GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Management of ovarian cysts

Document Type:	Clinical Guidelines
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
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Approved By:	**Health Board**
Approval / Effective Date:	September 2024
Review Date:	September 2027
Version:	2

Target Audience:

People who need to know about this document in detail	All staff providing care for management of ovarian cysts
People who need to have a broad understanding of this document	Care Group Directors Chief Operating Officer Executive Medical Director
People who need to know that this document exists	All staff providing care for management of ovarian cysts

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:** **Outcome:**
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

COMPONENTS:

A policy <u>must</u> contain the following components and must also be written to include the values and behaviours of the organisation wherever relevant:

It is accepted that for Clinical Policies and or other Written Control Documents (Procedures, Guidance etc.) the policy components below may not all be relevant.

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non Clinical Policy Development please contact:

CTM_Corporate_Governance@wales.nhs.uk

Or visit the Policy Author Page on SharePoint:

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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

- to ensure women presenting to CTM UHB with ovarian cysts have access to standardised care for their diagnosis and treatment.
- to ensure clinicians investigate and treat ovarian cysts according to evidence based practice
- provide coordinated care to ensure clinicians treat and refer appropriately according to severity of disease

Scope

This policy applies to all healthcare professionals in all locations including those with honorary contracts

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.

Introduction

This guideline is covering the management of ovarian cysts in premenopausal, postmenopausal, children and adolescents.

Ovarian cysts are very common and pre-menopause (including childhood and adolescence) are often physiological.

Any ovarian cyst (>1cm) in a post-menopausal patient needs to be followed up and requires an assessment with Ca 125.

Exclusions

This guideline does not cover the management of other types of adnexal cyst (for example those originating from the fallopian tubes), which should be managed under the gynaecology team's advice.

Documentation

Reporting of the ovarian cyst should be in conjunction with this guideline.

The follow up plan is the responsibility of both the sonographer and the person requesting the ultrasound scan, usually clinician.

Definitions and guidance

Cyst > 1cm in postmenopausal patient is considered abnormal, while in premenopausal patients only cysts >3cm should be investigated.

In children before menarche all cysts should be investigated with caution, and should be considered as abnormal finding. However, in children who reached menarche simple cysts <5cm are usually physiological and require no follow-up.

Regardless of age; all complex cysts of any size should be investigated with suspicion and followed up by the gynaecology team.

Postmenopausal Ovarian cysts

- Cysts up to 1 cm should be documented in the report, but does not need follow-up.
- Cysts >1cm and <5cm prompt obtaining CA125 and calculating the RMI regardless of the cyst features. Urgent gynaecology referral is required.
- If CA125 is normal (Low RMI), cysts 1-5cm can be followed up with 4-6 months USS for 12 months. They can be discharged after 12 months if cyst remains the same or shrink with normal CA125.
- Cysts > 5cm require urgent gynaecology referral, as surgery is usually indicated in these situation - CA125 and RMI is required to plan the place for surgery (Local vs Regional).

- Complex cysts of any size should be investigated with high suspicion compared to simple cysts. RMI should be calculated after obtaining the CA125. Urgent Gynaecology referral is indicated. CEA showed be obtained if ovarian cancer is suspected.

Premenopausal Ovarian cysts

- Simple cysts up to 3cm should not be reported as cyst (but follicles), and does not require follow-up.
- Simple cysts 3cm - 5cm should be documented on the ultrasound report, but does not require follow-up either.
- Simple cysts >5cm - <7cm are usually physiological in young patients and most likely to resolve within 3 months. RCOG (gtg no 62) suggest annual follow-up for these cysts. However, consider a repeat ultrasound scan in 3 months to confirm resolution of the cyst.
- Simple cysts >7cm prompts referral to the gynaecology team for consideration of surgery. Given the size of the cyst, often ultrasound might not give adequate assessment of the entire cyst, hence MRI can be considered for full assessment of the cyst.
- Laparoscopic cystectomy / oophorectomy / salpingo-oophorectomy should be considered as the first line management if surgery is felt appropriate and the cyst deemed benign.
- Complex cysts of any size should be investigated with higher suspicion. RMI should be calculated after obtaining the CA125. If the patient is <40 years old; HCG, AFP, LDH should be obtained. Urgent Gynaecology referral is indicated. If ovarian cancer is suspected, CEA should be obtained as well.
- Dermoid cysts and Endometrioma are often noted on ultrasound in this age group, and require referral to the gynaecology team for further management. MRI can be considered for detailed characterisation of the cyst*****

  ***Be aware** - *Araneoplastic syndrome due to NMDA receptor antibodies is a rare complication of dermoid cysts. This complication may occur in younger or older women, as well as in small- or large-diameter cysts. Thus, a high index of suspicion is required to correctly diagnose and treat women presenting with neurologic symptoms in the presence of dermoid cysts. In view of this small risk addition, the offer of laparoscopic removal of a benign dermoid should be discussed with the patient.*

Ovarian cysts in Children and Adolescents

Ovarian cysts before menarche

- Any cyst of any size before menarche should prompt referral to a gynaecologist (ideally with special interest in paediatrics and adolescents' gynaecology).
- Follow-up is usually individualised and arranged by the responsible gynaecologist.

