London Cancer
Guidelines for the management of gynaecological malignancies

Reviewed and agreed by the Pathway Board
September 2013
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1.1 Clinically effective pathway for the management of suspected ovarian cancer

**Referral**
- GP routine – Upgrade if urgent
- 2WW referral
- Tertiary
- A&E In-patients
- Incidental finding
- Ca125 / Ultrasound

**Rapid Access Clinic**
- RMI < 450
  - Clinical History and examination with results of above
- CT – If not suggestive of malignancy:
  - Manage at local unit
  - Use other markers – BHCG, AFP, LDH, Ca19-9, CEA
- RMI > 450
  - Specialist centre – SBH, UCLH
  - BHCG, AFP, LDH
  - cea, Ca19-9, Ca125-3
  - And CT, if not already done

**Diagnosis**
- Consider investigations:
  - Gastroscopy
  - Colonoscopy
  - Sigmoidoscopy
  - Laparoscopy
  - Hysteroscopy
  - CT or MRI
  - Radiologically guided bx
  - Mammography

**MDM**
- Follow up outpatients, CNS present

**Treatment**
- Neoadjuvant chemotherapy
  - Consider trial
- Surgery as per separate flow chart
  - Consider trial
- MDM with CT after 3#
  - Review response to chemo
- MDM
  - Review pathology

**Follow Up**
- Chemotherapy
- Follow up outpatients
- Follow up outpatients
1.2 Clinical management pathway of Postmenopausal bleeding

Protocols for assessment for Endometrial Cancer

- Women presenting with Post Menopausal Bleeding (PMB) are seen as an urgent Two Week Wait referral.
- Ideally a Transvaginal Ultrasound will have been arranged by the GP & done prior to arrival in clinic.
- The following assessments can then be made...

<table>
<thead>
<tr>
<th>Full history &amp; examination, including:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Age</td>
</tr>
<tr>
<td>✓ Menarch</td>
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<tr>
<td>✓ Menopause</td>
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<tr>
<td>✓ Parity</td>
</tr>
<tr>
<td>✓ Type of bleeding</td>
</tr>
<tr>
<td>✓ General examination</td>
</tr>
<tr>
<td>✓ Hx of diabetes</td>
</tr>
<tr>
<td>✓ Hx of hypertension</td>
</tr>
<tr>
<td>✓ Hormone Hx</td>
</tr>
<tr>
<td>✓ Family Hx</td>
</tr>
<tr>
<td>✓ Pelvic examination</td>
</tr>
<tr>
<td>± Smear (if one has not been done recently)</td>
</tr>
</tbody>
</table>

**Transvaginal Ultrasound**

- Endometrium > 4mm
  - OP Hysteroscopy + Pipelle Bx
    - Result inadequate or Unable to perform Pipelle Bx
      - Histology
        - G3 or clear cell non endometrioid
        - >1/2 myometrial invasion: Stage 1C
      - Refer to MDT at SBH SPECIALIST CENTRE

- Endometrium < 4mm
  - IP Hysteroscopy D & C
    - Take pipelle if negative
      - Reassure
      - If bleeding is persistent

  - Histology
    - G1 or G2
    - <1/2 myometrial invasion: Stage 1B or complex atypical hyperplasia
    - LOCAL management WXH / HW / SBH
    - Histology Benign
    - Discharge
1.3 Clinically effective pathway for the management of suspected Endometrial cancer

**Referral**
- GP routine – Upgrade if urgent
- 2WW referral
- Tertiary
- A&E In-patients
- Incidental finding

**Diagnostics**
- GA hysteroscopy
- Rapid access clinic
- Diagnostic hysteroscopy

**Evidence of cancer**
- Yes
  - MRI pelvis
  - CT abdo chest
- MDM

**Follow up outpatients, CNS present**

**Treatment**
- Surgical primary treatment – Minimal access unless clinical problems
  - Stage 1a (superficial invasion) G1,2 Local treatment
  - Stage 1b (deep invasion), G3 Specialist centre SBH, UCLH

- MDM with pathology
- If low risk – follow up
- If intermediate/high risk –
  - Review at specialist centre and consider nodal staging, adjuvant therapy, trials – see separate flow chart

**Follow up outpatients**
1.4 Clinically effective pathway for the management of suspected Cervix Cancer

PCB, IMB, PMB, abnormal appearing cervix

GP routine – Upgrade if urgent

2WW referral

Tertiary

A&E In-patients

Gynae onc / Rapid Access Clinic / colp clinic

Meet CNS

EUA, cystoscopy, sigmoidoscopy, bx

MRI / CT / XR pelvis, abdo, chest

Fbc, U&E, LFT’s

MDM with pathology and imaging

Oncology clinic follow-up, decision re treatment, see CNS again

Organise surgical treatments +/- see clinical oncology

Discuss trials

Laparoscopic Retro PA nodal staging

Cone biopsy

Trachelectomy

Simple hysterectomy

Radical hysterectomy

+-/ pelvic node dissection

Chemo RT

MDM with pathology

Adjuvant treatment

Begin follow up – see follow up appendix

MRI at 3/12 post RT
1.5. Clinically effective pathway for a suspected Vulval cancer

This pathway is just a guide; each patient should be managed on an individual basis

**SUSPICIOUS VULVAL LESION**

The following should prompt referral:
- A swelling polyp or lump
- An ulcer
- Colour change (white, pigment deposition)
- Elevation or irregularity of surface contour
- A clinical “wart”
- Irregular fungating mass
- An ulcer with raised, rolled edges
- Enlarged groin nodes

---

**Two week wait referral to any London Cancer hospital**

Clinically obvious cancer?

- YES
  - Refer to SPECIALIST CENTRE Barts / UCLH
  - EUA
  - Consider photography
  - Detailed diagram, if not already done locally
  - Lesion < 2cm & > 1cm free of any midline structure
  - Excisional biopsy with 1 cm margins
  - Representative biopsy including normal tissue

- NO
  - Management dictated by histopathological diagnosis & MDT discussion.
  - Definitive treatment of cancers should commence within 6 weeks of initial appointment.

