NOTE: This form is NOT for patients aged <16 years

East and North Hertfordshire NHS
NHS Trust

GYNAECOLOGY SUSPECTED CANCER REFERRAL FORM

Date of GP decision to refer: Click here to enter a date.

EMAIL REFERRAL TO: twowwgpreferrals.enh-tr@nhs.net

PATIENT DETAILS – Must provide current telephone number.

Last name: First name:

Gender: M ☐ F ☐ DOB:

NHS No:

Address:

Tel (mobile/daytime):

Tel (evening):

Patient agrees to telephone message being left? Y ☐ N ☐

Email:

Interpreter required? Y ☐ Language/Hearing:

Learning difficulties? Y ☐

Mental capacity assessment required? Y ☐

Known safeguarding concerns? Y ☐

Mobility requirements (unable climb on/off bed)? Y ☐

SYMPTOMS (SUSPECTED CANCER REFERRAL)

OVARIAN CANCER - please send Ca125 and USS results

☐ Ovarian mass consistent with cancer on USS and/or report recommends two week referral (see notes overleaf)

Postmenopausal or aged 50 years or over

☐ Palpable pelvic mass, not obviously fibroid, GI or renal tumour

☐ Raised CA125 with abnormal USS

☐ Unexplained persistent or rising CA125 with normal USS

ENDOMETRIAL CANCER - please perform pelvic & speculum exam

Premenopausal and aged over 45

☐ Persistent intermenstrual/irregular bleeding not attributable to contraception or polyp and/or not responsive to HRT or cyclical progesterones.

☐ Suspicious vaginal bleeding (sudden change/irregular/heavy)

Postmenopausal

☐ Bleeding (after 12 months of amenorrhoea)

☐ Recurrent bleeding (after previous investigation)

- ☐ in women who have not had hysteroscopy
- ☐ despite oestrogen treatment following normal hysteroscopy and biopsy

☐ Thickened endometrium as an incidental finding without PMB

- ☐ ETT (endometrial thickness) > 10mm
- ☐ USS recommends 2ww referral due to ETT 5-10mm with suspicious features

CERVICAL CANCER – please perform pelvic & speculum exam

Suspicious lesion that looks like tumour on: ☐ cervix or ☐ vagina

☐ Postcoital bleeding for > 4 weeks AND negative Chlamydia test

VULVAL CANCER

☐ Visible vulval tumour: exophytic 'cauliflower' or ?malignant ulcer

☐ Unexplained vulval bleeding ☐ Persistent vulval pain/itching

GP SUSPICION NOT FULFILLING SPECIFIC CRITERIA

☐ Ovarian ☐ Endometrial ☐ Cervical ☐ Vulval/Vaginal

Please specify concern in referral letter

GP DETAILS

GP name:

Practice Code:

Address:

TEL:

FAX:

Practice email:

Practice direct access telephone/GP mobile – for Consultant use only:

INVESTIGATIONS IN SUPPORT OF REFERRAL

Pelvic ultrasound normal? Y ☐ N ☐

Ca125 ☐ Result:

Date of last cervical smear: Result:

HORMONAL STATUS

☐ Premenopausal ☐ Postmenopausal (>1yr since LMP)

☐ On HRT Type of HRT:

☐ Hysterectomy

☐ Hormonal contraceptive Please specify:

PATIENT MEDICAL HISTORY

Existing conditions & risk factors (inc. smoking status):

☐ Current smoker ☐ Referred to stop-smoking service

History of cancer:

Breast ☐ Bowel ☐ Other (specify) ______________

Existing conditions & risk factors (more space overleaf):

Current medication (attach list & indications):

Tamoxifen/Raloxifene etc	Y ☐
Anticoagulants/Antiplatelets	Y ☐
Immunosuppressants	Y ☐
Diabetic	Y ☐
Allergies	Y ☐

WHO Patient Performance status (see key below)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

ADDITIONAL INFORMATION

DISCUSSIONS WITH PATIENT PRIOR TO REFERRAL

Cancer needs to be excluded	☐
Patient given referral information leaflet	☐

Date(s) unavailable in next 14 days:

***PLEASE ATTACH A PATIENT SUMMARY INCLUDING: REFERRAL LETTER, INVESTIGATION RESULTS, PMH, CURRENT MEDICATIONS LIST AND INDICATIONS**

If you have not received acknowledgement within 48 hours (Mon-Fri) contact 2ww supervisor on 01438 285206

WHO PATIENT PERFORMANCE STATUS KEY

0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out light/sedentary work, e.g. house or office work.
2	Ambulatory and capable of self-care, but unable to carry out work activities. Up and active > 50% of waking hours.
3	Capable of only limited self-care. Confined to bed or chair >50% of waking hours.
4	Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair.

