



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

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## CHANGE HISTORY

Version	Date	Author Job Title	Reasoning
V1.3	18/3/2025	Ceri Williams Advanced Nurse Practitioner Hysteroscopy	To incorporate the new guidance on unscheduled bleeding on HRT

## AUTHORSHIP, RESPONSIBILITY AND REVIEW

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## Table of Contents

<b>Background</b> .....	<b>3</b>
<b>Guideline Definition</b> .....	<b>3</b>
<b>Purpose</b> .....	<b>3</b>
<b>Scope</b> .....	<b>3</b>
<b>Roles and Responsibilities</b> .....	<b>3</b>
<b>Training Requirements</b> .....	<b>3</b>
<b>Monitoring of Compliance</b> .....	<b>3</b>
<b>Complaints</b> .....	<b>4</b>
<b>Gynaecology Rapid Access Service (GRAS) for Suspected Endometrial Cancer Guideline</b> .....	<b>4</b>
<b>Definition and Background</b> .....	<b>4</b>
<b>Audit and Research</b> .....	<b>4</b>
<b>Roles and responsibilities</b> .....	<b>5</b>
<b>Referrals</b> .....	<b>6</b>
<b>Gynae Rapid Access Service (Urgent Suspected Cancer)</b> .....	<b>6</b>
<b>References</b> .....	<b>7</b>
<b>Appendices</b> .....	<b>10</b>

## 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.

## **Gynaecology Rapid Access Service (GRAS) for Suspected Endometrial Cancer**

### **Guideline**

#### **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  $> / = 4\text{mm}$

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  $\leq 10\text{mm}$ . 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  $> 11\text{mm}$  had an endometrial cancer risk of 6.7%, which is a similar risk to post – menopausal women with bleeding and an ETT of  $>5\text{mm}$  (Feldman and Levine 2022). They also conclude that fluid in the cavity with an ETT  $<3\text{mm}$  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 managing women with PMB on HRT; follow the 'unscheduled bleeding on HRT 2024' guideline <https://wisdom.nhs.wales/health-board-guidelines/cwm-taf-gynaecology-file/unscheduled-bleeding-on-hrt/>

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 not on HRT 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.

## References

British Gynaecological Cancer Society (2021) Uterine Cancer Guideline. BGCS/RCOG

British Menopause Society (2021). Progestogens and Endometrial Protection. BMS, Tools for Clinicians.

Feldman S and Levine D (2022). Overview of the Evaluation of the Endometrium for malignant or premalignant disease. <https://www.uptodate.com/contents/overview-of-the-evaluation-of-the-endometriumfor-malignant-or-premalignant-disease/contributors>

Hanegem, Breijer C; Slockers A.C; Zafarm M.H; Geomini PMAJ; Catshoek R; Pijnenborg JMA; Van der Voet L.F; Dijkhuizen FPHLJ; Van Hoecke GCR; Reesink-Peters N; Veersema S; Van Hooff MHA; Van Kesteren PJM; Huirne JA; Opmeer B.C and Bongers M.Y (2016) Diagnostic workup for postmenopausal bleeding: a randomised controlled trial, *An International Journal of Obstetrics and Gynaecology* DOI: 10.1111/1471-0528.14126. <https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.14126>

NHS Wales Health Collaborative (2020) National Optimal Pathway for Endometrial Cancer. Single Cancer Pathway.

National Institute for Health and Care Excellence (2015) (updated 2021) Suspected Cancer: Recognition and Referral. NICE Guideline NG 12.

National Institute for Health and Care Excellence (2015) (updated 2019) Menopause: Diagnosis and Management. NICE Guideline NG 23.

Royal College of Obstetrics and Gynaecology (2016) Management of Endometrial Hyperplasia. Green top Guideline No. 67 RCOG

### Other useful references

Bertelli G; Hall E; Ireland E et al (2010), Long-term endometrial effects in postmenopausal women with early breast cancer participating in the Intergroup Exemestane Study (IES)--a randomised controlled trial of exemestane versus continued tamoxifen after 2-3 years tamoxifen, *Ann Oncol* vol 21, pp 498-505.

