Royal Cornwall Hospitals
NHS Trust

West Peninsula Gynaecological Cancer Centre Diagnostic and Surgical Guidelines

V2.0

November 2025

1. Aim/Purpose of this Guideline

1.1. The West Peninsula Gynaecological Cancer Service (WPGCS) is a Multidisciplinary Team (MDT) serving patients of Cornwall and Plymouth, a population of approximately 900,000 found to have, or suspected to suffer from, a gynaecological malignancy. These include all cancers arising from the female genital tract; vulva, vagina, cervix, uterus, ovary, fallopian tube and primary peritoneal cancers. Annually this amounts to approximately 350 cases in the Cornwall and Plymouth catchment areas combined.

1.2. The aim of these guidelines is to provide all relevant health care professionals guidance on:

- The provisional investigation and management for all women with suspected gynaecological cancer.
- The recommended standard of surgical treatment for women with gynaecological cancer.
- Criteria for discussion at joint gynaecology oncology MDT (multidisciplinary team meeting).
- Administration responsibilities.

1.3. This will allow all women in the West Peninsula region to have equal access to preoperative investigations and surgical treatment irrespective of their geographical area in a timely manner. As the WPGCS is covered by two NHS Trusts, Royal Cornwall NHS Trust and University Plymouth Hospital NHS Trust there are discrepancies with radiological and histological investigations based on current service capacity in individual Trusts.

1.4. All women with a new diagnosis of gynaecological cancer should be discussed at the WPGCS MDT at some time during their treatment pathway to ensure management and treatment plans are patient specific.

1.5. All women with a gynaecology malignancy should have access to a clinical nurse specialist.

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

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

The Trust has a duty under the Data Protection Act 2018 and UK 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 UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

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

2. Endometrial Cancer

2.1. Diagnostics for post-menopausal bleeding (PMB).

2.1.1. Please note that PMB refers to women who have vaginal bleeding after the menopause AND do not take HRT. Women who have vaginal bleeding after the menopause AND take HRT have a low risk of cancer and their bleeding should be termed “unscheduled bleeding on HRT”.

2.1.2. For further information please refer to individual Trust guidance related to PMB and unscheduled bleeding on HRT:RCHT; The Post-Menopausal Bleeding Service Clinical Guideline.

2.1.3. All post menopausal women with a uterus and vaginal bleeding not on HRT should be referred on urgent suspected cancer pathway (USCP) (previously known as 2ww (2 week wait))/consultant upgrade.

2.1.4. Women with unscheduled bleeding on HRT who are deemed high risk (such as BMI≥40, age ≥65 (RCHT), Lynch Syndrome etc.) are also accepted on the USCP.

2.1.5. Transvaginal ultrasound (TVUSS) scan and gynaecological examination should be performed on those who meet criteria for referral to the USCP (this can be as part of shared care with primary care).

2.1.6. Women can be discharged to the care of the GP with advice to re-present if the bleeding is persistent or recurs after 6 months, if ET (endometrial thickness) ≤ 4mm.

2.1.7. Further endometrial assessment should be undertaken if ET>4mm with endometrial biopsy and should be sent urgently to histology.

2.1.8. Diagnostic OPH may be considered for PMB women with:

- ET > 4mm.
- Endometrium not visible on USS (Ultrasound Scan).
- Suspicious/irregular endometrium.
- Risk factors for endometrial cancer (e.g. Tamoxifen).
- Recurrent PMB.

2.1.9. Diagnostic OPH (Outpatient Hysteroscopy) may also be considered for high risk women with unscheduled bleeding on HRT (see separate guideline as per 2.1.2).

2.1.10. Complex patients should be discussed with a consultant to determine appropriate management.

2.2. **Staging.**

2.2.1. Accurate staging of patients with endometrial cancer is vital to ensure that women receive the most appropriate treatment. Staging should be determined through a combination of imaging and surgery.

2.2.2. Until there is an agreed national consensus final staging classification should include both FIGO (International Federation of Gynaecology and Obstetrics) 2018 and 2023 criteria and be clearly identified.

