotherapy is recommended in order to increase loco-regional control.
 - High rates of distant metastases require novel adjuvant treatment strategies in order to increase survival in this group.
 - Recent studies have suggested a survival benefit of adjuvant chemotherapy

5.2.8 Figo stage II

- Stage IIa: treated as high risk stage I.
- Stage IIb: consider lymph node dissection if identified pre-operatively.
- Patients who have high-risk disease (according to definitions given for stage I) are recommended to have adjuvant pelvic (with or without intravaginal) radiotherapy.

5.2.9 Figo stage III and IV – diagnosed pre-surgery

- Maximal surgical cytoreduction may be considered in patients with good performance status
- Patients with stage III disease solely on the basis of positive peritoneal cytology are treated as patients with stage I or II disease, based on the other clinicopathological data.
- Pelvic control is increased with pelvic radiotherapy.
- Chemotherapy should be considered. Cisplatin, carboplatin, anthracyclines and paclitaxel show significant single-agent objective response rates.
- Progestational agents are active in steroid-receptor positive tumors (mostly G1 and G2 lesions)

5.2.10 Figo stage III and IV found after surgical staging

- Consider adjuvant external beam RT and brachytherapy
- Consider adjuvant chemotherapy or progesterones

5.2.11 Recurrent Disease

- Vaginal vault and central pelvic recurrences may be salvageable by radical radiotherapy or surgery according to previous treatment
- Inoperable recurrences after radical radiotherapy should be treated as Stage 4 with chemotherapy or hormones and palliative care.

5.2.12 Uterine sarcomas

(FIGO staging, 2009)

Staging for Uterine Sarcomas (Leiomyosarcoma, endometrial stromal sarcomas, adenosarcomas and carcinosarcoma)

5.2.13 FIGO staging 2009 Leiomyosarcoma

Stage	Definition
I	Tumour limited to uterus
IA	<5 cm
IB	>5 cm
II	Tumour extends to pelvis
IIA	Adnexal involvement
IIB	Tumour extends to extrauterine pelvic tissue
III	Tumour invades abdominal tissues (not just protruding into the abdomen)
IIIA	One site
IIIB	> one site
IIIC	Metastatic to pelvic and/or para-aortic lymph nodes
IV -IVA	Tumour invades bladder and/or rectum
IVB	Distant metastasis

5.2.14 FIGO Staging 2009, Endometrial stromal sarcomas (ESS) and adenocarcinoma*

Stage	Definition
I	Tumour limited to uterus
IA	Tumour limited to endometrium/endocervix with no myometrial invasion
IB	Less than or equal to half myometrial invasion
IC	More than half myometrial invasion
II	Tumour extends to the pelvis
IIA	Adenexal involvement
IIB	Tumour extends to extrauterine pelvic tissue
III	Tumour invades abdominal tissue (not just protruding into the abdomen)

IIIA	One site
IIB	> one site
IIIC	Metastasis to pelvis and/or para-aortic lymph nodes
IV -IVA	Tumour invades bladder and/or rectum
IVB	Distant metastasis

5.2.15 **Carcinosarcomas**- should be staged as carcinomas of the Endometrium (see above)

- Note-simultaneous tumours of the uterine corpus and ovary/pelvis in association with ovarian/pelvic endometriosis should be classified as independent primary tumours.
(Refer: International federation of Gynaecology and Obstetrics, Int Journal of Gyn and Obstetrics 105 (2009) 103-104.

5.2.16 **The input from the Sarcoma SMDT should be sought where necessary.**

5.2.17 **Malignant Mixed Mullerian Tumours (MMMT, carcinosarcoma)**

TAH, BSO, pelvic lymphadenectomy, omentectomy- staging surgery

Management should be jointly with gynaecological medical oncology and the sarcoma multi-disciplinary team.

Stage I disease - lymph node and staging negative

- no adjuvant treatment
- consider vault brachytherapy

Stage II plus - lymph node or staging positive

- External beam RT + vault brachytherapy
- Consider chemotherapy

5.2.17 **Leiomyosarcoma**

If identified pre-surgery consider staging with CT Chest Abdo pelvis.

TAH, BSO +/- pelvic lymphadenectomy

Discuss outcome with sarcoma multi-disciplinary team.

Stage I disease - lymph node and staging negative

- no adjuvant treatment
- consider vault brachytherapy

Stage II plus - lymph node or staging positive

- External beam RT + vault brachytherapy
- Consider chemotherapy

5.2.18 Endometrial stromal sarcoma

TAH, BSO +/- pelvic lymphadenectomy

If identified pre-surgery consider staging with CT Chest Abdo pelvis.

Low grade disease

- no adjuvant treatment

High grade disease

- External beam RT ± vault brachytherapy
- Consider chemotherapy: cisplatin + ifosfamide/ adriamycin
- Consider oestrogen blockade
- If no evidence of disease: observe
- If residual disease present: RT and chemotherapy according to site
- Consider use of progesterons

5.3 OVARIAN CANCER

5.3.1 Figo staging

Stage I growth limited to the ovaries.

IA growth limited to one ovary; no malignant ascites. No tumour on the external surface; capsule intact.

IB growth limited to both ovaries; no malignant ascites. No tumour on the external surfaces; capsules intact.

IC tumour either stage IA or IB, but with tumour on the surface of one or both ovaries; or with capsule ruptured; or with ascites present containing malignant cells or with positive peritoneal washings.

Stage II growth involving one or both ovaries with pelvic extension.

IIA extension and/or metastases to the uterus and/or tubes.

IIB extension to other pelvic tissues.

IIC tumour either stage IIA or stage IIB, but with tumour on the surface of one or both ovaries; or with capsule(s) ruptured; or with ascites present containing malignant cells or with positive peritoneal washings.

Stage III tumour involving one or both ovaries with peritoneal implants 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 verified malignant extension to small bowel or omentum.

IIIA tumour grossly limited to the true pelvis with negative nodes but with histologically confirmed microscopic seeding of abdominal peritoneal surfaces.

IIIB tumour of one or both ovaries with histologically confirmed implants of abdominal peritoneal surfaces, none exceeding 2 centimetres in diameter. Nodes negative.

IIIC abdominal implants greater than 2 centimetres in diameter and/or positive retroperitoneal or inguinal nodes.

Stage IV ovarian cancer is growth involving one or both ovaries with distant metastasis. If pleural effusion is present, there must be positive

cytological test results to allot a case to stage IV. Parenchymal liver metastasis equals stage IV.

Ref: International Federation of Gynaecology and Obstetrics 1989; Int J Gynecol Obstet, 28, 189-190

5.3.2 Pre-treatment Investigations

- Consider abdomino-pelvic CT scan,
- chest X-ray,
- serum CA125, CA 19.9 and CEA

5.3.3 Surgical Staging

- Neo-adjuvant chemotherapy may be considered in the context of a clinical trial or after SMDT discussion for stage III / IV disease.

5.3.4 Surgery

- Requires a median laparotomy

5.3.5 Early Stage Disease

- Frozen section should be considered if in doubt
- Total abdominal hysterectomy,
- Bilateral salpingo-oophorectomy,
- omentectomy,
- Peritoneal washings
- Consider further biopsies
- Pelvic/para-aortic lymph node dissection should be performed in potential Stage 1A/B disease.

5.3.6 In younger patients wanting to conserve fertility

- Localized, unilateral tumours (stage I) and favourable histology:
- Unilateral salpingo-oophorectomy may not be associated with a high risk of recurrence.
- Wedge biopsy of the contralateral ovary should be performed if the contralateral ovary is not normal on inspection.

5.3.7 Management by Stage

- Stage Ia/b well differentiated, non-clear cell histology: surgery alone is adequate.
- Stage Ia/b poorly differentiated, densely adherent, clear cell histology and all grades FIGO stage Ic and IIA: - optimal surgery and staging should be performed, and adjuvant chemotherapy considered.

5.3.8 Stage 2b to 3c

- Upfront maximal surgical effort at cytoreduction with the goal of no residual disease
- Followed by adjuvant chemotherapy
- Neo-adjuvant chemotherapy may be considered after SMDT discussion in Stage 3.