---

- NO
  - Management can continue at LOCAL CENTRE
  - Detailed diagram of vulva including site & size of area of abnormality, +/- photograph
  - +/- outpatient punch biopsy performed & Colposcopy (NB: excision not advised)
  - Urgent Histopathology review: result Benign

---

YES

- YES
  - Management dictated by histopathological diagnosis & MDT discussion.
  - Definitive treatment of cancers should commence within 6 weeks of initial appointment.
1.6. Clinically effective pathway for suspected Vaginal cancer

This pathway is just a guide; each patient should be managed on an individual basis.

Clinically obvious suspected VAGINAL CANCER

![Decision Tree Diagram]

NO

Management can continue at LOCAL CENTRE

All women having had a positive biopsy for vaginal carcinoma should be referred to the Specialist Centre for further management.

YES

Refer directly to SPECIALIST CENTRE

In such cases it is entirely appropriate to refer prior to histological diagnosis

Individual Management dictated by:
- Clinical assessment
- Histopathological diagnosis
- MDT discussion
- +/- Radiology review

NB: Ensure GP is faxed diagnosis Proforma within 24 hrs

Definitive treatment of cancers should commence within 6 weeks of initial appointment.
1.7. Clinically effective pathway for uterine Leiomyosarcoma

Pathway Summary:

Secondary Care → A&E → Suspected gynaecological cancer → GP (less likely) → Surgery

Suspected/gynaecological cancer → Local specialist Gynaecological MDT

- Register patient - Review diagnosis - Plan management

MDT Plan:
- Diagnostics/Biopsies - Radiology - Identification of treatment centre

OPD
- Results - Treatment plan - CNS Contact

Refer to GP/local trust as appropriate → Palliative Care → Chemotherapy +/- Radiotherapy (by sarcoma unit or agreed designated practitioners)

Follow Up
According to agreed gynaecology MDT guidelines and LSESN sarcoma follow-up guidelines

Recurrence

All histology reviewed by Specialist Sarcoma Pathologist

Patients under 24 will also be referred to the teenage and young adult or paediatric MDTs as appropriate

Refer to London Sarcoma Service

LSS MDT Coordinator Contact details:
Ucl-tr.LondonSarcomaService.nhs.net
Tel: 020 3447 4821

Unexpected diagnosis of soft tissue sarcoma

Complex surgery and second operations to be done at sarcoma centre
Pre-operative staging investigations
- MRI/CT pelvis (to stage primary tumor)
- CT thorax/abdomen (to exclude metastatic disease)
- Screening blood tests (FBC, U&E, LFT)

No distant metastases
M0

Surgery for early stage disease
- TAH
- BSO often performed, not mandatory if pre-menopausal
- Pelvic lymph node dissection not routinely indicated
- Check hormone receptor status on pathology specimen

Consider adjuvant chemotherapy in high risk groups
- NCRI/EORTC/GOG phase III Study (due to open in 2013)
- In selected high risk patients outside the study with Doxorubicin + Ifosfamide

Adjuvant Pelvic RT
(Not indicated in Stage I/II disease)

Distant metastases
M1

“First Line” Palliative Chemotherapy
- Doxorubicin
- Doxorubicin + Ifosfamide
- Oral cyclophosphamide and prednisolone
- Aromatase inhibitor
- GeDDIS phase III trial (Gemcitabine + Docetaxel vs Doxorubicin)

“Second Line” Palliative Chemotherapy
- Trabectedin
- Ifosfamide
- Gemcitabine + Docetaxel
- Pazopanib
- Oral cyclophosphamide
- Aromatase inhibitor

Consider neoadjuvant chemotherapy to downstage disease
- Doxorubicin + Ifosfamide

Locally advanced
(Potentially operable)

Surgery
(If possible)

Consider Pelvic RT
(If complete resection)
Surgical Management for Uterine Leiomyosarcoma

Suspected gynae sarcoma

Pre-operative staging investigations
- MRI/CT pelvis (to stage primary tumor)
- CT thorax/abdomen (to exclude metastatic disease)
- Screening blood tests (FBC, U&E, LFT)

Surgery
- Already performed

No distant metastases
- M0

Surgery for early stage disease
- TAH
- BSO often performed, not mandatory if pre-menopausal
- Pelvic lymph node dissection not routinely indicated, enlarged lymph nodes should be removed
- Check hormone receptor status on pathology specimen

Distant metastases
- M1 (at diagnosis/multiple sites)

Consider palliative chemotherapy
- See treatment pathway

Distant metastases
- M1 (indolent disease mainly lung)

Discuss management at Sarcoma MDT
- Lung metastasectomy
- RFA may be considered

Surgery
- Outside centre
If suspicion of RECURRENCE
Arrange appropriate investigations and referral to UCH / Barts

Follow-up Pathway for Uterine Leiomyosarcoma

Post-operative staging investigations
- Baseline MRI/CT abdomen/pelvis
- Blood tests (FBC, U&E, LFT)

Years 1-2
- 3 monthly clinical examination and chest x-ray
- 6 monthly CT/MRI scans of abdomen and pelvis

Years 3-4
- 6 monthly clinical examination and chest x-ray
- Annual CT/MRI scans of abdomen and pelvis

Years 5-10
- Annual clinical examination and chest x-ray

- Annual clinical examination and chest x-ray
Patient Pathway for Uterine Leiomyosarcoma

Pathway Summary:

- Register patient
- Review diagnosis
- Plan management

MDT Plan:
- Diagnostics/Biopsies
- Radiology
- Identification of treatment centre

OPD
- Results
- Treatment plan
- CNS Contact

Recurrence

Follow Up
According to agreed gynaecology MDT guidelines and LSESN sarcoma follow-up guidelines

Patients under 24 will also be referred to the teenage and young adult or paediatric MDTs as appropriate

All histology reviewed by Specialist Sarcoma Pathologist

Suspected gynaecological cancer

Local specialist Gynaecological MDT

Suspected/biopsy proven soft tissue sarcoma

Sarcoma MDT

MDT Plan:
- Diagnostics/Biopsies
- Radiology
- Identification of treatment centre

