

## 7.5 GYNAECOLOGICAL CANCERS

### Introduction

Gynaecological cancers affect the female reproductive system. They are made up of: 41% ovarian cancer; 17% cancer of the cervix; 33% cancer of the uterus or womb; and 9% other rarer cancers.

#### *Ovarian cancer*

- Cancers of the ovary represents 4% of all female cancers.
- It accounts for 41% of all gynaecological cancers.
- There are 191 cases and 116 deaths each year.
- Half of the women are diagnosed with ovarian cancer are under the age of 62 years. Five-year relative survival is 43%.
- Survival from ovarian cancer has increased significantly over the past 10 years and there are almost 1,000 women with ovarian cancer living in Northern Ireland.

#### *Cervical Cervix*

- Cancer of the cervix represents 2% of all female cancers and just under one in five (17%) of all gynaecological cancers.
- There are 78 cases and 29 deaths each year.
- Survival is good - around 7 out of 10 patients (68%) are alive five years after diagnosis.
- By 2001 there were 500 women who were living in Northern Ireland having had a diagnosis of cervical cancer within the previous nine years.
- There is a screening programme for cervical cancer for which the biggest risk factor is infection with Human Papilloma Virus (HPV), a common virus in the community. Recently a vaccine has been developed which has been shown to be effective preventing HPV infection and in the long term the risk of getting cervical cancer.

#### *Cancer of the Uterus*

- Cancer of the uterus accounts for around one in three gynaecological cancers.
- There are 155 cases and 20 deaths annually.
- A major risk factor for cancer of the uterus this is obesity.

**Other relevant standards** – Radiotherapy, lymphoedema.

**Overarching standard 37:**

All patients with *gynaecological* cancers should have access to diagnostic tests and *procedures* appropriate to their disease and have their management performed by an appropriately trained and experienced team.

**Rationale:**

There is evidence that patients with gynaecological cancer have improved *outcomes* if they have to access a range of treatment options appropriate to their needs. These treatment options should include access to appropriate surgery (e.g. *pelvic node dissection*) and appropriate *adjuvant therapy* (e.g. *radiotherapy* for *cervical* cancer and *chemotherapy* for early ovarian cancer). The treatment options should take account of their physical and psychological rehabilitation.

**Evidence:**

Clinical Standards Board for Scotland (2001) Clinical Standards, Gynaecological (Ovarian) Cancer

[http://www.nhshealthquality.org/nhsqis/files/Ovarian\\_Cancer%20jan%2001.pdf](http://www.nhshealthquality.org/nhsqis/files/Ovarian_Cancer%20jan%2001.pdf)

Scottish Intercollegiate Guidelines Network (SIGN) (2003) Epithelial Ovarian Cancer <http://www.sign.ac.uk/guidelines/fulltext/75/index.html>

Scottish Intercollegiate Guidelines Network (SIGN) (2008) Management of Cervical Cancer <http://www.sign.ac.uk/pdf/sign99.pdf>

Trimbos JB, Parmar M, Vergote I, et al. (2003) International Collaborative Ovarian Neoplasm Trial 1 and Adjuvant Chemotherapy In Ovarian Neoplasm Trial: Two parallel randomized phase III trials of adjuvant chemotherapy in patients with early-stage ovarian carcinoma. JNCI Journal of the National Cancer Institute, 2003 95(2): 105-112.

[http://jnci.oxfordjournals.org/cgi/content/abstract/95/2/105?ijkey=ea5295aa1d8b449645dcb202a9592d5e1b92ed99&keytype2=tf\\_ipsecsha](http://jnci.oxfordjournals.org/cgi/content/abstract/95/2/105?ijkey=ea5295aa1d8b449645dcb202a9592d5e1b92ed99&keytype2=tf_ipsecsha)

Young R.C. (2003) Early-stage ovarian cancer: to treat or not to treat. JNCI Journal of the National Cancer Institute, 2003 95(2): 94-95.

<http://jnci.oxfordjournals.org/cgi/content/full/95/2/94>

**Responsibility for delivery / implementation**

HSC Board

Public Health Agency

HSC Trusts

Multidisciplinary teams

**Quality Dimension****Effective & Patient Centred**

Adjuvant chemotherapy (i.e. chemotherapy given after surgery) in patients with stage 1c ovarian cancer is vital in terms of the lengthening of life. Evidence suggests that it is much less effective if given more than 4 weeks after surgery.

Pelvic node dissection improves the staging information and allows chemotherapy to be tailored to the needs of the individual. While this does not lengthen life, it does improve quality of life for the patient by keeping them disease free for longer.

Evidence shows that patients with cervical cancer who need chemoradiation have the best outcomes when the treatment is given over a period of no longer than 7 weeks.

<b>Performance Indicator</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Percentage of patients with cervical or endometrial cancers having an MRI reviewed by a radiologist with an expertise in gynae oncology	Clinical Minimum dataset	90% 95%	March 2011 March 2012
Percentage of patients undergoing pelvic node dissection who have had 15 or more nodes removed	Clinical Minimum Data Set	90%	March 2011

Percentage of patients receiving adjuvant chemotherapy for ovarian cancer who start treatment within 4 weeks of surgery	Clinical Minimum Data set	60% 75% 85%	March 2011 March 2012 March 2013
Percentage of patients who are undergoing radical <i>chemoradiation</i> for cervical cancer completing treatment within 7 weeks of starting the course of treatment	Radiotherapy audit	80% 90% 95%	March 2011 March 2012 March 2013

**NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.**

**Overarching standard 38:**

All *gynaecological* cancer patients should be assessed for *voiding difficulties* three months after treatment and be referred to a specialist physiotherapist if needed.

**Rationale:**

Many women who have had a *radical hysterectomy* or *radiotherapy* experience *incontinence*. This is a distressing problem that few patients talk about or ask for help with. As a result this is an area of unmet need.

**Evidence:**

Axelson, SM., Petersen, LK. Urogynaecological Dysfunction after Radical Hysterectomy, *Eur J Surg Oncol* (2006), 32(4):445-449. [http://www.cancer-surgery.net/article/S0748-7983\(06\)00043-6/abstract](http://www.cancer-surgery.net/article/S0748-7983(06)00043-6/abstract)

National Institute for Health and Clinical Excellence (NICE) (2006) Urinary incontinence: The management of urinary incontinence in women  
<http://guidance.nice.org.uk/CG40>

Haylen, B.T., Krishnan, S., Schulz, S., Verity, L., Law, Zhou, J.M., and Sutherst, J (2007) Has the true prevalence of voiding difficulty in urogynecology patients been underestimated? *Int Urogynecol J* (2007) 18: 53–56  
<http://www.springerlink.com/content/d318qp6857x8w537/?p=cffba18a35aa4be080f9a4bd64e65543&pi=10>

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**Quality Dimension****Timely, Effective & Patient Centred**

Timely assessment and referral of patients with voiding difficulties will maximise quality of life for this patient group.

<b>Performance Indicator</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Percentage of patients with gynaecological cancer who have been assessed for voiding difficulties	Manual audit	Establish baseline  Performance level to be determined once baseline established	March 2011
Percentage patients with voiding difficulties who have received specialist physiotherapy	Manual audit	Establish baseline  Performance level to be determined once baseline established	March 2011

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