Greater Manchester
Cancer Conference 2022

Gynaecology

Authors: Nadia Ali-Ross and Eden Tagg

GP Education

- Suspected cervical cancer referral training and education package development for GP's in conjunction with ED Programme. To be rolled out November 2022.
- Gateway C live webinar took place March 2022
- Webinar & In –person GP training session completed.
- Cervical assessment training planned and Atlases purchased for all primary care practices.

HPV Vaccination

HPV Vaccination has caught up with all backlog and are now up to date.

Best Timed Pathways

Best timed pathways support the ongoing improvement effort to shorten diagnosis pathways, reduce variation, improve experience of care, and meet the Faster Diagnosis Standard (FDS). Below are the best timed pathways for ovarian, endometrial and cervical, vulval & vaginal cancer. GM BTP are more ambitious in terms of SMDT review point compared to NHS Gynae BTP. Local unit audits commenced to identify any bottle necks to support the achievement of BTP across GM.

The Faster Diagnostic Standard

The faster diagnosis standard (FDS) aims to ensure patients will have cancer ruled out or diagnosed withing 28 days of referral.
Rapid Diagnostic Centres (RDC) are now part of the NHS Cancer Programme's strategic approach to FDS. This framework seeks to align this work with other programmes such as CDC.

The Benefits

- An earlier and faster diagnosis to patients whether or not they are ultimately diagnosed with cancer
- Excellent patient experience, a holistic assessment of patient needs, and streamlined support across community, primary and secondary care.
- Increased capacity in the system, through more efficient diagnostic pathways.

Support systems to reach the FDS

The 7 RDC principles remain the core underpinning of the framework and renamed as the Faster Diagnosis Principles, with the Best Practice Timed Pathways documents providing the clinical detail for how tests can be coordinated, and timely diagnosis achieved for patients with defined symptom criteria NSS pathways will be included in CWT data from October 2022.

Cervical, Vulval & Vaginal Cancer Best Timed Pathway

Day 1	<7	<14	15 – 20	<21	<28	<38
Cervical: Suspicious cervical lesion (mass/ulceration/ friable)	Cx biopsy Request MRI if obvious tumour Discharge if cervix normal	Histology reported Request MRI (if post-LLETZ biopsy allow 7- 10 days interval) Patient updated	MRI reported Consider PET CT if >stage 1B1	SMDT with all results (PET CT may not be available) including TYA input & fertility referral as required	SMDT IF delays due to needing GA procedure Patient updated CARP'd/listed locally/ref to Pall Care	SMDT & CARP deadline IF specific patient safety considerations (as above)
Vulval & Vaginal: Lesion/mass suspicious of cancer	Punch biopsy under LA. List for GA biopsy if needed (If requires excision biopsy refer to tertiary centre/ SMDT	Histo reported MRI/CT scan requested Patient updated	*MRI/CT scan reported*	SMDT with all results including TYA input & fertility referral as required	SMDT if delays due to needing GA procedure Patient updated CARP'd/listed locally/ref to Pall Care	SMDT & CARP deadline IF specific patient safety considerations (as above)

Ovarian Cancer Pathway

Day 0	<7	<14	<21	<28	<38
GP referral: •Abdo/pelvic solid mass not consistent with fibroids •Any ovarian cyst on USS & raised ca125 •Suspicious ovarian cyst (solid/cystic) on USS with normal/raised Ca125 •Ascites	Tel clinic review/FTF RMI calculated Request CT Scan/MRI scan as per guidelines LDH, AFP, HCG if <40yrs If benign disease : OFF the TWW & arrange tx/ MRI/ USS surveillance as appropriate.	CT/MRI reported Request imaging-guided biopsy if needed (if unsure seek opinion outside of SMDT) Patient updated If normal results- discharge	SMDT (if no biopsy needed) TYA input & fertility referral as required Patient update & CARP if appropriate. Imaging guided biopsy completed if indicated	SMDT with biopsy TYA input as required Patient update CARPd/listed locally/ref to Pall Care	SMDT & CARP deadline IF specific patient safety considerations (eg comorbidities needing specialist input re fitness for treatment? Best Interest Meeting).

Endometrial Cancer Best Timed Pathway

Day 1	<7	<14	15 – 20	<21	<28	<38
PMB Recurrent PMB >3-6 months Perimenopausal bleeding (≥45 years with > 3 months: •irregular bleeding •IMB •unresponsive HMB Abnormal bleeding at any age if Lynch syndrome/ on tamoxifen Incidental raised postmenopausal ET ->11mm (low risk) -> 6mm (high risk)*	TV USS, Blind pipelle biopsy if indicated Arrange hysteroscopy, biopsy if indicated** (ONE STOP CLINIC if feasible) Discharge if PMB & ET < 4mm.	OP hysteroscopy completed Histology reported MRI/CT requested Patient updated Discharge if histology negative.***	MRI/ CT TAP reported	SMDT with all results Including TYA input as required	SMDT IF delays due to needing GA procedure Patient updated CARp/listed locally/ref to Palliative Care	SMDT & CARP deadline IF specific patient safety considerations (eg comorbidities needing specialist input re fitness for treatment).

* tamoxifen, BMI>30, diabetes, HNPCC/ Lynch syndrome
**For women on tamoxifen, focal lesion on TVUSS, failed pipelle (unable to pass pipelle) or un- representative pipelle sample (not inserted > 4cm into uterine cavity or clinical opinion that the sample obtained not consistent with markedly thickened/suspicious endometrium on scan).
***Scanty or inadequate histology in absence of markedly thickened suspicious ET on TVUSS can be accepted as consistent with atrophic endometrium. No further sampling is required unless recurrent PMB.

GM Gynaecology Suspected Cancer Referrals. Pre-Covid (2019) and Recovery Period (2022)

The Graph shows the increase of two week wait referrals in GM, compared to prepandemic levels. The focus remains on cancer, and all localities are achieving the 14 day standard (Average wait time 12 days). Gynaecology across GM is recovering the COVID 18 week backlog for benign gynaecology which has also impacted clinical capacity.