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Royal Cornwall Hospitals NHS Trust

Surgical Follow-up for Gynaecological Cancers Clinical Guideline

V2.0

March 2023

1. Aim/Purpose of this Guideline

1.1. To provide guidance to clinicians and Clinical Nurse Specialists (CNS) on the follow-up of gynaecological cancer patients who do not receive chemotherapy or radiotherapy.

1.2. This version supersedes any previous versions of this document.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. All cases of gynaecology malignancy are discussed in the gynaecology multidisciplinary team (MDT) once surgery has been performed.

2.2. Decisions and recommendations for follow-up will be determined after definitive treatment on a case-by-case basis.

2.3. The purpose of this guideline is to be used as a general guide and are not absolute. Those patients undergoing primary or adjuvant chemotherapy or radiotherapy will be under the care of the Clinical Oncology team and are beyond the scope of this guidance.

2.4. All patients with gynaecological malignancy, borderline tumours or smooth muscle tumours of unknown malignant potential should be referred to gynaecology oncology clinical nurse specialists (GO CNS) and be given their contact number for easy access to the team

2.5. All patients are encouraged to contact the department if they experience any abnormal vaginal bleeding, regular pelvic or abdominal pains, abdominal mass or bloating, new leg swelling, new urinary symptoms, cough or weight loss.

2.6. Any patients presenting with new symptoms should aim to be reviewed by a clinician within 2 weeks.

2.7. The frequency, duration and location of follow-up will depend on the primary site of the cancer, stage of disease and treatment received and the patient's wishes.

2.8. Cervical Cancer.

2.8.1. Stage 1A1.

2.8.1.1. Post large loop excision of the transformation zone (LLETZ), cervix in-situ.

- Colposcopy follow-up with repeat cytology and HPV test is recommended at 6 and 12 months followed by annually for 10 years as per Public Health England Cervical Screening Programme and Colposcopy Management guidance https://www.gov.uk/government/publications/cervical-screening-programme-and-colposcopy-management

- After 10 years of colposcopy the patient can be discharged to continue routine cervical smear tests in the community.

- Consider completion hysterectomy after family is complete.

2.8.1.2. **Post simple hysterectomy:** absence invasive malignancy in specimen.

Colposcopy follow-up with repeat vault cytology and HPV test is recommended at 6 months. If HPV negative they can be offered patient initiated follow-up (PIFU) for 5 years.

2.8.1.3. **Post simple hysterectomy:** presence invasive malignancy (fully excised) in specimen.

Colposcopy follow-up with repeat vault cytology and HPV test at 6 months. If HPV negative they should be reviewed again at 12 months and then offered nurse-led telephone follow-up or PIFU for 5 years.

2.8.2. Stage 1A2/1B1.

2.8.2.1. **Post simple hysterectomy with pelvic lymph node dissection (LND)** (including those participating in SHAPE trial)

- Patients participating in the SHAPE trial will be followed up as per trial protocol.

- All other patients will be offered gynaeoncology (GO) clinic follow-up including regular gynaecological examination.

  - Every 3 months for year 1.

  - Every 3-4 months for year 2.

- Every 6 months for year 3-5.

- A vault cytology and HPV test may be performed at 6 months at the discretion of the clinician.

2.8.2.2. Post radical trachellectomy and pelvic LND.

- Clinical follow-up in GO clinic including gynaecology examination. Vault smear test is not recommended.

- As recurrence rates are higher in those having a radical trachellectomy versus radical hysterectomy, consider surveillance MRI pelvis at 6, 12 and 24 months of follow-up.

- After 5 years of clinical follow-up consider moving patient onto PIFU for a further 5 years due to higher rates of recurrence.

2.8.2.3. Post radical hysterectomy and pelvic LND.

- Clinical follow-up in GO clinic including gynaecology examination. Vault smear test is not recommended.

  - Every 3 months for year 1.

  - Every 3-4 months for year 2.

  - Every 6 months for year 3-5.

2.9. Endometrial Cancer.

2.9.1. Low risk - Stage IA (G1 and G2) with endometrioid type.

2.9.1.1. Patients with low risk endometrioid endometrial cancer should be reviewed in clinic 3 months post operatively and be offered a gynaecological examination.

2.9.1.2. If patient agrees further follow-up should be by nurse-led telephone clinic or PIFU.

- Every 3 months for year 1.

- Every 4 months for year 2.

- Every 6 months for year 3-5.

2.9.1.3. If patients opt for nurse-led telephone follow-up they should receive the nurse-led telephone service leaflet.

2.9.1.4. All patients should be encouraged to telephone the CNS number if there are any symptoms of recurrence.

2.9.2. Intermediate risk - Stage IA G3 with endometrioid type, Stage IB (G1 and G2) with endometrioid type.

2.9.2.1. Most patients with intermediate risk will be offered vaginal brachytherapy and will receive follow-up by the medical oncologists.

