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2
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
  - Check – 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

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

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

**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…

Full history & examination, including:
- Age
- Menarch
- Menopause
- Parity
- Type of bleeding
- General examination
- Hx of diabetes
- Hx of hypertension
- Hormone Hx
- Family Hx
- Pelvic examination
- Smear (if one has not been done recently)

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 1B
  - Refer to MDT at 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 1A
      - or complex atypical hyperplasia
  - LOCAL management

Discharge

Protocols for assessment for Endometrial Cancer

- Refer to MDT at SPECIALIST CENTRE

LOCAL management

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
- No - call pt - discharge
- 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 RLH or 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
- O-P
  - CNS available
  - Adjuvant Treatment if required
- 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

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

**Clinically obvious cancer?**

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

- **YES**
  - Refer to **SPECIALIST CENTRE RLH / UCLH**
  - EUA Consider photography Detailed diagram, if not already done locally
  - Lesion < 2cm & > 1cm free of any midline structure
    - **YES**
      - Excisional biopsy with 1 cm margins
    - **NO**
      - Representative biopsy including normal tissue

**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

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

NO

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 → GP (less likely) → Surgery

Suspected gynaecological cancer

Local specialist Gynaecological MDT

- Register patient
- Review diagnosis
- Plan management

Suspected/biopsy proven soft tissue sarcoma

Sarcoma MDT

- Diagnostics/Biopsies
- Radiology
- Identification of treatment centre

MDT Plan:

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

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

Refer to London Sarcoma Service

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

Unexpected diagnosis of soft tissue sarcoma

Complex surgery and second operations to be done at sarcoma centre

Suspected gynaecological cancer

Surgery
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)

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

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

- Register patient
- Review diagnosis
- Plan management

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

OPD:
- Results
- Treatment plan
- CNS Contact

- Register patient
- Review diagnosis
- Plan management

Secondary Care
A&E
Suspected gynaecological cancer
Local specialist Gynaecological MDT
Sarcoma MDT

Suspected/biopsy proven soft tissue sarcoma

Refer to London Sarcoma Service

Unexpected diagnosis of soft tissue sarcoma

Surgery

- Diagnostics/Biopsies
- Radiology
- Identification of treatment centre

OPD
- Results
- Treatment plan
- CNS Contact

Surgery

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

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

Recurrence

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

Refer to GP/local trust as appropriate

Palliative Care

Complex surgery and second operations to be done at sarcoma centre

GP (less likely)

Survey

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

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

Refer to GP/local trust as appropriate

Palliative Care

Complex surgery and second operations to be done at sarcoma centre

GP (less likely)
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)

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
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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
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

Surgery
- Outside centre

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
Pathway Summary:

- Secondary Care
- A&E
- GP (less likely)
- Surgery

Suspected gynaecological cancer

Local specialist Gynaecological MDT
- Register patient
- Review diagnosis
- Plan management

Suspected/biopsy proven soft tissue sarcoma

Sarcoma MDT
- Diagnostics/Biopsies
- Radiology
- Identification of treatment centre

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

OPD
- Results
- Treatment plan
- CNS Contact

Palliative Care

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

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

Recurrence

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

Refer to London Sarcoma Service

Unexpected diagnosis of soft tissue sarcoma

Refer to GP/local trust as appropriate

Complex surgery and second operations to be done at sarcoma centre

LSS MDT Coordinator Contact details:
UCL - London Sarcoma Service: nhs.net
Tel: 020 3447 4821

1.8. Clinically effective pathway for Endometrial stromal
**Diagnostic/Treatment Pathways 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**
  - Operable disease
    - 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

**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
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)

Suspected gynae sarcoma

No distant metastases
M0

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

Surgery
Outside centre

Distant metastases
M1 (at diagnosis/multiple sites)

Consider palliative chemotherapy
- See treatment pathway

Surgery
Already performed
If suspicion of **RECURRENCE**
Arrange appropriate investigations and referral to UCH / Barts
1.9 Clinically effective pathway for teenage and young adult gynaecological malignancies

Pathway 1a: Initial Management Pathway for the Principal Treatment Centre

Principal Treatment Centre: University College London Hospital
Tumour Type: Gynaecological Tumours

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 (Pathway 1b).

