ANNUAL CLINICAL REPORT 2016: GYNAECOLOGICAL ONCOLOGY COLPOSCOPY

Lois Eva

Clinical Director

Colposcopy 2016

- 2067 Colposcopies, 65% initial assessments
- 40% of referrals are for women <30
- 72% of LLETZs under local anaesthetic
  (NCSP standard 80%)

- Now using cQuip standards instead of BSCCP
- Awaiting changes to NCSP – primary HPV screening

NWH compared to cQuip standard

- 100% of colposcopists undertakes 75+ colposcopies per 3 year period: **100%**
- ≥ 95% of women with HG cytology have punch or excisional biopsy: **92%**
- ≥ 90% of biopsies suitable for histological interpretation: **98%**
- 100% of treatments should have a histological sample: **100%**
- ≥ 80% of treatment histology shows high grade changes: **87%**
- ≤ 5% of women treated for high grade histology will have treatment failure (HG histology within 12 months): **0.5%**

Faster Cancer Treatment Target

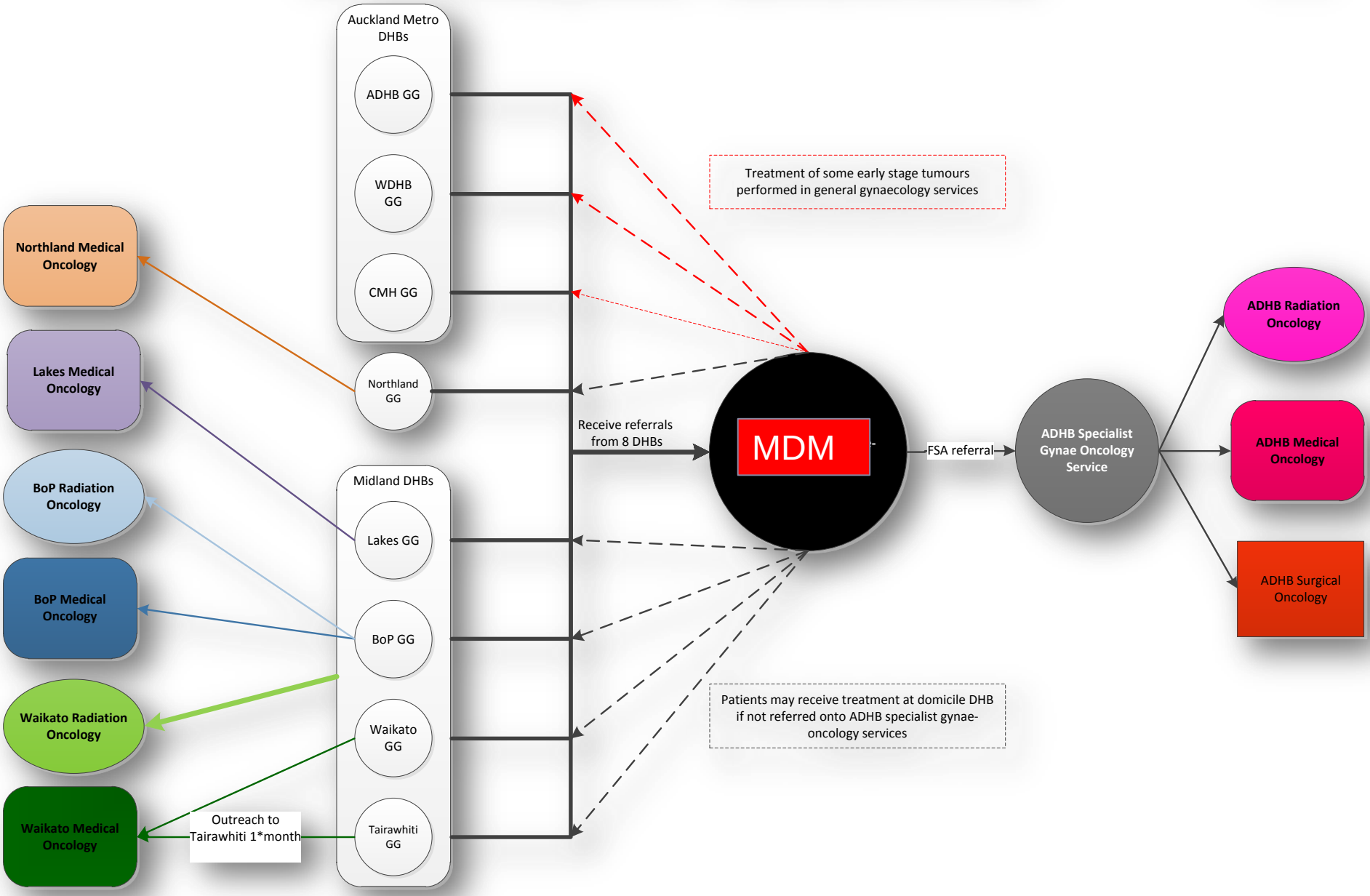
- The 62 Day Indicator
- Time taken for a patient referred with high suspicion of cancer without a confirmed pathological diagnosis of cancer at referral and where the triaging clinician believes the patient needs to be seen within two weeks to receive their first treatment or management for cancer