OPD
- Results
- Treatment plan
- CNS Contact

Suspected/biopsy proven soft tissue sarcoma

Sarcoma MDT
- Register patient
- Review diagnosis
- Plan management

Surgery

Refer to London Sarcoma Service

LSS MDT Coordinator Contact details:
Ucl-tr.LondonSarcomaService.nhs.net
Tel: 020 3447 4821

Complex surgery and second operations to be done at sarcoma centre

Surgery

Chemotherapy +/- Radiotherapy (by sarcoma unit or agreed designated practitioners)

Palliative Care

Refer to GP/local trust as appropriate
Pre-operative staging investigations
- MRI/CT pelvis (to stage primary tumor)
- CT thorax/abdomen (to exclude metastatic disease)
- Screening blood tests (FBC, U&E, LFT)

No distant metastases
M0

Operable disease
Surgery for early stage disease
- TAH
- BSO often performed, not mandatory if pre-menopausal
- Pelvic lymph node dissection not routinely indicated
- Check hormone receptor status on pathology specimen

Consider adjuvant chemotherapy in high risk groups
- NCRI/EORTC/GOG phase III Study (due to open in 2013)
- In selected high risk patients outside the study with Doxorubicin + Ifosfamide

Adjuvant Pelvic RT
(Not indicated in Stage I/II disease)

Distant metastases
M1

“First Line” Palliative Chemotherapy
- Doxorubicin
- Doxorubicin + Ifosfamide
- Oral cyclophosphamide and prednisolone
- Aromatase inhibitor
- GeDDIS phase III trial (Gemcitabine + Docetaxel vs Doxorubicin)

Locally advanced
(Potentially operable)

Consider neoadjuvant chemotherapy to downstage disease
- Doxorubicin + Ifosfamide

Surgery
(If possible)

Consider Pelvic RT
(If complete resection)

“Second Line” Palliative Chemotherapy
- Trabectedin
- Ifosfamide
- Gemcitabine + Docetaxel
- Pazopanib
- Oral cyclophosphamide
- Aromatase inhibitor

Adjuvant Pelvic RT
(May be considered in Stage III/IV disease completely resected)
Dose: 45-50.4Gy in 25-28 fractions and vaginal vault brachytherapy

Operable disease

Consider adjuvant chemotherapy in high risk groups
- NCRI/EORTC/GOG phase III Study (due to open in 2013)
- In selected high risk patients outside the study with Doxorubicin + Ifosfamide

Adjuvant Pelvic RT
(Not indicated in Stage I/II disease)
Surgical Management for Uterine Leiomyosarcoma

Suspected gynae sarcoma

Pre-operative staging investigations
- MRI/CT pelvis (to stage primary tumor)
- CT thorax/abdomen (to exclude metastatic disease)
- Screening blood tests (FBC, U&E, LFT)

Surgery
Outside centre

Surgery Already performed

No distant metastases
M0

Surgery for early stage disease
- TAH
- BSO often performed, not mandatory if pre-menopausal
- Pelvic lymph node dissection not routinely indicated, enlarged lymph nodes should be removed
- Check hormone receptor status on pathology specimen

Distant metastases
M1 (at diagnosis/multiple sites)

Consider palliative chemotherapy
- See treatment pathway

Distant metastases
M1 (indolent disease mainly lung)

Discuss management at Sarcoma MDT
- Lung metastasectomy
- RFA may be considered
Follow-up Pathway for Uterine Leiomyosarcoma

Post-operative staging investigations
- Baseline MRI/CT abdomen/pelvis
- Blood tests (FBC, U&E, LFT)

Years 1-2
- 3 monthly clinical examination and chest x-ray
- 6 monthly CT/MRI scans of abdomen and pelvis

Years 3-4
- 6 monthly clinical examination and chest x-ray
- Annual CT/MRI scans of abdomen and pelvis

Years 5-10
- Annual clinical examination and chest x-ray

If suspicion of RECURRENCE
Arrange appropriate investigations and referral to UCH / Barts
1.8. Clinically effective pathway for Endometrial stromal sarcoma

Pathway Summary:

- Secondary Care
  - Suspected gynaecological cancer
  - Local specialist Gynaecological MDT
    - Register patient
    - Review diagnosis
    - Plan management
  - Sarcoma MDT
    - Diagnostics/Biopsies
    - Radiology
    - Identification of treatment centre
  - OPD
    - Results
    - Treatment plan
    - CNS Contact
  - Surgery
  - Palliative Care
  - Chemotherapy +/- Radiotherapy
    (by sarcoma unit or agreed designated practitioners)
  - Follow Up
    According to agreed gynaecology MDT guidelines and LSESN sarcoma follow-up guidelines

- A&E
- GP (less likely)
- Surgery
- Unexpected diagnosis of soft tissue sarcoma
- Refer to London Sarcoma Service
- Complex surgery and second operations to be done at sarcoma centre
- Patients under 24 will also be referred to the teenage and young adult or paediatric MDTs as appropriate

All histology reviewed by Specialist Sarcoma Pathologist

LSS MDT Coordinator Contact details:
UCL-e LondonSarcomaService.nhs.net
Tel: 020 3447 4821
**Pre-operative staging investigations**
- MRI/CT pelvis (to stage primary tumor)
- CT thorax/abdomen (to exclude metastatic disease)
- Screening blood tests (FBC, U&E, LFT)

**No distant metastases M0**

- Surgery for early stage disease
  - TAH +/- BSO
  - Pelvic lymph node dissection not routinely indicated, enlarged lymph nodes should be removed

- Adjuvant chemotherapy may be considered in selected young fit patients
  - Doxorubicin + Ifosfamide

- Adjuvant Pelvic RT
  - (Should be considered)
  - Dose: 45-50.4Gy in 25-28 fractions and may be followed by vaginal vault brachytherapy