Diagnosis

- Suspicion of cancer or cancer diagnosis
  - (incidental/A&E/GP/Drop

Treatment

- Discussion at UCLH at
- Diagnostics
  - MRI abdo/pelvis
  - CT chest
  - Serum tumour markers

In treatment

- Treatment plan initiated by named oncologist:
  - Oncology
    - Dr M McCormack (≥20)
    - Dr J Lederman (≥20)
    - Dr S Stoneham (13-19)
  - Surgery
    - Miss N MacDonald
    - Mr T Mould

Post treatment

- End of First line treatment review
- End of treatment summary by 12 weeks by named oncologist or keyworker

Follow-up

- TYA oncology clinic and Gynaecology oncology clinic
- LTFU as required

TYA Team Supportive Model of Care

- Holistic Needs Assessment (HNA) first 4 weeks
- Patients / carer support
- Multi Discipline Team support as required/requested
- Family Support Network
- End of Treatment summary 12 weeks post completion of treatment

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
NWCIS - North West Cancer Intelligence Service
LTFU - Long Term Follow Up
CNS - Clinical Nurse Specialist
TYA - Teenagers and Young Adults
Pathway 1a: Initial Management Pathway for the Principal Treatment Centre

<table>
<thead>
<tr>
<th>Diagnostics</th>
<th>Treatment planning</th>
<th>After care monitoring</th>
<th>TYA team input</th>
<th>Transition to TYA</th>
<th>Referral to TYA LTFU</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UCLH</strong> MRI abdo/pelvis</td>
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<td>CT chest</td>
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<td>Serum tumour markers</td>
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<td><strong>SITE SPECIFIC MDT</strong> Gynae-Oncology</td>
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<td>Location: UCLH</td>
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<td>Lead Clinician: Miss N MacDonald</td>
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<tr>
<td>Coordinator: Amit Savani / Tim Milne</td>
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<tr>
<td>Phone: 020 3447 8636</td>
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<tr>
<td>Email: <a href="mailto:amit.savani@uclh.nhs.uk">amit.savani@uclh.nhs.uk</a> / <a href="mailto:tim.milne@uclh.nhs.uk">tim.milne@uclh.nhs.uk</a></td>
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<tr>
<td>1. Discussed at Site Specific MDT or Network Site Specific MDT</td>
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<td>2. The Site Specific consultant haematologist is the person who remains in overall charge of the patients treatment - any other consultant sharing care will be identified on treatment plan</td>
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<td>3. The treatment plan should include those responsible for; Surgical removal of tumours Chemotherapy Radiotherapy Cancer After Care</td>
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<td>4. Fertility preservation options discussed as appropriate and recorded in agreed treatment plan</td>
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<td>5. The Keyworker should be identified</td>
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<tr>
<td><strong>TYA MDT</strong></td>
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<td>Location: UCLH</td>
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<tr>
<td>Lead Clinician: Dr Rachael Hough</td>
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<tr>
<td>Coordinator: Maria Jose</td>
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<td>Phone: 020 3447 1858</td>
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<td>Email: <a href="mailto:ucl-tr.TYAMDT@nhs.net">ucl-tr.TYAMDT@nhs.net</a></td>
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<tr>
<td>1. All TYA patients will be discussed in the TYA MDT.</td>
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<td>2. The TYA MDT will review the treatment plan made by the site specific MDT and promote access to clinical trials wherever possible</td>
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<td>3. The TYA MDT will review the support network around each individual patient, identify any psychosocial issues and how these will be addressed.</td>
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<td>4. The TYA MDT will ensure that a keyworker and other allied health professionals are identified for each patient</td>
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<tr>
<td>5. The agreements reached between the site specific MDT and TYA MDT will be documented</td>
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<tr>
<td><strong>IT Systems</strong></td>
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<td>Data Register with NWCIS</td>
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<td>TYA DATA BASE</td>
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<td><strong>Note:</strong> Emergency or urgent treatment should not be delayed to allow discussion at the TYA</td>
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</tbody>
</table>

End of treatment review and clinic with patients oncologist or keyworker

End of treatment summary within 12 weeks of completion of therapy by oncologist or keyworker

Initial and long-term follow up will be by the named consultant and keyworker in the TYA oncology and gynae-oncology clinics

Patients entering a palliative phase of treatment, will be referred to the palliative care team, led by Dr Caroline Stirling, including liaison with local palliative care services as appropriate.

Introduce TYA service to patient (by post or face to face assessment)

Discuss at TYA MDT allocate key worker

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

Transition into the TYA service will be around the 13th birthday at a time appropriate in the patient’s treatment. These patients will usually be transitioned from GOSH or the paediatric oncology team at UCLH.

Within the TYA service, transition from the teenage to young adult teams will occur at or around the 20th birthday.

Full transition into adult facilities will occur at or around the 25th birthday.

**Note:** transition will be planned for and discussed with patients well in advance. Transition at a time of crisis eg relapse, intensive chemotherapy will be avoided wherever possible. Transition will be facilitated by the keyworkers

Referral into the LTFU clinic according to individual needs
<table>
<thead>
<tr>
<th>MDT</th>
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</tbody>
</table>

23
2.1. Surgical pathway for Ovarian cancer

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

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 > 200

ANAESTHETIC REVIEW

LAPAROTOMY

ASCITES PRESENT?