If initial maximal cytoreduction was not performed:

- Interval debulking surgery should be considered in patients responding to chemotherapy.

5.3.9 Stage 4

- Patients may obtain a survival advantage from being maximally surgically cytoreduced at initial laparotomy after SMDT discussion.
- Chemotherapy as for stage IIb–IIIc disease.

5.3.10 Recurrent disease

- Patients with long intervals (>1 year) from primary treatment should be considered for surgical resection.
- Patients with long intervals (>6 months) from initial chemotherapy may be offered platinum-based combination chemotherapy.
- For patients with short treatment-free intervals and with second and later recurrences, palliative chemotherapy should be considered.

5.3.11 Ovarian tumours of borderline malignancy

Family completed

- TAH BSO staging or debulking

Fertility desired

- staging or debulking surgery
- preserve uterus and ovarian tissue

Diagnosis after ovarian cystectomy, family completed

- TAH BSO staging or debulking

Diagnosis after ovarian cystectomy, fertility desired

- Oophorectomy, staging or debulking surgery
- preserve uterus and ovarian tissue

5.3.12 Chemotherapy

(Refer to also section 6)

The choice of chemotherapy drugs will be according to NICE guidelines and network harmonisation.

5.3.13 Response Evaluation

- CA125 levels during chemotherapy can accurately correlate with tumour response and with survival: should be measured at regular intervals during chemotherapy (e.g. before each cycle).
- CT scan after three cycles of chemotherapy should be considered for a patient who is CA125 negative, or for interval debulking surgery

5.3.14 Duration of Chemotherapy

- Current data do not support a recommendation of maintenance/ consolidation treatment beyond six cycles.
- Patients with a partial response (or elevated CA125) after six cycles of chemotherapy but continuing evidence of response by CA125 can be considered for a further three

cycles of the same chemotherapy.

5.3.15 Follow-up

- Every 3 months for 2 years,
- Every 4 months during the third year
- Every 6 months during years 4 and 5 or until progression
- CA125 can accurately predict relapse, and should be considered at each follow-up visit
- CT if clinical or CA125 evidence of progressive disease.

5.3.16 Non-epithelial ovarian cancers

Germ cell tumours to be cross reference with Pan-Anglia Germ Cell SMDT Clinical Guidelines (lead - NS)

- Surgical management is carried out at either of the two network centres. Cases should also be referred to Anglia Germ Cell SMDT.
- Choriocarcinomas should be referred to Charring Cross Trophoblastic Centre

5.3.17 Figo stage I

- Primary debulking with conservation of uterus and ovarian tissue in young woman. For very large tumours consider neoadjuvant chemotherapy
- Dysgerminoma,
grade 1 immature teratoma
 - observe
- Yolk sac tumour (endodermal sinus)
embryonal carcinoma
grade 2 & 3 immature teratoma
 - consider chemotherapy

5.3.18 Figo stage II and beyond

- Primary debulking with conservation of uterus and ovarian tissue in young woman. For very large tumours consider neoadjuvant chemotherapy
 - chemotherapy
- If primary chemotherapy failed
 - second-line chemotherapy

5.3.19 Ovarian sex cord stromal tumours (OSCST)

Figo stage I

- Totally resected (not grade 2 or 3 sertoli leydig)
 - Observe
- Grade 2 or 3 sertoli leydig
 - Adjuvant chemotherapy

Figo stage II or beyond

- Chemotherapy

5.3.20 Recurrent Granulosa cell tumour

- Localised, and disease free interval > 12 months
 - secondary debulking
 - consider adjuvant chemotherapy or radiotherapy
- Disseminated
 - Chemotherapy

5.4 Vulval Cancer

5.4.1 Figo staging

FIGO staging (revised 2009)

- **Stage I** Tumour confined to the vulva.

IA Tumour confined to the vulva or perineum, ≤ 2cm in size with stromal invasion ≤ 1mm, negative nodes

IB Tumour confined to the vulva or perineum, > 2cm in size or with stromal invasion > 1mm, negative nodes

- **Stage II** Tumour of any size with or without extension to adjacent perineal structures (1/3 lower urethra, 1/3 lower vagina, anus) with negative nodes
- **Stage III** Tumour of any size with or without extension to adjacent perineal structures (1/3 lower urethra, 1/3 lower vagina, anus) with positive inguinal-femoral lymphnodes.

IIIA Tumour of any size with positive inguino-femoral lymph nodes

(i) 1 lymph node metastasis greater than or equal to 5 mm

(ii) 1-2 lymph node metastasis(es) of less than 5 mm

IIIB (i) 2 or more lymph nodes metastases greater than or equal to 5 mm

(ii) 3 or more lymph nodes metastases less than 5 mm

IIIC Positive node(s) with extracapsular spread

- **Stage IV** Tumour invades other regional (2/3 upper urethra, 2/3 upper vagina) or distant structures.

IVA (i) Tumour invades other regional structures (2/3 upper urethra, 2/3 upper vagina), bladder mucosa, rectal mucosa, or fixed to pelvic bone

(ii) Fixed or ulcerated inguino-femoral lymph nodes

IVB Any distant metastasis including pelvic lymph nodes

The depth of invasion is defined as the measurement of the tumour from the epithelial-stromal junction of the adjacent most superficial dermal papilla to the deepest point of invasion.

(Refer: International federation of Gynaecology and Obstetrics, Int Journal of Gyn and Obstetrics 105 (2009) 103-104)

5.4.2 Vulval squamous cell carcinoma

Diagnosis

- Ideally Incisional biopsy (if clinically suspicious, **excisional** biopsy is not recommended)
- Document size and location of the lesion and state of the groins
- Histopathology report must record depth of invasion

5.4.3 Pre-treatment investigations

- MRI – pelvis to assess pelvic and groin nodes
- Chest X – ray
- EUA, cystoscopy in advanced cases

5.4.4 Treatment

General principles:

- Surgical excision with a clinical margin of 15mm to obtain a histological margin of 8 mm.
- Whenever possible a wide local excision is preferred, minimizing disfigurement.
- Larger lesions require hemi or total vulvectomy
- When primary closure is not deemed possible plastic surgical reconstruction is undertaken.
- In the old/frail groin node dissection may be omitted
- In the old/frail margins may be sacrificed simply to obtain symptomatic relief
- Histology reports to record margins and depth of invasion, measurements stated. LVSI needs commenting. Lymph node metastasis state degree of tumourous replacement and breach of capsule.
- Stage 1A
- Local excision, no lymphnode dissection
- Stage 1B – Stage 3
- lateral lesions (excision line *more* than 1cm from midline), wide local excision or hemivulvectomy and unilateral groin node dissection
- Lesions not defined as lateral, wide local excision or vulvectomy and bilateral groin node dissection
- Stage 3 (advanced) and Stage 4
- Primary radio/chemotherapy

- Neoadjuvant chemotherapy or chemo/radiotherapy may be considered followed by surgery
- Non fixated groin nodes removed surgically
- Fixated nodes treated by radiotherapy and/or surgery
- Extensive disease may require bowel or urinary stomas
- Postoperative radiotherapy
- to groins and deep pelvis if there is more than one positive lymph node
- to be considered for perineum/vagina where margins are small
- Recurrent disease
- local recurrence, no groin disease, wide excision +/- adjuvant radio therapy
- Radiotherapy +/- chemotherapy an option to sacrificing the sphincter
- Groin recurrence treated with radio therapy preferred option if that hasn't already been given.

5.4.3 Adenocarcinoma of Bartholin's gland

This cancer is managed in the same way as the common squamous cancers of the vulva

5.4.4 Basal cell carcinoma of vulva

- Excision according to the same principles as for the squamous cell cancers
- No lymph node dissection is required
- If sphincter function is endangered these tumours are amenable to radio therapy

5.4.5 Malignant melanoma of vulva

- Wide local excision is the preferred option, 2 cm margins.
- No groin node dissection required
- Use Breslow's classification
- Refer these cases to the skin MDT for consultation, input from melanoma medical oncologist

5.5 VAGINAL CANCER

5.5.1 Figo staging

Stage 0	VAIN
Stage I	Limited to vaginal wall
Stage II	Involving the subvaginal tissue but not extending to pelvic side wall
Stage III	Extending to pelvic side wall
Stage IVA	Spread to adjacent organs and / or direct extension to beyond the true pelvis
Stage IVB	Spread to distant organs

5.5.2 Figo stages I - IV

Radiotherapy is the mainstay for treatment of vaginal cancer

5.5.3 Role of surgery

The following surgical can be considered after discussion at SMDT

Figo stage I and II

- TAH + partial total vaginectomy + pelvic or groin node dissection
- Consider primary chemoRT

Locally advanced disease

- pelvic exenteration

Central pelvic recurrence

- pelvic exenteration

Young women wishing to preserve ovaries

- transposition of ovaries out of radiation field

5.5.4 Trophoblastic disease

Gestational trophoblastic disease should be referred to Charing Cross Hospital as has been practised in the past.