**Locally advanced (Potentially operable)**

- Consider neoadjuvant chemotherapy to downstage disease
  - Doxorubicin + Ifosfamide

- Surgery
  - (If possible)

- Consider Pelvic RT
  - (If complete resection)

**Distant metastases M1**

**“First Line” Palliative Chemotherapy**
- Doxorubicin
- Doxorubicin + Ifosfamide
- Oral cyclophosphamide and prednisolone
- Aromatase inhibitor
- GeDDiS phase III trial (Gemcitabine + Docetaxel vs Doxorubicin)

**“Second Line” Palliative Chemotherapy**
- Trabectedin
- Ifosfamide
- Gemcitabine + Docetaxel
- Pazopanib
- Oral cyclophosphamide
- Aromatase inhibitor
Surgical Management for Undifferentiated Endometrial Sarcoma

Pre-operative staging investigations
- MRI/CT pelvis (to stage primary tumor)
- CT thorax/abdomen (to exclude metastatic disease)
- Screening blood tests (FBC, U&E, LFT)

No distant metastases
M0
- Surgery for early stage disease
  - TAH +/- BSO
  - Pelvic lymph node dissection not routinely indicated, enlarged lymph nodes should be removed

Distant metastases
M1 (at diagnosis/multiple sites)
- Consider palliative chemotherapy
  - See treatment pathway
If suspicion of RECURRENCE
Arrange appropriate investigations and referral to UCH / Barts

Follow-up Pathways for Undifferentiated Endometrial

Post-operative staging investigations
- Baseline MRI/CT abdomen/pelvis
- Blood tests (FBC, U&E, LFT)

Years 1-2
- 3 monthly clinical examination and chest x-ray
- 6 monthly CT/MRI scans of abdomen and pelvis

Years 3-4
- 6 monthly clinical examination and chest x-ray
- Annual CT/MRI scans of abdomen and pelvis

Years 5-10
- Annual clinical examination and chest x-ray
1.9 Clinically effective pathway for teenage and young adult gynaecological malignancies

**North Thames TYACNCG Initial Management Pathways:**

<table>
<thead>
<tr>
<th>Treatment Planning</th>
<th>Diagnosis</th>
<th>In Treatment</th>
<th>Post Treatment</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI abdo/pelvis, CT chest, Serum tumour markers</td>
<td>MRI abdo/pelvis, CT chest, Serum tumour markers</td>
<td>Treatment plan initiated by named oncologist at one of the following centres</td>
<td>End of first line treatment review</td>
<td>PTC TYA oncology clinic or designated hospital adult oncology clinic</td>
</tr>
</tbody>
</table>

**Team Members**
- Consultant Clinician
- CNS (Key Worker)
- Social Workers
- Youth Support Coordinator
- Specialist psycho-oncology team
- Allied Health Care
- Late Effects Team

**Transition**
- Referral into the UCLH TYA service at age 13 years
- Referral into the adult TYA team at around 20th birthday
- TYA MDT patients aged 24+ transition to adult services

**Abbreviations Key**
- MDT: Multi Disciplinary Team
- NWICS: North West Cancer Intelligence Service
- LTFU: Long Term Follow Up
- CNS: Clinical Nurse Specialist
- TYA: Teenagers and Young Adults

**Note:** Patients up to and including the age of 18 years should be treated at UCLH. Patients aged 19-24 years should be offered the choice between UCLH or a TYA designated hospital.
### North Thames TYACNCG Initial Management Pathway: Gynaecological Cancer

#### Contact Information

<table>
<thead>
<tr>
<th>Trust</th>
<th>Switchboard</th>
<th>Contact Person</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTC: UCLH</td>
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<td>Dr Sara Stoneham</td>
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</tr>
</tbody>
</table>

#### Treatment Planning

**SITE SPECIFIC MDT**

1. Discussed at Site Specific MDT or Network Site Specific MDT

2. The Site Specific consultant oncologist is the person who remains in overall in charge of the patients treatment - any other consultant sharing care will be identified on treatment plan

3. The treatment plan should include those responsible for:
   - Surgical removal of tumours
   - Chemotherapy
   - Radiotherapy
   - Cancer After Care

4. Fertility preservation options discussed as appropriate and recorded in agreed treatment plan

5. The Keyworker should be identified

**TYA MDT**

Location: UCLH
Time: Wednesdays, 15:00-17:00
Lead Clinician: Dr Rachael Hough
Coordinator: Alexandra Wood
Phone: 07892147785
Email: ucl-tr.TYAMDT@nhs.net

1. All TYA patients will be discussed in the TYA MDT.
2. The TYA MDT will review the treatment plan made by the site specific MDT and promote access to clinical trials wherever possible
3. The TYA MDT will review the support network around each individual patient, identify any psychosocial issues and how these will be addressed.
4. The TYA MDT will ensure that a keyworker and other allied health professionals are identified for each patient
5. The agreements reached between the site specific MDT and TYA MDT will be documented

**IT Systems**

COSD reporting (13-24yrs) by TYA MDT TYA DATA BASE

<table>
<thead>
<tr>
<th>Notes</th>
<th>End of treatment review and clinic with patients oncologist or keyworker</th>
<th>End of treatment summary within 12 weeks of completion of therapy by oncologist or keyworker</th>
<th>Introduce TYA service to patient (by post or face to face assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Transition to TYA MDT allocate key worker</td>
<td>Transition into adult services is planned for and discussed with patients well in advance. Transition at a time of crisis e.g. relapse, intensive chemotherapy will be avoided wherever possible. Transition will be facilitated by the keyworkers</td>
<td></td>
</tr>
</tbody>
</table>

#### After care Monitoring

- Holistic Needs Assessment (HNA) done within 4 weeks of referral to team
- Support from TYA MDT members throughout the patients treatment pathway according to patient wishes
- Information and support patient and carer (TYA team) supporting age appropriate care
- Invite to end of treatment group/meet face to face for after treatment review
- Family support network

#### Referral to TYA LT FU

Patients at high risk of late effects or those who develop late effects of therapy will be referred into specific late effects service
2.1. Surgical pathway for Ovarian cancer

Decision made for laparotomy for OVARIAN Ca
Theatre dates offered & negotiated: within 31 days of diagnosis

Pre Admission Clinic or on admission:
- Full SHO clerking inclusive of all investigations, 4 units X-matched, consent & bowel prep.
- Review by fellow or consultant

Counselling by stoma nurse & stoma site marking

YES

GASTROINTESTINAL SYMPTOMS?