YES

ASPIRATION OF ASCITES FOR CYTOLOGY

NO Pelvic washings 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

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

YES Obvious extra-ovarian disease?

Pelvic + PA lymph node + washings + omentum

Suspicion of malignancy

Benign

Desire for conservative surgery?

YES

Conservative surgery still possible & appropriate

Desire for conservative surgery?

NO

TAH BSO + omentectomy

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

YES

TAH + BSO + omental biopsy

TAH BSO + Biopsies of peritoneum + washings

NO

FROZEN SECTION

TAH + BSO + Biopsies of peritoneum + washings
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, MMTT
- 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, RLH or UCLH
- Many women with endometrial carcinoma are of high anaesthetic and surgical risk due to obesity, hypertension and diabetes should be considered for referral to the Specialist Centre.
- In these cases laparoscopic surgery is preferable
- Women with G1-2 tumours with < ½ invasion, should be managed at the Local Centre

Hysterectomy
- Full exploratory laparotomy OR this can be done Laparoscopically if the expertise is available
- Bilateral salpingo-oophorectomy
- Omental biopsy for serous disease, or G3 / undifferentiated tumour
- +/- Pelvic/PA lymphadenectomy
- To be done at RLH / 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**
  - 1. Stage 1a/1b
  - 2. Grade 1/2
  - 3. Optimally staged

- **Primary Debulking Surgery**

#### Adjuvant Chemotherapy

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

**Observe**

**ICON8b**

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

1. Carboplatin
2. Carboplatin & Paclitaxel
6 Cycles

NO

Neoadjuvant Chemotherapy

1. Carboplatin
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
**London Cancer Chemotherapy Algorithm**

<table>
<thead>
<tr>
<th>Algorithm Version</th>
<th>Date approved by CCPC</th>
<th>Author(s)</th>
<th>Responsible MDT</th>
<th>Contact Pharmacist(s)</th>
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</thead>
<tbody>
<tr>
<td>Rare ovarian tumours</td>
<td>1.0</td>
<td></td>
<td>Gynae</td>
<td>Danielle Ohana, Emma Riches</td>
</tr>
</tbody>
</table>

**Key**

- **Black**: London Cancer Standard treatment
- **Green**: NICE approved treatment
- **Blue**: Clinical trial
- **Purple**: Treatment approved via Cancer Drugs Fund
- **Red**: Available via compassionate use programme
- **Amber**: Requires funding confirmation prior to prescribing

**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

**OSI-906**

**SAPPRO**

**6MP BRCA**

**PHASE 1 TRIAL**
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

**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)

**Recurrent Disease**
- consider for clinical trials / Phase I studies
4.1. Radiotherapy with concurrent chemotherapy for Cervical cancer

INDICATIONS

- Radical treatment of locally advanced disease IB2 – IVA.
- Patients with earlier disease who decline surgery.
- Post-operative patients where surgery inadequate or where there is extensive disease.

ESSENTIAL PRE-TREATMENT CHECKS/INVESTIGATIONS

- Contrast-enhanced MRI imaging of the pelvis
- Contrast-enhanced CT imaging of the Chest and Abdomen
- EUA at centre (surgeon + oncologist) + biopsy of any suspicious lesions
- If there is hydronephrosis on imaging, this should be confirmed on renal ultrasound and be stented prior to radiotherapy
- Routine serum biochemistry and FBC
- SCC antigen in patients with squamous cell tumours.
- EDTA-GFR 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 to be given on
- Pelvic EBRT and brachytherapy, including expected site specific side effects
- Concurrent chemotherapy with cisplatin

CONSENT

- Required for all patients – scanned onto CDR

TRIALS

- INTERLACE Trial

CHEMOTHERAPY

- Concurrent cisplatin chemotherapy is used when GFR > 50ml/min.
- Cisplatin 40mg/m$^2$ (max 70mg) weekly for a maximum of 6 weeks during radiotherapy. [Green et al Lancet 2001 Sep 8; 358(9284) 781-6]
- Chemotherapy is delivered on Mondays or Tuesdays.
- Post operative chemoradiation may be considered in patients with high risk pathology such as nodal involvement and/or positive resection margins.
POSITION / IMMOBILISATION

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

PLANNING TECHNIQUE

- 3D planning using CT data

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 28 daily fractions over 5.5 weeks delivered in a single phase.
- Concomitant chemotherapy should be delivered unless medically unfit.
- 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.

- 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.