British Society of Gynaecology Endoscopy (2011) Best Practice in Out Patient hysteroscopy. Green Top Guideline 59. BSGE/RCOG

Gupta JK, Chien PF, Voit D et al. Ultrasonographic endometrial thickness for diagnosing endometrial pathology in women with postmenopausal bleeding: a meta-analysis. *Acta Obstet Gynecol Scand* 2002; 81:799-816.

NHS Kernow Commissioning Group (2017) Endometrial Thickening. Asymptomatic endometrial thickening in post-menopausal women

Opmeer BC; Van Doorn HC; Heintz AP et al (2007) Improving the existing diagnostic strategy by accounting for characteristics of the women in the diagnostic work up for postmenopausal bleeding. *BJOG* , Vol 114, pp 51-58.

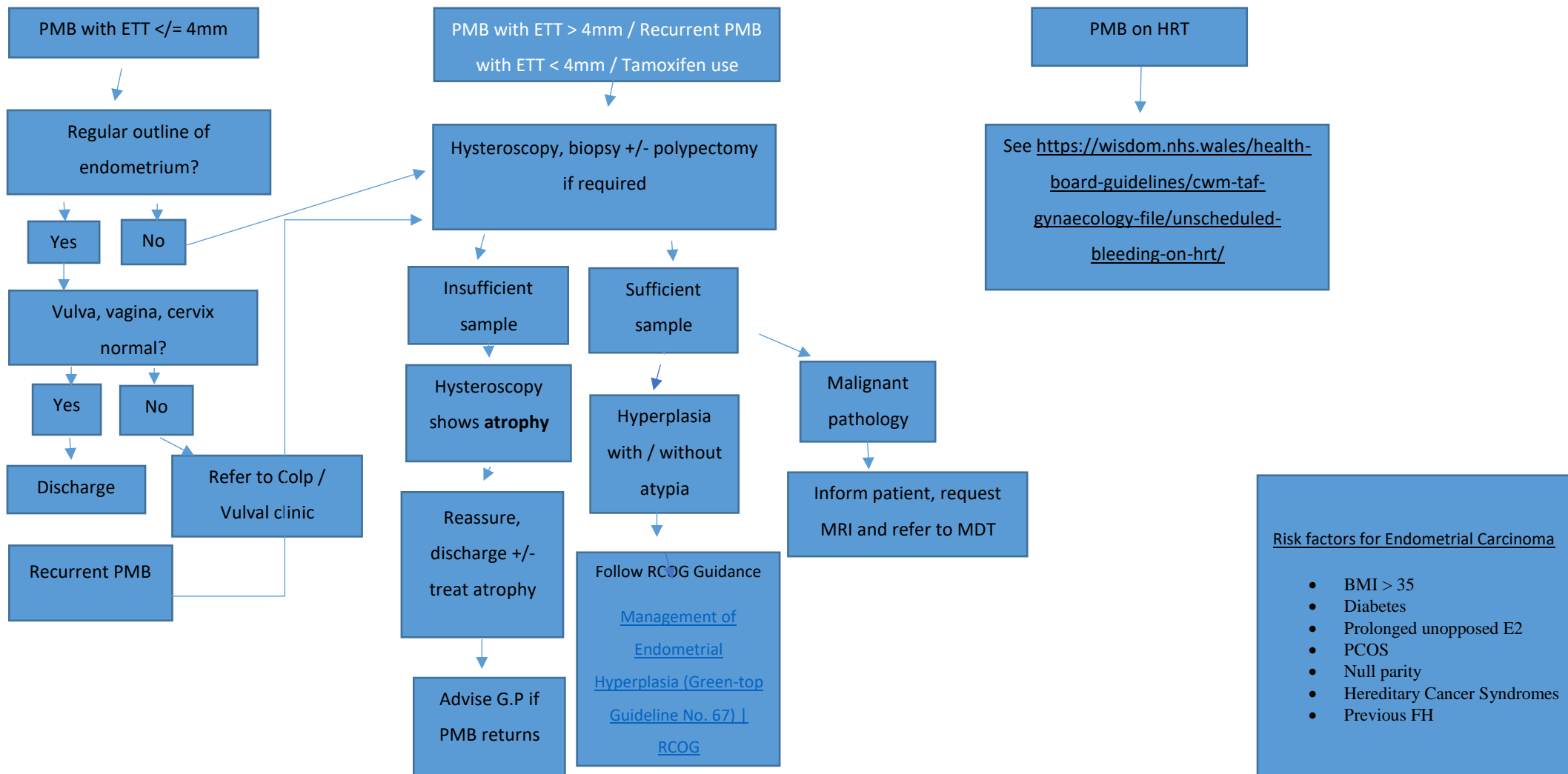
Otify, M; Fuller, J; Ross, J; Shaikh, H and Johns, J. (2015) endometrial pathology in the postmenopausal woman—an evidence based approach to management. *The Obstetrician & Gynaecologist* Vol 17(1) pp.29-38.