Ovarian cysts beyond menarche

- Simple cysts <5cm require no follow-up or further input.
- Simple cysts 5cm-7cm require annual follow-up with ultrasound.

- Simple cysts >7cm require urgent referral to the gynaecology team for consideration of surgery. If the cyst was not fully assessed with the ultrasound, MRI should be considered to complete the assessment.
- If surgery is considered, laparoscopic route should be the first line treatment.

Calculation of the RMI

- The RMI combines three pre-surgical features. It is a product of the serum CA125 level (iu/ml); the menopausal status (M); and an ultrasound score (U) as follows:

  RMI = U X M X CA125.

- The ultrasound result is scored 1 point for each of the following characteristics: multilocular cysts, solid areas, metastases, ascites and bilateral lesions. U = 0 (for an ultrasound score of 0), U = 1 (for an ultrasound score of 1), U = 3 (for an ultrasound score of 2–5).
- The menopausal status is scored as 1 = premenopausal and 3 = postmenopausal.
- Serum CA125 is measured in iu/ml and can vary between zero and hundreds or even thousands of units.
- If the RMI is > or = to 200 – the patient needs a staging CT (CAP) and referral to Cancer MDT locally, where onward referral (If RMI > or = 250) to regional oncology unit can be determined. Although if endometriosis is suspected clinically, in addition - please discuss with Gynae radiologist re suitability for an MRI. Ca 125 can be markedly raised (case reports document Ca 125>600) in Deep Infiltrative Endometriosis.
- If the RMI is < 200 and Cyst has any of the following features: Non-simple features, >5cm (postmenopausal) >7cm (premenopausal), Multi-locular, or Bilateral; For discussion at Local MDT prior to considering further imaging CT CAP / MRI prior to consideration of Surgery.
- If endometriosis suspected clinically, especially if the Ca 125 is significantly raised - please discuss with a Gynae radiologist re suitability for MRI's

References

British Society for Paediatric & Adolescent Gynaecology (2017)Guideline for the management of ovarian cysts in children and adolescents

RCOG (2016) The Management of Ovarian Cysts in Postmenopausal Women

Green-top Guideline No. 34

RCOG (2011) Management of Suspected Ovarian Masses in Premenopausal Women

Green–top Guideline No. 62

Appendix A

Appendix II: Clinical algorithm for the management of postmenopausal women with ovarian cysts

Abbreviations
- **BSO** bilateral salingo-oophorectomy
- **CT** computed tomography
- **MDT** multidisciplinary team
- **RMI** risk of malignancy index
- **TAH** total abdominal hysterectomy
- **TAS** transabdominal scanning
- **TVS** transvaginal scanning

Postmenopausal ovarian cyst (cystic lesion 1 cm or more)

→ Measure CA125, TVS ± TAS, Calculate RMI I

→ **RMI I < 200** (low risk of malignancy)
- Cysts fulfilling **ALL** of the following criteria: asymptomatic, simple cyst, < 5 cm, unilocular, unilateral
  - → Consider conservative management
  - → Repeat assessment in 4–6 months CA125, TVS ± TAS
  - → Resolve → Discharge
  - → Persistent unchanged → Repeat assessment in another 4–6 months (→ Resolve / → Change in features) → Individualise treatment after discussion with woman → Discharge / Consider intervention
  - → Change in features → Consider intervention
- Cysts with **ANY** of the following features: symptomatic, non-simple features, > 5 cm, multilocular, bilateral
  - → Consider surgery salpingo-oophorectomy (usually bilateral)

→ **RMI I ≥ 200** (increased risk of malignancy)
- → CT scan (abdomen and pelvis), Referral for gynaecological oncology MDT review
  - → **MDT review** High likelihood of ovarian malignancy → **Laparotomy** Full staging procedure by a trained gynaecological oncologist
  - → **MDT review** Low likelihood of ovarian malignancy → **Laparotomy** Pelvic clearance (TAH + BSO + omentectomy + peritoneal cytology) by a suitably trained gynaecologist

CALCULATION OF THE RMI I

The RMI I combines three presurgical features. It is a product of the serum CA125 level (iu/ml); the menopausal status (M); and an ultrasound score (U) as follows:

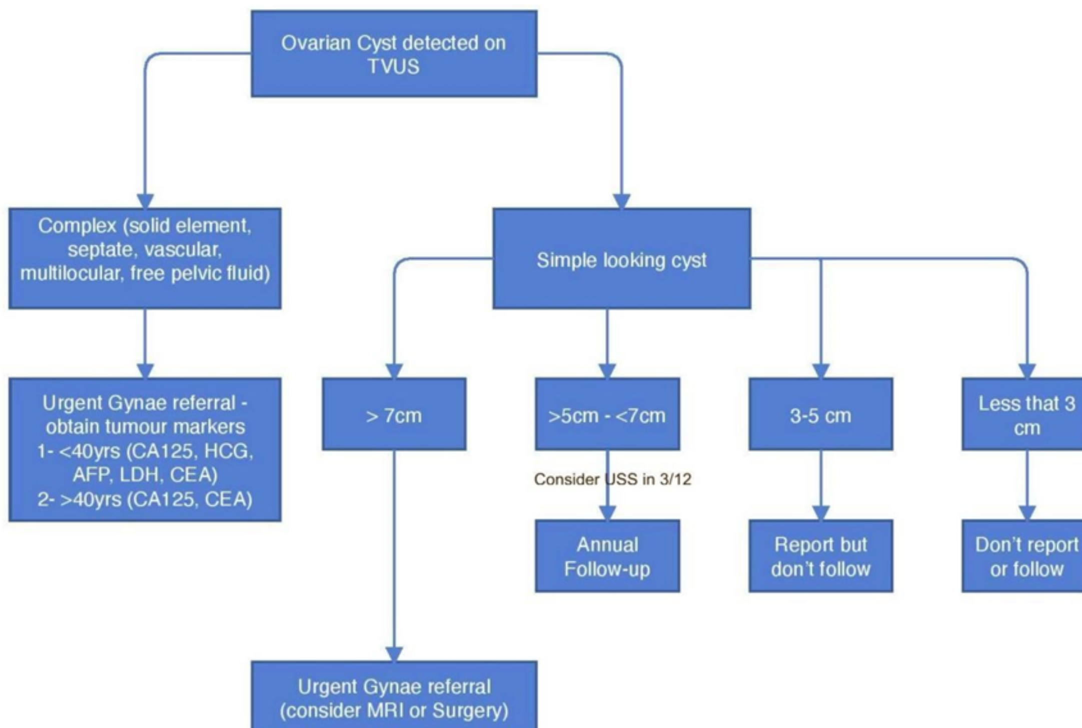
RMI = U x M x CA125

- The ultrasound result is scored 1 point for each of the following characteristics: multilocular cysts, solid areas, metastases, ascites and bilateral lesions.
  U = 0 (for an ultrasound score of 0)
  U = 1 (for an ultrasound score of 1)
  U = 3 (for an ultrasound score of 2–5)
- The menopausal status is scored as:
  1 = premenopausal
  3 = postmenopausal
  This guideline is directed at postmenopausal women and therefore all will be allocated the same score of 3 for menopausal status.
- Serum CA125 is measured in iu/ml and can vary between zero and hundreds or even thousands of units.

RCOG Green-top Guideline No. 34 30 of 31 © Royal College of Obstetricians and Gynaecologists

