Pan-Birmingham NHS
Cancer Network

Coversheet for Network Site Specific Group Agreed Documentation

This sheet is to accompany all documentation agreed by Pan Birmingham Cancer Network Site Specific Groups. This will assist the Network Governance Committee to endorse the documentation and request implementation.

Document Title	Guidelines for the Management of Familial Risk of Ovarian Cancer
Document Date	June 2009
Document Purpose	These guidelines have been developed to ensure that any patient identified as being at high risk of developing a familial ovarian cancer receives care and information from the appropriate local experts and that care is co-ordinated following best current evidence.
Authors	Cyril Chapman — Cancer Geneticist Anna Considine — Cancer Genetic Counsellor James Nevin — Consultant Gynae-Oncologist Lara Barnish — Project Lead
References	1 www.bwhct.nhs.uk/wmfacs 2 http://www.nice.org.uk/guidance/cg41/quickrefguide/pdf/English 3 James PA, Doherty R, Harris M, et al: Optimal selection of individuals for BRCA mutation testing: A comparison of available methods. J Clin Oncol 24:707-714, 2006
Consultation Process	Gynaecology NSSG, James Nevin, Cyril Chapman, Anna Considine, Colorectal and Breast NSSGs
Review Date (must be within three years)	June 2012
Approval Signatures: Network Site Specific Group Clinical Chair	K Singh
Date Approved by Network Governance Committee	10/06/09

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Guidelines for the Management of Familial Risk of Ovarian Cancer

Version History

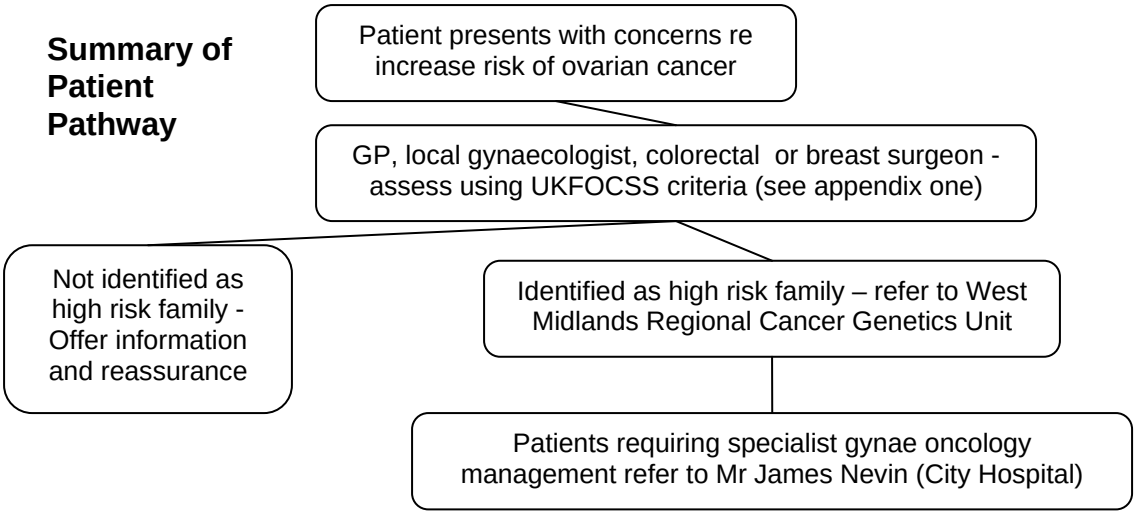
Version	Date Issued	Brief Summary of Change
0.1	20.11.06	First draft presented at Gynae NSSG (Cyril Chapman)
0.2	29.02.07	Following consultation with Cyril Chapman
0.3	31.01.07	Following meeting with Cyril Chapman and Anna Considine – for consultation with James Nevin
0.4	01.02.07	Following consultation with James Nevin, for email consultation with the NSSGs for colorectal, breast and gynaecology
0.5	20.02.07	Following consultation, for submission to the Clinical Governance Committee
1.0	March 2007	Endorsed by the Governance Committee
1.1	February 2009	Prepared for review
1.2	15.04.09	Circulated to the Gynae NSSG for review
1.2	29.04.09	Approved by the Gynae NSSG (no changes)
2	10.06.09	Endorsed by the Network Governance Committee Guidelines Sub Group

1. Background Information

1.1 These guidelines have been developed to ensure that any patient identified as being at high risk of developing a familial ovarian cancer receives care and information from the appropriate local experts and that care is co-ordinated following best current evidence.

