



GYNAECOLOGICAL ONCOLOGY

Follow up from 2014 and what's new
Annual Clinical Report 2014
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SCD Regional Gynaecology

Recommendations

- Need to formulate plan to comply with National Standards
- Need to increase resource to match demand

- 969 new referrals
- 2075 discussions

- Combined MDM with live VC to all 8DHBs
- Unit leads in most units
- 95% < 14 days

- Faster Cancer Treatment Ministry of Health target

Faster Cancer Treatment Target

- The 62 Day Indicator
- Time taken for a patient referred with high suspicion of cancer without a confirmed pathological diagnosis of cancer at referral and where the triaging clinician believes the patient needs to be seen within two weeks to receive their first treatment or management for cancer
- The 31 Day Indicator
- Time from date of decision made for treatment to receiving first treatment or management of cancer

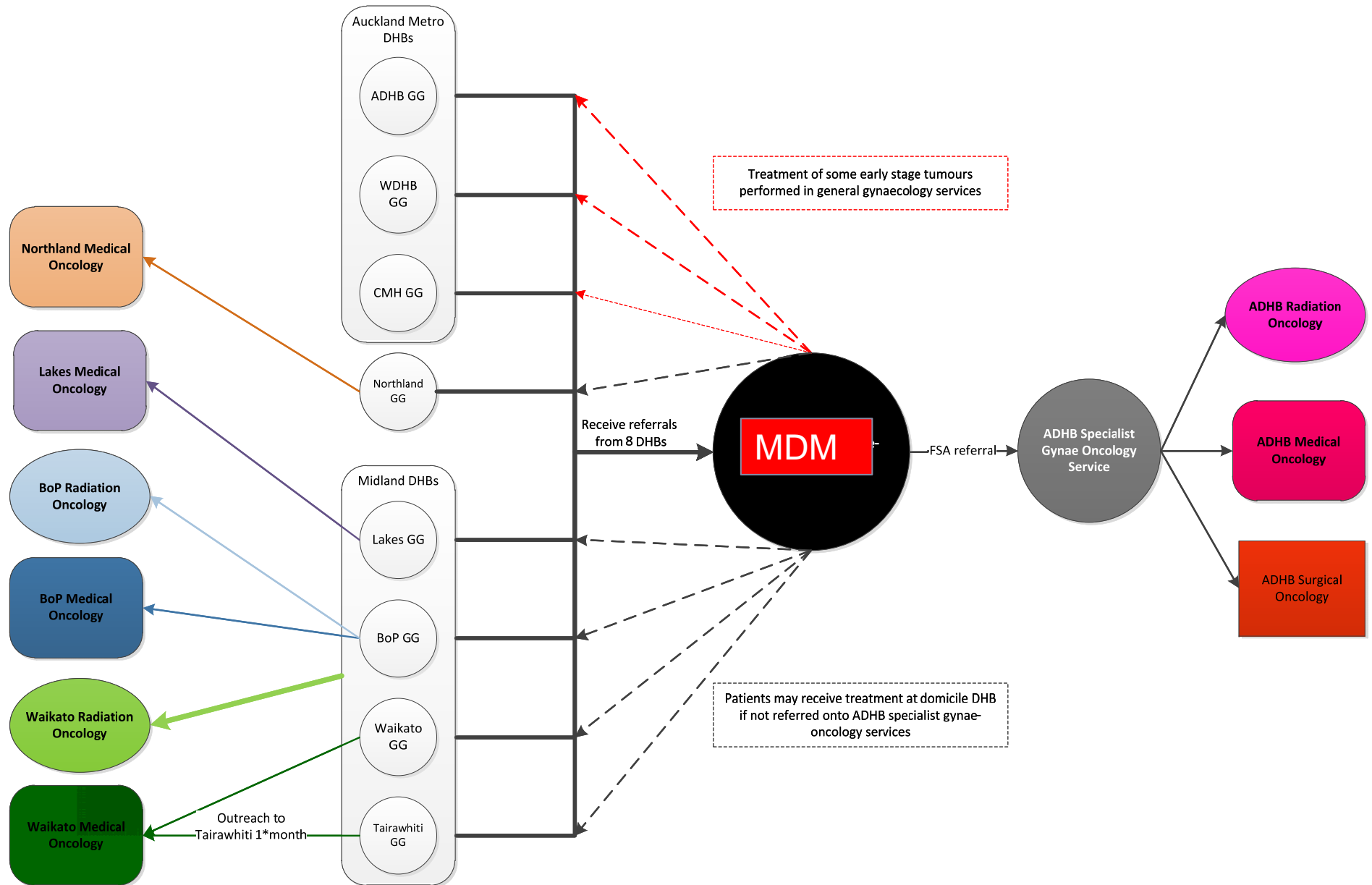
62 Day FCT Targets

- 85% expected to be achieved by July 2016
- 90% expected by June 2017