6.0 CHEMOTHERAPY GUIDELINES

Where possible, patients suitable for trials should be randomized as such e.g. CHORUS, DNA Methylation Study, SCOTROG 4.

6.1 Epithelial Ovarian Cancer

6.1.1 First-line

Stage I

- Do not offer adjuvant chemotherapy to women who have had optimal surgical staging and have low-risk stage I disease (grade 1 or 2, stage Ia or Ib).
- Adjuvant Carboplatin AUC 6 q 21D x 6 for women with high-risk stage I disease (grade 3 or stage Ic).

For stage Ic clear cell consider carboplatin/paclitaxel, as tumours less sensitive to platinum-based therapy.

Stage II-IV

- Do not offer intraperitoneal chemotherapy to women with ovarian cancer, except as part of a clinical trial.
- Carboplatin AUC 6 q 21D x 6

or

- Carboplatin AUC 6 q 21D x 6
- Paclitaxel 175mg/m² q 21D x 6

1. [McGuire *et al*/NEJM 1996 Jan 4; 334:1-6, ICON3 Lancet 2002 Aug 17;360(9332):505-15]
2. NICE guidelines on chemotherapy for ovarian cancer

6.1.2 Neoadjuvant chemotherapy

As above but for patients who are systemically unwell with large volume inoperable disease consider weekly chemotherapy

- Carboplatin AUC 2 q 7D x 6
- Paclitaxel 80mg/m² q 7D x 6

in patients who respond then continue with three-weekly cycles of carboplatin/paclitaxel (4 cycles)

These patients should be considered for debulking surgery after 3 or 6 cycles of chemotherapy.

6.1.3 Recurrent disease

Indications: Symptomatic recurrence / Elevated CA125 + radiological clinical changes

A. "Platinum-sensitive" [Defined as progression 6 months platinum-free interval]

- Carboplatin (2nd line and subsequent)
or
- Carboplatin/paclitaxel (recommended 2nd line and subsequent)
(doses as in 1.1)

Or

- Liposomal doxorubicin 30 mg/m² + Carboplatin AUC 5 28d x6 (recommended 2nd line and subsequent)

Or

- Gemcitabine 1000 mg/m² day 1 and day 8 + carboplatin AUC 4 day 1, q21d
NICE do not approve the use of this regimen at the first recurrence of platinum-sensitive disease (TA389); i.e. for 3rd or subsequent line use

- For mucinous tumours, recommended

FOLFOX

Oxaliplatin 85 mg/m² IV day 1

Calcium folinate 400 mg/m² IV day 1

5-fluorouracil 400 mg/m² IV bolus day 1

5-fluorouracil 2400 mg/m² IV over 46 hours

or

XELOX:
Oxaliplatin 130 mg/m² IV day 1
Capecitabine 1000 mg/m² PO BID day 1-15
Q21D

- For relapsed, platinum sensitive ovarian, fallopian tube or peritoneal cancer who have BRCA1 or BRCA2 mutations and whose disease has responded to 3rd (or consequent) course of platinum based chemotherapy

Olaparib 400 mg PO BID

[NICE TA38, 2016]

[Markman et al J Clin Oncol. 1991 Mar;9(3):389-93, ICON4 Lancet. 2003 Jun 21;361(9375):2099-106]

B. “Platinum-insensitive” [Defined as progression < 6 months after platinum therapy]

- Liposomal doxorubicin 50mg/m² q 28 x 6

- For patients with poorer performance status consider starting at 40 mg/m²

Different pattern of toxicity to topotecan. Easier administration, generally better tolerated but hypersensitivity may occur.

- Paclitaxel 175mg/m² q 21 x 6

- This should be considered in patients who have not previously received paclitaxel

An alternative to above. More often considered as third-line, or for patient choice

- Etoposide (oral) 50mg bd D1-10 q 21

Or

- Cyclophosphamide 50 mg/m² daily PO continuous

NB starting dose is 50 mg bd D1-7, increasing to 10 days if neutrophil nadir (D10) is satisfactory.

- Van der Burg Regimen (modified)

- Recent phase II evidence suggests increased activity of etoposide in combination with cisplatin (weekly). For suitable patients, i.e. those with symptoms that require a more rapid induction of response and with adequate performance status and renal function.

- Cisplatin 60mg/m² weekly x 6 D1, 8, 15, 29, 36, 43.

- Etoposide 50mg od D1-15, D29-43

- Patients with a response or stable disease after the 6th cisplatin administration continued treatment with:
 - Etoposide 50 mg bd for 21 days, every 4 weeks for 6-9 cycles. [van der Burg et al (2002) Br J Cancer 86: 19-25]
- Rarely used drugs are:
 - altretamine
 - tamoxifen or any aromatase inhibitor in presence of contraindications to tamoxifen
 - Clinical studies (phase II or phase I)

Notes:

1. Liposomal doxorubicin and topotecan have been compared directly [Gordon et al.(2001) JCO 19: 3312-3322,; Gordon et al. Gynecol Oncol (2004) 95: 1-8]. The former is the preferred option – if contra-indications do not apply. Paclitaxel and topotecan have also been compared in the relapsed setting and both drugs had similar efficacy [ten Bokkel Huinink et al JCO (1997); 15: 2183-2193]. Paclitaxel and liposomal doxorubicin have also been compared with no difference in outcome [O’Byrne KJ (2002) ASCO Annual Meeting Abstr 808].

2. Oral Etoposide: [Rose, P. G. et al. (1998). J Clin Oncol 16(2): 405-10; Seymour, M. T et al. (1994) Br J Cancer 69(1): 191-5].

3. Weekly cisplatin and daily oral etoposide [van der Burg et al Br J Cancer. 2002 Jan 7;86(1):19-25]

4. Some patients with ovarian cancer respond well to repeated administration of chemotherapy. Movement through second-line therapy options is dependent on clinical judgement. [for estimations of probability of response in relapsed ovarian cancer see Eisenhauer et al, Ann Oncol 10:963-968, 1997]

- The total number of cycles given may be less than intended as patients should be carefully monitored for drug efficacy and toxicity.
- Current chemotherapy trials for ovarian cancer: SCOTROG4 and CHORUS.

6.2 Ovarian Carcinoma with sarcomatous elements (Mixed mesodermal Tumours)

6.2.1 Stage I disease

- no adjuvant chemotherapy shown to be effective

6.2.2 Advanced disease/Metastatic disease, chemotherapy may provide palliation

- Carboplatin AUC 5 q21 x 6
- Carboplatin AUC 5, Paclitaxel 175 mg/m² q21 x6
- CAP (cyclophosphamide 500 mg/m², doxorubicin 50 mg/m² and cisplatin 50 mg/m² q 21d x 6)
- Doxorubicin/ ifosfamide (doxorubicin 25 mg/m² D1-3, Ifosfamide 3 g/m² with MESNA D1-3 q 21 d x 6 has some activity in patients with predominantly sarcomatous elements
- Cisplatin/ifosfamide
- Carboplatin/ifosfamide

- Clinical trials may be available.

All regimens have comparable efficacy. The decision is based on the extent of the sarcomatous element and the physical fitness of the patient.

[Harris et al Br J Cancer 2003 Mar 10;88(5):654-7, Duska et al Gynecol Oncol. 2002 Jun;85(3):459-63

6.2.3 Intraperitoneal chemotherapy

Should be considered an option for selected patients in centres where the expertise exists and in the context of a clinical trial.