  2016 Target 85%

- The 31 Day Indicator
- Time from date of decision made for treatment to receiving first treatment or management of cancer

ADHB Specialist Oncology Services – relationship with other DHBs

GG = General Gynaecology



MoH 62 day FCT targets: ADHB Gynae

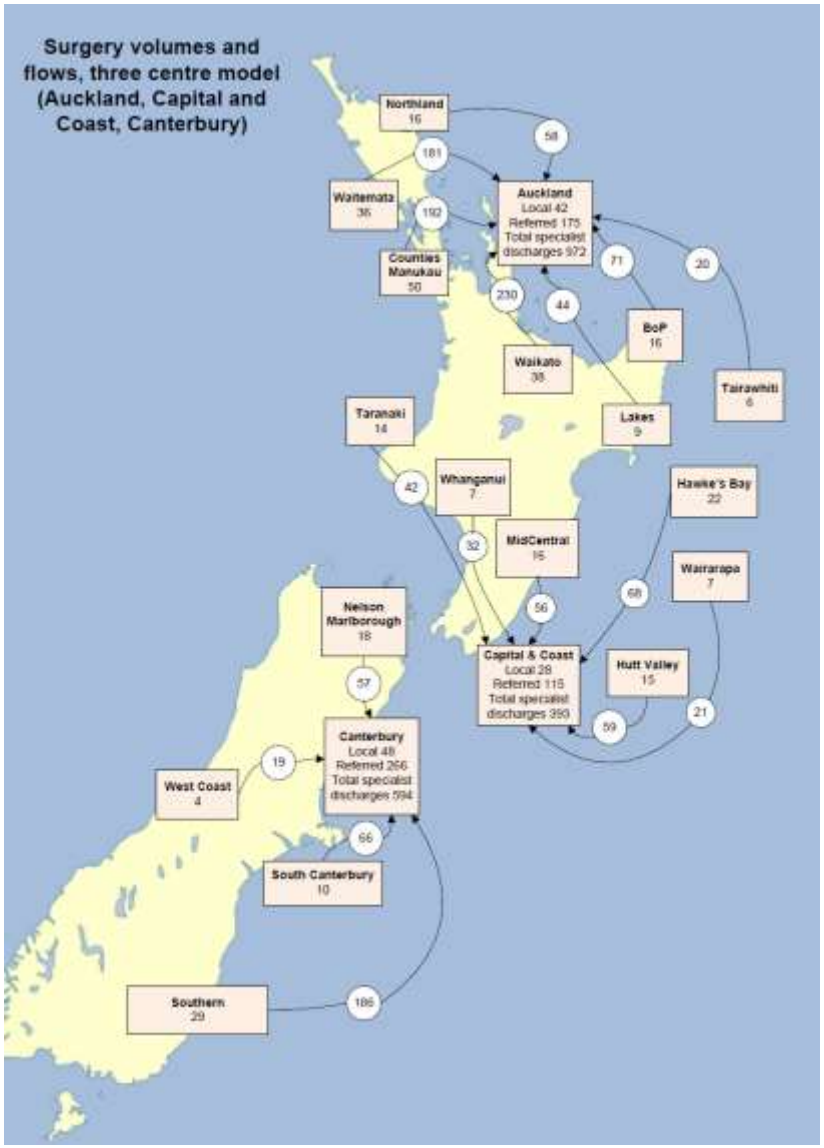
Reporting Month	Target Met	Grand Total	62 Day Performance-Gynaecological
Jan-16	2	2	100%
Feb-16	3	4	75%
Mar-16	5	5	100%
Apr-16	6	8	75%
May-16	1	4	25%
Jun-16	4	7	57%
Jul-16	2	5	40%
Aug-16	5	7	71%
Sep-16	5	6	83%
Oct-16	5	6	83%
Nov-16	5	5	100%
Dec-16	0	0	
Grand Total	43	59	73%

