Gynaecology CRG

Uterine Cancer Guidelines

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UTERINE CANCER GUIDELINES

EPIDEMIOLOGY

The incidence of this disease is rising in line with increasing life expectancy and levels of obesity. Endometrial cancer is now the most common gynecological malignancy in the UK in peri and postmenopausal women with an annual incidence of 9300 and 2300 deaths each year.

The majority of patients have early disease, survival being 90% in Stage I. The overall 10-year survival rate is 78%.

A significant minority of women with endometrial cancer have significant (sometimes life-limiting) co-morbidity and/or morbid obesity. There are significantly increased peri-operative requirements for this group of women and an increasing dependence on High Dependency Unit support. Pelvic surgery in women with morbid obesity can be particularly challenging.

This, together with the need for a high degree of peri-operative support is likely to lead to an increased trend towards centralization of even “low risk” cases in the future.

PATHOLOGY

Should be reported according to the RCPAth standards and datasets (December 2017 for endometrial cancer and September 2018 for uterine sarcoma)

FIGO STAGING OF UTERINE CANCER

FIGO STAGING 2009 FOR UTERINE CARCINOMA

1A Tumour confined to the uterus, none or <50% myometrial invasion

1B Tumour confined to the uterus, ≥50% myometrial invasion

2 Tumour involves the uterus and the cervical stroma

3A Tumour invades serosa or adnexa

3B Vaginal and/or parametrial involvement

3C1 Pelvic lymph node involvement

3C2 Para-aortic lymph node involvement, with or without pelvic node involvement

4A Tumour invasion bladder mucosa and/or bowel mucosa

4B Distant metastases including abdominal metastases and/or inguinal lymph nodes

PATHOLOGICAL GRADING

Endometrial cancer can be grouped with regard to the degree of differentiation of the adenocarcinoma, as follows:

- G1: no more than 5% of a nonsquamous or nonmorular solid growth pattern.
- G2: 6% to 50% of a nonsquamous or nonmorular solid growth pattern.
- G3: greater than 50% of a nonsquamous or nonmorular solid growth pattern.

Widespread high-grade nuclear cytology increases the grade by 1.

PRESENTATIONAND DIAGNOSIS

The diagnosis is usually made following a curettage, hysteroscopy or endometrial biopsy following postmenopausal bleeding.

A full history and clinical examination are particularly relevant to identify significant co-morbidity, which is not uncommon with this disease.

PRE-TREATMENTINVESTIGATION

A full blood count and serum biochemistry should be performed.

MR of the pelvis should also be performed if appropriate, to evaluate myometrial invasion, cervical stromal involvement and the presence of pelvic/paraaortic lymphadenopathy. Ultrasound or MR scans can assess depth of myometrial invasion (CT not as good) and MR or CT scans can assess lymph nodes. Staging is surgico-pathological, based on operative findings and histopathology. The value of MRI in guiding treatment decisions in endometrial malignancy is less well evidenced than for cervical cancer.

MRI is not routinely indicated in **low grade (FIGO G1),** clinical early stage endometrial adenocarcinoma in women fit for hysterectomy.

MRI may be helpful in bulky tumours of histological **grade 2 or 3** on biopsy, to identify cervical involvement and lymphadenopathy, and therefore predict the need for extended surgery.

Locally the Lancashire and South Cumbria Network has adopted the use of MRI for determining depth of myometrial invasion to assess depth of myometrial invasion, cervical involvement, lymph node status and that MRI should be available for pre-treatment “staging” at cancer units/Centre in endometroid endometrial cancer.

The network currently perform CT scans for **non-endometroid cancers** for radiological staging.

All Network patients diagnosed with atypical hyperplasia or endometrial cancer should have their pathology peer reviewed by the central pathology team. The optimum and most efficient pathway is for the unit pathology consultants to directly refer biopsies / slides to the central pathology team.