6.3 Germ Cell Tumours of the ovary

6.3.1 Those other than Stage 1A

- 3 cycles of 3 day BEP (bleomycin 30iu D 2,8,15, etoposide 165 mg/m² D1-3 and cisplatin 50 mg/m² D1-2 (repeat d 21 days)

6.3.2 Patients with very advanced disease

- 4 cycles of BEP given as 5 day regimen (NB. Etoposide given at 100mg/m²
- or
- consider modified POMB ACE (3 day POMB – 14 day cycle, cycles 1,2 and 4 with 3-day ACE- 14 day cycle, cycles 3 & 5.

POMB

vincristine 1mg/m² (max. 2 mg)D 1
 methotrexate 300mg/m² D 1 with FA rescue
 bleomycin 15,000units D 2
 cisplatin 120mg/m² D 3

ACE

actinomycin D 500mcg D 1-3,
 cyclophosphamide 500mg/m² D 3
 etoposide 100mg/m² D 1-3

[Mitchell et al Cancer 1999 May 1585(10) 2232-44, Bower et al Eur J Cancer 1996 Apr 32A (4) 593-7]

6.4 Endometrial Cancer

6.4.1 Primary treatment

- FIGO I-II no role for adjuvant chemotherapy
- FIGO III, or papillary/serous or clear cell any stage- consider Carboplatin or Carboplatin/paclitaxel +/- pelvic RT

[Hoskins et al. (2001) J Clin Oncol 19: 4048-4053]

6.4.2 Recurrent disease- palliative chemotherapy

- Carboplatin and paclitaxel have been reported to have activity in some patients but responses are not common and the duration is short.
[see Hoskins et al above]
- Consider phase I or phase II trials if available.

6.4.3 Metastatic Disease

- Consider megestrol 160mg od

7.0 RADIOTHERAPY GUIDELINES

- Carcinoma of the cervix
- Carcinoma of the endometrium

7.1 CARCINOMA OF THE CERVIX

7.1.1 Patient Assessment

Indication for radical treatment:

Locally advanced disease IB2 – IVA.

Patients with earlier disease who decline surgery.

Post-operative patients where surgery inadequate/extensive disease.

MDM review –pathology & radiology

7.1.2 Pre-treatment checks

- EUA at centre (surgeon + oncologist) - biopsy of any suspicious lesions
- CT abdo (+chest if advanced disease)
- MRI pelvis

ALL EXTERNAL SCANS MUST BE REVIEWED AT MDT

- Any degree of hydronephrosis- patients to be stented prior to RT
- CT PET scan on all patients deemed fit for laparoscopic node dissection and extended field RT if indicated
- Bloods – routine biochemistry and FBC, SCC antigen in patients with squamous cell tumours
- Info sheet on cisplatin.
- Consent for chemo -RT
- Gynae booklet / pack for RT

7.1.3 Clinical Target Volume

This includes:

The upper half of the vagina - unless this is involved by disease – then it is 2 cm below apparent disease. The tissues of the true pelvis, the obturator, internal and external iliac node chains up to the bifurcation of the aorta.

The patient is treated supine. A 3 or 4 field technique is used to cover the target volume. This is usually defined using antero-posterior and lateral fields , but taking account of MRI findings.

A marker is placed on introitus.

Planning films and portal films taken to ensure correct field position.

7.1.4 Definition of Volume (PTV) -Pelvis

Must take account of information on MRI.

Superior field – L 4/5 junction.

Inferior field – bottom of ischium or clinical disease + margin 2cm.

Lateral vol – 1.5cm lateral to bony pelvic wall.

Anterior vol – anterior to pubic ramus.

Posterior vol –depends on extent of disease on MRI + 1.5cm margin

The PTV should be covered by 98% isodose.

7.1.5 Parametrial boost

All patients FIGO IIb and above- ie any parametrial extension

Plan after 1st HDR brachy insertion

fields matched to 70% isodose from HDR brachytherapy reconstruction onto AP film

Sup- mid SI joint

Inf - bottom of obturator foramen Lat - as for previous EXBRT field

Dose : 5.04Gy/3#/10MV/MPD

7.1.6 Extended field treatment - indications

To be considered in medically fit patients with;

FIGO II/III disease with pelvic nodes on MRI who have not undergone laparoscopic lymph node dissection (LND)

Positive para-aortic lymph nodes (PAN) on LND

Positive common iliac LN where PAN not surgically assessed

7.1.7 Treatment Plan – Pelvis

Dose :50.4Gy /28#/5½ weeks/10MV/ 100% +concomitant chemotherapy unless medically unfit.

Category 1 patients so no treatment gaps .If unavoidable then compensate by hyperfractionation

Chemotherapy – weekly cisplatin 35mg/m² /week (max 70mg) with hydration as per chemo protocol – providing \sphericalangle GFR \square 50ml/min.

Chemo is given on any day of the treatment week.

7.1.8 Extended field - PTV

Patients to be planned on Virtual sim as pelvic and para-aortic fields to be matched at depth

Borders

- superior : T12/L1

- inferior : L4/5
- width : usually 8cm but check position of kidneys

7.1.9 Treatment plan –PA field

DOSE : 45Gy/25#/5weeks/MPD/10 mv photons

7.1.10 Microselectron (HDR)

Full insertion with intrauterine and intravaginal sources. All patients have 7Gy x 2 to point A

External beam and brachytherapy treatment should be completed within 50 days of the first fraction hence concomitant brachytherapy boost may be necessary.

7.1.11 Patient management during treatment

Patients seen weekly

Weekly FBC, weekly biochemistry – keep Hb 11.0 throughout.

Patient to see CNS before, and after treatment.

7.1.12 Late and Acute side effects and Organs at risk

Chemo – nausea, vomiting, neutropenia, peripheral neuropathy, lethargy.

Organs at risk – rectum and bladder

Acute side effects – cystitis, diarrhoea, lethargy, skin reaction.

Late effects – bowel stricture, or obstruction – infrequently, rarely incontinence of the bladder and fistulas.

7.1.13 Follow up

Patients to be followed up in joint clinic

Alternating appointments between surgical and non surgical oncological teams

Initial review 6/52 post chemo-rad, then 3/12 year1, 4/12 year2, 6/12 year3-5, then annually to year 10

7.2 CARCINOMA OF THE ENDOMETRIUM

7.2.1 Patient Assessment

Outside of a clinical trial adjuvant radiotherapy is indicated in high risk patients with FIGO stage I disease (outlined below) and all patients with stage II, and III disease. In Stage I disease indications for radiotherapy are based on the histopathological findings:

- Poorly differentiated tumour. (G3)
- Infiltration of outer half of the myometrium.
- Clear cell or serous papillary subtype

7.2.2 Pre-treatment checks

- Pathology report– histological type, grade, depth of myometrial infiltration
- FBC, U&E, LFT

- CT chest /abdo– for all with Stage III
- Consent for RT
- Patient information – Gynae Booklet and RT Booklet.

7.2.3 Planning

The patient is treated supine. A 3 or 4 field technique is used to cover the target volume. This is usually defined using CT techniques and virtual simulation planning system.

7.2.4 Definition of Volume/ Field Length (PTV)

- Superior - L5/S₁ junction
- Inferior - bottom of obturator foramina
- Lateral - 1 cm lateral to pelvic side wall
- Anterior - Mid pubic symphysis
- Posterior - In front of S2/3 junction

7.2.5 Clinical Target Volume

This includes: the upper half of the vagina
The tissues of the true pelvis
The obturator, internal and external iliac node chains.

7.2.6 Treatment

Stage I

G3 IA/IB treat the vault with brachytherapy 10Gy x 4
All IC regardless of grade have ExBRT 45Gy in 25# + 10Gy x 2 to the vaginal vault.

Stage II – ExBRT + Brachy as above.

Stage II –(No surgery – exceptional case as patient needs to be fit for brachytherapy) –
ExBRT - 50.4Gy in 28# to the whole pelvis plus Brachytherapy – tube and two ovoids,
7.0 Gy to point A x 2 (once a week)

Stage III – Confined to the pelvis – i.e. no PA nodes
Pelvic ExBRT – 45Gy in 25# followed by vaginal vault brachytherapy of 10Gy x 2

7.2.7 Patient management

Patients are seen weekly in the on-treatment review clinics. Follow up 6 weeks post treatment, then alternating with the surgeon: 3 monthly in year 1, - 4 monthly year 2, and then 6 monthly to year 5, then if all well discharge.