	Midland Region	Northern Region
Q3 July-Sept 2014		
31D	67%	89.9%
62D	33%	27.8%

ADHB Specialist Oncology Services – relationship with other DHBs

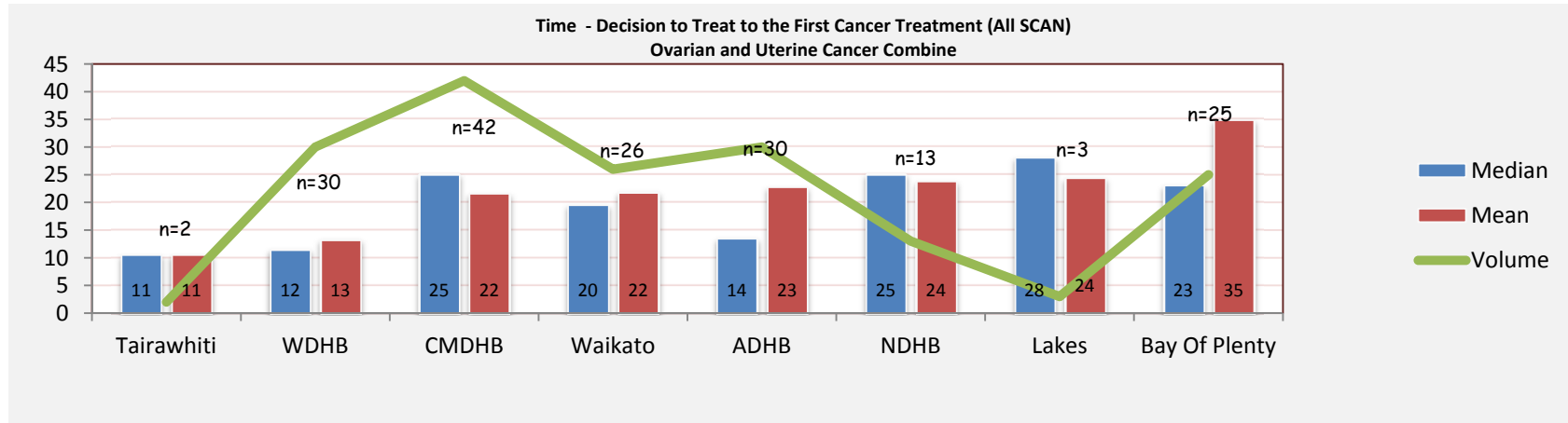
GG = General Gynaecology



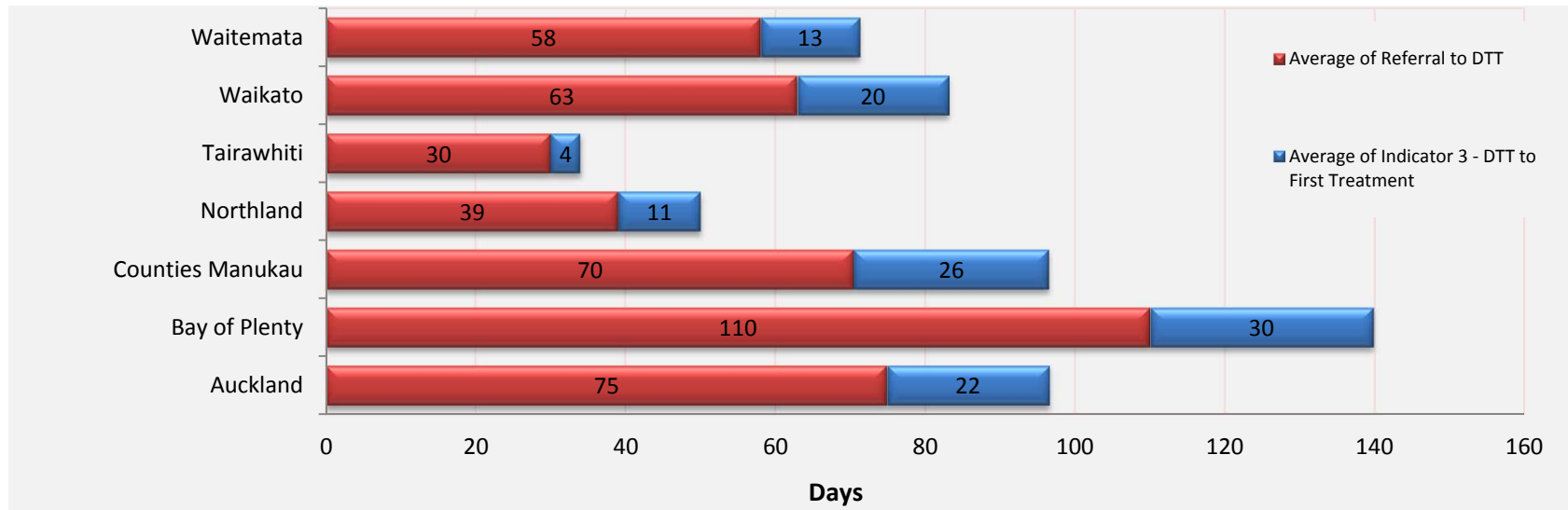
MoH FCT Project

- Ovarian and endometrial cancers over 6/12
 - Map patient pathways across regions
 - Identify bottlenecks
-
- Date of referral
 - Date of FSA
 - Date of Diagnosis
 - Date of MDM referral
 - Date of MDM discussion
 - Date of Decision to Treat (DTT)
 - Date of First Treatment