SURGICAL TREATMENT PRINCIPLES

Staging in endometrial cancer is surgico-pathological and in almost all cases surgery should be the primary treatment.

Endometrioid carcinoma – presumed Stage 1

Only 10% of apparent stage I endometrial cancers have pelvic lymph node metastasis, but in the high-risk categories, i.e. deep myometrial invasion (MI), grade 2-3, this can be as high as 33%. Patients without extrauterine disease could be spared from adjuvant radiotherapy, while those with positive lymph node (stage IIIC) could be considered for systemic treatment.

Most endometrial cancers are diagnosed at an early stage and are low grade endometroid histological sub-types (Type I). These tumours have a good prognosis with hysterectomy alone (90% five-year survival).

However approximately 30% are of high grade Endometrioid or clear cell, serous, carcinosarcoma histological sub-types (Type2 diagnosed at a more advanced stage. The prognosis for these tumours is far less favourable (< 58% five-year survival). Poor prognostic types of endometrial cancer often have cancer metastasis/ spread to the lymph nodes at first presentation. Extra-uterine lymphatic disease upstages the disease and is an indication for adjuvant treatment with chemotherapy and/or radiotherapy.

Lymphadenectomy

The only way to reliably detect these metastases at the moment is to remove the lymph nodes surgically (lymphadenectomy). The prime indication for lymphadenectomy is to complete staging by identifying extra-uterine disease, subsequent tailoring of adjuvant treatment and more accurate estimation of prognosis and survival by accurate staging.

Lymphadenectomy for endometrial cancer increases treatment related morbidity and mortality with the risk of complications increasing with the number of nodes removed. Potential complications include blood loss, vascular injury, lymphocyst formation, thromboembolic disease and lymphoedema. Many women with endometrial cancer are elderly and have significant co-morbidity. Such complications can have a permanent adverse impact on the quality of life in this high-risk group. Lymphadenectomy alone in endometroid endometrial cancer does not show therapeutic benefit as demonstrated by ASTEC and PANICI trials 2009, however accurate staging does determine women that might benefit from adjuvant treatment by reducing the risk of pelvic recurrence.

The Network guideline group decided that lymphadenectomy in high risk cases was appropriate in order to surgico-pathologically stage the disease. Lymphadenectomy should be performed, if it is safe to do so. A proportion of women with uterine cancer will have significant co-morbidities, it is the responsibility of the surgeon to tailor surgery appropriate.

Sentinel lymph node assessment has been extensively investigated in endometrial cancer. Prospective and retrospective studies have demonstrated that SLN algorithms for surgical staging of endometrial cancer have high Negative Predictive Values. For

women with endometrial cancer where lymph node dissection is indicated, the use of SLN algorithms can be considered for surgical staging when imaging suggests that there are no metastases and there is no obvious extra-uterine disease at initial surgical inspection. The use of SLN algorithms compared to systematic lymphadenectomy in endometrial cancer results in significantly less complications (including lymphoedema and lymphocysts). The use of SLN algorithms in conjunction with systematic lymphadenectomy has a higher positive node rate than systematic lymphadenectomy alone. A cervical injection of dye/tracer has emerged as the most suitable technique for SLN detection in endometrial cancer. For SLN in endometrial cancer, either Indo-Cyanine Green (ICG) or a combination of blue dye and Tc99m labelled colloid have emerged as having higher reported detection rates than blue dyes alone. Histological ultra-staging protocols should be utilised in SLN algorithms for endometrial cancer. The omission of a systematic lymphadenectomy in favour of SLN mapping using histological ultra-staging and recourse to a full lymphadenectomy in unmapped cases, is acceptable in the management of endometrial cancer patients if resources are available. Surgeons who perform SLN mapping in endometrial cancer should audit their outcomes including the overall detection rate, the detection rate for each hemi-pelvis, the bilateral detection rate, the presence of macro-metastases, the presence of micro-metastases, the presence of isolated tumour cells, the lymphoedema rate, the lymphocyst rate, complications and disease-free survival. Mapping SLN in endometrial cancer is best performed using a laparoscopic or robotic approach. The use of SLN algorithms in endometrial cancer can be considered in women with high risk pathological types (e.g. clear cell, papillary serous, and carcinoma sarcoma). When SLN algorithms are used in endometrial cancer, a hemipelvis without a detectable SLN should have a full lymphadenectomy on that side.