Vaginal vault smears have no role in follow up.

7.2.8 Late and Acute side effects and Organs at risk

Organs at risk – rectum and bladder

Acute side effects – cystitis, diarrhoea, lethargy, skin reaction.

Late effects – bowel stricture, or obstruction - rarely incontinence of the bladder and fistulas.

8.0 FOLLOW UP SCHEDULES AND INVESTIGATIONS

Follow-Up:

	Year 1	Year 2	Year 3-4	Year 5
Ca cervix	3 monthly	4 monthly	6 monthly	Visit at year 5 and discharge if no sign of disease
Ca uterus	“	“	“	“
Ca ovary	“	3 monthly	“	“
Ca vulva	“	4 monthly	“	“
Ca vagina	“	“	“	“

Investigations:

	Pap smear	Tumour markers	CT / MRI	Colposcopy	CXR
Ca cervix	See <u>Appendix 1</u> for National Guidance		If recurrence suspected. Single post chemo/DXT MRI at 3 mths if surgical salvage	If recurrence suspected	If recurrence suspected
Ca uterus					
Ca ovary		Ca 125 should be considered every visit (if raised at diagnosis)			
Ca vulva					
Ca vagina					

Where there is a suspicion of recurrence or there are other situations, the plan should be altered accordingly.

*Pap smears have not been shown to be helpful in the follow up of women with cervical and endometrial ca

The follow up at the units will be in clinics run by the lead and the deputy leads.

8.1 FOLLOW-UP FOR WOMEN IN PRIMARY CARE

- Women who have been discharged from the cancer unit or centre after 5 years do not require routine follow-up at the GP surgery. Women will be encouraged to contact gynae CNS post 5 year discharge if concerns arise which will enable them to be fast-tracked back to clinic as required.
- Women who have had a hysterectomy for CIN or CGIN, will not be followed up for 5 years in most cases. See appendix 1 for national guidance on recall status of women having vault cytology

* BSCCP guidelines

* Soutter et al. Lancet. 1997 vol 349 p978-80

9.0 CLINICAL AND MOLECULAR TRIALS SUPRA NETWORK

All women treated for gynaecological malignancy in the Supra-Network should be considered for a clinical trial. Consent should be taken for collection of clinical material for laboratory based trials, and on review of management at the multi-disciplinary meeting, every patient should be reviewed for suitability for entering into a trial.

9.1. CLINICAL TRIALS

9.1.1 Ovary

- ***CHORUS (Chemotherapy vs Upfront Surgery)***
- ***Prospective randomized controlled study comparing conventional follow up with Nurse-led follow up for Epithelial ovarian cancer after completion of primary Treatment (currently awaiting ethics approval) – collaboration with UCL.***
- ***UK OPS***

9.1.2 Endometrium

- ***PORTEC 3***

9.2 LABORATORY BASED STUDIES

All women having surgery should be consented for specimen use in laboratory based trials

9.2.1 Ovary

- ***MICROARRAY STUDIES AND SENSITIVITY TESTING***
- ***PROTEOMIC PROFILING STUDY FOR BIOMARKERS FOR OVARIAN CANCER – UKOPS***
- ***DNA Methylation study***

10.0 COLLECTION OF THE MINIMUM DATA SET ACROSS SUPRANETWORK

- All hospitals agree to collect the minimum data set and cancer waiting times data.

* Patient Identifier

* Date of Birth

* Referral Date

* Decision to Refer Date (2 Week Wait)

* Referral Status

* Referring Trust

* Cancer Status

* First Definitive Treatment

* Date of First Treatment

* Provider of first Treatment

* Primary Diagnosis

* Age at Treatment

- This data is kept at the centre on a designated data base on the hospital server.
- The network will aim to have compatible software to facilitate the exchange of information about patients to collect the minimum data set.
- The cancer waiting times and patient pathway data is collected by the MDT Co-ordinator / Pathway Tracker
- The responsibility for collecting the clinical information in the Minimum Data Set lies with the respective clinical teams. This dataset is currently undergoing reconfiguration with the IT Department to streamline the data collection and is expected to go live by the second half of 2009.

11.0 NETWORK AUDIT PROJECTS ACROSS THE SUPRA NETWORK

There are ongoing network audits in the network. All hospitals will participate in these audits.

11.1 PATIENT SATISFACTION SURVEYS

It is envisaged that besides clinical outcome measures, patient satisfaction surveys should be monitored by performing regular audits.

APPENDICES:

Appendix 1: National Guidance relating to Recall Status of Women having vault cytology

Appendix 2: Follow-up Protocol for patients undergoing Radical Trachelectomy for early stage Carcinoma of the Cervix

Appendix 3: Network Agreed Chemotherapy Algorithms

Appendix 4: Terms of Reference and membership

Appendix 5: Sarcoma Pathways.

Appendix 6: Rehabilitation Pathways.

Appendix 7: TYA pathways.

Appendix 8: Care pathway for Cervical cancer

Appendix 9: Care pathway for Uterine cancer

Appendix 10: Care pathway for Ovarian/fallopian tube cancer

Appendix 11: Care pathway for Vulval/vaginal cancer

National Guidance relating to Recall Status of Women having vault cytology

With effect from 1st April 2008 there will be changes to the NHS Cervical Screening Programme relating to recall status of women having vault cytology. This applies to the Programme in England only.

Because of a variety of problems with the recall of women for vault cytology following treatment of CIN it has been decided that this would be best managed by ceasing the recall of these patients from the National Screening Programme.

It is important to remember that women who undergo a subtotal hysterectomy will still have their cervix in situ and so must remain within the National Screening Programme.

These women will still require to be followed up as per guidelines in NHS CSP Document No 21.

At a meeting of the National Colposcopy Professional Advisory Group in March 2008 guidance was further clarified.

- For women who were on routine recall and no CIN was present in the hysterectomy specimen then no further vaginal vault cytology is required.
- For women not on routine recall and with no CIN in the hysterectomy specimen the gynaecologist may need to arrange appropriate investigations. These may include colposcopic examination of the vaginal vault or vaginal vault cytology.
- For women who undergo hysterectomy and are found to have completely excised CIN it is still recommended these women should undergo vaginal vault cytology at 6 and 18 months following hysterectomy.
- In women who undergo hysterectomy and have incompletely excised CIN then follow up should be conducted as if the cervix was still in situ. For CIN I this would be vault cytology at 6, 12 and 24 months and for CIN II or III then vault cytology at 6 and 12 months followed by 9 annual vault cytologies.
- Women who undergo radical trachelectomy as part of conservative management of cervical cancer should remain under the care and guidance of the treating gynaecologist. Future follow up will be determined by the treating gynaecologist and the woman will no longer be deemed to be within the National Screening Programme.

The responsibility for undertaking the above follow up policies will now reside with the gynaecologist. It would be therefore sensible for any gynaecologist discharging a patient who requires further vault cytology to make sure that the GP receives specific written guidance as to future follow up. The clinician in charge, i.e. gynaecologist or GP when the woman is discharged back to their care, will be responsible for failsafe mechanisms for this small group of women.

Follow-up Protocol for patients undergoing Radical Trachelectomy for early stage Carcinoma of the Cervix

Anticipated in-patient stage: 5-7 days

Follow-up

2/52 following discharge:	pathology review, discussion regarding prognostic factors, checks voiding, any other possible abnormal symptoms such as bleeding. Discuss contraception which should be advised for at least six months
6 weeks:	see at 6/52 if necessary if there are any problems such as voiding at the 2/52 visit
3 months:	otherwise see at 3/12 for general gynaecological examination and review. Smears to be taken from vaginal vault and isthmus using spatula and brush
6 months:	general review with check of periods, clinical examination, colposcopy, smear from vaginal vault and isthmus, MRI abdomen and pelvis. If all clear, with no evidence of recurrence, she may proceed to considering conception if patient so wishes
9 months:	review, clinical examination, vaginal vault and isthmus smears
1 year:	general review gynaecological and physical condition, clinical examination, colposcopy, vaginal vault and isthmus smears, MRI
1-2 years:	4 monthly review with vaginal vault and isthmus smears
2-5 years:	6 monthly visits, vaginal vault and isthmus smears. At 2 years MRI abdomen and pelvis
5-10 years:	yearly visits, vaginal vault and isthmus smears
10 years:	discharge to GP, return to 3 yearly screening programmes

Patients advised to report the following directly to Barts/RMH – either to CNS or Oncology Fellow:

- a) pregnancy
- b) outcome of pregnancy
- c) symptoms

Network Agreed Chemotherapy Algorithms.