PTV

- PTV Nodes = CTV Pelvic Nodes + 8mm
- PTV Tumour = CTV Tumour + 15mm

However, more detailed guidelines are given in the INTERLACE protocol, reproduced below (see table)
Clinical Target Volume and Planning Target Volume Margins Clinical Target Volume 1 (CTV1)

CTV1 should include the whole cervical tumour and its local extension (GTV). Also, the cervix and uterus.

Planning guidelines and expansions from INTERLACE trial

| Clinical Target Volume 2 (CTV2) | 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. |
| Clinical Target Volume 3 (CTV3) (Extended field) | Where nodes at the aortic bifurcation or at the level of the common iliac vessels are positive (histology/CT PET /> 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. |
| Planning Target Volume 1 (PTV1) | Add 15 to 20mm to CTV1 anterior/posterior/superior and inferior, 7 to 10mm in the lateral extension. |
| Planning Target Volume 2 (PTV2) | Add 7 to 8mm to CTV2. |
| Planning Target Volume 3 (PTV3) | Add 5mm to CTV3. |
FIELD ARRANGEMENT

A 3 or 4 field technique is used to cover the target volume

PARAMETRIAL BOOST

- Indicated in all patients stage FIGO IIb and above (i.e., 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: 5.4 Gy 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 8 mm margin to give PTV PAN.
- Field Borders
  - Superiorly - approximately T12/L1
  - Inferiorly - matched to pelvic volume
  - Width - approximately 8 cm but may be amended with reference to the position of the kidneys
- Generally treated with a PA field
- Dose is 45 Gy in 25 daily fractions over 5 weeks

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

PORTAL IMAGING

- First 3 fractions and weekly thereafter
MICROSELECTRON (HDR BRACHYTHERAPY)

- Full insertion with intrauterine and intravaginal sources.
- All patients have 15 Gy in 2 fractions to point A or 21Gy in 3 fractions 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.
- The department is currently evaluating image guided (MRI) brachytherapy with a view to dose intensification.

ON TREATMENT REVIEW CLINICS

- Patients seen weekly in Monday morning on treatment review clinic
- Twice weekly FBC, weekly biochemistry – keep serum Haemoglobin > 12.5g/dl throughout treatment.
- Patient to see CNS before and after treatment to give advice on vaginal dilators.
- Initial review 4 weeks following chemo-radiation completion.
- MRI scans of the Abdomen and Pelvis 12 weeks following completion of treatment.
- Patients to be followed up in joint Gynae-oncology clinic
- Alternating appointments between surgical and non surgical oncological teams every 3 months in Year 1; 4 monthly in Year 2; and 6 monthly in Years 3-5

ARRANGEMENTS FOR TREATMENT SUMMARY

- Treatment summary will be scanned into CDR
- The treatment details are also held in the ARIA database.
- End of treatment letter to be dictated by SpR on 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 +/- staging or ExtBRT + VB</td>
<td></td>
</tr>
<tr>
<td>G3</td>
<td>IA</td>
<td>&lt;50%</td>
<td>Intermediate risk</td>
<td>Staging or ExtBRT + VB</td>
<td></td>
</tr>
<tr>
<td>G3</td>
<td>IB</td>
<td>&gt;50%</td>
<td>High risk</td>
<td>ExtBRT + VB</td>
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</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:
  - Grade 3 FIGO 2009 Stage IA with lymphovascular invasion AND myometrial invasion
  - Grade 3 FIGO 2009 Stage IB or Stage II Stage III /IV disease
  - Serous or clear cell subtype
- Vault brachytherapy may be considered as a sole modality in patients with Grade 1 or 2, Stage II disease with no lymphovascular invasion, no deep stromal infiltration and non clear cell or serous histology.

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 and Abdomen for all high risk patients undergoing adjuvant treatment.
- 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.
- Patient to see CNS before and after treatment (at approx 6 weeks) to give advice on vaginal dilators.

CONSENT

- Required for all patients – scanned onto CDR

TRIALS

- PORTEC 3 - closed
POSITION / IMMOBILISATION

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

PLANNING TECHNIQUE

- 3D planning using CT data

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 in 25 daily fractions over 5 weeks in a single phase.
- 48.6Gy in 27 daily fractions over 5 and a half weeks in a single phase if PORTEC.

CTV

- CTV Pelvic Nodes:
  - Obturator, internal and external iliac and distal common iliac nodes up to upper S1 level (approx 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
  - 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 + 8mm
- PTV Parametrium = CTV Parametrium + 10mm

FIELD ARRANGEMENT

- A 3 or 4 field technique is used to cover the target volume
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 <70Gy
- 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.
- All patients have 12 Gy in 2 fractions to 0.5cm from the surface of the applicator.

