Pan Birmingham NHS
Cancer Network

Guideline for the Follow-up of Patients with Gynaecological Malignancies

Version History

Version	Date	Summary of Change/Process
2.0	20.02.08	Endorsed by the Governance Committee
2.1	18.11.10	Circulated at NSSG meeting
2.2	18.02.11	Presented at Gynae NSSG
2.3	13.04.11	With comments following consultation. For finalising by Suhail Anwar (SA)
2.4	15.07.11	With revision by SA
2.5	22.07.11	With reformatting by Lara Barnish
2.6	25.07.11	With revision by SA
2.7	25.07.11	With SA revisions agreed, sent for final consultation with the Gynae NSSG
3.0	20.09.11	Reviewed and endorsed by Guidelines Sub Group

Date Approved by Network Governance	**September 2011**

Date for Review	**September 2014**

Changes made during review in 2011

- There has been a distinction made between discharge and patient initiated follow up.
- Due to the introduction of high dose rate brachytherapy, the follow up of mainly cervical but also some endometrial cancer patients treated radically with radiotherapy\chemo-radiotherapy may be required for longer period of time (mostly 5 years).

1 Scope

This guideline has been produced to support the follow-up of patients with the following malignancies:

- Vulval cancer
- Cervical cancer
- Endometrial cancer
- Ovarian cancer

2 Guideline Background

All Trusts undertaking gynaecological surgery in Pan Birmingham Cancer Network are recognised as cancer units. One Trust: Sandwell and West Birmingham Hospital NHS Trust (City Hospital site) is recognised as the Gynaecological Cancer Centre.

Guideline Statements

3 All patients

3.1 All patients undergoing treatment for a gynaecological malignancy should be offered follow-up after completion of their treatment.

3.2 Follow-up should be by the treatment team for the first post treatment appointment. Following this, follow-up by the patient's local team should be offered to those treated at the specialist centre.

3.3 A follow-up plan should be developed as part of the MDT discussion, this should be recorded in the patient's summary notes and the GP informed.

3.4 Any patient in a clinical trial should be followed up as per trial protocol.

3.5 Since April 2007 all new patients completing treatment for vulval, cervical and endometrial cancer have routinely been considered for patient initiated follow-up as outlined in appendix 1.

3.6 The decision to offer patient initiated follow-up is a clinical decision and should be documented in the notes.

3.7 By 12 months following completion of treatment, all patients (**irrespective of the type of follow-up**) should have been formally advised of the symptoms of recurrence, and who to contact should they be concerned about new signs or symptoms. This is most likely to have been done by a clinical nurse specialist and should be accompanied by disease specific written information.

3.8 Ovarian cancer: those with borderline and stage Ia tumours may be suitable for patient initiated follow-up from the outset and this should be decided at the MDT meeting. Other patients with early stage disease not deemed to require chemotherapy should be followed up every three months in the first year, six monthly in the second and third year and then annually to five years.

3.9 Patients with ovarian cancer that required chemotherapy should be offered the following follow-up:

a) 3 monthly for 2 years
b) 4 monthly in the 3rd year
c) 6 monthly in years 4 to 5

Ideally the follow-up for these patients should be alternated between surgical gynae-oncologist and clinical/medical oncologist.

3.10 With the introduction of high dose rate (HDR) brachytherapy treatment for patients with cervical cancer (stages Ib2 and above mainly) it is imperative that the results are audited. Follow-up of patients should be for at least 5 years if they have been treated with chemo-radiation or radiation upfront. After 24 months these patients should continue yearly follow-up for 5 years. This should be done mainly in the oncology clinic.

3.11 Trusts should be aware that by altering the follow-up in this way (to facilitate patient initiated follow-up) will alter the dependency of patients attending clinic. The proportion of clinic patients that are unwell or require a greater time input is likely to increase – clinic slots and the seniority of staff will need to reflect this.

4 Other tumours not covered by any of the above

Any patient who has not received any disease directed treatment for five years is not likely to require hospital-based surveillance. However, there are many individual scenarios that arise with rare and common tumours that cannot be covered in such a follow up guideline. It is suggested that all tumours have a follow-up plan agreed as part of their MDT discussion.

Monitoring of the Guideline

Implementation of the guidance will be considered as a topic for audit by the NSSG in 2013

Authors of Versions 1 and 2

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Approval Signatures

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Appendix 1 – Schedule for patient initiated follow-up

All Patients

All patients should be made aware that they can bring their appointments dates forward.
All patients should be made aware of how to contact the CNS.
In some instances, a patient's first follow-up appointment may be at 6 weeks.

Ovarian cancer

Those with borderline and stage Ia tumours may be suitable for patient initiated follow up from the outset and this should be decided at the MDT meeting.

Vulval Cancer

Patients managed by surgery alone should be seen at 3 months and 6 months following treatment to assess its morbidity, and discharged to patient initiated follow-up at 12 months.

Patients managed by surgery and/or radiotherapy

These patients are at higher risk of local and or regional relapse and should be seen at 3 months and 6 months following treatment to assess its morbidity.
They should be reviewed at 12 months and discharged at 24 months.

Cervical Cancer

Patients managed by surgery alone should be seen at 3 months and 6 months following treatment to assess its morbidity, and discharged at 12 months. In patients where residual VaIN (vaginal intraepithelial neoplasia) is suspected from assessment of the excision margins, or where the pathological examination of the hysterectomy specimen shows incompletely excised CIN (cervical in situ neoplasia), vaginal vault cytology should be undertaken at follow up.

Patients managed by surgery and adjuvant radiotherapy

These patients are at higher risk of local, regional and distant relapse and should be seen at 3 months and 6 months following treatment to assess its morbidity and relapse status. They should be reviewed at 12 months and at 24 months. Those who have received HDR Brachytherapy then require yearly follow-up for a total of 5 years.

Patients managed by radiotherapy/chemoradiotherapy alone

These patients will usually have presented with either more advanced disease or have been deemed unsuitable for surgery. They therefore have both disease-associated risk of relapse and probable significant co-morbidity. They are at higher risk of local, regional and distant relapse and should be seen at 3 months and 6 months to assess the morbidity of treatment and relapse status. They should be further reviewed at 9 and 12 months and at 24 months. Following this they need to be seen on yearly basis for a total of 5 years if they had received HDR Brachytherapy.

Endometrial Cancer

Serous carcinomas are excluded and should be followed as for ovarian cancer.

Patients managed by surgery alone

These patients are generally at low risk of relapse. Should relapse occur, some may be salvaged by either radiotherapy of vaginal vault excision (small vaginal recurrences). The evidence is available suggests that most relapses in this group are recognised following patient initiated consultations. These patients should be seen at 3 months and 6 months to assess the morbidity of treatment, and patient initiated follow up should commence at 12 months.

Patients managed by surgery and adjuvant radiotherapy

These patients are at higher risk of local, regional and distant relapse and should be seen at 3 months and 6 months to assess the morbidity of treatment and relapse status. They should be further reviewed at 12 months and patient initiated follow up should commence at 24 months.

Patients managed by radiotherapy/chemoradiotherapy alone

These patients will usually have presented with either more advanced disease or have been deemed unsuitable for surgery. They, therefore, have both disease-associated risk of relapse and probable significant co-morbidity. They are at higher risk of local, regional and distant relapse and should be seen at 3 months and 6 months to assess the morbidity of treatment and relapse status. They should be further reviewed at 9 and 12 months and patient initiated follow up should commence at 24 months. Following this they need to be seen on yearly basis for a total of 5 years if they had received HDR Brachytherapy to higher doses.