Ovary



Visio-Ovarian cancer
flowchart.pdf

Cervix



Visio-Cervical cancer
Treatment Algorithm.

Endometrial



Visio-Endometrial
Cancer Treatment Al

Vulva



Visio-Vulva Cancer
Treatment Algorithm.

Uterine and Mixed Tumours



Visio-Mixed Mullerian
Cancer Treatment Al

TERMS OF REFERENCE AND MEMBERSHIP

Purpose

The Gynae NSSG is the primary source of advice on issues relating to gynaecological cancers for the Network Board. The group is multidisciplinary with representation from professionals involved in Brain & CNS Oncology and has the active engagement of the leads from the relevant constituent organisations in the Supranet work. Core membership also includes user representation to enhance service planning and review.

The group provides a forum for idea-sharing and the promotion of service improvement and development.

The group has corporate responsibility as delegated by the network board to ensure co-ordination and consistency across the network for the implementation of the gynaecological measures and ensuring co-ordination and consistency of gynaecological practice in the member organisations across the network.

It is the network group responsible for consulting the NDSG'S, RT, imaging, pathology and Chemo boards on the Gynae referral guidelines.

The representation on the Group is such that the Network Board agrees to authorise it as the primary source of the Network's clinical opinion on matters relating to Gynae-Oncology.

It is the group with delegated corporate responsibility from the board for ensuring coordination and consistency across the network on cancer policy, patient pathways, practice guidelines, audit, research and service improvement and for the implementation of the Brain & CNS measures and for ensuring consistency in gynae-oncology across the network.

It will consult with relevant cross cutting groups on issues relating to gynae-oncology for example the medicines management board, Radiotherapy Board, imaging and Pathology groups and the Palliative care board.

Quorum

A quorum will be no fewer than 8 core members provided that the Chairman or Deputy Chairman is present.

Agenda

Regular agenda items:

- Work Programme & Service Delivery Plan
- Peer review
- Change Management
- Training & Development
- New Business

Minutes

Minutes will be taken and circulated to the group within 1 month following the meeting by a member of the network admin team. Copies will also be forwarded to the network board and commissioning director's forum. Copies will also be available on the open section of the ECN website.

Format, Frequency & Links

Meetings will be held quarterly at Essex Cancer Network Offices. The agenda will be circulated prior to the meeting.

Roles & Responsibilities of the NSSG:

Service Planning

The NSSG should ensure that service planning:

- Is in line with national guidance/standards
- Promotes high quality care and reduces inequalities in service delivery.
- Takes account of the views of patients and carers.
- Takes account of opportunities for service and workforce redesign.
- Establishes common guidelines/protocols

The NSSG should

- Recommend priorities for service development to the network board.
- Ensure decisions become integrated into constituent organisational structures and processes.

Change Management

The NSSG should

- Discuss the most recent/proposed changes in practice
- Changes may include operational procedures, clinical practice, staff, equipment or facilities
- Agree action and implementation plans and timescales
- Where appropriate undertake risk analysis of the change
- Where necessary amend standard operational procedures/written protocols

Service Improvement/Redesign

- All The NSSG and individual cancer teams should commit to service improvements.
- Process mapping and capacity and demand analyses should become part of the norm.
- Requests for additional resources from the network should be accompanied by evidence of involvement in service improvement/redesign.
- The NSSG should develop/approve high quality information for patient, for use across the network. Including the review of information to be uploaded to the patient information prescriptions.

Service Quality Monitoring and Evaluation

The NSSG should:

- Agree on a minimum dataset for common data collection; where possible and appropriate; but go beyond this where possible.
- Review the quality and completeness of data, recommending corrective action where necessary.
- Produce audit data and participate in open review.
- Ensure services are evaluated by patients and carers.
- Monitor progress on meeting national cancer measures and ensure agreed action plans following self-assessment/peer review are implemented.
- Ensure co-ordination and consistency across the network for implementing the radiotherapy measures and for the work of the radiotherapy departments
- Consult with the Network Site Specific Groups on the radiotherapy aspects of their clinical and referral guidelines

Workforce Development

The NSSG should:

- Consider the overall workforce requirements for the Network.
- Consider the education and training needs of teams and, where appropriate, of Individuals.
- Liaise with the Network Board and with the Workforce Development Confederation to ensure that appropriate workforce numbers and CPD are available.
- Develop common recruitment/retention strategies.
- Take account of opportunities for skill mix changes.

Research and Development

All patients should be considered for inclusion in clinical trials and other well designed research studies. Research nurses at each site are encouraged to attend MDTs and out patients to facilitate recruitment into studies.

The Cancer Research Network Manager and or Clinical Lead for Research attend the NDSG to provide reports on recruitment and the current portfolio of research trials available. The NDSG will regularly review and agree studies available and identify a lead responsible for ensuring recruitment into clinical trials and other well designed studies is integrated into the function of the NDSG. There will be a requirement to produce remedial action plans where recruitment in to the network agreed list of plans is below agreed numbers.

Work Plan and Annual Report

The NSSG should:

- Draw the above together in to a 3 year work plan in the context of a prioritised clinical governance development plan, for approval by the network board.
- Ensure this is fed into commissioning, with agreements specifying standards, service developments and improvement, data collection, audit, research, education and training.
- Provide an annual report of activity to feed health economy clinical governance reporting processes.

Role of NSSG Chair

The term of office for the Chair will be 3 years duration. The post holder will be elected by a majority vote of the full membership of the NDSG and ratified by the Medical Director and Director of the Cancer Network. It will be the responsibility of the Medical Director to ensure the post is filled at all times. The current Chair is Mr K Razvi; he will have an Annual Review with the Medical Director of the Network.

Responsibilities of the NSSG Chair include:

- To ensure a multi-professional Network-wide site specialist group is established with membership in accordance with Peer Review guidance and the manual for cancer services.
- To ensure that the group meets regularly (4 times per annum minimum) and provides minuted records of meetings which are disseminated to the members and to the ECN board and commissioning directors forum.
- To appoint leads within the group for trial recruitment, audit, data/information and service improvement, and other leads as deemed necessary.
- To organise working groups and receive reports as appropriate.
- To agree a constitution and network clinical guidelines and to review both annually.
- To provide an annual report which will include activity, targets, organisation of services, NICE, and Peer Review and including key audit findings, service improvement, research participation and educational events. The annual report should include a review of the work plan and outline time scales for future activity.
- To agree a 3 year work plan based on the conclusions of the annual report and in line with the network capacity expansion plans.
- To meet regularly with the Medical Director of the ECN with whom they will also have a formal annual review.
- To participate in relevant Network meetings and to represent the NSSG in any other network, regional or national activity as required.

Network support

Managerial support

The ECN Network Team has nominated a member of the management team to work with the NSSG. The NSSG is currently supported by Sue Maughn. The role of the Network management team is to support the NSSG Chair as required to help develop a fully functional NSSG including guidance on the content and process of Peer Review and Improving Outcomes; a strategy for Cancer.

Administrative support

The Network Team; Jill Butten/Tara Large will provide administrative support as required, for example co-ordinating meetings; type minutes/agendas (however the Groups will need to provide someone with a clinical background to take the minutes at each meeting); prepare and plan audit days; assist with the co-ordination of Peer Review evidence and circulate documents/papers etc.

User Involvement

The NSSG aims to involve user representatives when planning and reviewing its work-streams. It also ensures that services are evaluated by patients and carers.

The Chairman of the NSSG, together with the ECN User Involvement facilitator, will endeavour to ensure user representation on the group. The CNS's are the NHS employed members of the NSSG nominated as having specific responsibility for user issues and information for users and carers. They will also ensure users' views are obtained as necessary.