FOR HOSPITAL USE ONLY

Date referral received:	_ _/_ _/_ _ _ _	If 1st appointment date not accepted, give reason/s:
1st appointment date offered:	_ _/_ _/_ _ _ _	
2nd appointment date offered:	_ _/_ _/_ _ _ _	

GUIDANCE ON REFERRAL CRITERIA

The monthly conversion rate of two week wait referral to a diagnosis of a gynaecological cancer fluctuates between 4% and 14% and yet many cancers are still referred acutely or to other specialities. This guidance draws on the latest evidence, the experience of the multidisciplinary team and latest NICE guidelines. It is intended to help GPs navigate the referral criteria so that resources can be concentrated on those patients most at risk, thereby reducing delays to diagnosis and avoiding unnecessary anxiety to women who do not merit a two week wait referral.

OVARIAN CANCER

Please follow NICE CG122 only for women after 50 or after menopause
CA125 should not be the first test below 50 years
Referral with single raised CA125 result is not indicated unless scan is abnormal
USS is recommended as well as CA125 even if normal

Postmenopausal

1. New diagnoses of IBS (recent change in bowel habit) are unusual in women over 50. Ovarian cancer should always be suspected (NICE 122) & CA125 tested. USS should be arranged if CA125 is raised.
2. Unilocular ovarian cysts (no septations or solid areas) are likely to be benign and can be referred non urgently ***providing CA125 is not elevated.***
3. All other ovarian/uterine masses on USS or palpable pelvic masses in postmenopausal women should be referred on a two week wait.
4. High CA125 may be caused by an ovarian cancer despite a normal USS although there are other causes such as diverticular disease or IBD. Consider urgent referral for patients with significantly raised or rising CA125.

Premenopausal

1. Two week referral should be made if USS report suggests cancer.
2. “Complex” masses described as haemorrhagic, dermoid, endometrioma or fibroid do not suggest cancer and should be referred routinely as should any other “Significant Abnormality” alerts that do not state likelihood of cancer. USS reports should clarify this.
3. An elevated CA125 is not diagnostic of ovarian cancer. Many benign conditions which cause peritoneal inflammation will raise CA125 including cyclical change, endometriosis, haemorrhagic cysts, infection, diverticular and inflammatory bowel disease, ascites from liver or cardiac disease.etc.

ENDOMETRIAL CANCER

Pelvic examination must be performed before referral to exclude cervical cancer (NICE)
Endometrial measurements before menopause have no value in diagnosing cancer

Postmenopausal

1. All cases of postmenopausal bleeding need to be investigated.
2. Consider stopping HRT first and referring if bleeding persists.
3. Pelvic ultrasound (TVS) with endometrial thickness (ETT) <5mm is reassuring.
4. Women with persistent bleeding or abnormal ETT need biopsy.
5. Women with continued or recurrent bleeding should be re-referred for hysteroscopy if not previously done, as should women with persistent bleeding despite reassuring hysteroscopy and treatment with oestrogen.

Premenopausal

1. About 20% of endometrial cancers are diagnosed in women under 55 years and are very rare in women under 45 years. Delayed diagnosis does not seem to be a major problem in premenopausal women.
2. Algorithms to refer “at risk women” are difficult to develop or validate but investigation is based upon biopsy triggered by symptoms and not on USS findings.
3. Menorrhagia is not a reason for two week referral. Abnormal bleeding may be treated empirically.

4. Sudden, recent and significantly abnormal bleeding patterns merit two week referral as does non-response to hormonal treatment.

Incidental finding without PMB

1. Incidental finding of “thickened” endometrium >10 mm requires investigation.
2. Investigation is required for ETT 5-10mm only if advised because of additional suspicious features.

CERVICAL CANCER

1. Women with smear suggesting invasion will have automatic two week direct referral to colposcopy.
2. All women with postcoital bleeding for >4 weeks should undergo pelvic examination in primary care, be screened for chlamydia and have cervical smear if they do not have an in-date smear.
3. Two week referral is not indicated for cervical polyps.

VULVAL CANCER

1. Most vulval cancers are obvious with raised or ulcerated tumour and may be sore or itchy or bleed.
2. Vulval ulceration (unless obvious herpes) is regarded as malignant until proven otherwise.
3. Smooth vulval lumps deep to the vulval skin do not suggest cancer and should be referred routinely, or urgently if recent growth raises suspicion.