FCT initiatives

- HiSCAN triaging
- RAC
- OP Hysteroscopy
- Lead clinician
- Cancer tracker
- Weekly report

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[1]	
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** • 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)	

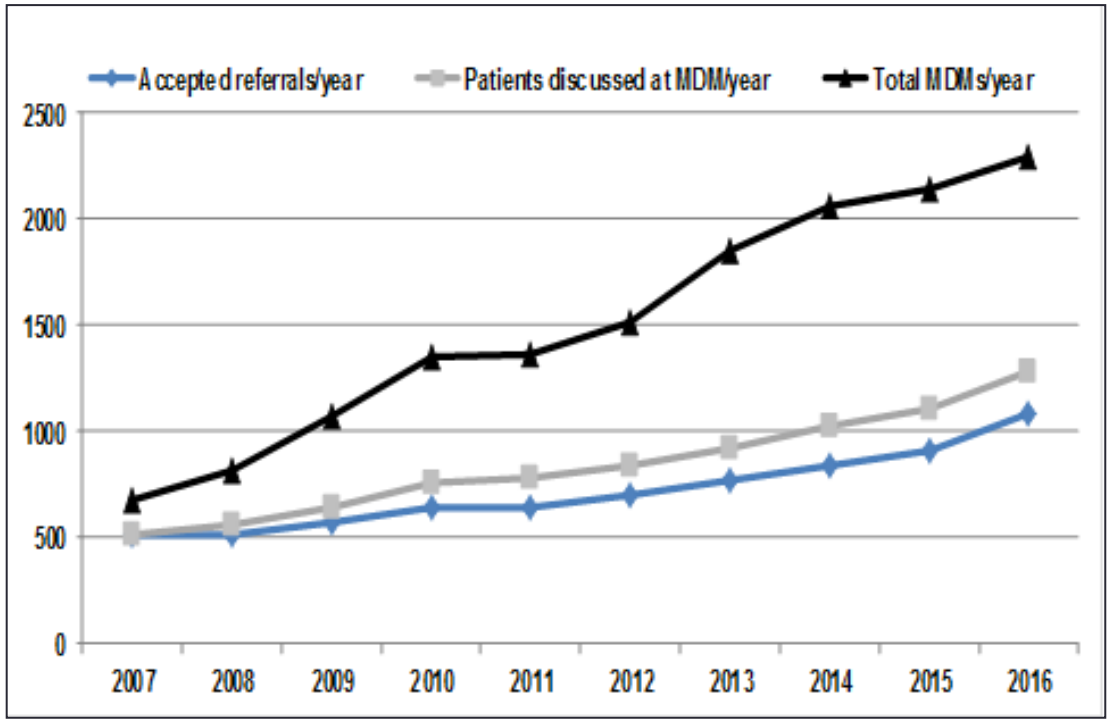
Ministry of Health: 3 centre model



- ADHB catchment