ON TREATMENT REVIEW CLINICS

- Patients seen weekly in nurse led on treatment review clinic
- Weekly FBC – keep serum Haemoglobin ≥11.5g/dl throughout treatment.
- Patient to see CNS after treatment (at approx 6 weeks) to give advice on vaginal dilators.

FOLLOW UP AFTER RADIOTHERAPY

- Initial review 6 weeks after radiotherapy course completion.
- 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
- Patients may then be discharged to their local unit with 6-monthly follow-up until 5 years

ARRANGEMENTS FOR TREATMENT SUMMARY

- Treatment summary will be scanned into CDR
- The treatment details are also held in the ARIA database.
- End of treatment letter to be dictated by SpR on completion of treatment.
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**

**Follow-up: 1-2 weeks post discharge**
- Appointments to be made from ward on discharge
- Confirmation of histological diagnosis and MDT discussion
- Notification proforma sent to GP from WOPD
- Indications for adjuvant chemotherapy?
- Ensure appropriate referral in place

**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:** Self-managed follow-up for low risk cancers. Patients receiving 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

3 monthly follow-up for 1st year

4 monthly follow-up for 2nd year

6 monthly follow-up for year 3

12 monthly follow-up for years 4 & 5

---

**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,  
1. A history of symptoms  
2. A full systemic examination & peripheral lymph node survey  
3. A pelvic examination  
4. 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
London Cancer Gynaecological Cancer Pathway Board

Best practice for Endometrial cancer pathway

Author: London Cancer Gynaecological Pathway Board
Approved: June 2015 by Board
Contents

1 Purpose

2 Background

3 Case for change

4 Pathway

5 Factors for implementation

6 Timing of implementation and monitoring compliance
1 Purpose

This document outlines the London Cancer Best Practice Endometrial Cancer Pathway as identified and mandated by the London Cancer Gynaecology Pathway Board. The board has been represented by the Leads subgroup representing all the hospitals in the integrated cancer programme. This document is not a comprehensive set of clinical guidelines with references, but rather details the sequencing and timeliness of the various elements of the endometrial cancer pathway to ensure it is delivered within the 62 day target and aiming for a 42 day target.

2 Background

The key aims of the London Cancer Gynaecological Pathway Board (LCGPB) are to improve patient satisfaction and reduce mortality. The LCGPB met on 8.4.14 and set an aspirational target for best practice in endometrial cancer of initiating treatment within 42 days. The Leads subgroup meeting 28.7.14 assessed the results from the network audit of 2014 looking into the endometrial cancer pathway, and concluded that best practice from all the hospitals in the network could result in a 42 day pathway. This meeting also assessed a pathology audit which explored the best practice turnaround times for pathology analysis. The Pathway director was asked to put together a timeline for approval by the board. This timeline was approved at the LCGPB meeting of 4.12.15, and has been developed into the flowchart shown in the Pathway section of this document. The flowchart and final document was signed off at the LCGPB meeting of 2.3.15 ready for presentation and feedback from the network education meeting on 18.6.15.

3 Case for change

A 62 day target for treatment should be regarded at the latest possible time for treatment as opposed to an aspirational target. An aspirational target should be 42 days. Analysis of the 2014 network audit in endometrial cancer showed that this was an achievable target.

The majority of 62 day breaches occur in endometrial cancer where the pathway involves a number of steps. These steps include first appointment, ultrasound, endometrial biopsy and pathology analysis, MRI and reporting, referral to and appointment with the specialist centre, review of patient, pathology and radiology at the specialist centre, and surgery at specialist centre.

The number of referrals to 2WW clinics is increasing, and the number of breaches of the 62 day target is increasing.

Each part of the endometrial cancer pathway is performed optimally at one of the network hospitals, but no single hospital is achieving optimal practice across the whole pathway.
### Pathway

<table>
<thead>
<tr>
<th>Pathway Point</th>
<th>Standard from 2014 Audit</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target referral</td>
<td>To be seen in 7 days</td>
<td>Homerton practice</td>
</tr>
<tr>
<td>U/S</td>
<td>Before or on day of 1(^{st}) clinic visit</td>
<td>All hospitals</td>
</tr>
<tr>
<td>Biopsy</td>
<td>Outpatient hysteroscopy target 85%</td>
<td>All hospitals</td>
</tr>
<tr>
<td></td>
<td>In-pt biopsy within 5 working days</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>Turnaround of 5 working days</td>
<td>UCH audit</td>
</tr>
<tr>
<td></td>
<td>PMB section of MDT</td>
<td></td>
</tr>
<tr>
<td>Results to pt</td>
<td>Call within 2 working days by nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not wait for MDM</td>
<td></td>
</tr>
<tr>
<td>Imaging</td>
<td>MRI / CT requests same day</td>
<td></td>
</tr>
<tr>
<td>MRI / CT</td>
<td>Report within 7 days</td>
<td>All hospitals</td>
</tr>
<tr>
<td>Referral to centre</td>
<td>Immediate for G3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>On receipt of MRI report for deep invasion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not wait for MDM</td>
<td></td>
</tr>
<tr>
<td>Centre</td>
<td>Schedule surgery on receipt referral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduce Surgery waiting time to 2 week from receipt referral</td>
<td></td>
</tr>
</tbody>
</table>