NO Elevated CEA or radiological suspicion of bowel involvement

YES

ANAESTHETIC REVIEW

NO

LAPAROTOMY

ascites present?

YES

Aspiration of ascites for cytology

FULL EXPLORATORY LAPAROTOMY

Examination of all pelvic structures,
- Pelvic & abdominal peritoneum
- Pelvic & para-aortic lymph nodes
- Stomach, spleen, small & large bowel
- Liver, kidneys, pancreas & diaphragm
- Omentum

Obvious extra-ovarian disease?

YES

TAH + BSO + omentectomy + debulking
Aim for NO residual disease

NO

Frozen section

Pelvic + PA lymph node + washings + omentum

Suspicion of malignancy

Benign

Desire for conservative surgery?

NO

Conservative surgery still possible & appropriate

YES

TAH BSO + Biopsies of peritoneum + washings

Desire for conservative surgery?

NO

Appropriate conservative surgery, + Biopsies of peritoneum & contralateral ovary + D & C

YES

TAH + BSO + omental biopsy

Conservative surgery
2.2. Surgical pathway for Endometrial cancer

Endometrial Cancer Management

? Specialist or Local Centre?

MDT Histology Review: Pre procedure Assessment of Tumour Grade & associated risk

↑ HIGH RISK HISTOLOGY
- Grade 3 lesions
- Papillary serous
- Clear cell, MMT
- Adenosquamous

↓ LOW RISK HISTOLOGY
- Grade 1/2
- Can be managed at LOCAL centre

MDM Radiology Review: Pre procedure Assessment of Endometrial Thickness, Endocervical involvement and tumour size by MRI. If high risk histology or MRI suggest 1B or above for CT C/A/P

Myometrial invasion:
- Outer ½
- Cervical involvement

Myometrial invasion:
- < ½ or no invasion

MDT Management Discussion:
- All high risk & G3 surgery to be performed at Specialist Cancer Centre, SBH or UCLH
- Many women with endometrial carcinoma are of high anaesthetic and surgical risk due to obesity, hypertension and diabetes. In these cases laparoscopic surgery is preferable

Hysterectomy
- Full exploratory laparotomy OR this can be done Laparoscopically if the expertise is available
- Bilateral salpingo-oophorectomy
- Pelvic/PA lymphadenectomy
- To be done at SBH / UCLH

Hysterectomy
- Vaginally
- Laparoscopically
- Laparotomy if uterus too large
- Can be managed at LOCAL centre
3.1. Chemotherapy protocols for Ovarian Cancer

**1st Line Therapy**

- Stage 1a/1b

**Primary Debulking Surgery**

- 1. Stage 1a/1b
- 2. Grade 1/2
- 3. Optimally staged

- 1. Incompletely staged
- 2. Grade 3
- 3. Surgical 1c

**Observe**

**Adjuvant Chemotherapy**

**ICON 8**

- 1. Carboplatin (Not in clear cell)
  - OR
- 2. Carboplatin & Paclitaxel

_Evidence: ICON 1, ACTION, ICON 3, Cochrane Review_
Stage 1c, II-IV

Primary Surgery?

YES

Trio 14
ICON 8
MEOC
Post-operative Chemotherapy

1. Carboplatin OR 2. Carboplatin & Paclitaxel 6 Cycles

NO

Neoadjuvant Chemotherapy

1. Carboplatin OR 2. Carboplatin & Paclitaxel 3 Cycles

Interval Debulking Surgery

1. Carboplatin 2. Carboplatin & Paclitaxel 3 Cycles

Consider weekly carboplatin & weekly paclitaxel if:
1. Bowel Obstruction
2. Poor Performance Status (D1,D8,D15 – 21 day cycle)

Consider 3-weekly carboplatin & weekly paclitaxel if:
1. Poor response to surgery
### RELAPSE DISEASE

#### Relapse < 6 Months
- **Platinum Refractory/Resistant**
  1. Weekly Paclitaxel (28 day cycle)
  2. van der Burg (Weekly cisplatin & oral etoposide)
  3. PLD
  4. Oral Etoposide
  5. Metronomic Cyclophosphamide
  6. Topotecan
  7. Tamoxifen

#### Relapse 6-12 Months
- **Platinum Partially Sensitive**
  1. Carboplatin/PLD
  2. Carboplatin/Gemcitabine
  3. Carboplatin/Paclitaxel

#### Relapse > 6 Months
- **Platinum Sensitive**
  1. Carboplatin/Paclitaxel
  2. Gemcitabine/Carboplatin
  3. Carboplatin/PLD
  4. Carboplatin

**Phase 1 Trial**

**Key**
- **Black**: London Cancer Standard treatment
- **Green**: NICE approved treatment
- **Blue**: Clinical trial
- **Amber**: Treatment approved via Cancer Drugs Fund
- **Purple**: Available via compassionate use programme
- **Red**: Requires funding confirmation prior to prescribing
3.2. Chemotherapy protocols Rare Ovarian Tumours

**Mucinous Carcinomas**
- Relapsed stage I
- Stage II-IV
- carboplatin + paclitaxel
  - OR
  - mEOC

**Clear Cell Cancers**
- ≥ Stage Ic
- carboplatin + paclitaxel

**Recurrent Disease**
- consider for clinical trials / Phase I studies

**Granulosa Cell Tumours or recurrent sex cord tumours**
- Recurrent and non-surgically resectable
- BEP (3 day) (for fit patients)
  - OR
  - carboplatin + paclitaxel
    - (if not fit for BEP)
4.1 Radiotherapy for carcinoma of the CERVIX

Indications

- Radical treatment of locally advanced disease IB2 – IVA.
- Patients with stage 1A disease who decline or are unfit for surgery.
- Post-operative patients with high risk features or positive margins

Essential PRE-TREATMENT CHECKS/investigations

- Contrast-enhanced MRI imaging of the pelvis
- Contrast-enhanced CT imaging of the Chest to include abdomen if not imaged on MR
- PETCT scan according to local guidelines
- EUA (ideally with surgeon and oncologist) + biopsy of any suspicious lesions
- If there is hydronephrosis on imaging, this should be stented prior to radiotherapy
- Routine serum biochemistry and FBC
- Optional SCC antigen in patients with squamous cell tumours.
- EDTA-GFR or formal calculation of renal function for all patients to receive concurrent cisplatin chemotherapy
- Pathology, radiology and management plan for all patients should be discussed on an individual basis in the Gynaecology MDT.

