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| **GYNAECOLOGY SUSPECTED CANCER REFERRAL FORM** Date of GP decision to refer: <Today's date> |

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| **PATIENT DETAILS** – **Must provide current telephone number** |
| Last name: <Patient Name> First name: <Patient Name> Gender: <Gender> |
| DOB: <Date of birth> NHS No: <NHS number> |
| Address: <Patient Address> |
| Tel (mobile/daytime): <Patient Contact Details> Tel (evening): <Patient Contact Details> |
| Tel (home): <Patient Contact Details> Patient agrees to telephone message being left? Y [ ]  N [ ]  |
| Email: <Patient Contact Details> 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: <GP Name> Practice Code: <GP Details> |
| Address: <GP Details> |
| TEL: <GP Details> 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 report recommends two week referral (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** **[ ]**  |
| **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/irregular bleeding not attributable to contraception or cyclical progesterones [ ]  Suspicious vaginal bleeding (sudden change/irregular/heavy) **Postmenopausal**[ ]  USS report recommends 2WW referral 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) |
| **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 2ww referral. Please refer to the PCB pathway, manage and investigate as stated and if persistent then refer routinely (18ww) to general Gynaecology clinic |
| **VULVAL CANCER** |
| [ ]  Visible vulval tumour: 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: <Numerics>** |
| **MANDATORY INFORMATION SUPPORTING REFERRAL** |
| [ ]  Premenopausal [ ]  Postmenopausal (>1yr since LMP) [ ]  On HRT Type of HRT:        |
| [ ]  Hysterectomy [ ]  Hormonal contraceptive Please specify:        |
| Date of last cervical smear: <Diagnoses> Result: <Diagnoses> |
| **PATIENT MEDICAL HISTORY** |
| *Existing conditions & risk factors (inc. smoking status):* *[ ]* Current smoker [ ]  Referred to stop-smoking service<Diagnoses>*History of cancer:* *[ ]  Breast* *[ ]  Bowel Other (specify):*      *Existing conditions & risk factors (more space overleaf):*      *Current medication (attach list & indications):* ***See below****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** |
|      <Event Details> |

**Radiology:** (In last 6 months)

<Arden's Ltd - Investigations: Radiology last 6m (view)>

**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:  |       |

**Patient summary**

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| **Medical Problems:**     <Problems><Summary> |
| **Medication:** Acutes | <Medication> |
|  Repeats | <Repeat templates> |
| **Allergies:** <Allergies & Sensitivities> |

**Minimum Dataset:** (recordings in last 6months)

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| --- | --- |
| **Blood Pressure** | <Latest BP>, <Numerics> |
| **Heart rate** | <Numerics>, <Diagnoses> |
| **Height**  | <Numerics> | **Alcohol Intake** | <Diagnoses>, <Numerics> |
| **Weight** | <Numerics> | **Exercise tolerance:**  | <Diagnoses><Diagnoses> |

**Radiology:** (In last 6 months)

<Arden's Ltd - Investigations: Radiology last 6m (view)>

**Blood Results (Last 12m):**

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| --- | --- | --- |
| **FBC** | <Numerics> | Hb <Numerics>, WCC <Numerics>, Plts <Numerics>, MCV <Numerics>, Neut <Numerics> |
| **UE** | <Numerics> | Na <Numerics>, K <Numerics>, Urea <Numerics>, Creat <Numerics>, eGFR <Numerics> |
| **LFT** | <Numerics> | ALT <Numerics>, Alk Phos <Numerics>, Bili <Numerics>, Alb <Numerics>, GGT <Numerics> |
| **CRP** | <Numerics> | <Numerics> | **ESR** | <Numerics> |
| **TFTs** | <Numerics> | TSH <Numerics>, Free T4 <Numerics> | **INR** | <Numerics> |
| **Bone** | <Numerics> | Ca <Numerics>, Ca cor <Numerics>, Ca adj <Numerics>, Phos <Numerics> |
| **Iron** | <Numerics> | Ferritin <Numerics>, Iron Saturation <Numerics>, TIBC <Numerics>  |
| **Vitamins** | <Numerics> | B12 <Numerics>, Folate <Numerics> |
| **Lipids** | <Numerics> | Chol <Numerics>, LDL <Numerics>, HDL <Numerics>,Chol:HDL ratio <Numerics>, Tri <Numerics> |
| **Random Glucose** | <Numerics> | **Fasting Chol.** | <Numerics> |
| **Fasting Glucose** | <Numerics> | **HbA1c** | <Numerics> |
| **CA 125** | <Numerics> |

**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) 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***

***For patients with ongoing tamoxifen use, or tamoxifen use within the last year, or if bleeding is heavy, prolonged or progressive, refer on 2ww for hysteroscopy at the same time as requesting TVUS (do not await results of TVUS before referral on 2ww form)***

***Refer all other patients with postmenopausal bleeding for an urgent USS (select 2ww when ordering on ICE, the scan will be performed and report available within 2 weeks) and refer as 2WW if indicated from results***

***Postmenopausal***

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.

***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 ≥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. Two week referral is not indicated for cervical polyps.
3. Post coital bleeding with normal appearance of cervix is no longer a criteria for 2ww referral. Please refer to the PCB pathway, manage and investigate as stated and if persistent then refer routinely (18ww) to general Gynaecology clinic

**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.