Stage II Endometrioid Endometrial Disease

If cervical involvement is evident clinically or on MR scan, then a radical hysterectomy may be appropriate. Radical hysterectomy + BSO with lymphadenectomy alone are a curative option in stage II disease where the nodes contain no metastases (Grade B). Women with endometrial carcinoma frequently have other medical problems including morbid obesity and these may preclude radical surgery. Stage II disease may be diagnosed following simple hysterectomy for disease that appears clinically or radiologically confined to the uterine corpus.

Stage III-IV disease

Stage III-IV disease may be managed by surgery with adjuvant radiotherapy and/or chemotherapy and/or hormonal therapy depending on extent of disease and the general health of the patient. If locally advanced disease is suspected, EUA should be performed to determine operability. If the patient is considered inoperable initially, primary radiotherapy should be carried out and if a response occurs surgery can be considered secondarily. Hysterectomy may provide good palliation of local symptoms even if metastatic disease is present although the role of more aggressive debulking surgery in advanced disease is controversial.

SURGICAL TREATMENT RECOMMENDATIONS

Low risk - Stage I disease

Cases of probable Stage IA-IB (G1) and Stage 1A (G2) endometrioid carcinoma comprise approximately 70% of cases. The risk of lymph node metastasis is low (approximately 5%) in this group. Women in this group should be operated upon by the designated gynaecologist in the Cancer Unit.

Surgery should comprise the following:

- Total hysterectomy
- Bilateral salpingooophorectomy
- Inspection / palpation of the upper abdomen and peritoneal surfaces.

The route of hysterectomy should be the most appropriate for the patient and consistent with the surgeon's surgical competencies. There is evolving evidence of the safety and benefit of laparoscopic hysterectomy (TLH or LAVH) for women with endometrial cancer (LAP2 and LACE studies). This has advantages of faster recovery and reduced length of hospital stay. L&SCCN patients should be offered laparoscopic surgery when possible.

Increasing BMI correlates with surgical morbidity and the risk of failed laparoscopic procedures. Alternative surgical strategies include combining apronectomy with laparotomy and hysterectomy with the aim of reducing post-operative wound morbidity and promoting mobility.

Indications for Referral to the Cancer Centre.

Women with the following characteristics should be referred to the cancer centre for treatment in line with Improving Outcomes Guidance:

- evidence of >50% myometrial invasion (suspected stage IB) in G2 disease
- Lymphadenopathy on pre-operative imaging
- Suspected cervical involvement by tumour
- Grade 3 Endometrioid carcinoma
- Non-Endometrioid carcinoma (e.g. serous, clear cell, carcinosarcoma)
- Where the women may not be fit for surgery

The nature of the surgery at the centre will depend upon the tumour histology, preoperative imaging and general health of the patient.

Summary of Network guidance for triaging surgical treatment of Stage 1 Endometrial Endometrioid Uterine Cancer

	G1	G2	G3
No myometrial invasion (Stage 1A)	Low risk	Low risk	High risk
<50% myometrial invasion (Stage 1A)	Low risk	Low risk	High risk
>50% myometrial invasion (Stage 1B)	Low risk	High risk	High risk