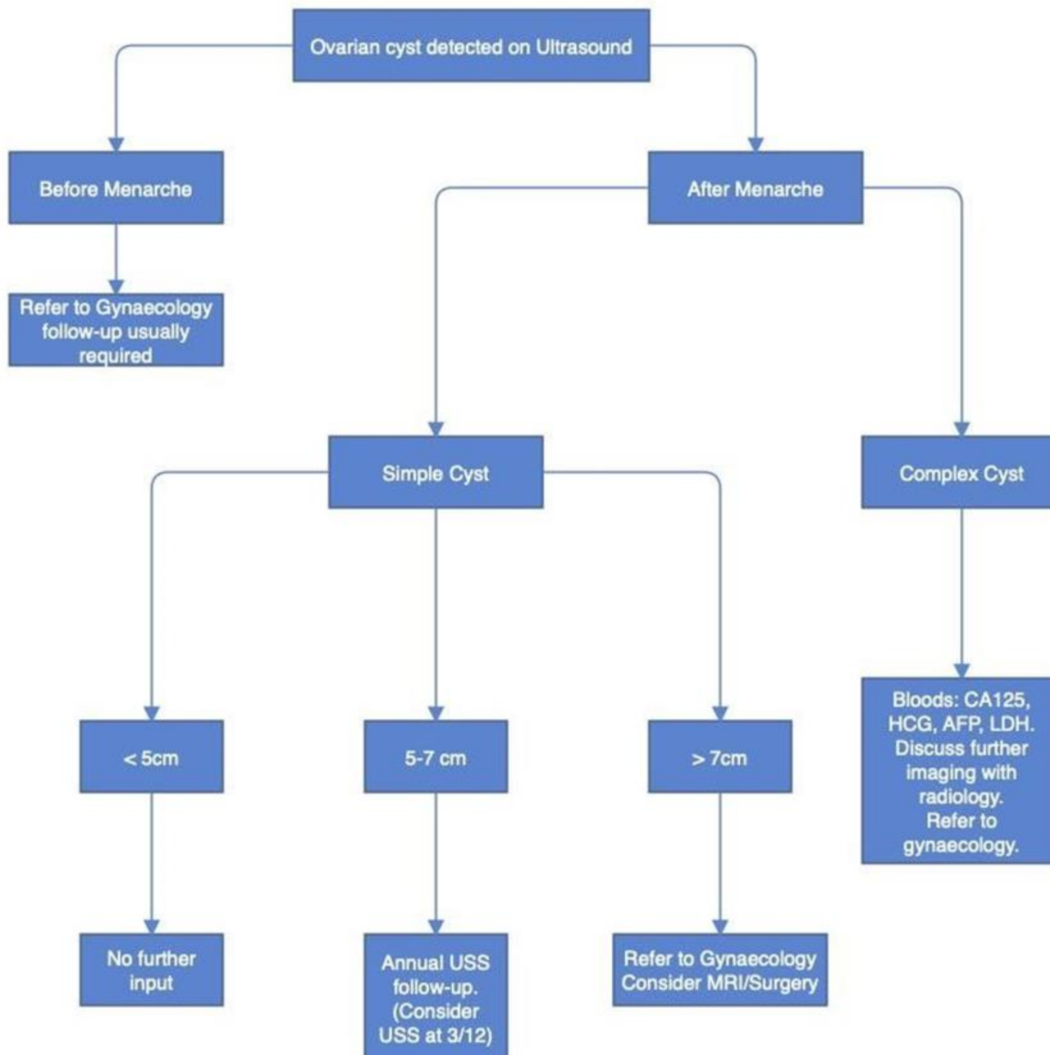
Appendix B

Premenopausal Cysts Management:



Dermoid cysts and Endometriomas should be referred directly to the gynaecology team

Appendix C



INTRODUCTION

1. POLICY STATEMENT

A concise statement of the rationale for the policy, including where necessary reference to external regulations or other relevant guidance. This should also reference the organisational values and behaviours.

2. SCOPE OF POLICY

Exactly who the policy applies to and the consequences for non-compliance where appropriate.

3. AIMS AND OBJECTIVES

This should be a statement of the desired outcome the organisation is seeking to achieve through the policy and how this aligns with corporate objectives and values and behaviours.

4. RESPONSIBILITIES

Describes the responsibilities and duties of both management and employees. It should include any particular functions that a particular post or department may have, relevant to the policy or its implementation

5. DEFINITIONS

Definition of terms where required

6. IMPLEMENTATION/POLICY COMPLIANCE

Reference to how the policy is to be implemented. This will be the main part of the policy, generally divided into sections and describe in detail what has to be done in order to comply with the policy, and achieve the policy statement. The document needs to set out how compliance with the policy is to be measured and reported.

7. EQUALITY IMPACT ASSESSMENT STATEMENT

A summary of the outcome of the EIA must be present on the front cover of the document.

Either

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

Or

This policy has been subject to a full equality impact assessment and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy.

Either statement needs to be approved by a member of the Equality team (CTM_Equality@wales.nhs.uk), and the date this was done noted.

Under Welsh Language Standard 82 policies which cover the following areas need to be made available in Welsh:

(a) a policy relating to behaviour in the workplace;
(b) a policy relating to health and well-being at work;
(c) a policy relating to salaries or workplace benefits;
(d) a policy relating to performance management;
(e) a policy relating to absence from work;
(f) a policy relating to working conditions;
(g) a policy relating to work patterns.

If one or more of the above apply, this should be indicated on the template and the policy (once approved) should be made available in Welsh. A Welsh version of a health board policy has equal status and authority to any English version. It should be published at the same time and it is vital that any changes made to either version are reflected immediately in the other.

Translations can be sent to ctt_welsh_translation@wales.nhs.uk.

8. REFERENCES

Policies must be based on sound evidence and be appropriately referenced.

9. GETTING HELP

Details of the specific office or department to contact for interpretations, resolution of problems and other special situations

A policy may also need to contain the following additional components:

10. RELATED POLICIES

Where other policies are relevant these should be listed.

11. INFORMATION, INSTRUCTION AND TRAINING

This section is relevant where instruction, training and supervision is necessary for to meet the policy requirements. It should detail when, how often and by whom the action will be taken and any requirement for keeping training records should be indicated.

12. MAIN RELEVANT LEGISLATION

A list of the relevant statutory provisions which influence the organisation’s operation in relation to the policy.