See appendix 1 for pathway
5 Factors for implementation

The key component in implementation of the pathway to achieve the reductions in timings is communication and co-ordination. All MDT’s should have a co-ordinator. This person should have a list of all 2WW referrals, and monitor the progress, with particular attention to the endometrial biopsy results. The co-ordinator must work closely with the CNS support in order to facilitate fast transfer of information to the patient to allow the next step to occur rapidly. It is envisaged that patient satisfaction with the pathway will improve in proportion to the effectiveness of the MDT co-ordinator and the CNS in these roles.

A second factor will be the capacity of 2WW clinics to be able to achieve the first appointment within 7 days.

A third factor will be the capacity of the surgical theatre space at the specialist centres to achieve surgery dates within two weeks of receiving the referral.

6 Timing of implementation and monitoring compliance

The document will be presented at the open education meeting on 18.6.15.

A leads subgroup meeting with invitation to co-ordinators, CNS’s and cancer managers will be organised.

It is anticipated that new capacity in 2WW clinics and theatre space required could be achieved during 2016.

The pathway will be re-audited in 2016.
Appendix 1. Endometrial cancer pathway

If in-patient biopsy (bx), perform within 7/7 days.

Day 1
- Referral triaged

Day 7
- Seen in RAC, U/S, outpatient biopsy
- If in-patient bx, perform within 7/7 days

Day 12
- Pathology result available in 5 days
- Pathology to contact co-ordinator

Day 14
- CNS contacts patient within 2 days,
  not waiting for MDM,
  Requests MRI / CT

Day 21
- MRI result available in 7 days
  If deep invasion, refer immediately
  Review in MDM post referral

Day 28
- Specialist centre - On receipt of referral:
  Request radiology and histology and put on MDM list
  Schedule operation date
  Send outpatient appointment date for within 7 days

Day 42
- MDM review
  Surgery within 14 days

If G3, immediate referral to centre, and reflex sending of slides.
Author: London Cancer Gynaecological Pathway Board

For approval: July 2016 by Board

London Cancer Gynaecological Cancer Pathway Board

Best practice for Ovarian cancer pathway
Contents

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9 Case for change

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11 Factors for implementation, timing, monitoring compliance

12 Diagram of pathway
7 Purpose

This document outlines the London Cancer Best Practice Ovarian Cancer Pathway as identified and mandated by the London cancer Gynaecology Pathway Board. The board has been represented by the Leads subgroup representing all the hospitals in the integrated cancer programme. This document is not a comprehensive set of clinical guidelines with references, but rather details the sequencing and timeliness of the various elements of the endometrial cancer pathway to ensure it is delivered within the 62 day target and aiming for a 42 day target.

8 Background

The key aims of the London Cancer Gynaecological Pathway Board (LCGPB) are to improve patient satisfaction and reduce mortality. The LCGPB had a leads meeting on 8.2.16 to analyse the results from the network audit of 2015/6 looking into the ovarian cancer pathway. The conclusion was that best practice from all the hospitals in the network could result in a 42 day pathway. The Pathway director was asked to put together a timeline for approval by the board. This timeline was approved at the LCGPB meeting of 8.2.16, and has been developed into the flowchart shown in the Pathway section of this document. The flowchart and final document was signed off at the LCGPB meeting of 12.7.16 ready for presentation and feedback from the network education meeting on 20.10.16.

9 Case for change

A 62 day target for treatment should be regarded at the latest possible time for treatment as opposed to an aspirational target. An aspirational target should be 42 days. Analysis of the 2015/16 network audit in ovarian cancer showed that this was an achievable target.

The audit showed that the majority of 62 day breaches occur in ovarian cancer where the pathway involves a number of steps. These steps include first appointment, ultrasound, CT/MRI and reporting, referral to and appointment with the specialist centre, review of patient, and radiology at the specialist centre, and surgery at specialist centre.