2.3. **Radiological staging.**

2.3.1. Grade 1 endometrioid endometrial cancer should be preoperatively staged through a TVUSS (Trans Vaginal Ultrasound Scan) due to the low risk of lymph node and distant metastasis. A chest X-Ray (CXR) can also be considered as part of staging.

2.3.2. If there is suspicion of cervical involvement or extension through the uterine serosa on TVUSS a pelvic MRI (Magnetic Resonance imaging) and CT (Computed Tomography) chest/abdomen/pelvis (CT CAP) is required to plan surgical management and exclude metastasis.

2.3.3. If the clinical history is in keeping with a delayed diagnosis (e.g. delayed referral to secondary care, prolonged bleeding history) consider CT CAP.

2.3.4. The risk of lung metastasis is low in Grade 2 endometrioid endometrial cancers and therefore a CT abdomen/pelvis (CT AP) is adequate in determining distant disease preoperatively. In cases which are found to be ≥stage 2 disease after surgery a CT chest can be ordered post operatively if required.

2.3.5. Those with type 2 tumours (grade 3 endometrioid, high grade serous, clear cell and carcinosarcoma endometrial cancer) have a higher risk of lymph node and distant metastasis and CT CAP should be performed.

Table 1. Summary of preoperative imaging required for those with endometrial cancer based on histology at each Trust.

Histopathological Subtype		RCHT	UPH (University Plymouth Hospitals)
Type 1 tumours.	Grade 1 endometrioid.	Pelvic USS +/- CXR.	Pelvic USS + CXR.
	Grade 2 endometrioid.	CT CAP.	CT AP + CXR.
Type 2 tumours.	Grade 3 endometrioid, high grade serous, clear cell, carcinosarcoma.	CT CAP.	CT CAP.

2.4. **Surgical staging and management.**

2.4.1. Women should be surgically treated with a minimally invasive approach whenever possible.

2.4.2. Women with a grade 1 endometrial cancer with appearances of stage 1 disease on preoperative imaging do not require sentinel lymph node biopsy (SLNB) or lymph node dissection (LND).

2.4.3. Women with a grade 2 endometrioid endometrial cancer with appearances of stage 1 disease on preoperative imaging should be offered a sentinel lymph node biopsy if there are no clinical contraindications to this. If the sentinel node cannot be detected, systematic lymphadenectomy is not undertaken.

2.4.4. Women with high grade (G3/type 2) endometrial cancer with appearances of stage 1 disease on preoperative imaging should be offered sentinel lymph node biopsy. If the sentinel lymph node cannot be detected, consider proceeding with a side-specific pelvic lymph node dissection +/- para-aortic lymph node dissection if clinically appropriate.

2.4.5. Women with p53 mutation on endometrial biopsy should also undergo omentectomy/omental biopsy for adequate staging.

2.4.6. If SLN is not identified in p53 mutated tumours a full lymph node dissection may be omitted as the results do not change adjuvant therapy.

2.4.7. Treatment decisions for patients whose tumours show multiple classifiers (e.g. MMR (Mismatch Repair) deficient and p53 mutated) or mixed morphology will be determined through the MDT.

2.5. **Histology.**

2.5.1. Immuno-histochemistry (IHC) in endometrial cancer is required to risk-stratify tumours, enable adjuvant treatment decisions and detect those at higher risk of Lynch syndrome.

2.5.2. Reflex IHC for all endometrial tumours should be performed as below:

- Mismatch Repair (MMR) Protein. Further information can be found on the pathway for those with abnormal/deficient MMR proteins in the South West Genomics Laboratory Hub (SWGLH) guidance. Those with loss of MLH1 +/- PMS2 on MMR IHC should have tissue sent to SWGLH for MLH1 methylation analysis. Those with loss of MSH2, MSH6 or isolated PMS2, or absence of MLH1 hypermethylation should have Lynch genetic testing offered either in-house or through referral to Clinical Genetics.

- Estrogen receptor +/- progestogen receptor.

- P53.

- POLE (DNA Polmerase Epsilon). As per BAGP (British Association of Gynaecological Procedures) POLE testing is routinely recommended for those with:

  - MMR deficiency or p53 mutation or ER negative tumours or those with substantial LVSI (lymphovascular space invasion).

  - High grade endometrioid tumours, stage 1A (FIGO 2018) with no LVSI.

  - Any histology and stage 1B or 2 (FIGO 2018).

2.5.3. Histopathological analysis of pelvic sentinel lymph nodes in endometrial cancer should include ultrastaging as per The British Association of Gynaecological Pathology Guidelines:

- A single H and E (haematoxylin and eosin) section of each slice of SLN, with minimal trimming to avoid tissue wastage, should be examined in the first instance.

- If this is negative for tumour, SLN-US should be carried out following the appropriate protocol as below.

- In a bilateral procedure, if one SLN is positive on the initial H and E, but the node(s) on the contralateral side are negative, ultra staging should be carried out only on the contralateral node(s).

- Two additional pairs of sections are cut at 50-micron intervals.

- One section from each of the two pairs is stained with H&E and the other with immunohistochemistry (IHC) for a broad-spectrum cytokeratin (CK), AE1/AE3 is currently widely used.

2.5.4. Ultra staging is not currently being performed at UPH but should be anticipated in the future.

2.5.5. Until there is an agreed national consensus final staging classification should include both FIGO 2018 and 2023 criteria and be clearly identified.

2.6. Cervical Cancer (Squamous Cell Carcinoma and Adenocarcinoma)

Other rarer subtypes are beyond the scope of this guideline and should be individually discussed at the gynaecology MDT.

2.6.1. Diagnostics.

2.6.1.1. All women with suspected cervical cancer should be referred on USCP (2ww) cancer pathway/consultant upgrade.

2.6.1.2. If cervical cancer is suspected multiple cervical biopsies, cervical wedge biopsy or a LLETZ (Large Loop Excision of Transformation Zone)/NETZ (Needle Excision of Transformation Zone) should be performed and sent for urgent histology.

2.6.1.3. Women should be informed that cancer is suspected at the earliest available opportunity, ideally at the time of the biopsy.

2.6.1.4. Women should undergo examination in the outpatient setting to assess vaginal and parametrial involvement. Involvement of bladder and bowel mucosa may be assessed on MRI.

2.6.1.5. Examination under anaesthesia can be considered for those with locally advanced cervical cancer or if there is concern of bladder or bowel involvement on imaging. Disease location should be accurately recorded to aid brachytherapy planning.

2.6.2. Radiological staging.

2.6.2.1. If a macroscopic cervical tumour is evident at the time of initial diagnosis urgent radiology should be requested prior to confirmatory histology results to plan treatment in a timely manner.

2.6.2.2. Cross sectional imaging is not required for women with confirmed stage 1A1 cervical cancer.

2.6.2.3. Women with stage 1A2 or higher should have a cross-sectional imaging to the level of the renal vessels for assessment of pelvic and para-aortic lymphadenopathy.

2.6.2.4. Chest radiology should be performed in all women with ≥ 1A2 cervical cancer prior to surgery.

2.6.2.5. CT PET (Positron Emission Tomography) should be performed in those with stage ≥1B1 disease to minimise risk of requiring both surgery and radiotherapy which leads to a higher risk of morbidity with no benefit in terms of overall survival.

Table 2. Summary of radiology and surgical management of cervical cancer dependent on tumour stage.

Presumed Stage.	Imaging	Management
1A1 (depth of invasion <3mm).	None required.	LLETZ. Clear margins required for both malignant and pre-malignant component. Offer definitive simple hysterectomy if family complete.
1A2 (depth of invasion ≥3mm and <5mm).	UPH; MRI (to the level of the renal vessels) and CXR RCHT; CT CAP.	Dependent on fertility wishes after radiological staging: • LLETZ and pelvic LND or, • Simple hysterectomy and pelvic LND.
1B1 (depth of invasion ≥5mm and <2cm in dimension or positive margins on LLETZ). Grade 1 and 2 SCC and LVSI negative.	MRI and CT PET.	Simple hysterectomy (with or without ovarian conservation) may be considered with pelvic LND +/- sentinel LNB after MDT discussion. Fertility sparing surgery may be considered after MDT discussion.
1B1 (depth of invasion ≥5mm and <2cm in dimension or positive margins on LLETZ). Grade 3 SCC or LVSI positive or adenocarcinoma.	MRI and CT PET.	Open radical hysterectomy (with or without ovarian conservation). Fertility sparing surgery may be considered after MDT discussion.
1B2 and above (tumour ≥2cm) .	MRI and CT PET.	Tumours between 2-4 cm - consider surgery or chemoradiation (dependent on risk factors). Tumour ≥4cm – chemoradiation.

2.6.3. Surgical management.

2.6.3.1. Surgical management will depend on histopathology, radiological and clinical staging and should be decided upon in the MDT.

2.6.3.2. Refer to table 2 for general recommendations of surgical management of cervical cancer based on clinical and radiological staging.

2.6.3.3. Patients with Silva pattern A adenocarcinomas have a very favourable prognosis and, in most cases, pelvic lymph node assessment can be omitted.

2.6.3.4. Following results of the SHAPE trial, a simple hysterectomy may be considered if MDT in agreement and if patient meets these specific criteria <2cm tumour, grade 1 or 2 squamous cell carcinoma histology and LVSI negative.

2.6.3.5. If a simple hysterectomy is planned the pros and cons of the route of surgery (laparoscopic versus open) should be carefully discussed with the patient and recorded in the MDT.

2.6.3.6. Sentinel lymph node biopsy can be performed in combination with full pelvic lymph node dissection.

2.6.3.7. Open radical hysterectomy should be recommended over laparoscopic radical hysterectomy.

2.6.4. Histopathology.

2.6.4.1. HPV (Human Papilloma Virus) status of the tumour should be assessed by p16 immunoreactivity.

2.6.4.2. PDL1 testing should be considered especially in advanced disease.

2.7. Vulval Cancer (Squamous Cell Carcinoma)

Other types of vulva cancer e.g. Bartholin's tumours, Paget's Disease, malignant melanoma are beyond the scope of this guideline and should be discussed at the Gynaecology MDT.

2.7.1. Diagnostics.

2.7.1.1. Women with a suspicious vulval lesion should have an incisional biopsy (punch or wedge) for histopathological diagnosis.

2.7.1.2. Detailed description of the site and size of the tumour plus site and size of associated dVIN (Differentiated Vulvar Intraepithelial Neoplasia) /VIN (Vulvar Intraepithelial Neoplasia) should be included in patient records.

2.7.1.3. Where possible a medical photograph of the lesion, included in the patients' medical records, should be taken to aid surgical planning.

2.7.1.4. Women found to have premalignant disease (high grade usual type VIN or differentiated VIN) should be managed by a gynaecologist who specialises in vulval disease.

2.7.1.5. Women with a confirmed squamous cell carcinoma (SCC) stage 1A (depth of invasion ≤1mm, maximum diameter ≤2cm) do not require imaging. Clinical examination of inguinal lymph nodes is recommended.

2.7.1.6. All women with confirmed SCC, with a depth of invasion >1mm on histology or maximum diameter >2cm need cross sectional imaging to exclude nodal disease and distant metastasis.

- UPH- CT AP and CXR.
- RCHT- CT CAP.

2.7.1.7. MRI may be helpful when the tumour is close to urethra or anus to aid management and surgical planning.

2.7.2. Surgical management.

2.7.2.1. Surgery is the mainstay of treatment for vulval cancer.

2.7.2.2. Wide local excision/vulvectomy should be performed when feasible aiming for macroscopic clearance of at least 1cm in situ.

2.7.2.3. If final histopathological margins of excision are <2mm re-excision should be considered.

2.7.2.4. Sentinel LNB should be performed in those with presumed stage 1B tumours where the primary lesion is <4cm, no suspicious nodes on imaging and unifocal disease.

2.7.2.5. In those with multifocal disease, tumours ≥4cm or suspicious lymph nodes on imaging, inguinal LND should be offered (bilateral if the tumour is within 1cm of the midline or the ipsilateral nodes are involved either on imaging or subsequent histology).

2.7.2.6. If SLNB is positive for metastasis or macro-metastasis (tumour deposits within the node are ≥2mm) a side specific inguinal LND should be performed (when clinically appropriate).

2.7.2.7. If SLNB is positive for micro-metastasis (tumour deposits within the node are <2mm) adjuvant radiotherapy instead of inguinal LND can be considered.

2.7.3. Histopathology.

2.7.3.1. HPV (by p16 block-type immunoreactivity) and p53 status of the tumour should be assessed.

2.7.3.2. Background VIN, dVIN or LS (Lichen Sclerosus) should also be reported to aid post operative management decisions.

2.7.3.3. Margin status of invasion, VIN and dVIN should be reported

2.7.3.4. Histopathological analysis of inguinal SLN in vulva cancer should include ultra staging (SLN-US) as per The British Association of Gynaecological Pathology Guidelines, as described below:

- A single H and E section of each slice of SLN, with minimal trimming to avoid tissue wastage, should be examined in the first instance.
- If this is negative for tumour, SLN-US should be carried out following the appropriate protocol as below.
- In a bilateral procedure, if one SLN is positive on the initial H&E, but the node(s) on the contralateral side are negative, ultra staging should be carried out only on the contralateral node(s)
- 4 sections are cut at 200 micron intervals through the block until all nodal tissue is exhausted; theoretically this should result in 10 additional sets of 4 slides.
- One section from every set of 4 is stained with H and E and one with CK.
- Two additional sections are retained at each level in case there is a problem with H&E or IHC staining, to see if the focus becomes larger on additional levels, or to use additional levels for further IHC to determine the nature of indeterminate CK-positive cells. If not used these additional sections should be stored for possible future use.

2.8. Epithelial Ovarian Cancer (Including Primary Peritoneal and Fallopian Tube)

Malignant germ cell tumours and sex-cord stromal tumours are beyond the scope of this guideline and should be discussed at the Gynaecology MDT.

2.8.1. Diagnostics.

2.8.1.1. Women with a complex ovarian mass suspicious of malignancy should have Ca125 and CEA tumour markers.

2.8.1.2. CT CAP is recommended on all women with complex adnexal masses suspicious of malignancy to determine metastatic spread and plan management.

2.8.1.3. All women should have an individualised discussion at gynaecology MDT to plan treatment and determine whether primary debulking (cytoreductive) surgery or neoadjuvant chemotherapy would be more appropriate.

2.8.1.4. Women undergoing neoadjuvant chemotherapy should (when feasible and clinically appropriate) have a histopathological diagnosis in preference to a cytological diagnosis.

2.8.1.5. Image guided biopsy is preferential to laparoscopic biopsy.

2.8.1.6. Women with moderate to large pleural effusions should be offered drainage with fluid being sent to cytology, to enable medical optimisation prior to treatment and allow for accurate staging.

2.8.1.7. Women with confirmed non-mucinous epithelial ovarian cancer (all stages) should be offered germline BRCA testing in-house or through referral to Clinical Genetics.

2.8.1.8. Women with confirmed advanced (stage 3 and 4), high grade, non-mucinous epithelial ovarian cancer should have reflex Homologous Recombination Deficient (HRD) testing on tumour tissue.

2.8.2. Surgical management.

2.8.2.1. The aim of cytoreductive surgery (either in the primary setting or after neoadjuvant chemotherapy) should be to achieve no macroscopic residual disease (0mm residual disease) whenever feasible.

2.8.2.2. The decision for primary surgery versus neoadjuvant chemotherapy should be made in combination with MDT opinion, the patient's wishes, and performance status.

2.8.2.3. Women with advanced disease on imaging should be made aware of the risk of multi-visceral resection such as bowel resection, stoma formation, diaphragm stripping and splenectomy

2.8.2.4. If metastatic disease is suspected on preoperative imaging, cytoreductive surgery should be carried out by a gynaecological oncology surgeon with expertise in upper abdominal debulking as this increases the rate of complete cytoreduction.

2.8.2.5. All women having neoadjuvant chemotherapy for epithelial ovarian cancer should have their disease response assessed by CT CAP after 3 cycles of chemotherapy.

2.8.2.6. When clinically appropriate all women with complete or partial response to 3 cycles of neoadjuvant chemotherapy should be discussed at the Gynaecology MDT to determine their suitability for interval debulking surgery.

2.8.2.7. Secondary debulking surgery should be considered in those with recurrence within platinum sensitive interval (≥6 months), with a performance status of 0-1, ascites <500mls and previous complete macroscopic debulking at primary surgery. These cases should be discussed at the gynaecology MDT.

