A close-up of a logo

AI-generated content may be incorrect.**NOTE: This form is NOT for patients aged <16 years**

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| **GYNAECOLOGY SUSPECTED CANCER REFERRAL FORM**  Date of GP decision to refer: Click here to enter a date. |

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| **PATIENT DETAILS** – **Must provide current telephone number** |
| Last name: First name: Gender: |
| DOB: NHS No: |
| Address: |
| Tel (mobile/daytime): Tel (evening): |
| Tel (home): Patient agrees to telephone message being left? Y  N |
| Email: Interpreter required? Y  N  Language/Hearing:  Learning difficulties? Y  N  Mental capacity assessment required? Y  N  Known safeguarding concerns? Y  N  Mobility requirements (unable climb on/off bed)? Y  N  Other factors to be considered e.g. Dementia. Please specify: |
| **GP DETAILS** |
| GP Name: Practice Code: |
| Address: |
| TEL: Practice email: |
| **DISCUSSIONS WITH PATIENT PRIOR TO REFERRAL** |
| Cancer needs to be excluded  Patient given referral information leaflet |
| Date(s) **unavailable** in next 14 days: |
| **Practice direct access telephone/GP mobile – for Consultant use only:** |
| **SYMPTOMS INDICATING A CANCER REFERRAL** |
| **OVARIAN CANCER: Ca125 and USS results must accompany referral for it to be accepted** |
| Initial investigation (CA125, USS) in line with NG12/CG122 carried out, **Reports attached**.  Ovarian mass consistent with cancer on USS and/or cancer alert on report (see notes overleaf). **Report attached**  Palpable pelvic mass, consistent with cancer on USS. **Report attached**  Unexplained ascites **Report attached**  **Postmenopausal or aged 50 years or over**  Unexplained persistent or rising CA125 with normal USS **Report attached**  **Premenopausal**  US scan result **MUST** be attached. If ovaries normal and no ascites, do not refer on suspected cancer pathway. If you require any advice, kindly submit through the Advice and Guidance portal. Ca125 can be raised with endometriosis, menorrhagia, fibroids, peritoneal inflammatory conditions, pelvic infection. |
| **ENDOMETRIAL CANCER - please perform pelvic & speculum exam. All women must have USS before referral unless specified below. Report must be attached.** |
| **Premenopausal and aged over 45**  Persistent intermenstrual bleeding over three consecutive months not attributable to infection , contraception or cyclical progesterone  Suspicious vaginal bleeding (sudden change/frequent/heavy)  **Postmenopausal NOT on HRT**  Cancer alert on USS report for incidental finding (without PMB) of >10mm or 5-10 mm with suspicious features**.**  **Report attached**  Bleeding (after 12 months of amenorrhoea) and an abnormal USS (ET ≥5mm). **Report attached**  Bleeding in women with recent (within 12 months) Tamoxifen use **Do not wait for the USS report.**  Bleeding is heavy/ prolonged/ progressive/persistent (even if USS is normal) **Report attached**  Bleeding within six months of normal ultrasound (despite adequate treatment for vaginal atrophy)  Recurrent bleeding within 6 months of normal hysteroscopy (Please give the name of the consultant who performed hysteroscopy)  **Unscheduled bleeding on HRT**  HRT type  Continuous combined (ccHRT)  Sequential (sHRT)  Name of HRT :  **Date HRT commenced:**  **(** *Bleeding within 6 months of starting or 3 months of changing HRT does not require referral)*  **Please tick her risk factors below. Only refer on this pathway if there is 1 major risk factor or 3 minor risk factors. If does not meet this criteria, please follow BMS guidance for management https://thebms.org.uk/wp-content/uploads/2024/12/01-BMS-GUIDELINE-Management-of-unscheduled-bleeding-HRT-NOVEMBER2024-A.pdf.**  **Major risk factor** :  BMI ≥ 40  Genetic predisposition to endometrial cancer (Lynch/Cowden syndrome)  Oestrogen-only HRT for more than 6 months in women with a uterus  Tricycling HRT (quarterly progestogen course) for more than 12 months  Prolonged sHRT regimen: use for more than 5 years when started in women aged ≥ 45  12 months or more of using Norethisterone or medroxyprogesterone acetate for < 10 days/month or, micronised progesterone for < 12 days/month, as part of a sequential regimen  **Minor risk factor** :  BMI 30–39  Unopposed estrogen for more than 3 months but less than 6 months  Tricycling HRT (quarterly progestogen course) for more than 6 months but less than 12 months  More than 6 months, but less than 12 months, of using Norethisterone or medroxyprogesterone acetate for < 10 days/month or, micronised progesterone for < 12 days/month, as part of a sequential regimen  Where the progestogen dose is not in proportion to the Oestrogen dose for > 12 months (including expired 52 mg LNG-IUD  Anovulatory cycles, such as in PCOS  Diabetes  *Abnormal US scan result :*  *ET* ≥5mm *on ccHRT*  *ET > 7 mm on sHRT* |
| **CERVICAL/VAGINAL CANCER** – **please perform pelvic & speculum exam** |
| Suspicious lesion that looks like cancer on:  cervix or  vagina  NB: Post coital bleeding with normal appearance of cervix is no longer a criteria for suspected cancer referral. Please refer to the PCB pathway, manage and investigate as stated and if persistent then refer routinely (18ww)  to general Gynaecology clinic. Nabothian cyst and ectropion are normal findings and do not require referral. Refer cervical polyps under routine pathway. |
| **VULVAL CANCER** |
| Visible vulval cancer : exophytic ‘cauliflower’ or ?malignant ulcer  Unexplained vulval bleeding |
| **INVESTIGATIONS IN SUPPORT OF REFERRAL** |
| Pelvic ultrasound (mandatory for suspected ovarian and endometrial cancer) Normal  Abnormal  Ca125 (mandatory for suspected ovarian cancer)  Result: |
| **MANDATORY INFORMATION SUPPORTING REFERRAL** |
| Premenopausal  Postmenopausal (>1yr since LMP)  On HRT Type of HRT: |
| Hysterectomy  Hormonal contraceptive Please specify: |
| Date of last cervical smear: Result: |
| **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)*:*  Is the patient taking any of following medication: Tamoxifen/Raloxifene etc.? Y  N  Anticoagulants/Antiplatelets? Y  N  Immunosuppressants? Y N Diabetic? Y N Allergies? Y  N  *WHO Patient Performance status* (see key below)  0  1  2  3  4 |
| **ADDITIONAL INFORMATION** |
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**PLEASE COMPLETE ADDITIONAL INFORMATION (ABOVE) OR ATTACH REFERRAL LETTER. PLEASE INCLUDE INVESTIGATION RESULTS, PMH, CURRENT MEDICATIONS LIST & INDICATIONS**