2.9.2.2. For those not receiving adjuvant treatment, options of follow-up should be discussed. They can opt for clinical follow-up, nurse-led telephone follow-up or PIFU.

2.9.2.3. Patients opting for clinic based follow-up, will be examined every 3 months for the first year and then encouraged to transfer to nurse-led follow-up clinic or PIFU.

2.9.3. High risk - Stage IB G3 with endometrioid type, all stages with non-endometrioid type.

2.9.3.1. Most patients with high risk endometrial cancer will be offered adjuvant external beam radiation therapy (EBRT) +/- chemotherapy and will receive follow-up by the medical oncologists.

2.9.3.2. For those not receiving adjuvant treatment, patients should be offered clinic based follow-up including gynaecology examination.

- Every 3 months for year 1.
- Every 3-4 months for year 2.
- Every 6 months for year 3-5.

2.10. Vulva cancer.

2.10.1. Patients can be offered PIFU or clinic based follow-up for all stages of vulva cancer.

2.10.2. Those patients who are unable to self-examine should be encouraged to remain on clinic based follow-up.

2.10.3. At clinic based follow-up the patients will have a vulva examination (with or without vulvoscopy) and inguinal lymph-node palpation.

2.10.4. All patients should be encouraged to self-examine and to report any concerns through the CNS telephone number where an earlier appointment can be made.

2.11. Ovarian cancer.

2.11.1. Most women presenting with ovarian cancer will have advanced stage disease and will receive chemotherapy.

2.11.2. For those with low risk epithelial cancer, germ-cell or sex-cord stromal tumours who have not received chemotherapy will continue clinical follow-up including abdominal examination with or without gynaecological examination.

2.11.3. Monitoring with blood tumour markers can be considered if these were raised preoperatively.

- Ca-125 for all tumour types.
- CEA for mucinous tumours.
- Inhibin A/B for granulosa cell tumours.
- AFP/LDH/HCG for germ-cell tumours.

2.11.4. Pelvic ultrasound scans should be performed regularly for those who have had fertility sparing surgery.

- Every 3-4 months for year 1-2.
- Every 6 months for year 3-5.

2.11.5. Those with low risk ovarian cancers can be offered PIFU or telephone nurse-led follow-up for 5 years.

2.12. Borderline ovarian tumours.

2.12.1. Fertility sparing surgery.

2.12.1.1. Ovarian cystectomy only.

- Patients with a mucinous or serous borderline tumour who have had ovarian cystectomy only have a high risk of recurrence (approximately 30%) and should have regular pelvic ultrasound scans.
  - Every 4 months for year 1-2.
  - Every 6 months for year 3-5.
  - Yearly for 10 years.
- Blood tumour markers may be considered.
- Serous Borderline Ovarian Tumours (BOT) with a micropapillary architecture have a higher risk of recurrence and disease dissemination and patients should be carefully counselled in regards to the lack of safety ovarian cystectomy in these cases.

2.12.1.2. Unilateral Salpingoophrectomy.

- Patients with a mucinous or serous borderline tumour who have had a unilateral salpingoophrectomy have a low-moderate risk of recurrence (10%) in the contralateral ovary.

- These patients should also be offered regular ultrasound scans and may have blood tumour markers taken but this can be offered at a lower frequency than those having a cystectomy; every 6 months for 5 years and then yearly for 10 years.

2.12.1.3. Patients should be encouraged to report any concerns through the CNS telephone number if symptoms of recurrence such as abdominal pain or bloating occurs and an earlier appointment will be made.

2.12.1.4. Patients can consider completion surgery when their family is complete or they have reached the menopause as late recurrence is recognised.

2.12.2. Full staging surgery.

2.12.2.1. Stage 1 and 2.

- Patients with Stage 1 and 2 borderline serous/mucinous tumours who are fully staged have a low risk of recurrence.

- Patients should be reviewed 3-6 months following surgery and offered 6 monthly nurse-led telephone clinic follow-up with or without blood tumour marker testing or PIFU.

- Patients should be encouraged to call the CNS telephone number if symptoms occur.

2.12.2.2. Stage 3 and 4.

- Patients with stage 3 or 4 disease at presentation have a higher risk of recurrence and malignant transformation, however long-term outcomes are still favourable.

- As symptoms are often vague, regular clinical follow-up is recommended every 6 months for 5 years.

- Serial cross-sectional imaging can be considered.

- After 5 years patients can be offered yearly clinic based, nurse-led telephone clinic or PIFU for a further 5 years.