2.9. Vaginal Cancer

2.9.1. Primary vaginal cancer is rare, and all patients require an individual treatment plan formulated by the MDT.

2.9.2. In primary vaginal cancer obtaining incisional biopsies of sufficient depth to confirm or refute the presence of stromal invasion can be challenging given anatomical constraints. Trucut biopsies can be useful in this scenario.

2.9.3. MRI is more sensitive than clinical examination in detecting tumour size, as well as paravaginal or parametrial involvement. MRI is a useful tool owing to its superior soft tissue resolution, especially in cases where histology has not been able to confirm or refute myoinvasion. MRI pelvis should therefore be offered in all cases of suspected or confirmed vaginal cancer.

2.9.4. CT PET in primary vaginal cancer has been found superior compared with other imaging modalities for detecting nodal disease. As this is vital in selecting those few patients who may be suitable for surgery (local vaginal excision alone or RHND (Radical Hysterectomy with Pelvic Node Dissection) with extended vaginal cuff) it should be offered to all patients.

2.10. Joint MDT Referral Criteria

2.10.1. All patients meeting the below criteria should be discussed at the joint gynaecology oncology MDT involving RCHT and UPH.

2.10.2. There should be appropriate job planning for the designated MDT Chair to allow adequate time to effectively prepare the MDT to ensure that these guidelines implemented.

2.10.3. Ovary.

2.10.3.1. Ovarian masses which appear clinically suspicious of malignancy and/or IOTA-Adnexa score of >10% and/or high risk O-RADS score following staging CT CAP.

2.10.3.2. All new suspected advanced ovarian cancers following staging CT CAP.

2.10.3.3. All confirmed new ovarian cancers following histology (biopsy or

surgical treatment). Detailed surgical documentation is required for patients undergoing diagnostic laparoscopy or laparotomy for advanced ovarian cancer. Information should include volume and size of disease and which intrabdominal structures are involved specifically; right and left diaphragm, liver and splenic capsule, stomach, large and small bowel serosa, large and small bowel mesentery. This information should be available at the joint MDT.

2.10.3.4. All confirmed borderline ovarian tumours following histology (surgical treatment).

2.10.3.5. All patients receiving NACT after 3 cycles of chemotherapy. CT should be performed within the second week of 3rd cycle of chemotherapy and be ready for discussion at MDT the subsequent week.

2.10.3.6. Patients who have a radiological diagnosis of recurrent ovarian cancer who underwent primary or interval cytoreductive surgery with a residual disease of 0mm, have a performance status of PS of 0-1, platinum free interval of ≥6 months and ascites <500mls should be discussed for consideration of secondary debulking surgery.

2.10.4. Endometrial.

2.10.4.1. Newly diagnosed low grade endometrial cancer, after surgical treatment or if surgical treatment deemed not appropriate by the clinician or declined by the patient

2.10.4.2. Newly diagnosed grade 2 and grade 3 endometrial cancer after staging imaging has been performed and then again subsequently after surgical treatment

2.10.4.3. Patients who present with advanced disease and have downstaging neoadjuvant chemotherapy to determine whether they would benefit from surgical treatment.

2.10.5. Vulva.

2.10.5.1. All patients with newly diagnosed vulva cancer confirmed with histology after staging imaging has been performed. Histology should be confirmed by incisional biopsy (ie. Keys-punch biopsy) rather than excisional biopsy. Detailed description of the site and size of the tumour plus site and size of associated dVIN/VIN should be included.

2.10.5.2. Patients who present with advanced disease and have downstaging neoadjuvant chemotherapy to determine whether they would benefit from surgical management.

2.10.6. Cervix.

2.10.6.1. Patients with newly diagnosed cervix cancer confirmed with histology after staging imaging has been performed

2.10.6.2. Patients who have undergone primary treatment and there is evidence of residual disease after chemo-radiotherapy or those with an isolated pelvic recurrence without evidence of distant disease.

2.10.7. Vagina.

Patients with newly diagnosed vaginal cancer confirmed with histology after staging imaging has been performed.

