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Diagnosis, Pathways of Management and Investigations in Endometrial Cancer

Graham Geary, ST7
Royal Derby Hospital
Gynae Oncology Symposium 2018

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Aims and objectives

- History and risk factors
- Pathways of referral and management
- Investigations
- Breaking bad news

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History – abnormal menstrual bleeding

- Post menopausal bleeding = vaginal bleeding 12 months or more after last period (5-10% risk of cancer)
- Unscheduled/breakthrough bleeding on HRT
- Persistent prolonged or intermenstrual bleeding
- Over 45 and menorrhagia or irregular bleeding

NICE / BGCS

Risk factors for endometrial cancer

- 37% linked to major lifestyle factors
- Unopposed oestrogens – lifetime exposure
- Increasing age
- Obesity (2.5x)
- Diabetes (40-81% increase)
- HRT use
  - 2.3x higher oestrogen-only vs non-users -> heavily monitored
  - 22% lower in continuous/combined HRT
- Tamoxifen (3x, but high false positive rate)
- Lynch syndrome (early, 42-60% lifetime)

Screening

- Screening for asymptomatic women in general population – no evidence of reduction in mortality
  - Has unacceptable false positive rates
- Lynch syndrome – annual screening from age 35 with endometrial biopsy and transvaginal ultrasound scan
- Not effective for those on tamoxifen

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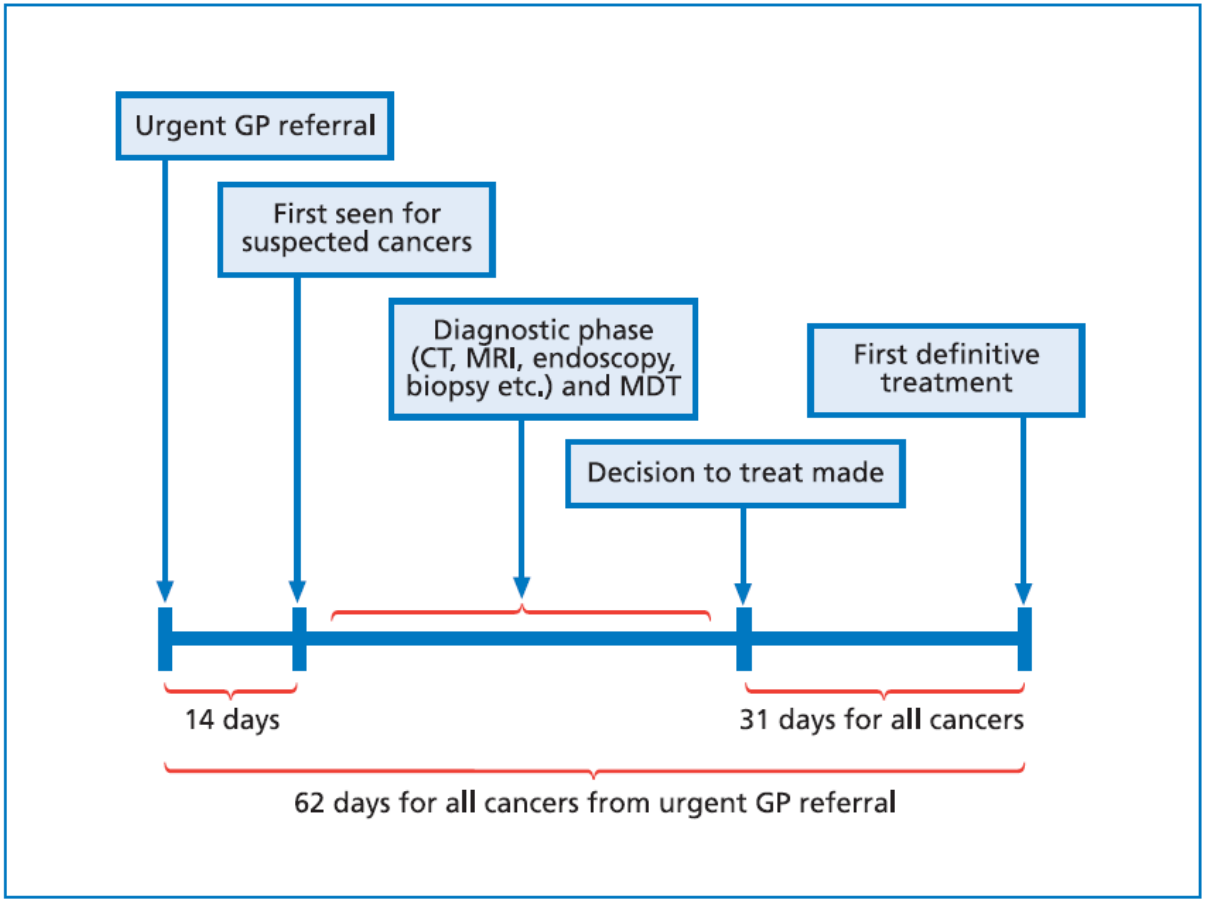
Pathways – policy milestones