Each part of the ovarian cancer pathway is performed optimally at one of the network hospitals, but no single hospital is achieving optimal practice across the whole pathway.
<table>
<thead>
<tr>
<th>Pathway Point</th>
<th>Standard from 2014 Audit</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target referral</td>
<td>To be seen in 7 days</td>
<td>Homerton practice</td>
</tr>
<tr>
<td>U/S</td>
<td>On first appointment, or within 5 days</td>
<td>All hospitals</td>
</tr>
<tr>
<td>MRI / CT</td>
<td>Report within 7 days of request</td>
<td>All hospitals</td>
</tr>
<tr>
<td>Result to patient</td>
<td>Within 3 days</td>
<td>All hospitals</td>
</tr>
<tr>
<td>Result to Referral to centre</td>
<td>1 day</td>
<td>All hospitals</td>
</tr>
<tr>
<td>Seen at centre</td>
<td>Within 7 days</td>
<td>UCH/Barts</td>
</tr>
<tr>
<td>Seen at centre to surgery</td>
<td>14 days</td>
<td>UCH/Barts</td>
</tr>
<tr>
<td>Seen at centre to biopsy and chemotherapy</td>
<td>21 days</td>
<td>UCH/Barts</td>
</tr>
</tbody>
</table>

See appendix 1 for pathway
11 Factors for implementation

The key component in implementation of the pathway to achieve the reductions in timings is communication and co-ordination. All MDT’s should have a co-ordinator. This person should have a list of all 2WW referrals, and monitor the progress. The co-ordinator must work closely with the CNS support in order to facilitate fast transfer of information to the patient to allow the next step to occur rapidly. It is envisaged that patient satisfaction with the pathway will improve in proportion to the effectiveness of the MDT co-ordinator and the CNS in these roles.

A second factor will be the capacity of 2WW clinics to be able to achieve the first appointment within 7 days.

A third factor will be the capacity of the surgical theatre space at the specialist centres to achieve surgery dates within two weeks of receiving the referral.

12 Timing of implementation and monitoring compliance

The document will be presented at the open education meeting on 20.10.16.

A leads subgroup meeting with invitation to co-ordinators, CNS’s and cancer managers will be organised.

It is anticipated that new capacity in 2WW clinics and theatre space required could be achieved during 2016.

The pathway will be re-audited in 2016/17.
Appendix 1. Ovarian cancer pathway

Day 1
- Referral triaged

Day 7
- Seen in RAC, U/S, CT/MRI requested

Day 14
- Results of CT/MRI

Day 17
- Patient informed of results of scans, and referral to centre
- Specialist centre - On receipt of referral:
  - Request radiology and histology and put on MDM list
  - Schedule operation date
  - Send outpatient appointment date for within 7 days

Day 21
- Patient seen in centre, reassessment, arrange surgery, or admission for biopsy and chemotherapy date

Day 35
- Surgery

Day 42
- Biopsy reviewed, and chemotherapy started
Stratified follow-up
and
patient self-management
Contents

13 Purpose

14 Background

15 Key features

16 Present stratified follow up

17 Proposed extension

18 Factors for implementation

19 Timing of implementation and monitoring compliance
13 Purpose

This document outlines the stratified follow up policy for gynaecological cancers in London Cancer as identified and mandated by the London cancer Gynaecology Pathway Board. The board has been represented by the Leads subgroup representing all the hospitals in the integrated cancer programme. This document is not a comprehensive set of clinical guidelines with references, but rather details the sequencing and timeliness of the various elements of stratified follow up for women treated for endometrial, ovarian, cervical and vulval cancers.

14 Background

Stratified follow-up for individuals with cancer has been recommended for implementation by the NCSI in the ‘Living with and Beyond Cancer: Taking Action to Improve Outcomes’ document published in March 2013.

The overall aim of the stratified follow up is to improve patient experience and outcomes, and quality of care, by tailoring aftercare and embedding supported self-management within the cancer pathway.

The move toward stratified follow-up is consistent with The Model of Care for Cancer Services (Commissioning Support for London, 2010) which recommends a transition to personalised assessment, information provision and care planning. The rationale for this shift is that there is no evidence that traditional follow-up consisting of regular appointments in secondary care provides the most effective care or best means to detect disease recurrence. In addition, longer life expectancy combined with more intensive treatments are resulting in increasing numbers of individuals living with consequences of treatment, which may manifest years after treatment ends (Macmillan 2013). These consequences of cancer need to be addressed by an effective model of aftercare.

The key aims of the London Cancer Gynaecological Pathway Board (LCGPB) are to improve patient satisfaction and reduce mortality. The use of stratified follow up is consistent with these aims.

The LCGPB met on 8.7.16 and agreed the stratified follow up for endometrial, ovarian, cervical and vulval cancers.