1.2 Pan Birmingham Cancer Network hosts the West Midlands Regional Cancer Genetics Unit at Birmingham Women's Hospital, and has an identified gynae-oncologist at the cancer centre (Sandwell and West Birmingham NHS Trust - City Hospital site), for the management of patients identified as requiring further information, clinical procedures and follow-up.

Summary of Patient Pathway



Guideline Statements

2. Basic Principles

2.1 Women should be assessed using the UKFOCSS recruitment guidelines (see summary in appendix one) to identify those with an increased lifetime risk of more than 10% (i.e. about a six-fold increase in risk above that of the rest of the population).

2.2 Individuals (affected or unaffected by cancer) who meet these criteria should be referred to the West Midlands Regional Clinical Genetics Unit, Birmingham Women's Hospital for a risk assessment.

2.3 Any woman whose family history does not fit into the UKFOCSS recruitment guidelines is not likely to be helped by screening for ovarian cancer. They should be offered information on a healthy lifestyle and reassured that their risk is essentially the same as rest of population.

2.4 Screening for ovarian cancer using regular blood CA125 estimation and ovarian ultrasound examination has not been proven to have a significant effect in reducing the risk of dying from ovarian cancer. Preliminary indications are that benefit, if any, is likely to be relatively small, particularly in the context of a significant familial risk of ovarian cancer.

2.5 There are significant possible harms from ovarian cancer screening, both psychological and physical. The likelihood of a diagnostic laparoscopy or laparotomy being performed may be as high as 12%, the great majority of which will be negative for cancer.

2.6 The risk of ovarian cancer can be reduced by surgery – bilateral salpingo-oophorectomy, and the contraceptive pill if taken for 5 years.

2.7 Women with One First Degree Relative with ovarian cancer have a relative risk of two-to-three fold (depending on the age of the affected relative at diagnosis) and thus are below the risk level for UKFOCSS. Under these circumstances no screening would be recommended. The patient should be given information on the signs and symptoms of ovarian cancer so they can report these to the GP early.

3. Lifetime Risk Groups

3.1 Following assessment at the West Midlands Regional Clinical Genetics Unit the overall percentage lifetime risk will have been calculated for these women and the following groups recognised:

a) Women whose lifetime risk is deemed to be greater than 10%.

b) Women whose lifetime risk is deemed to be greater than 10% but whose family is unlikely to have a mutation in BrCa1 or BrCa2:
These women are eligible for entry to UKFOCSS (second phase). They should be referred to a gynae-oncologist at the gynae cancer♦ centre for discussion of their risk and their options but without the assumption that they will be offered screening or risk-reducing surgery.

c) Women at 50% Risk of Having a Mutation in BrCa1 or BrCa2
These women will have a lifetime risk of 10% to 30%. They should be referred to a gynae-oncologist at the gynae cancer centre for discussion of their risk and their options, including screening under the UKFOCSS protocol: four monthly ca125's and the ROCA (risk of ovarian cancer algorithm) and risk-reducing surgery (bilateral salpingo-oophorectomy).

d) Women Who Have a BrCa1 or BrCa2 Mutation
Women affected by breast or ovarian cancer are screened for mutations if they have a 20% chance or greater of having a BrCa1 or BrCa2 mutation. The likelihood is assessed on the family history of cancer (see appendix 2 and NICE clinical Guideline 41) and the histological grade and hormone receptor status (James PA, Doherty R, Harris M, et al) of any breast cancers. Unaffected women are offered a test only if a relative has been shown to have mutation.