- "NHS Cancer Action Plan" – 2000. DoH, Alan Milburn
  - "in too many areas the reality of our cancer services fails…"
  - "a programme of investment and reform to tackle these problems"
  - Two week, one month and two month targets
  - Rolled out between 2002-2007

- "Ensuring Better Treatment: Going Further on Cancer Waits" – 2009. NHS Improvement
  - Improvements in data collection mandated – in line with 18 week pathway –
  - New data rules highlighted deficiencies
  - Case studies to make practical

Pathways - overview



Source: Department of Health 2008

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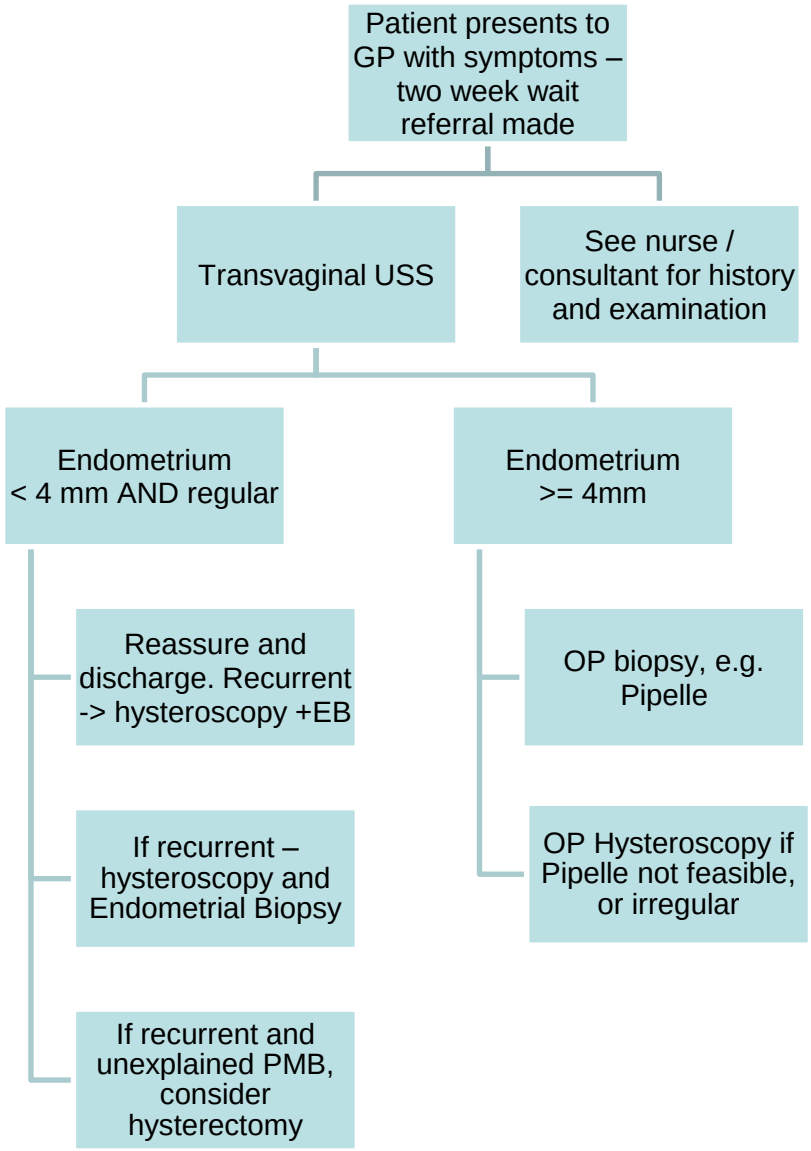
Referral and investigation pathway (BGCS)