2.13. Uterine sarcomas and smooth-muscle tumour of unknown malignant potential (STUMP).

2.13.1. Uterine sarcomas.

2.13.1.1. Leiomyosarcoma, endometrial stromal sarcoma and adenosarcoma are rare and decisions on follow-up recommendation should be based on a case-by-case basis and following full discussion in the gynaecology oncology and sarcoma MDTs

2.13.1.2. Those with early-stage uterine sarcomas have a relatively high risk of recurrence and consideration should be made for serial cross-sectional imaging.

- Every 3-6 months for year 1.
- Every 6-12 months for the subsequent 4 years.

2.13.1.3. Patients should be offered clinic-based follow-up including gynaecological examinations.

- Every 3 months for year 1.
- Every 4 months for year 2.
- Every 6 months for year 3-5.

2.13.1.4. Patients should be encouraged to report any concerns through the CNS telephone number if symptoms of recurrence such as abdominal pain or bloating, leg swelling or persistent cough and an urgent appointment or imaging requested.

2.13.2. STUMPS

2.13.2.1. Final pathology from STUMP tumours should be reviewed by the gynaecology oncology and sarcoma MDTs with an aim to differentiate high-risk to low-risk tumours.

2.13.2.2. Those with high risk tumours should be managed as per uterine sarcoma guidance above.

2.13.2.3. Those with low risk tumours should be managed on a case-by-case basis. Follow-up options include regular clinical follow-up with gynaecological examination, nurse-led telephone follow-up or PIFU for 5 years.

2.13.2.4. Patients should be encouraged to report any symptoms or concerns through the CNS telephone number.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Recurrence rates in Gynaecology Oncology (GO) in patients with surgical follow-up
Lead	Gynaecology MDT
Tool	Datix and MDT outcomes
Frequency	Yearly GO report
Reporting arrangements	Peninsular Gynaecology Cancer MDT
Acting on recommendations and Lead(s)	Gynaecology MDT. As required
Change in practice and lessons to be shared	Gynaecology Mortality and Morbidity Audit

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Surgical Follow- Up for Gynaecological Cancers Clinical Guideline V2.0
This document replaces (exact title of previous version):	Surgical Follow- Up for Gynaecological Cancers Clinical Guideline V1.0
Date Issued/Approved:	March 2023
Date Valid From:	March 2023
Date Valid To:	March 2026
Directorate / Department responsible (author/owner):	Jane Borley; Consultant Gynaecological Oncologist
Contact details:	01872 252729
Brief summary of contents:	Guidance for follow-up strategy for gynaecological cancer dependent on type, stage and grade
Suggested Keywords:	Gynaecology cancer
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Gynaecology MDT
General Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming approval by specialty and care group management meetings:	Caroline Amukusana
Links to key external standards:	None required
Related Documents:	BGCS gynaeonc PIFU meeting https://www.bgcs.org.uk/wp-content/uploads/2019/08/BGCS-patient-initiated-

Information Category	Detailed Information
	followup-consensus-outcomes-sumary-final.vs3587.pdf
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/ Gynaecology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
25.02.2020	V1.0	Initial issue	Jane Borley Consultant Gynaecological Oncologist
February 2023	V2.0	Full Update - Amendments following patient feedback: Added: Instructions that all STUMP tumours should be referred to the sarcoma MDT. Ensure instructions for radiological follow up, if applicable, are discussed and documented at MDT review. Instructions that women with STUMP tumours should be referred to the Clinical Nurse Specialisits at diagnosis for support and guidance. Follow up guidance on STUMP and uterine soft tissue sarcoma management.	Jane Borley Consultant Gynaecological Oncologist

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Surgical Follow- Up for Gynaecological Cancers Clinical Guideline V2.0
Directorate and service area:	Gynaecology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Jane Borley; Consultant Gynaecological Oncologist
Contact details:	01872 252729

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Guidance for clinicians and CNS' for surgical follow-up of gynaecology cancer patients
2. Policy Objectives	To guide clinicians and allied health professionals on the requirements of follow-up
3. Policy Intended Outcomes	To standardise management
4. How will you measure each outcome?	Please see section 3.
5. Who is intended to benefit from the policy?	Patients with gynaecology cancer and those involved in their post-treatment care

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Gynaecology Specialty business meeting
6c. What was the outcome of the consultation?	Approved- 17 March 2023
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the parent/ carer/ patient's needs- i.e., available in different languages if required/access to an interpreter if required

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those parent/ carer/ patients with any identified additional needs will be referred for additional support as appropriate- i.e., to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat and should respond accordingly.
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Jane Borley; Consultant Gynaecological Consultant

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis