Gynaecology Rapid Access Service (GRAS) for Suspected Endometrial Cancer Guideline

Initiated By	Cwm Taf Morgannwg University Health Board Obstetrics and Gynaecology Directorate
Approval Group	Integrated Business, Obstetrics, Gynaecology, Sexual Health & Quality And Safety Group
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CHANGE HISTORY

Version	Date	Author Job Title	Reasoning

AUTHORSHIP, RESPONSIBILITY AND REVIEW

Author	Mr Sean Watermeyer and Ceri Williams	Ratification Date	January 2023
Job Title	Consultant Gynaecologist and Lead Hysteroscopist	Review Date	January 2026
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BACKGROUND

Guideline Definition

Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Purpose

The aim of the Rapid Access Service is to provide the highest quality: evidence based service for all women presenting with post-menopausal The provision of this clinic will assist the Gynaecology Department in achieving the cancer two week targets and urgent referrals for PMB. Patients will benefit in terms of early diagnosis, continuity and reduction in the number of appointments and clinic visits

Scope

For all staff, medical, nursing and clerical, to provide uniformity in the management and standardisation of the referral to treatment process across the Health Board for suspected Endometrial Cancers.

Roles and Responsibilities

In seeking further advice on any uncertainties contained in this document, or if you feel that there is new or more updated advice it is your responsibility to contact the guideline author or Approval Group manager so that any amendments can be made.

The guideline Approval Group is responsible for disseminating this guideline to all appropriate staff.

The guideline author or a named alternative is responsible for updating the guideline with any amendments that they become aware of or are highlighted to them.

All health professionals are responsible to ensure that the guideline is utilised effectively, and to ensure that they are competent and compassionate in the implementation of it.

Training Requirements

There is no mandatory training associated with this guideline.

Monitoring of Compliance

- By audit and review of complaints relating to miscarriage diagnosis and management.
- The Governance Department will collate any complaints and distribute to the relevant individuals for comments, and share any learning points.
- The Service Lead will oversee any governance issues, make relevant recommendations to the directorate, and advise the Clinical Director or the directorate of any matters that require implementation.

- The Health Board reserves the right, without notice, to amend any monitoring requirements in order to meet any statutory obligations or the needs of the organisation

Complaints

All complaints should try to be resolved with the patient during any contact to avoid escalation. There concerns should be listened to and documented. If it is not possible to address any concerns at the time, or if the complaint is of a serious nature, the patient's complaint should be discussed with the consultant in charge for the day, or the patient should be given details of how to raise a formal complaint via the local governance department.

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Definition and Background

Endometrial Cancer (E.C) is the fourth most common gynaecological malignancy in the UK and Endometrial Hyperplasia can be a precursor (British Gynaecological Cancer Society 2021 (BGCS)).

Post-Menopausal Bleeding (PMB) is defined as a vaginal bleed that has occurred more than one year since a woman's last menstrual bleed (BGCS 2021). PMB is the most common presentation to give suspicion of EC, but others can include intermenstrual bleeding (IMB), unscheduled bleeding on hormone replacement therapy (HRT), post-coital bleeding (PCB) or an incidental finding on Ultrasound Scan (USS) (Royal College of Gynaecologists (RCOG) 2016).

It is the aim within Cwm Taf Morgannwg UHB to provide an effective and efficient out-patient Hysteroscopy/Gynaecology service to diagnose and treat EC promptly, as recommended by RCOG, British Society of Gynaecology Endoscopists (BSGE), National Institute of Clinical Excellence (NICE) and The Welsh Cancer Network (WCN).

This document aims to standardise the referral to treatment process across the Health Board for suspected E.C's.

Audit and Research

NHS Wales Health Collaborative (review 2021) state that all efforts should be made for Urgent Suspected Cancer (USC) referrals to have completed their diagnostic procedures, within 28 days from the point of suspicion and the treatment pathway should be commenced within 21 days of the decision to treat (< 62 days for the first definitive treatment from the point of suspicion).

NICE (2015, updated 2021) state that referrals for suspected EC should be seen within two weeks.

Previous internal audits into Hysteroscopy waiting times have indicated that compliance with the above targets were sub-optimal, hence the requirement for a Gynaecology Rapid Access Service (GRAS) to ensure timely review and adequate diagnostic facility.

According to the BGCS (2021), Trans-vaginal Ultra-sound should be employed as an initial investigation for women presenting with PMB. In such women, if the endometrial thickness (ETT) is less than 4mm (in the absence of any irregularity such as the presence of fluid, disparity of ETT within the endometrial echo) no further investigation is required (pending a normal speculum examination). However, in the presence of recurrent PMB, further investigation needs to be undertaken. Hanegem et al (2016) support the requirement to perform Hysteroscopy with an ETT > / = 4mm

Along with this, the BGCS (2021) also state that an incidental finding (i.e. no PMB) of a 'thickened endometrium' on USS on a woman not using HRT do not necessarily require a Hysteroscopy or endometrial biopsy if reported as </= 10mm. Recurrent PMB will require a hysteroscopy irrelevant of their USS results (Appendix A).

In addition, a well-designed decision analysis calculated that post-menopausal patients without vaginal bleeding, with an ETT > 11mm had an endometrial cancer risk of 6.7%, which is a similar risk to post – menopausal women with bleeding and an ETT of >5mm (Feldman and Levine 2022). They also conclude that fluid in the cavity with an ETT <3mm can be disregarded.

Risk factors that pre-dispose women to endometrial carcinoma are listed in appendix A and clinicians are encouraged to use their clinical judgement when deciding if further investigation is warranted, aside from the results of the USS.

Roles and Responsibilities

When a patient presents with any of the discussed presenting symptoms, the primary healthcare professional should undertake a full abdominal and pelvic examination, including speculum examination of the cervix. The clinician should obtain a detailed account of the presenting symptoms, a full drug history (including use of HRT, oral contraceptive pill, tamoxifen etc), and a Gynaecological history (early menarche/late menopause, known endometrial hyperplasia, parity). Medical, family and surgical history may be relevant (obesity, treatment for breast cancer, diabetes mellitus, hypertension, and Lynch syndrome) (BGCS 2021).

Transvaginal Scan (TVS) with measurement of ETT should be employed as initial investigation for women presenting with PMB or IMB. The strategy with TVS within 10 days, +/- Hysteroscopy +/- Endometrial BX (appendix A), is the most effective method for the UK population (BGCS 2021).

Women on HRT for < 4-6 months, should be managed by the G.P to consider altering the Progestogen element i.e. inserting the Mirena IUS / altering the progestogen dose (British Menopause Society (BMS) 2021)

For women on HRT > 4-6 months, they should follow the standard PMB pathway (Appendix A) (NICE 2019).

It should be noted that women who are post-menopausal should be on Continuous Combined HRT which confers a lower risk of EC, compared with the general population (BMS 2021). However, the use of sequential HRT for > 5 years, increases the risk of EH and EC.

Referrals

All women with PMB or suspicious vaginal bleeding should be referred into the GRAS service.

A Gynaecologist or Nurse Hysteroscopist will triage referrals to determine if the patient is to be seen in Gynaecology Out-patient Clinic (GOPD) or GRAS, based on the information provided by the Primary Care Practitioner and following the algorithm attached (Appendix A).

If there is no scan attached to the USC referral, the triaging clinician will request for the woman to be allocated to GRAS, to have an USS performed +/- Hysteroscopy depending on the USS findings.

Gynaecology Rapid Access Service (Urgent Suspected Cancer)

GRAS facility includes:-

- The woman receiving a USS of pelvis (if not already performed by the GP)
- +/- an endometrial biopsy, based on USS report and symptoms
- +/- referral for a Hysteroscopy, based on USS report and symptoms
- +/- referral to Colposcopy / Vulvoscopy if a suspicious cervix / vulval lesion is noted on speculum examination.

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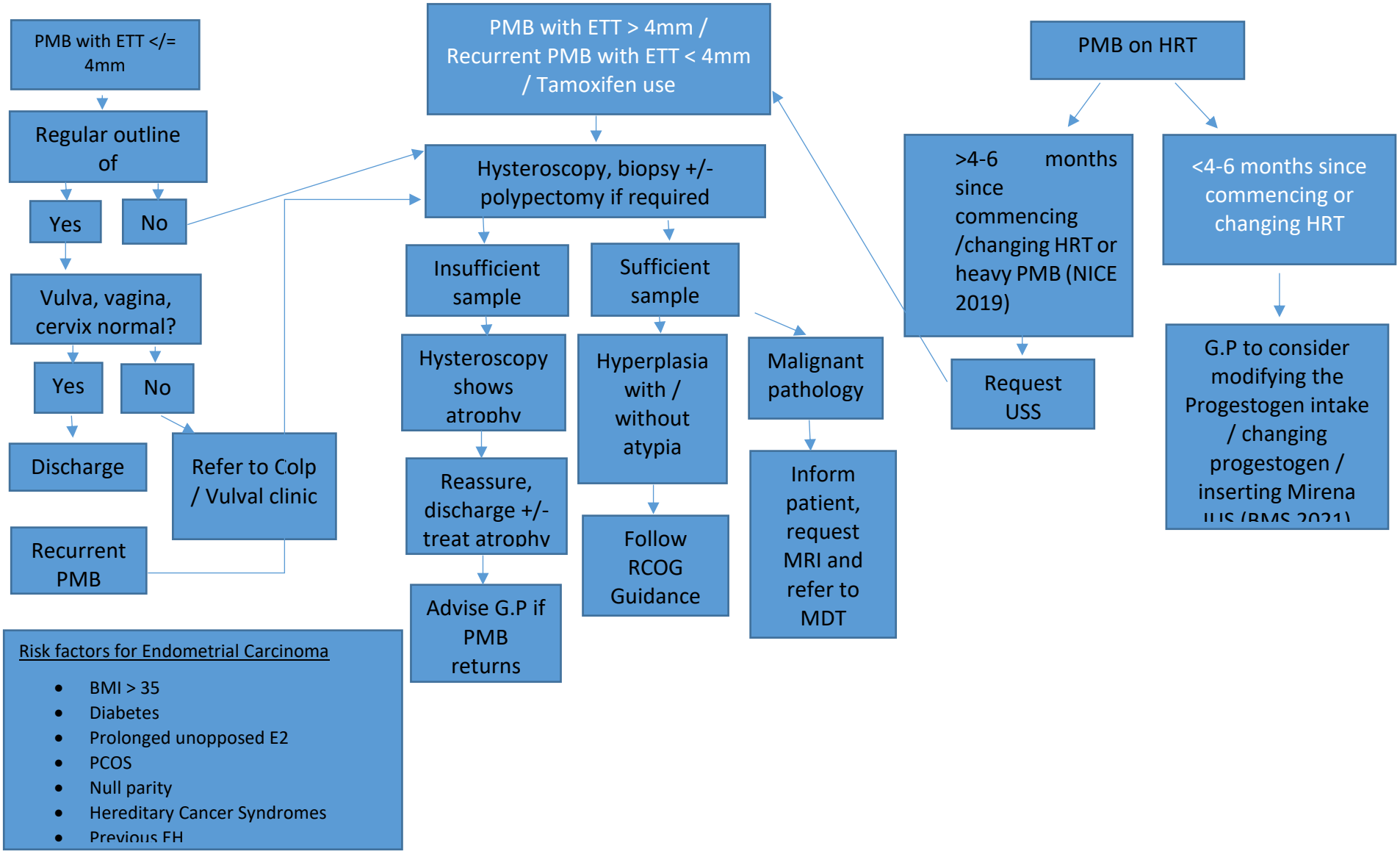
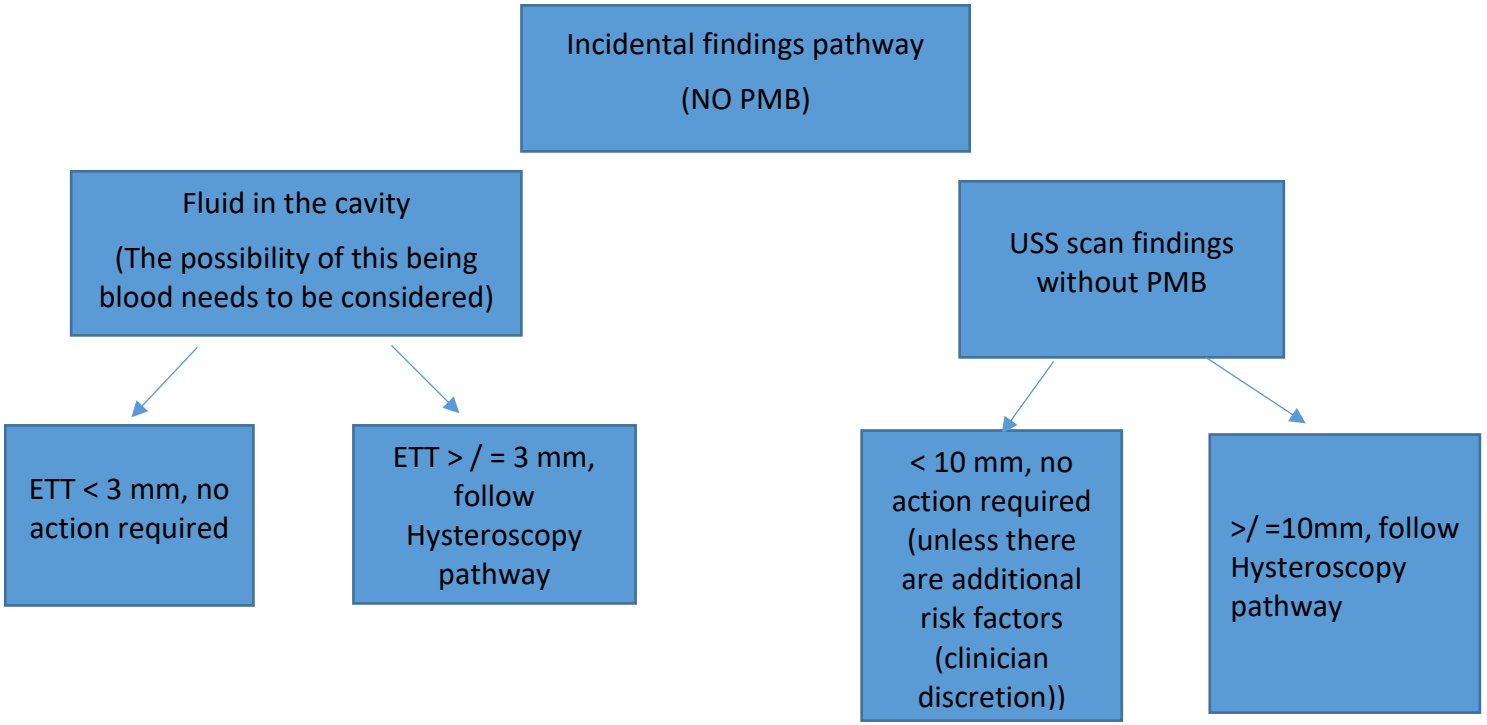
Appendix A


PMB with ETT </= 4mm
Regular outline of
Yes
No
Vulva, vagina, cervix normal?
Yes
No
Discharge
Refer to Colp / Vulval clinic
Recurrent PMB
PMB with ETT > 4mm / Recurrent PMB with ETT < 4mm / Tamoxifen use
Hysteroscopy, biopsy +/- polypectomy if required
Insufficient sample
Sufficient sample
Hysteroscopy shows atrophy
Hyperplasia with / without atypia
Malignant pathology
Reassure, discharge +/- treat atrophy
Follow RCOG Guidance
Inform patient, request MRI and refer to MDT
Advise G.P if PMB returns
PMB on HRT
>4-6 months since commencing /changing HRT or heavy PMB (NICE 2019)
<4-6 months since commencing or changing HRT
Request USS
G.P to consider modifying the Progestogen intake / changing progestogen / inserting Mirena
Risk factors for Endometrial Carcinoma
BMI > 35
Diabetes
Prolonged unopposed E2
PCOS
Null parity
Hereditary Cancer Syndromes
Previous FH


Incidental findings pathway
(NO PMB)
Fluid in the cavity
(The possibility of this being blood needs to be considered)
USS scan findings without PMB
ETT < 3 mm, no action required
ETT > / = 3 mm, follow Hysteroscopy pathway
< 10 mm, no action required (unless there are additional risk factors (clinician discretion))
>/ =10mm, follow Hysteroscopy pathway

Abbreviations Used:

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PMB	Post-Menopausal Bleeding
Endo Bx	Endometrial Biopsy
Hyst	Hysteroscopy
ETT	Endometrial Thickness
LA	Local Anaesthesia
GA	General Anaesthetic
BX	Biopsy
HRT	Hormone Replacement Therapy
USS	Ultrasound Scan
PV	Per Vagina
RCOG	Royal College of Obstetrics & Gynaecology
MRI	Magnetic Resonance Imaging
MDT	Multi-Disciplinary Team
CC HRT	Continuous Combined Hormone Replacement Therapy
E2	Oestrogen
BMS	British Menopause Society
IUS	Intra uterine system
EH	Endometrial Hyperplasia
PCOS	Polycystic Ovarian Syndrome