  2.3 million

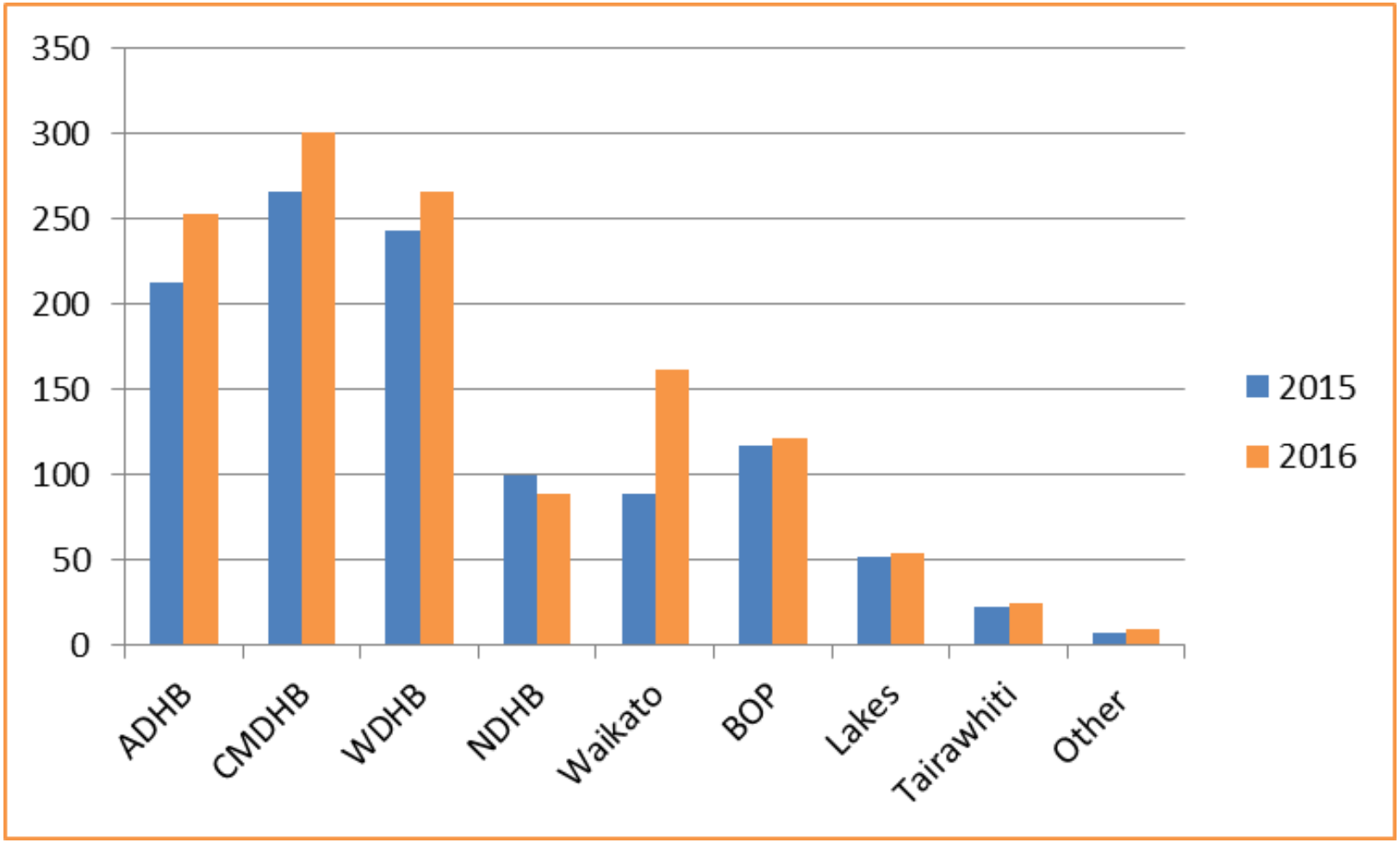
Referral numbers



- 1089 referrals
- 16.9% increase

- 2299 MDM discussions
- 1277 patients
- 7% increase

DHB of Domicile



Time for referral to first MDM

Table 237: Time from referral (referrals received in 2016) to first MDM.		
	2016	
	N=	965
	n	%
<7 days	351	36.4
7-14 days	521	54.0
>14 days	93	9.6

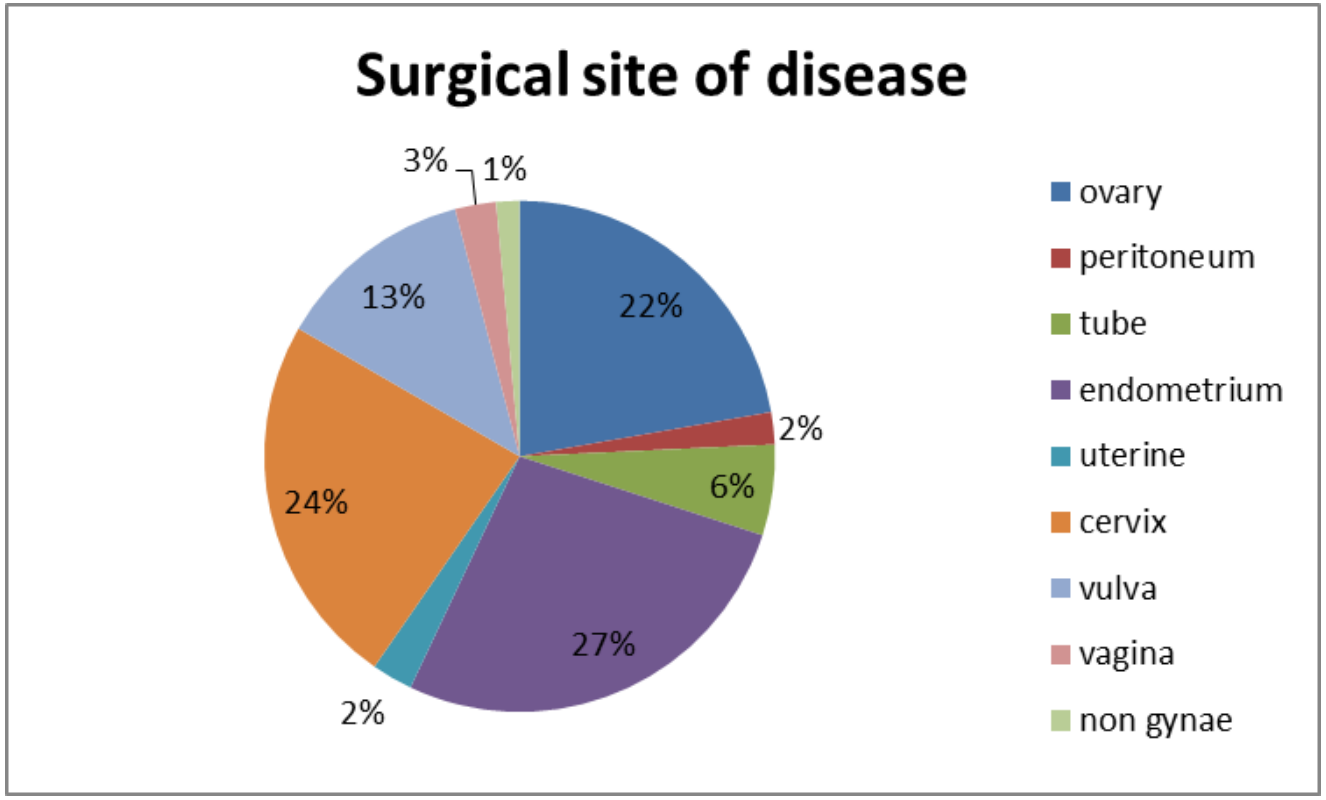
- NMGOTS
- Regional pathways
- Electronic referral
- Agreed investigations
- Pathology coordination