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Triage of referrals

- GPs – Choose and Book - all 2 ww
  - Quite some choice available
- Vetted by consultants/CNS/nurse hysteroscopists
  - Often to ensure scan first
- Specialist PMB clinics
  - Some with hysteroscopy as “one-stop”
  - Overflow to GOPD
- Different configurations across Trusts

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Pathways – Local Experience

2WW Referrals to Gynae for Derby Teaching Hispitals

	Total referrals seen during the period	Seen within 14 days	% meeting standard	National % meeting standard	Target
Apr-17	133	132	99.25%	94.3	93%
May-17	132	132	100.00%	95.8	93%
Jun-17	113	113	100.00%	95.3	93%
Q1 2017-18	378	377	99.74%	95.2	93%
Jul-17	145	143	98.62%	95.6	93%
Aug-17	131	129	98.47%	95.1	93%
Sep-17	143	139	97.20%	94.9	93%
Q2 2017-18	419	411	98.1%	95.2	93%
Oct-17	148	146	98.65%	95.6	93%
Nov-17	142	141	99.30%	95.8	93%
Dec-17	119	117	98.32%	95.7	93%
Q3 2017 - 18	409	404	97.96%	95.7	93%

- Large majority are seen within 2 weeks of referral
- Target 93%

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Pathways – Local Experience

31d First Treatments for Gynae at Derby Teaching Hospitals						
Tumour Type	Total treated	Treated on or within 31 days	Treated after 31 days	% Meeting Standard	National % meeting standard	Target
Apr-17	12	11	1	91.67%	97.1	96%
May-17	18	17	1	94.44%	96.9	96%
Jun-17	17	17	0	100.00%	97.3	96%
Q1 2017 - 18	47	45	2	95.74%	97.1	96%
Jul-17	19	17	2	89.47%	96.7	96%
Aug-17	14	14	0	100.00%	97.4	96%
Sep-17	9	9	0	100.00%	96.1	96%
Q2 2017 - 18	42	40	2	95.24%	96.9	96%
Oct-17	11	11	0	100.00%	97.1	96%
Nov-17	27	26	1	96.30%	96.5	96%
Dec-17	17	17	0	100.00%	97.6	96%
Q3 2017 - 18	55	54	1	98.18%	97.1	96%

- Majority receive first treatment within 31 days of decision to treat
- Target 96%

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Pathways – Local Experience

62d Standard for Gynae at Derby Teaching Hospitals

-	Derby Gynae %	National Apr 17	Target
Apr-17	54.55%	82.1	85%
May-17	100.00%	78.1	85%
Jun-17	85.71%	73.8	85%
Qtr 1 17/18	82.22%	77.7	85%
Jul-17	73.68%	73.8	85%
Aug-17	100.00%	79.1	85%
Sep-17	100.00%	76.0	85%
Qtr 2 17/18	88.64%	76.6	85%
Oct-17	100.00%	81.00	85%
Nov-16	74.19%	77.00	85%
Dec-17	88.24%	80.30	85%
Qtr 3 17/18	83.05%	79.40	85%

- Some months more challenging than others – majority start their treatment within 62 days of referral
- Target 85%

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Pathways for management

- All should be discussed at a specialist MDT
- Presumed Grade 1/Grade 2, FIGO 1a

  ⇨ Diagnostic Centre AKA Cancer Unit

- Presumed 1b or above OR Grade 3 OR other subtype

  ⇨ Cancer Centre

Coordination of Pathway

- MDT co-ordinators
  - Keep a database of patients and progress – Infoflex
  - Target dates shared at MDT
  - Chase up histology/radiology results
  - Discussion of cases at MDT to decide management
- Weekly patient tracking meeting
  - Pt's day 28 – all discussed
  - Any patient close to treatment dates
  - CNS/MDT coordinator/Managers/Waiting lists
- Clinical Nurse Specialists
  - See in clinic when diagnosis given
  - Contact for patients
  - Support groups
  - Disease info
  - Local services info
- "Identified Key Worker and responsible clinician" at all times (BGCS)

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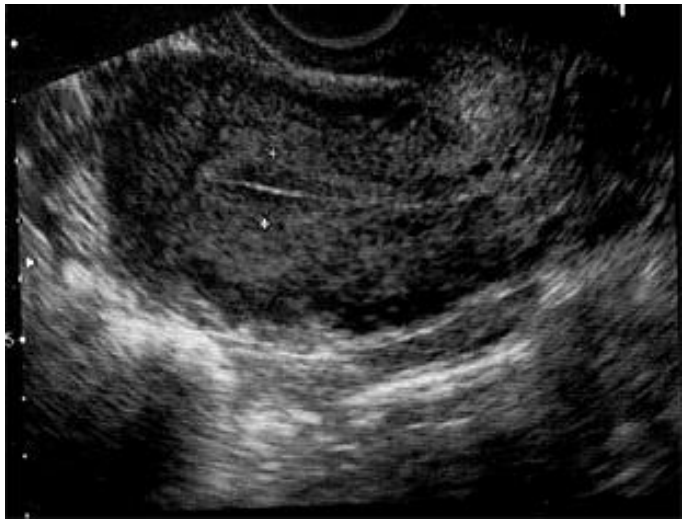
Investigations - overview

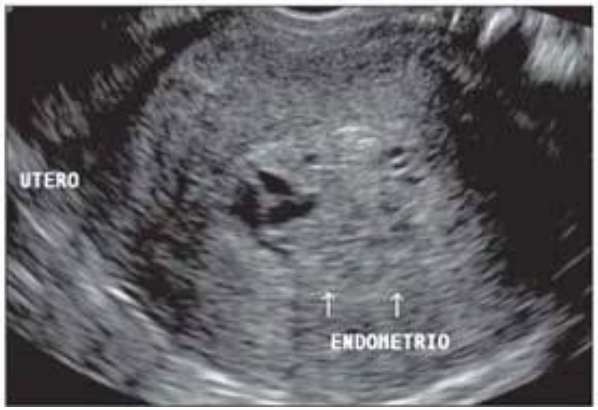
- “Transvaginal scan with measurement of endometrial thickness should be employed as initial investigation for those presenting with PMB”
- Most cost effective approach given <15% prevalence (as in UK)
- If >4mm, outpatient endometrial biopsy
- Hysteroscopy if above not feasible OR ultrasound irregularities and high risk of endometrial cancer

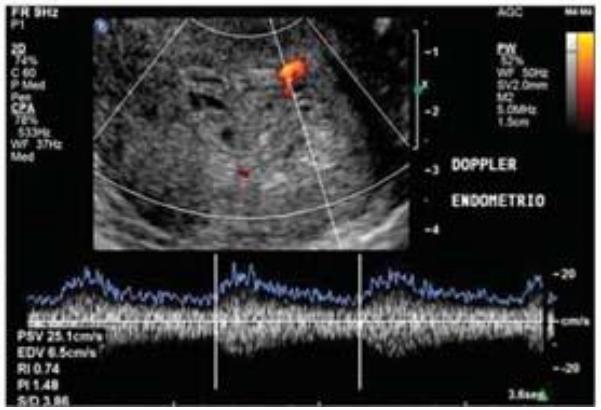
Transvaginal ultrasound scan - Endometrial thickness

- Double thickness of both endometrial surfaces at the thickest point in the mid-sagittal view



- Excludes fluid





Endometrial thickness cut off for further investigation? (BGCS)

- 3mm -> 98% sensitivity to exclude endo ca
- 4mm -> 95%
- 5mm -> 90%

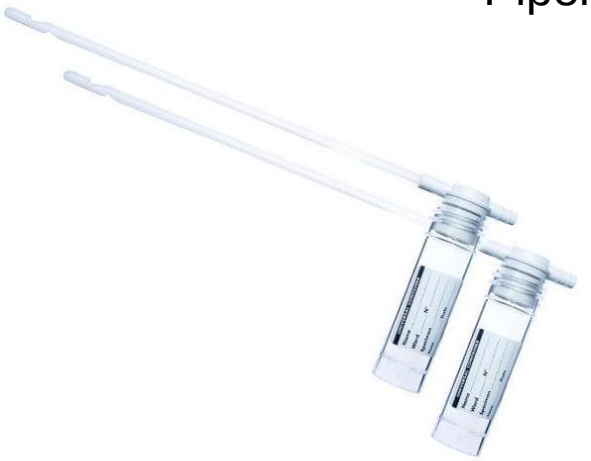
- 8mm if asymptomatic on HRT
- 5mm if symptomatic on HRT / if on tamoxifen