Smith-Bindman R; Kerlikowske K; Feldstein VA et al. Endovaginal ultrasound to exclude endometrial cancer and other endometrial abnormalities. *JAMA*, Vol 280. Pp 1510-1517.

Van Hanegem N; Prins MM; Bongers MY et al (2016), The accuracy of endometrial sampling in women with postmenopausal bleeding: a systematic review and meta-analysis. *Eur J Obstet Gynecol Reprod Biol*, Vol 19 pp 147-155.

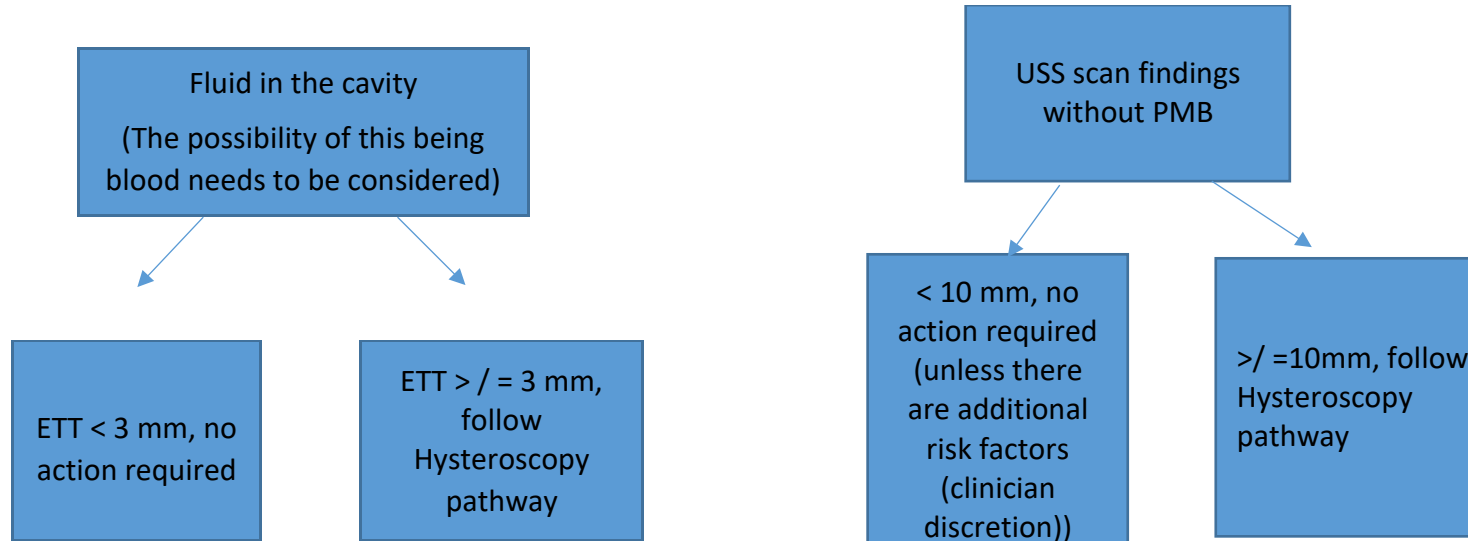


Appendix A



Incidental findings pathway

(NO PMB)



**Abbreviations Used:**

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