**Membership List
April 2018**

NAME	JOB TITLE	ORGANISATION	NSSG RESPONSIBILITY
Ipswich			
Jannabel Said	Oncologist	East Suffolk	
Alison Garnham	CNS	East Suffolk	Responsible for Patient Issues *
Jamie Morgan	Oncologist	East Suffolk	
Barnaby Rufford			
Barnaby Rufford	Gynaecologist	East Suffolk	Deputy Chair
Colchester			
Jonathan Evans-Jones	Gynae Surgeon	North East	
Rosemary Thompson	CNS	North East	Responsible for patient issues *
Dr Alan Lamont	Oncologist	North East	
Chelmsford			
Colin Partington	Gynae Surgeon	Mid Essex	
Eimear Walker	CNS	Mid Essex	Responsible for Patient Issues *
Abby Cyriac	Clinical Oncologist	Mid Essex	
Sasha Badzek	Medical Oncologist	Mid Essex	
Emma Azeem	CNS	South East	Service Improvement Lead and responsible for Patient Issues *
Southend			
Rachel Keenan	CNS	South East	Service Improvement Lead and responsible for Patient Issues *
Elizabeth Lawrence	CNS	South East	
Krishnaswamy Madhavan	Oncologist	South East	
Khalil Razvi	Gynaecologist	South East	Chair
Marilyn Lewis	CNS	South West	Responsible for Patient Issues *
R. Varma	Gynae Surgeon	South West	
NSSG			
Ashley Solieri	Research Manager	Essex Cancer Research Network	
Jane Beatty	Research Manager	East Anglia Cancer Research Network	
Sue Maughn	Interim Network Director	ECN	
Alan Lamont	Lead Clinician	ECN	
Wendy Davies	Patient Representative		
Martin Wilson	Carer Representative		

*CNSs share responsibility for patient issues through their joint meetings

Admin Support will be provided by the Network Admin team; Jill Butten and Tara Large.

Appendix 5

Sarcoma Pathways



LSESN Shared Care
Pathway_Gynaev3.d

Appendix 6

Rehabilitation Pathways



Final ECN
Gynaecological Cance

Appendix 7

Teenage and Young Adults (TYA)

MDT: For each patient within the TYA group (16-24), the MDT should agree the following decisions with the TYA MDT and record them as part of the patient's joint treatment planning decision:

- The multidisciplinary treatment planning decision i.e. to which modality(s) of treatment: surgery, radiotherapy, chemotherapy, biological therapy or supportive care or combination of the same, they are to be referred to for consideration.
- The named consultant in charge of each modality of definitive treatment and the named person in charge of organising arrangements for the age- appropriate support and care environment including those when the treatment is delivered outside the Primary Treatment Centre (PTC) facility.

For those in the age range 16 to the end of their 18th birthday should be treated in the PTC. For those in the age range 19 to the end of their 24th birthday may choose where they receive the treatment, which can be at the PTC or at a named designated hospital for TYAs.

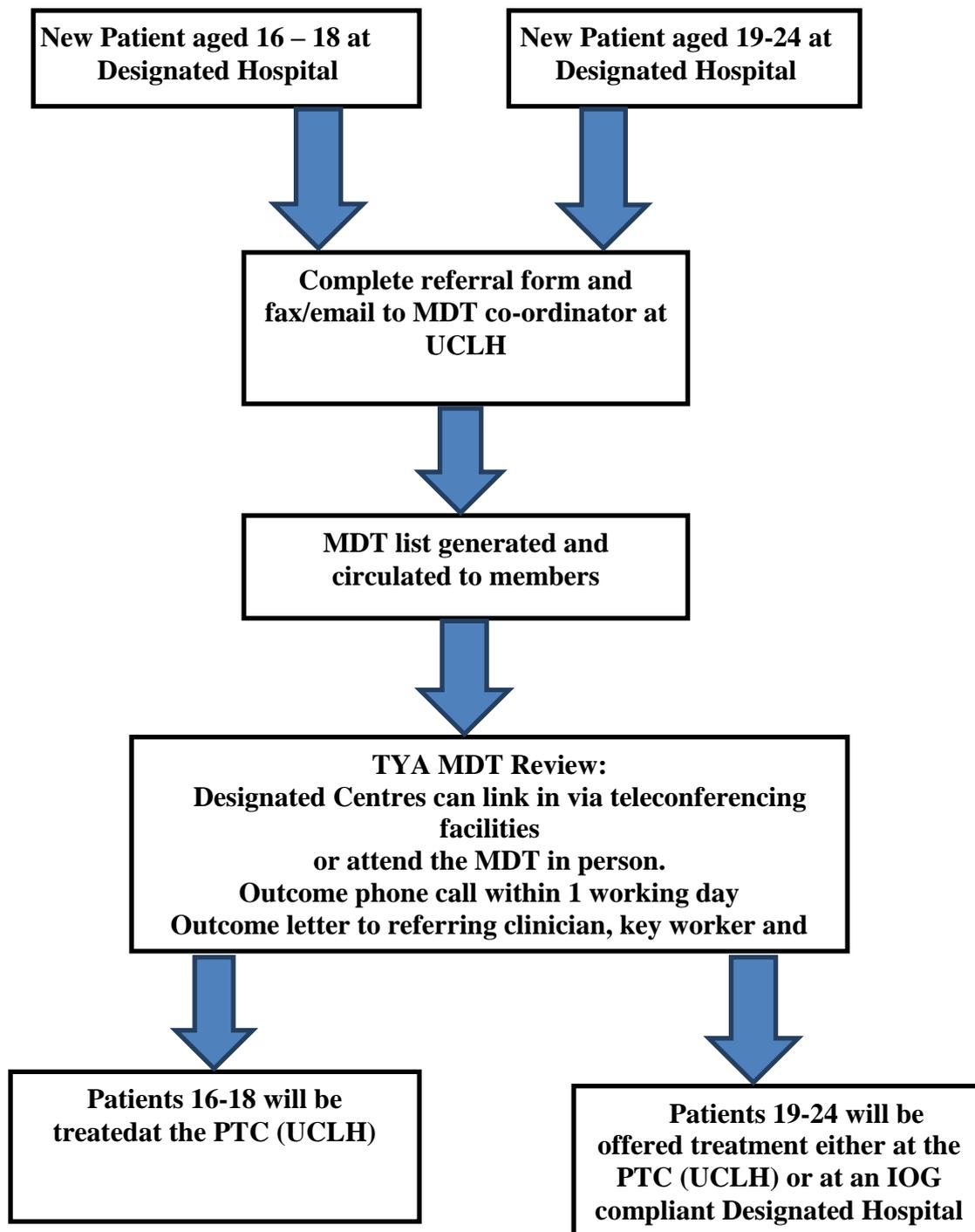
The treatment location should be should be recorded in the patients treatment plan.

Agreed List of Approved Trials for TYAs (Applicable only to MDTs dealing in Malignancies common to TYAs)

The MDT should produce a written response annually to the TYACNCG's approved list of trials and other well designed studies which fulfils the following:

- For each clinical trial and well defined study the MDT should agree to enter patients or state the reason why it is not able to;
- The programme for improvement for recruitment into approved trials and other well designed studies arising from the MDT's recruitment results

Gynaecology Pathway for Teenagers and Young Adults



Primary Treatment Centre (PTC) Contacts:

TYA MDT Meeting: The TYA MDT meets on a weekly basis on Wednesday from 4pm to 5pm in the Second Floor Podium Seminar Room located on TO2 in UCLH main hospital. Teleconference facilities are available for the designated centres to link into the MDT, or alternatively, members of the external team may attend in person.