- Important to take risk factors into account
- Open for debate

Endometrial biopsy

- Avoids hysteroscopy
- Safe, cheap and acceptable to patients
- 81% possible
- Post test probability of Ca 81.7% if +ve, 0.9% if negative
- If inserted more than 4cm, an insufficient sample acceptable
- High sensitivity for hyperplasia with atypia and carcinoma
- More likely to miss simple hyperplasia and polyps

Pipelle



Vabra

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Out-patient hysteroscopy

- "Hysteroscopy should, where possible, be carried out as an outpatient" (BGCS)
- Higher failure rate than under general/regional anaesthetic
- Pain/anxiety
- Local anaesthetic/dilatation
- OPH not acceptable to all women

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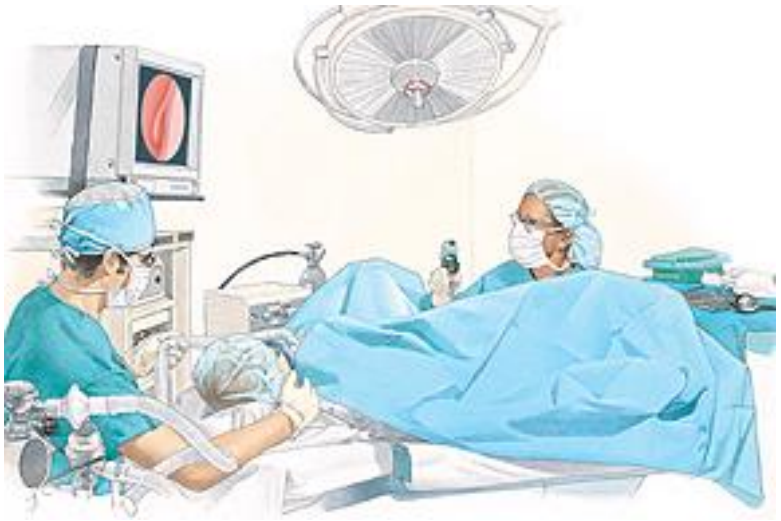
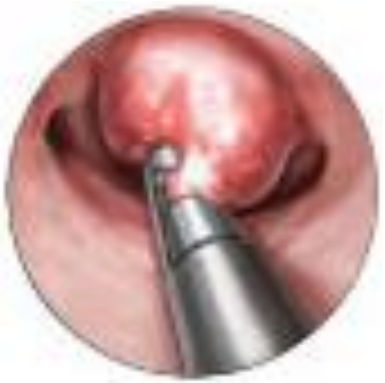
Hysteroscopy - general or regional anaesthetic

- Failed or declined OPH
- Stenosed cervix/nulliparous/older women
- Lower failure rate than OPH
- Anaesthetic risks
- Higher cost
- Time consuming



Innovation in hysteroscopy - Truclear

- Allows removal of tissue, e.g. Polyps or irregular endometrium under direct visualisation
- Mechanical, rotational system
- Continuous cutting
- Fluid management – clear field
- More complete polyp removal?
- Fibroids/RPOC/Myomectomy



Truclear - video

https://www.youtube.com/watch?v=bDK6T5-Ntwc

Pipelle vs D&C

	Pipelle	D&C
Concordance with hysterectomy	67%	70%
Sensitivity for detection of hyperplasia	67%	62%
Sensitivity for detection of atypia	75%	83%
Negative predictive value for malignancy	99%	99%

- "Neither pipelle nor D&C are adequate for focal endometrial pathologies"
- "Consider ultrasound findings prior to endometrial biopsy"

Arch Gynecol Obstet. 2012

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Breaking bad news

- Preparation
  - Read the notes
  - Bleep free time
  - Appropriate team present
- Clinical Nurse Specialists
  - Spend further time with patients
  - Ensure and check on understanding
  - Provide point of contact for patient
- Structure the consultation
  - Identify the patient's starting point
  - Warning shots
  - Ask if pt ready to hear results
  - Be flexible as needed by the patient
  - Summarise
  - Agree a plan
- Factual but empathetic style
  - Non-judgemental
- Treatment summaries – written information

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Breaking bad news – SPIKES framework