These women will have a lifetime risk of 20% to 60%. They should be referred to a gynae-oncologist at the gynae cancer centre for discussion of their risk and their options, including screening and risk-reducing surgery. Those who wish to delay or avoid the surgical option should be offered screening within the UKFOCSS study, with the restricted benefit and possible harms clearly explained.

♦ This is currently Mr. James Nevin at City Hospital

4. Carriers of HNPCC Mutations

4.1 People affected by colorectal, uterine or ovarian cancer are screened for mutations if they have a reasonable chance or greater of having a mutation in one of the mis-match repair genes (risk is assessed using the Amsterdam II Criteria – see appendix 3). The likelihood is assessed on the family history of cancer and the histological characteristics of any cancers (in general colorectal or uterine are preferred). Unaffected women are offered a test only if a relative has been shown to have mutation.

4.2 A mutation carrier has a lifetime risk for endometrial cancer of 40% to 60% and an ovarian cancer risk of about 10%. Such women should be referred to a gynaecologist for discussion of the options for the prevention of these gynaecological cancers.

5. HNPPC Families

5.1 Given that a mutation carrier has a lifetime risk of ovarian cancer of about 10%, a possible mutation carrier will have a risk of about 5% and therefore is not at sufficiently increased risk to suggest ovarian cancer screening. However, their risk of endometrial cancer will be 20% to 40%, suggesting that referral to a gynaecologist may be helpful. There is no evidence that would assist in making decisions about the use of endometrial cancer screening in this group, or of any surgical options or advice about the follow-up symptoms of endometrial cancer.

6. Patient Information and Counselling

6.1 All patients, and with their consent, their partners will be given access to appropriate written information during their investigation and treatment, and on diagnosis will be given the opportunity to discuss their management with a clinical nurse specialist who is a member of the relevant MDT. The patient should have a method of access to the Gynae team at all times.

6.2 Access to psychological support will be available if required. All patients should undergo an Holistic Needs Assessment and onward referral as required.

7. Palliative Care

7.1 Palliative care services will be made available to all patients as deemed appropriate by the MDT.

Monitoring of the Guideline

Implementation of the guidance will be considered as a topic for audit by the NSSG in 2012.

References

1 www.bwhct.nhs.uk/wmfacs
2 http://www.nice.org.uk/guidance/cg41/quickrefguide/pdf/English
3 James PA, Doherty R, Harris M, et al: Optimal selection of individuals for BRCA mutation testing: A comparison of available methods. J Clin Oncol 24:707-714, 2006

Authors

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2	Anna Considine	Cancer Genetic Counsellor
3	James Nevin	Consultant Gynae-Oncologist
2	Lara Barnish	Project Lead