15 Key features

The National Cancer Survivorship Initiative advises that individuals are assessed to determine which tier of follow-up would best meet their needs. Individuals deemed at low risk of recurrence and late effects (physical and psychosocial) are encouraged towards supported self-management, those at medium risk receive planned, co-ordinated care and those at high risk receive complex care from specialist services.
Overall key features of stratified follow-up:

- Enables people who are willing and able to undertake self-management to do so in a safe and supported manner.
- Incorporates NCSI Recovery Package interventions (Holistic Needs Assessment and care plan, Treatment Summary, Health and Wellbeing event) to improve outcomes and co-ordination of care.
- Improves patient experience by eliminating anxiety and stress induced by attending unnecessary appointments.
- Rapid re-entry into the specialist cancer service as required. This reassures individuals that they are able to access appropriate, named support quickly should they need it, without having to go via their GP. The ability to re-access services quickly and easily has been shown to be crucial to the confidence of people undertaking supported self-management, and consequently to the long term success of a supported self-management programme.
- Removal of routine follow-up appointments from the pathway. Routine surveillance tests can still be completed at set intervals if needed. However, these do not require the individual to automatically see a hospital doctor or nurse to receive their results. The individual is sent an appointment for the tests. The results will be reviewed by an appropriately qualified staff member and the patient is informed of the results by letter, phone, or in person (as per clinical judgement). Recall back into specialist services is can be via the 2WW system, or a specific pre organised contact number.
### Present stratified follow up situation - for discussion

<table>
<thead>
<tr>
<th>Tumour</th>
<th>Follow up site</th>
<th>Discharge at</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endometrium – low risk</td>
<td>Unit</td>
<td>3 years</td>
</tr>
<tr>
<td>Endometrium – high risk</td>
<td>Centre for 1-3 years, then Unit from year 3-5</td>
<td>5 years</td>
</tr>
<tr>
<td>Cervix – low risk</td>
<td>Centre or unit</td>
<td>3 years</td>
</tr>
<tr>
<td>Cervix – moderate risk</td>
<td>Centre for 1 year, then Unit years 2-5</td>
<td>5 years</td>
</tr>
<tr>
<td>Cervix high risk</td>
<td>Centre for 1-3 years, then Unit 3-5</td>
<td>5 years</td>
</tr>
<tr>
<td>Ovary – stage 1</td>
<td>Centre for 1-3 years, then Unit 3-5</td>
<td>5 years</td>
</tr>
<tr>
<td>Ovary – stage 2 onwards</td>
<td>Centre for 2 years – 5 years,</td>
<td>5 years</td>
</tr>
<tr>
<td>Vulva – HPV related, low risk</td>
<td>Centre for 1 year, then Unit years 2-5</td>
<td>5 years</td>
</tr>
<tr>
<td>Vulval – LS related, high risk</td>
<td>Centre for 1 year, then Unit years 2-5</td>
<td>5 years, then vulval clinic</td>
</tr>
</tbody>
</table>
17 Proposed extension

<table>
<thead>
<tr>
<th>Tumour</th>
<th>Follow up site</th>
<th>Discharge at</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endometrium – low risk</td>
<td>SELF management</td>
<td>3 years</td>
</tr>
<tr>
<td>Endometrium – high risk</td>
<td>Centre for 1-3 years, then Unit from year 3-5</td>
<td>5 years</td>
</tr>
<tr>
<td>Cervix – low risk</td>
<td>Centre or unit</td>
<td>3 years</td>
</tr>
<tr>
<td>Cervix – moderate risk</td>
<td>Centre for 1 year, then Unit years 2-5</td>
<td>5 years</td>
</tr>
<tr>
<td>Cervix high risk</td>
<td>Centre for 1-3 years, then Unit 3-5</td>
<td>5 years</td>
</tr>
<tr>
<td>Ovary – stage 1</td>
<td>Centre for 1-3 years, then Unit 3-5</td>
<td>5 years</td>
</tr>
<tr>
<td>Ovary – stage 2 onwards</td>
<td>Centre for 2 years – 5 years,</td>
<td>5 years</td>
</tr>
<tr>
<td>Vulva – HPV related, low risk</td>
<td>Centre for 1 year, then Unit years 2-5</td>
<td>5 years</td>
</tr>
<tr>
<td>Vulval – LS related, high risk</td>
<td>Centre for 1 year, then Unit years 2-5</td>
<td>5 years, then vulval clinic</td>
</tr>
</tbody>
</table>

18 Factors for implementation

The key component in implementation of the stratified follow up is communication and co-ordination. All MDT’s should have a co-ordinator.

The co-ordinator must work closely with the CNS support in order to facilitate fast transfer of patients back into the system.

It is envisaged that patient satisfaction with the pathway will be in proportion to the effectiveness of the MDT co-ordinator and the CNS in these roles.

The document will be presented at the pathway board of 18.7.16. It is anticipated that revisions would be complete by the Open pathway meeting of 20th October for presentation to the extended London Cancer gynaecology team.
The system will be audited in 2018.