- **S**etting up the discussion
- Assessing patient's **P**erception
- Obtaining patient's **I**nvitation to receive information
- Giving **K**nowledge and information to the patient
- Addressing patient's **E**motions with **E**mpathetic response
- Having a **S**trategy and **S**ummarising

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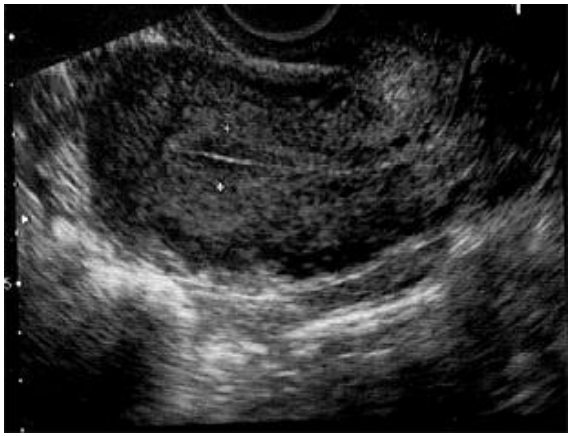
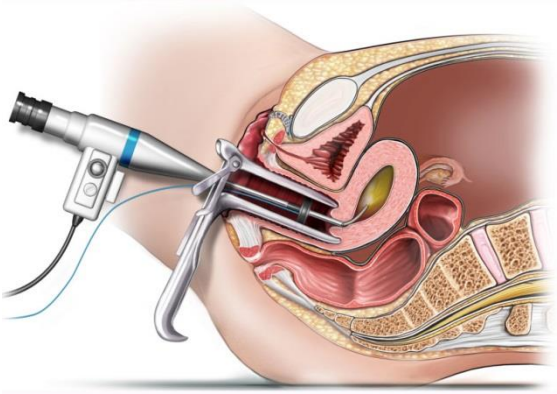
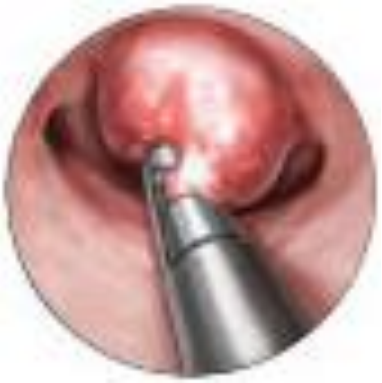
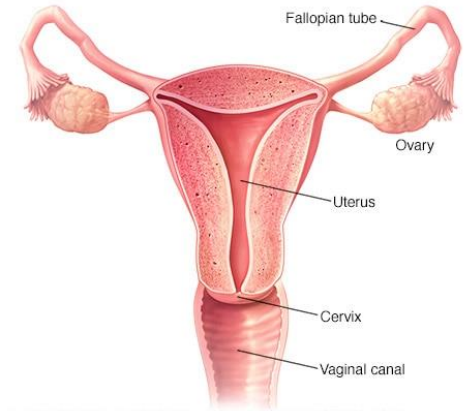
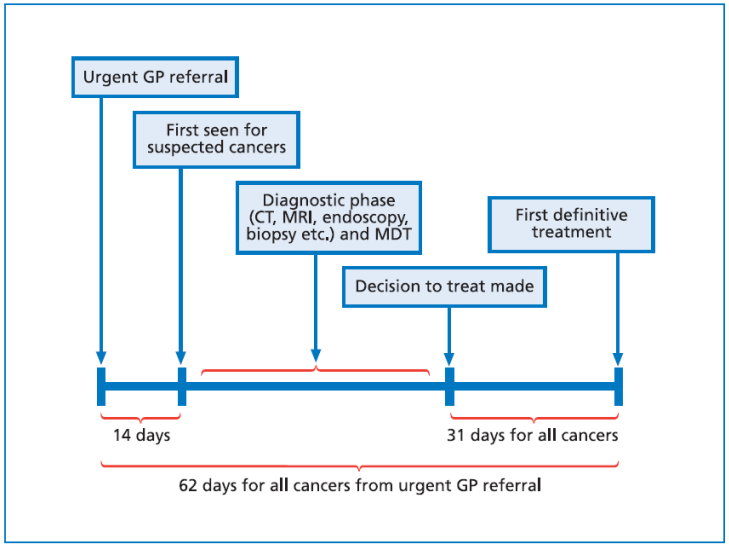
Thank you











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