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

**WHO Patient Performance status**

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| **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. |

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| **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**

***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) ≥3 cm are likely to be benign and can be referred non-urgently ***providing CA125 is not elevated.***
3. All other ovarian/uterine masses with cancer alert on USS or palpable pelvic masses in postmenopausal women should be referred on a Suspected urgent cancer referral pathway
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. A cancer alert on USS report should be referred under suspected cancer referral pathway
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***

***For patients with ongoing tamoxifen use, or tamoxifen use within the last year, or if bleeding is heavy, prolonged or progressive, refer on USCP for hysteroscopy at the same time as requesting TVUS (do not await results of TVUS before referral on USCP form)***

***Refer all other patients with postmenopausal bleeding not on HRT for an urgent USS (select cancer referral when ordering on ICE, the scan will be performed and report available within 2 weeks) and refer as USCP if indicated from results***

***Postmenopausal NOT on HRT***

1. All cases of postmenopausal bleeding need to be investigated.
2. Pelvic ultrasound (TVS) with endometrial thickness (ETT) <5mm is reassuring.
3. Women with abnormal ETT or with persistent bleeding despite a normal USS need biopsy.
4. 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.

***Unscheduled bleeding on HRT***

1. In the absence of risk factors for endometrial cancer, offer adjustments in the progestogen or HRT preparation, for 6 months in total, if unscheduled bleeding a) occurs within six months of starting HRT or persisting three months after a change in HRT dose or preparation.
2. If unscheduled bleeding continues in low-risk women, after six months of adjustments, discuss the options of an urgent ultrasound (within six weeks) versus weaning off HRT and consideration of non-hormonal alternatives (to avoid invasive investigations).
3. For those women who elect to stop HRT, if the bleeding has settled at a 4-week follow-up, and continued cessation of HRT is acceptable, no further investigations are required. If the bleeding has settled at a 4-week follow-up and there is a preference to restart HRT, offer adjustments in HRT for six months and then an urgent ultrasound if bleeding is heavy / persistent during the 6 months or, is continuing after this interval.
4. **Offer an urgent TVS (within 6 weeks)** if the first presentation with bleeding occurs more than six months after initiating, or three months after changing, the HRT preparation.
5. **Offer an urgent TVS (within 6 weeks),** irrespective of interval since starting, or changing, HRT preparations if a) bleeding is prolonged / heavy or, b) there are 2 minor risk factors for endometrial cancer.
6. **Offer an urgent suspicion of cancer pathway (USCP)** referral to women with one major or three minor risk factors for endometrial cancer – irrespective of bleeding type or interval since starting or changing HRT preparations. Adjustments to the progestogen, or stopping HRT, should be offered whilst awaiting assessment

***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 suspected cancer 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 ≥10mm in women requires investigation as per local protocol.
2. Investigation is required for ETT 5-10mm 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. USCP referral is not indicated for cervical polyps.
3. Post coital bleeding with normal appearance of cervix is no longer a criteria for cancer referral. Please refer to the PCB pathway, manage and investigate as stated and if persistent then refer routinely (18ww) to general Gynaecology clinic
4. Nabothian cyst and ectropion are normal findings and do not require referral

**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.