Gynae MDT Meeting: The GynaeMDT meets weekly on Tuesday from 3.15pm to 6pm

MDT Co-ordinator:

Tim Milne

Tel:

Fax:

Email: tim.milne@uclh.nhs.uk

Clinicians:

< 19 years Dr Sara Stoneham (TYA consultant oncologist)

Email: sara.stoneham@uclh.nhs.uk

>19 years Miss Nicola Macdonald (TYA consultant Gynae consultant surgeon)

Email: Nicola.macdonald@uclh.nhs.net

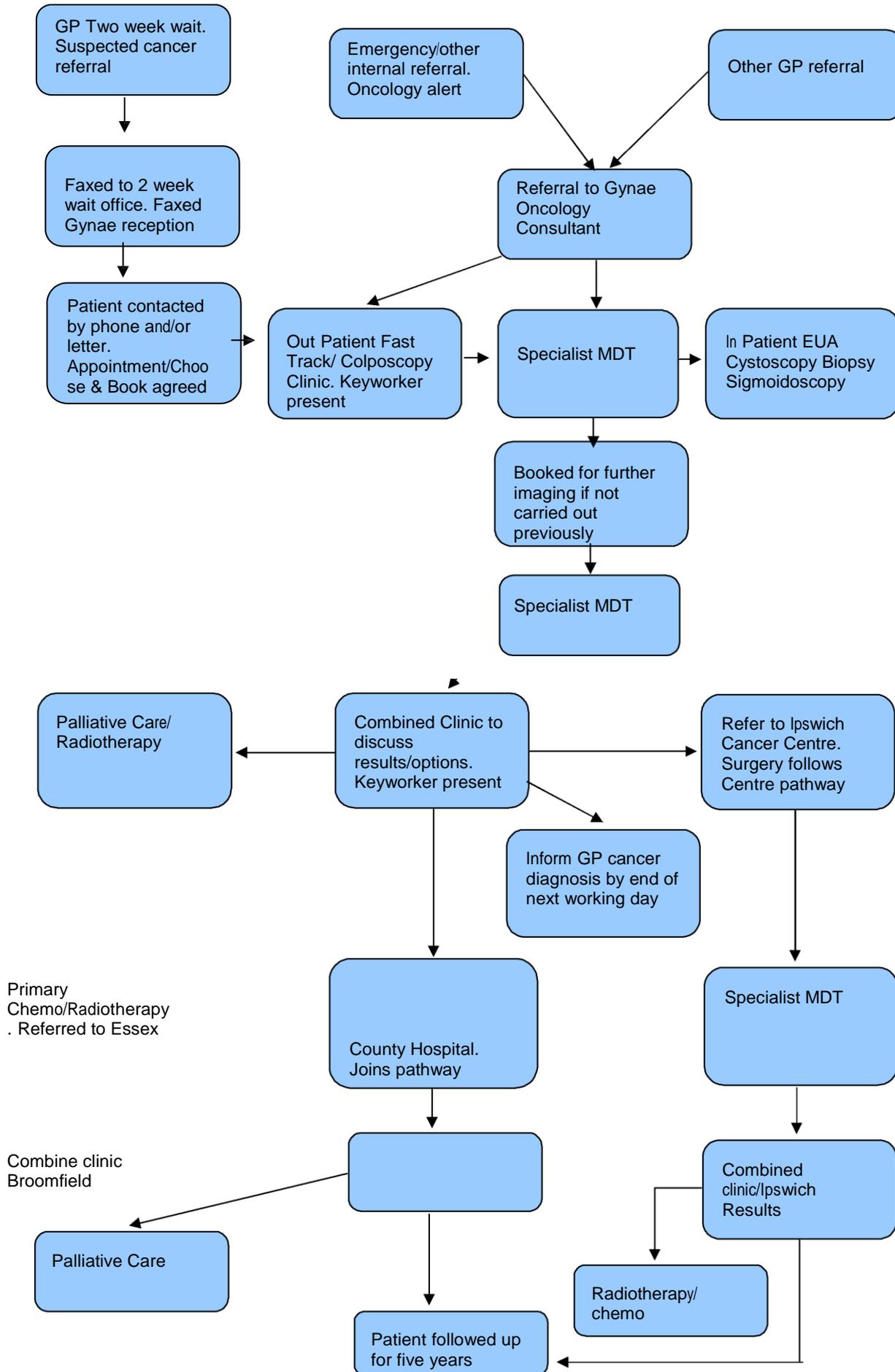
Clinical Nurse Specialists:

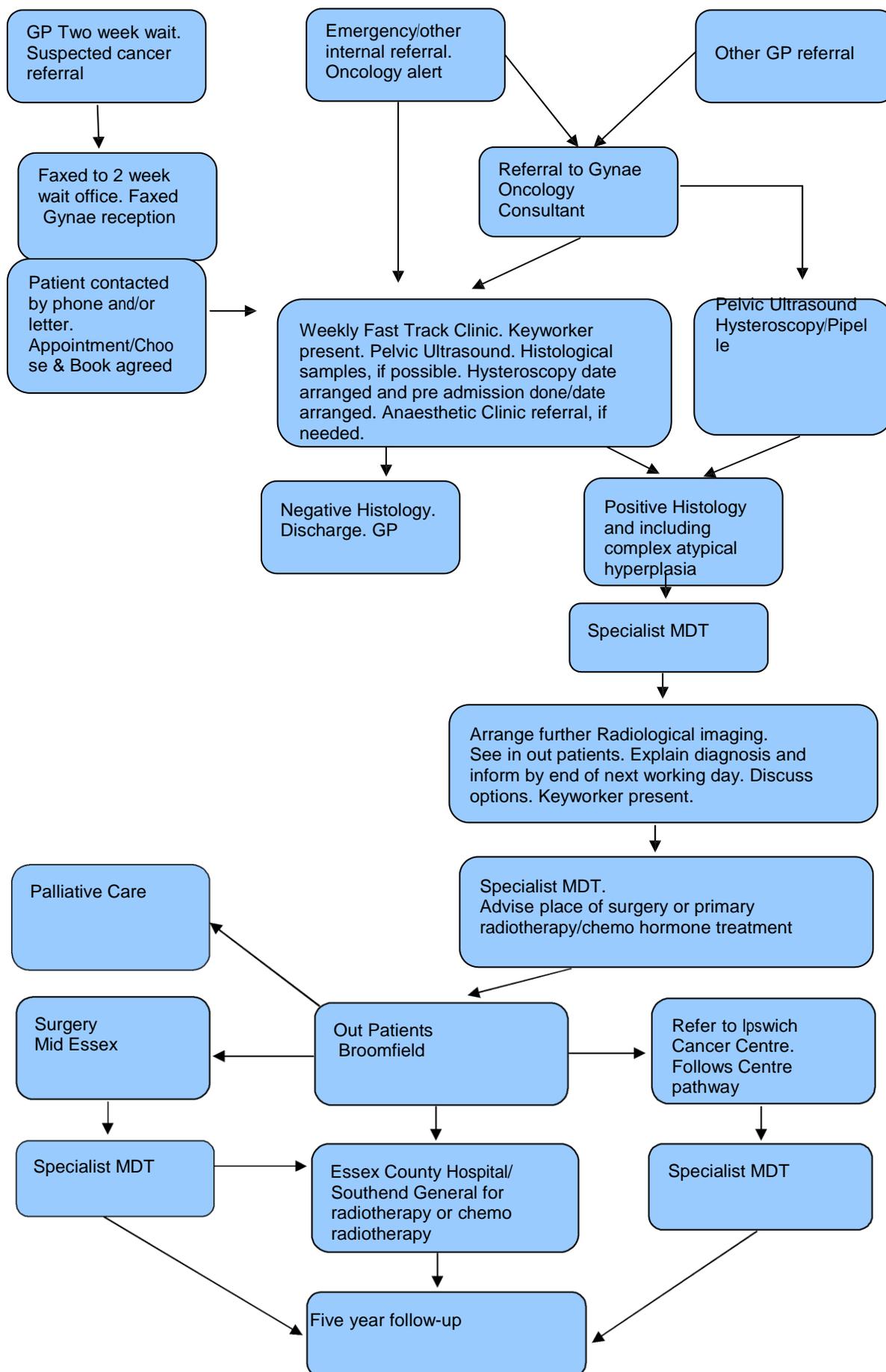
Currently recruiting.

Interim cover arrangements Dee Collison Email: dee.collison@uclh.nhs.uk

Care-pathway for Cervical cancer (MEHT)

Appendix 8





Patient pathway for ovarian/fallopian tube cancer (MEHT)

Appendix 10