FSA: Gynaecological Oncology

Table 238: Time from first MDM (first MDM in 2016) to first Clinic appointment				
All cases	N=958	2016	2015 N= 837	
	n	%		
Seen in GO clinic	340	35.5	278	33.2%
Clinic before MDM	11	1.1		
No clinic	618	64.5		
New cases seen in GO clinic	N=340	%	2015	N=278
<7 days	92	27.1	10	
7-14 days	150	44.1	55	
>14 days	87	25.6	34	
Clinic before MDM	11	3.2	1	

Surgical activity

	Surgical cases
2016	544
2015	454
2014	431



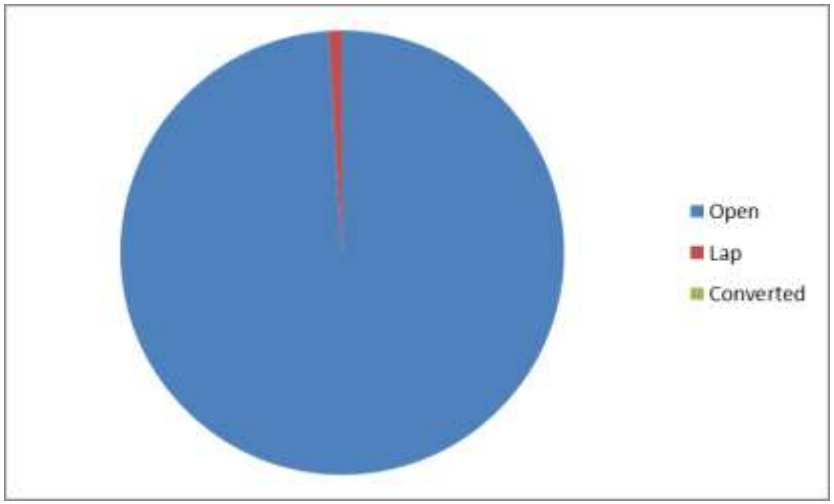
Use of theatre resources

Table 9: Malignant status prior to and after surgery by primary site among all surgical procedures performed by the GO team in 2016 (some women will have multiple surgeries included)

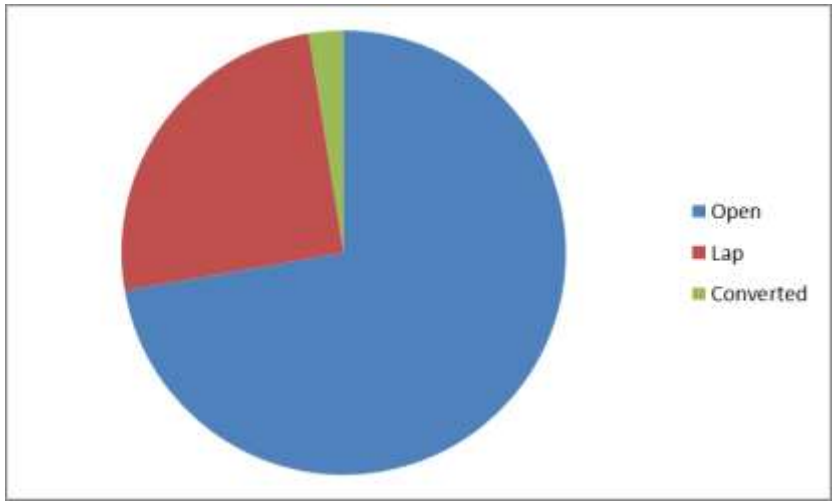
	Total		Ovarian		Peritoneum		Fallopian tube		Endometrium		Uterus		Cervix		Vulva		Vaginal		Non-gynae cancer	
	N=	544	N=	120	N=	11	N=	31	N=	146	N=	14	N=	128	N=	68	N=	14	N=	8
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Diagnosis (after surgery)																				
Benign	59	10.8	37	30.8	0	0	1	3.2	8	5.5	1	7.1	0	0	8	11.8	2	14.3	1	12.5
Pre-malignant	30	5.5	0	0	0	0	0	0	1	0.7	0	0	12	9.4	13	19.1	4	28.6	0	0
Malignant	427	78.5	83	69.2	11	100	30	96.8	137	93.8	12	85.7	111	86.7	33	48.5	5	35.7	5	62.5
Missing	28	5.1	0	0	0	0	0	0	0	0	1	7.1	5	3.9	14	20.6	3	21.4	2	25.0

MAS for endometrial staging

2015



2016



Cytoreduction for Ovarian, Tubal, Peritoneal cancers

	Total 2016		2015	Primary surgery 2016		2015	Interval surgery 2016		2015
	N	116	90	N	81	64	N	35	26
Residual disease		%		n	%	%	n	%	%
None	79	68.1	77.8	57	70.4	81.3	22	62.9	69.2
<1cm	21	18.1	12.2	14	17.3	7.8	7	20.0	23.1
>=1cm	16	13.8	8.9	10	12.3	9.4	6	17.1	7.7
Bowel surgery									
Yes	23	19.8	7.8	17	21.0	3.1	6	17.1	19.2
No	93	80.2		64	79.0		29	82.9	

Surgical waiting times: FSA to surgery for new cancers

	2016		2015
	N=	**265**	**N=221**
	n	**%**	
<14 days	78	29.4	34.4
14 - 31 days	113	42.6	38.5
>31 days	65	24.5	24.4
Surgery before clinic	9	3.4	3.7

Complications

	Total		Malignant		Premalignant/ Benign	
	N	544	N	427	N	89
	n	%	n	%	n	%
Intraoperative complications						
>1000ml blood loss	20	3.7	18	4.2	2	2.2
Bowel injury	1	0.2	1	0.2	0	0.0
Bladder injury	6	1.1	5	1.2	1	1.1
Ureteric injury	1	0.2	1	0.2	0	0.0
Other	11	2.0	9	2.1	1	1.1
Postoperative complications						
Transfusion	50	9.2	49	11.5	1	1.1
Febrile morbidity	25	4.6	24	5.6	1	1.1
Wound infection	9	1.7	7	1.6	2	2.2
Thromboembolism	2	0.4	2	0.5	0	0.0
Cardiovascular	5	0.9	5	1.2	0	0.0
Gastro-intestinal	24	4.4	5	1.2	0	0.0
Urinary retention	33	6.1	26	6.1	7	7.9
Return to theatre within 6 wks	13	2.4	12	2.8	1	1.1
Readmission within 6 wks	47	8.6	42	9.8	5	5.6

Readmission rate doubled

Return to theatre increased

Bladder injury increase

Febrile morbidity increased

Retention increased

Transfusion rate decreased

Bowel injury decreased

No perioperative deaths

In summary: the good and the bad

- Colposcopy standards
- Increased biopsy rate
- Lead clinician ADHB
- SMO FTE, list cover
- Fellow and CNS funding
- MDM
- Supraregional tumour stream
- Engagement from referring DHBs
- Move to MAS
- Surgical wait times
- Theatre capacity
- FCT targets
- M+M inadequate
- Data

Future direction

- Plan for population growth and increasing comorbidities
- Balance Service delivery and Surgical training
- Balance limited resources and quality of care

- Recognise changing practices
  - Sentinel nodes
  - Robotics

- Improve data collection
  - Survival data
  - Long term morbidity
  - Links with other departments

Acknowledgements

- Deralie Flower Lead Colposcopist
- Colposcopy nursing and admin staff
- Pam Cunningham

- Gyn Oncology Registrars and House Officers

- Gyn Oncology MDT:
  - Gynae Oncology
  - Medical Oncology
  - Radiation Oncology
  - Radiology
  - Pathology
  - CNS
  - Administrator
  - Unit leads and CNCs
  - Ward 97
  - Level 9 theatre staff
  - Anaesthetics, DCC
  - ADHB surgeons