Approval Date of Network Site Specific Group: Date 29 April 2009

Date Approved by the Clinical Governance Committee: Date 10 June 2009

Approval Signatures

Pan Birmingham Cancer Network Governance Committee Chair

Name: Doug Wulff

Signature Date 10 June 2009

Network Site Specific Group Clinical Chair

Name Kavita Singh

Signature Date 29 April 2009

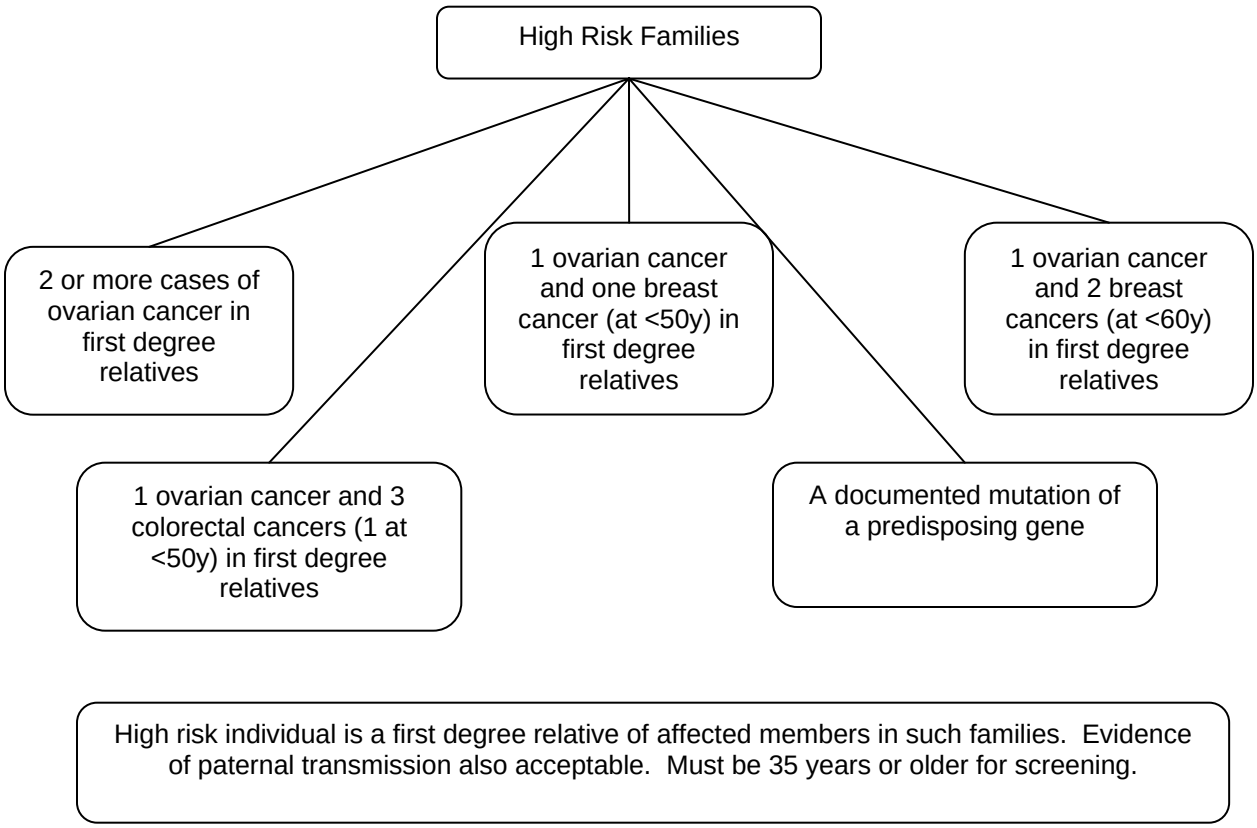
Pan Birmingham Cancer Network Manager

Name Karen Metcalf

Signature Date 10 June 2009

Appendix One

UKFOCSS Inclusion Criteria



NB practitioners may also choose to refer patients to the West Midlands Cancer Genetics Unit in the following circumstances:

- Where there are three or more first degree relatives, with other gastrointestinal renal, urinary tract, uterine or ovarian cancer at any age.
- Where there are three or more relatives with a combination of cancers of breast, ovary, prostate, pancreas, melanoma or thyroid.
- Individuals with an Eastern European/Jewish origin who do not meet the above criteria could still be considered because of their increased risk of BRCA1 and BRCA2 mutations.

Appendix – 2

NICE Criterion for screening for a BrCa1 or BrCa2 mutation – taken from NICE Clinical Guideline 41 – Familial Breast Cancer (page 27). Risk is calculated using the family history screening tools outlined (page 6 and 7).

High Risk
Risk is estimated based on family history. High risk of developing breast cancer is defined as an estimated risk of:

- Greater than 8% between age 40 and 50 years
- Or a greater lifetime risk of 30% or greater.

High risk also includes a 20% or greater chance of a faulty BRCA1, BRCA2 or TP53 gene in the family. If, however, a person has a genetic test and is found not to be carrying the identified faulty gene, their risk is then in most cases, average.

Less than 1% of women will have a high risk of developing breast cancer.

Appendix 3 – The Amsterdam II Criteria

3 close relatives affected by CRC or 2 with CRC and 1 with endometrial cancer across 2 generations.

- 1 must have been diagnosed before 50 years of age and
- 1 affected relative must be a first degree relative of the other two.