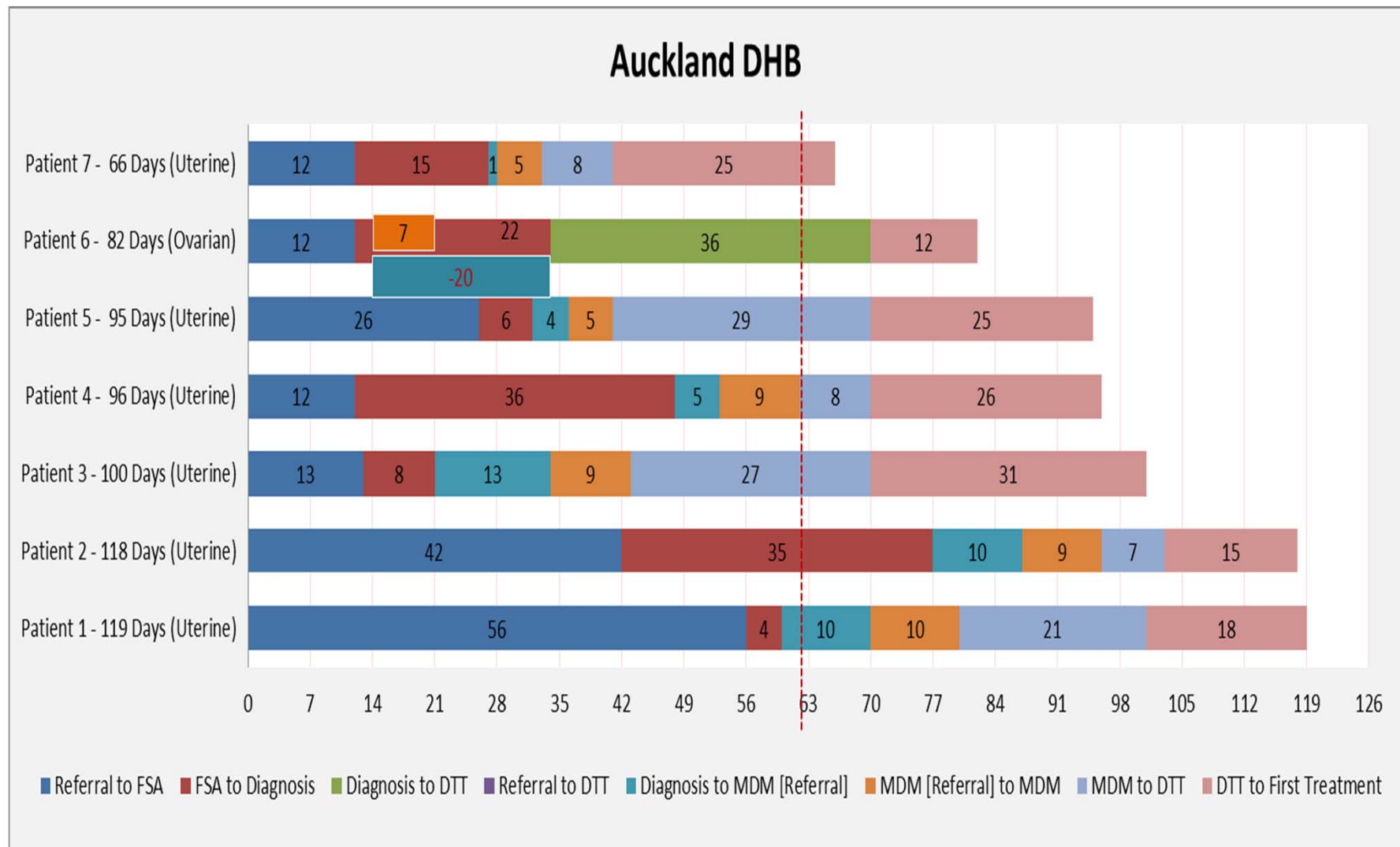
31 day



62 day



ADHB: Individual patient pathways



Issues Identified at ADHB

- 62D indicator target not met
- Small number identified as HiScan and triaged to pathway
- No Unit Lead SMO
- No dedicated cancer coordinator/CNS
- No consistent primary referred practice
- Delays in FSA
- Delay in access to Imaging
- Knock on effect to delay MDM discussions
- Delay in patients receiving diagnosis after investigation
- Delay in follow up appointments after MDM

HiScan Definitions for Triage

GYNAECOLOGICAL CANCER	
Red flags	
If at least one of the following red flags is reported, then the patient should be triaged as 'High Suspicion of Cancer'	Y/N
Biopsy-proven gynaecological malignant or premalignant disease (including endometrial hyperplasia) or Gestational Trophoblastic Disease	
A cervical or vaginal smear suspicious of malignancy†	
A visible abnormality suspicious of a vulval, vaginal or cervical cancer (such as an exophytic, ulcerating or pigmented lesion)	
Significant symptoms (including abnormal vaginal bleeding, discharge or pelvic pain) AND abnormal clinical findings suspicious of gynaecological malignancy (including lymphadenopathy, vaginal nodularity or pelvic induration)	
Post-menopausal bleeding (N.B. High suspicion of cancer may be excluded if physical examination, smear and vaginal ultrasound are normal.)	
A rapidly growing pelvic mass or genital lump	
Women with a palpable or incidentally-found pelvic mass (including any large complex ovarian mass >8 cm) UNLESS investigations (ultrasound and tumour markers) suggest benign disease <ul style="list-style-type: none"> • N.B. Radiological suspicion of ovarian malignancy, ascites or metastatic disease is indicated by a raised CA125 in a post-menopausal woman or germ cell markers in a woman under 25 	
Women with a documented genetic risk who have a suspicious pelvic abnormality or symptoms (usually women with strong family history or known HNPCC or BRCA mutations)	

Conclusion

- 62D target more likely to be achieved if diagnosis made by Day 28
- Major problems before diagnosis
- Need dedicated team
- Active tracking
- Rapid access clinic
- Imaging
- Communication

MDT

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- Kathryn Chrystal
- Rose Fisher
- Peter Fong
- Anand Gangji
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