2.11. Responsibilities for Clinicians and Administration Teams for Patients Transferred Between Trusts

2.11.1. To meet cancer treatment targets and allow optimal theatre utilisation it is imperative that patients from UPH who require surgical treatment at RCHT are referred in a timely manner.

2.11.2. Following decision at the joint MDT for surgery at RCHT the patient will be provisionally scheduled into individual surgeons RCHT theatre diaries.

2.11.3. The patient should be informed on need for transfer by UPH team as soon as possible and administrator to send relevant documents including inter provider transfer form, MDT outcomes, clinic letters, imaging reports and enable PACS transfer of images.

2.11.4. On receipt of relevant documents at RCHT, administrator should upload documents to the patients electronic record and request PACS transfer of images.

2.11.5. Face to face appointment for clinic review at RCHT made within 1-2 weeks of receipt of referral and where possible a preoperative assessment appointment will be made for the same day to reduce travel time and expenses to the patient.

2.11.6. For patients who are receiving neoadjuvant chemotherapy for ovarian cancer, once the first cycle of chemotherapy has been scheduled:

2.11.6.1. Oncology team to contact surgical team with proposed date of second and third cycles of chemotherapy.

2.11.6.2. Surgical and administrator team provisionally schedule patient in theatre diary for appropriate consultant four to six weeks after third or forth cycle.

2.11.6.3. Once patient has been discussed at MDT and surgery agreed upon patient will be scheduled for appointment at RCHT surgical clinic.

2.11.7. Following surgery at RCHT the UPH CNS team must be informed when UPH patients are discharged from RCHT so that open access arrangements can be made on Ocean Suite.

2.11.8. Patient is discussed in joint MDT to review histology and plan future management.

2.11.9. Residual disease and final histopathological diagnosis to be recorded in MDT.

2.11.10. Following MDT, patient contacted by surgical team to ensure no immediate postoperative complications and relay conclusions from MDT and referred back to UPH oncology team.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Numbers of cancer cases and outcomes.
Lead	J. Borley; Consultant Gynaecological Oncologist.
Tool	WPGCS annual report.
Frequency	Yearly.
Reporting arrangements	WPGCS annual report.
Acting on recommendations and Lead(s)	Gynaecology MDT. As required.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months, immediately if required. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant staff/stakeholders.

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 Diversity And Inclusion 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:	West Peninsula Gynaecology Cancer Cantre Diagnostic and Surgical Guidelines V2.0
This document replaces (exact title of previous version):	West Peninsula Gynaecology Cancer Cantre Diagnostic and Surgical Guidelines V1.0
Date Issued/Approved:	November 2025
Date Valid From:	November 2025
Date Valid To:	November 2028
Directorate/Department responsible (author/owner):	Jane Borley; Consultant Gynaecological Oncologist
Contact details:	01872 252729
Brief summary of contents:	Guidance for clinicians on the investigations and surgical management of women with gynaecological malignancy.
Suggested Keywords:	Gynaecology cancer, staging, surgical management.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Gynaecology Business and Governance Meeting
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	None required
Related Documents:	1 Recommendations | Testing strategies for Lynch syndrome in people with endometrial cancer | Guidance | NICE.

Information Category	Detailed Information
	The British Association of Gynaecological Pathology Guidelines for Ultra Staging Gynaecological Malignancy.
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
February 2022	V1.0	Initial issue	Jane Borley, Consultant Gynaecological Oncologist
October 2025	V2.0	Revision of previous guideline and additional information regarding criteria for joint gynaecology MDT discussion and administrator responsibilities.	Jane Borley, Consultant Gynaecological Oncologist

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

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:	West Peninsula Gynaecology Cancer Cantre Diagnostic and Surgical Guidelines 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)	To provide evidence-based guidance to clinical staff who investigate or treat women with gynaecological cancer.
2. Policy Objectives	To standardise management across the West Peninsula Gynaecology Cancer Service.
3. Policy Intended Outcomes	To ensure patients with gynaecological cancer are managed in accordance to local and national guidance.
4. How will you measure each outcome?	Cancer pathway and treatment targets.
5. Who is intended to benefit from the policy?	Patients with gynaecology cancer and those responsible for their healthcare.

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 Business and Governance Group.
6c. What was the outcome of the consultation?	Approved.
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 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 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.
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 Oncologist.

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