Information for patients

Information leaflets may be given on

- Pelvic EBRT and brachytherapy, including expected site specific side effects
- Concurrent chemotherapy with cisplatin

Consent

- Required for all patients according to local guidelines

Trials

- INTERLACE Trial
- DEPICT

Chemotherapy

- Concurrent cisplatin chemotherapy may be used if GFR > 50ml/min.
- Cisplatin 40mg/m² (max 70-80mg) weekly for a maximum of 6 weeks during radiotherapy. [Green et al Lancet 2001 Sep 8; 358(9284) 781-6]
- Post operative chemoradiation may be considered in patients with high risk pathology such as nodal involvement and/or positive resection margins.

Position / Immobilisation

According to local guidelines and may include

- Supine with knee supports
- Midline and lateral bony pelvis permanent markers.
Planning technique

- 3D planning using CT data
- Use MRI or PET-CT planning where indicated and according to local practice

Imaging required for GTV definition

- Contrast enhanced planning CT Abdomen and Pelvis
- Levels to be defined according to individual patient but usually from L2 - L3 to below the introitus.
- Fusion with diagnostic MRI Abdomen and Pelvis

Dose / Time / Fractionation/ Category (for unscheduled gaps)/ number of phases

- 50.4Gy in 25 - 28 daily fractions over 5-5.5 weeks delivered in a single phase.
- Concomitant chemotherapy should be given (unless medically unfit, inadequate renal function or poor performance status)
- Category 1 patients so no treatment gaps. If gaps are unavoidable, patients should be hyperfractionated

As a simple rule of thumb, consider using the guidelines below:

CTV

- CTV Pelvic Nodes:
  - Obturator, internal and external and common iliac nodes up to the bifurcation of the aorta using blood vessels as a surrogate with a 7 mm margin modified.
- CTV Tumour:
  - Gross tumour, uterus and parametrium and upper third of vagina (unless there is involvement by disease, in which case a 2 cm margin below apparent disease should be used). Consider inclusion of proximal half of utero-sacral ligaments. Cervix and uterus can be outlined as a separate volume from parametrium and upper vagina unless the INTERLACE guidelines are being followed.

PTV

- PTV Nodes = CTV Pelvic Nodes + 7- 8mm
- PTV parametrium and upper vagina = CTV Tumour + 7mm
- PTV cervix and uterus lateral margins 7mm. Sup/Inf and Ant/Post 12-18mm

However, the alternative is to follow the INTERLACE guidelines to produce PTV1, PTV2, and PTV3 as per table below:
Planning guidelines and expansions from INTERLACE trial

<table>
<thead>
<tr>
<th>Clinical Target Volume and Planning Target Volume Margins</th>
<th>Clinical Target Volume 1 (CTV1)</th>
<th>Planning Target Volume 1 (PTV1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Target Volume 2 (CTV2)</td>
<td>CTV1 should include the whole cervical tumour and its local extension (GTV). Also, the cervix and uterus.</td>
<td>Add 15 to 20mm to CTV1 anterior/posterior/superior and inferior, 7 to 10mm in the lateral extension.</td>
</tr>
<tr>
<td>Clinical Target Volume 3 (CTV3) (Extended field)</td>
<td>Proximal half of the uterosacral ligament, bilateral parametria and upper half of the vagina, or 2 cm below known vaginal disease. If there is uterosacral involvement, the entire ligament needs to be encompassed. The external iliac, obturator, internal iliac and common iliac nodes are also included in this volume. The superior extent is at the aortic bifurcation. The nodal areas are defined by using a 7mm around blood vessels. It should be extended to include visible disease and lymphoceles. It should be modified to exclude bone, psoas muscle, bladder and bowel. The subaortic presacral nodes can be covered by connecting the nodal areas either side of S1 and S2 with a 10 mm strip volume. Where nodes at the aortic bifurcation or at the level of the common iliac vessels are positive (histology/CT PET &gt;/= 15mm on imaging) the most superior extent of CTV3 will be at the renal hilum. In general, a margin of at least 2cm should be added above the highest involved lymph node region.</td>
<td>Add 7 to 8mm to CTV2.</td>
</tr>
<tr>
<td>Planning Target Volume 3 (PTV3)</td>
<td>Add 5 to 7mm to CTV3.</td>
<td>Add 5 to 7mm to CTV3.</td>
</tr>
</tbody>
</table>
**Field arrangement**

A 3 or 4 field technique is used to cover the target volume
If IMRT or RAPIDARC is used this is done according to local guidance

**Parametrial boost**

This is optional
- May be used in patients stage FIGO IIb and above (ie any parametrial extension)
- Plan after 1st HDR brachytherapy insertion
- Fields are matched to 70% isodose from HDR brachytherapy reconstruction onto AP film
- Field Borders:
  - Superior field border - mid SI joint
  - Inferior field border - bottom of obturator foramen
  - Lateral field border - as for previous EBRT field
- Dose: 5.4Gy in 3 daily fractions over 3 days

**Extended field**

- To be considered in medically fit patients with:
  - Positive Para-aortic lymph nodes (PAN) on lymph node dissection
  - Positive Common Iliac LN where PAN have not been surgically assessed
- PTV:
  - CT planned, outlining the nodes around the aorta plus 7-8mm margin to give PTV PAN.
- Field Borders
  - Superiorly - approximately T12/L1
  - Inferiorly - matched to pelvic volume
  - Width - approximately 8cm but may be amended with reference to the position of the kidneys
- Field arrangement according to local guidelines. Ant and post fields not encouraged
- Dose is 45 Gy in 25 daily fractions over 5weeks

**Use of MLC**

- As required to spare normal tissue

**Critical organs and tolerance doses**

- Organs at risk include the rectum and bladder
- Rectal dose for the entire course should be limited to <70-75Gy

**PORTAL Imaging**

- First 3 fractions and weekly thereafter

**Microselectron (HDR brachytherapy)**

- Full insertion with intrauterine and intravaginal sources.
- All patients have 21Gy in 3 fractions to 100% or point A.
- External beam and brachytherapy treatment should be completed within 42 to 50 days of the first fraction hence concomitant brachytherapy boost may be necessary.
On treatment review clinics

Patients seen in on treatment review clinic according to local practice
- weekly FBC, Ideal Haemoglobin > 12-12.5g/dl throughout treatment.
- If having chemo weekly biochemistry otherwise week 1 and 5 and as indicated
- Baseline and weekly weight and RTOG toxicities may also be documented.
- Patient to see CNS before and after treatment
- Pelvic after care, information and advice on vaginal dilators.

Follow up after radiotherapy

- Initial review 4 weeks following completion of radiotherapy
- MRI scans of the Abdomen and Pelvis 12 weeks following completion of treatment should be considered if patient is suitable for a salvage surgical approach
- Follow up; Year 1 - 3 monthly; Year 2 - 3 to 4 monthly; Year 3- 4 to 6 monthly; Years 4 and 5- 6 to 12 monthly.
- Follow up after this is at the clinicians discretion
- Referral to menopause clinic advised for pre-menopausal patients

Arrangements for treatment summary

- End of treatment letter to be dictated within 14 days from completion of treatment
4.2. Indications for Adjuvant Radiotherapy treatment in Endometrial cancer

This pathway is just a guide; each patient should be managed on an individual basis.

<table>
<thead>
<tr>
<th>GRADE</th>
<th>STAGE</th>
<th>LVSI</th>
<th>MYOMETRIAL INVASION</th>
<th>Risk according to PORTEC</th>
<th>TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1</td>
<td>IA</td>
<td>0 or &lt;50%</td>
<td>Low risk</td>
<td>No Adjuvant Tx</td>
<td></td>
</tr>
<tr>
<td>G1</td>
<td>IB</td>
<td>&gt;50%</td>
<td>Intermediate risk</td>
<td>Staging + VB or ExtBRT + VB</td>
<td></td>
</tr>
<tr>
<td>G2</td>
<td>IA</td>
<td>0</td>
<td>Low risk</td>
<td>No adjuvant Tx</td>
<td></td>
</tr>
<tr>
<td>G2</td>
<td>IA</td>
<td>&lt;50%</td>
<td>Intermediate risk</td>
<td>+/- VB</td>
<td></td>
</tr>
<tr>
<td>G2</td>
<td>IB</td>
<td>&gt;50%</td>
<td>Intermediate risk</td>
<td>Staging + VB or ExtBRT + VB</td>
<td></td>
</tr>
<tr>
<td>G3</td>
<td>IA</td>
<td>0</td>
<td>Intermediate risk</td>
<td>VB or ExtBRT + VB</td>
<td></td>
</tr>
<tr>
<td>G3</td>
<td>IA</td>
<td>&lt;50%</td>
<td>Intermediate risk</td>
<td>PORTEC or ExtBRT + VB</td>
<td></td>
</tr>
<tr>
<td>G3</td>
<td>IB</td>
<td>&gt;50%</td>
<td>High risk</td>
<td>PORTEC or ExtBRT + VB</td>
<td></td>
</tr>
</tbody>
</table>

VB : Vaginal Vault Brachytherapy
ExtBRT : External Beam Radiotherapy
4.3. Adjuvant Radiotherapy adjuvant for Endometrial cancer

Indications

- Patients whose disease is assessed as sufficiently high risk to warrant adjuvant EBRT:
  - FIGO Stage IA Grade 3 with lymphovascular invasion
  - FIGO Stage IB Grade 2 with lymphovascular space invasion
  - Grade 3 FIGO Stage IB
  - Stage II
  - Stage III /IV disease
  - Serous or clear cell subtype
- Vault brachytherapy may be considered as a sole modality in patients with FIGO IB Grade 1 or 2, Stage II disease with no lymphovascular invasion, no deep stromal infiltration and non clear cell or serous histology.
- Patients not suitable for surgery but fit for radical radiotherapy and brachytherapy.

Essential PRE-TREATMENT CHECKS/investigations

- Pathology, radiology and management plan for all patients should be discussed on an individual basis in the Gynaecology MDT.
- The pathology report should include histological type, grade, depth of myometrial invasion, clearance to serosa and presence of lymphovascular invasion.
- Contrast-enhanced CT scans of the Chest for all high risk patients undergoing adjuvant treatment (to include abdomen if not already imaged).
- Baseline serum Full Blood Count, Urea & Electrolytes and Liver Function Tests.

Information for patients

- Information leaflets to be given on Pelvic External Beam Radiotherapy and brachytherapy, including expected site specific side effects in the Gynae-Oncology Clinic.
- Advice on aftercare including vaginal dilators to be given during or after treatment
- CNS review before and after treatment

Consent

- Required for all patients according to local guidelines

Position / Immobilisation

According to local guidelines and may include

- Supine with knee supports
- Midline and lateral bony pelvis permanent markers.
- Bladder comfortably full

Planning technique

- 3D CT planning
- MR Planning where appropriate

Imaging required for GTV definition

- Contrast enhanced planning CT Abdomen and Pelvis
- L2 to below the introitus unless individually defined on booking form.

Dose / Time / Fractionation/ Category (for unscheduled gaps)/number of phases
• Radical treatment, RCR Category 2.
• 45 Gy to 50.4 Gy in 25 to 28 daily fractions.

CTV
• CTV Pelvic Nodes:
  o Obturator, internal and external iliac and distal common iliac nodes up to midpoint between aortic bifurcation and common iliac bifurcation unless iliac node involvement when extension of field to aortic bifurcation is recommended. The blood vessels should be used as a surrogate (i.e. 7mm around blood vessels edited for anatomical boundaries).
• CTV Parametrium
  o Includes the parametrium and upper third of vagina (unless there is involvement by disease, in which case a 2 cm margin below apparent disease should be used)

PTV
• PTV Nodes = CTV Nodes + 7-8mm
• PTV Parametrium = CTV Parametrium + 7 - 10mm
• PTV margin may be increased in obese patients to allow for greater set up uncertainty

Field arrangement
• For standard conformal plans a 3 or 4 field technique is used to cover the target volume
• IMRT/Rapid ARC - according to department protocol

Use of MLC
• As required to spare normal tissue

Critical organs and tolerance doses
• Organs at risk include the rectum and bladder
• Rectal dose for the entire course should be limited to <70 Gy
• Bladder dose for the entire course should be limited to <60 Gy

PORTAL Imaging
• First 3 fractions and weekly thereafter

**microselectron (HDR vault brachytherapy)**
• Full insertion of intravaginal applicator.
• Patients have 8-12 Gy in 2 fractions to 0.5cm from the surface of the applicator.
• For patients who are having radiotherapy as sole treatment specialist input regarding dose and method of brachytherapy delivery advised.
On treatment review clinics
- Patients seen on treatment review clinic according to local guidelines
- Patient to see CNS after treatment

Follow up after radiotherapy
- Initial review 4-6 weeks after radiotherapy course completion or sooner if needed
- Patients to be followed up in joint Gynae-Oncology clinic, with alternating appointments between surgical and non-surgical oncological teams) every 3 months for 2 years.
- 6 monthly for a further 3 years
- Patients may then be discharged to their local unit at 2 years if appropriate with 6-monthly follow-up until 5 years

Arrangements for treatment summary
- Treatment summary to be completed with 14 days of finishing radiotherapy
5.1 Follow up for Ovarian Cancer

*This pathway is just a guide; each patient should be managed on an individual basis*

- Stage 1 surgically treated patients can be referred back to the local centre after 1 year
- Follow-up may be shared between surgeons and oncologists or with a local centre
- After five years follow-up may be discontinued unless clinically indicated

MDM Review: Histological diagnosis & plan concerning adjuvant therapy

**Guiding principles for follow-up appointments:**
Every follow-up appointment should include the following:
1. A history of symptoms
2. A full systemic examination and peripheral lymph node survey
3. A pelvic examination
4. Relevant tumour markers
5. TVUSS if had ovarian conservation

**Indications for a CT or MRI scan:**
1. Prior to starting and on completion of adjuvant chemotherapy
2. The presence of symptoms or a suspicious examination
3. Rising tumour markers

3 monthly follow-up for 1st year (& 2nd if stage 3c)
4 monthly follow-up for 2nd year
6 monthly follow-up for 3rd year

High risk—may be extended follow-up for 10 years
Low risk—discharge after 5 years

Suspicion of **RECURRENCE:**
Arrange appropriate investigation & immediate referral to Specialist Centre

MDT Review and discussion concerning further management

- Experimental protocol
- Further surgery
- Salvage therapy
- Palliative Care
5.2 Follow up for Endometrial Cancer

This pathway is just a guide; each patient should be managed on an individual basis

Where: For the first five years follow-up may be shared with a local centre, or the patient referred back to the local centre after 1 year

Who: Patients who have received radiotherapy should have alternate follow-up with the clinical oncology team

How long: Follow up can cease after 3 years for low risk cancer - stage 1A G1 and G2, and after 5 years for other stages unless clinically indicated

MDM Review: Histological diagnosis & plan concerning adjuvant therapy

Guiding principles for follow-up appointments:
Every follow-up appointment should include the following,
1. A history of symptoms
2. A full systemic examination & peripheral lymph node survey
3. A pelvic examination and speculum examination

Follow-up: 1 - 2 weeks post discharge
- Appointment to be made from ward on discharge.
- Confirmation of histological diagnosis and MDT discussion.
- Notification proforma sent to GP from WOP’s
- Indications for adjuvant chemoradiation? if so refer to oncology team – see separate table for indications for adjuvant treatment

Suspicion of RECURRENCE:
Arrange appropriate investigation & immediate referral to Specialist Centre

MDT Review and discussion concerning further management

Experimental protocol Further surgery Salvage therapy Palliative Care
5.3 Follow up for Cervical Cancer

This pathway is just a guide; each patient should be managed on an individual basis

Where: For the first five years follow-up may be shared with a local centre, or the patient referred back to the local centre after 1 year

Who: Patients who have received radiotherapy should have alternate follow-up with the clinical oncology team

How long: Follow up can cease after 3 years for stage 1Ai, and after 5 years for other stages unless clinically indicated

MDM Review: Histological diagnosis & plan concerning adjuvant therapy

Guiding principles for follow-up appointments:
Every follow-up appointment should include the following.
4. A history of symptoms
5. A full systemic examination & peripheral lymph node survey
6. A pelvic examination
7. Smear may be taken in surgically treated patient if HPV +ve

Follow-up: 1 - 2 weeks post discharge
- Appointment to be made from ward on discharge.
- Confirmation of histological diagnosis and MDT discussion.
- Notification proforma sent to GP from WOP’s
- Indications for adjuvant chemoradiation? if so refer to RT planning
  - Node +ve
  - Involved surgical margins
  - Adverse histological features

Suspicion of RECURRENCE: Arrange appropriate investigation & immediate referral to Specialist Centre

MDT Review and discussion concerning further management

- Experimental protocol
- Further surgery
- Salvage therapy
- Palliative Care