- Low risk – TLH, BSO (Unit or Centre)
- High risk (EEC/type1) – TLH, BSO, pelvic lymphadenectomy +/- para-aortic lymphadenectomy or sentinel lymph node assessment
- High risk (NEEC/type2) – TLH, BSO, pelvic lymphadenectomy +/- para-aortic lymphadenectomy or sentinel lymph node assessment and omentectomy/omental biopsy.
- Presumed stage 2 disease – consider radical hysterectomy, BSO, pelvic lymphadenectomy +/- para-aortic lymphadenectomy or sentinel lymph node assessment
- Presumed stage 3/4 disease – debulking of disease with TAH/ TLH, BSO, omentectomy +/- lymphadenectomy

5) Laparoscopic surgery in the management of endometrial cancer

Laparoscopic surgery for endometrial cancer is associated with reduced postoperative morbidity and can be performed with low complication rates in elderly and obese women with endometrial cancer (Grade B). Either, a total laparoscopic hysterectomy + BSO (TLH/BSO) or laparoscopically assisted vaginal hysterectomy + BSO (LAVH/BSO) may be used. The aims of surgery are the same as those with an open surgical approach.

Lymphadenectomy and/or omental biopsy are performed where clinically indicated. As with benign conditions, laparoscopic surgery for endometrial cancer should be performed only by surgeons with appropriate training and expertise in this type of surgery.

Standard vaginal hysterectomy and BSO is not recommended in women who are fit for a general anaesthetic as the peritoneal cavity and upper abdomen cannot be adequately inspected by this approach.

Non-Endometrioid carcinoma (Type II disease)

Serous carcinoma, clear cell carcinoma and carcinosarcoma behave more aggressively with higher recurrence rates. Serous carcinomas have a tendency to intra-peritoneal spread and recurrences are often located outside the pelvis. Omental biopsy is usually

performed. Absence of myometrial invasion does not predict negative lymph nodes or exclude extra-uterine metastasis in non-Endometrioid tumours.
There have been no adequately powered prospective randomised trials addressing the role of full surgical staging in women with these tumour types. In the absence of trial data, the surgical management of these women is:

- total hysterectomy
- bilateral salpingo-oophorectomy
- peritoneal washings
- pelvic lymphadenectomy +/- para-aortic lymphadenectomy or sentinel lymph node assessment
- omental biopsy
- inspection / palpation of upper abdomen and peritoneal surfaces

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A D J U V A N T T R E A T M E N T

1] Endometrioid endometrial adeno, adjuvant post op therapy for stage 1 disease.

Supporting documentation-ESGO, BGCS, NCCN

Risk definition	TLH BSO	Lymphadenectomy TLH BSO (node negative)
Low risk: Stage 1A endometrioid, Grade 1-2, LVSI neg	Observe	Observe
Intermediate risk: Stage 1B endometrioid, Grade 1-2, LVSI neg	Vaginal vault brachytherapy (BT)	Observe or Vaginal vault brachytherapy (BT)
High Intermediate risk: Stage 1A endometrioid, G3	LVSI neg - BT LVSI pos – External Beam Radiotherapy (EBRT) and BT boost (or EBRT boost to vault)	BT

High Intermediate risk: Stage 1 endometrioid, Grade 1-2, LVSI positive, regardless of depth of invasion	EBRT and BT boost (or EBRT boost to vault)	BT
High Risk: Stage 1B endometrioid Grade 3 regardless of LVSI	EBRT and BT boost (or EBRT boost to vault)	BT

2] Endometrioid endometrial adeno, adjuvant post op therapy for stage 2 disease (high risk).

Supporting documentation-ESGO, BGCS, NCCN:

Risk definition	TH BSO	Lymph node assessment with simple TH BSO (node negative)
Grade 1-2, LVSI negative	EBRT + BT	BT
Grade 3 or LVSI positive	EBRT + BT	EBRT + BT

3] Endometrioid endometrial adeno, adjuvant post op therapy for stage III, no residual disease (high risk).

Supporting documentation-ESGO, BGCS, NCCN:

Risk definition	TH BSO	Lymphadenectomy simple TH BSO
Stage 3A	• EBRT + BT. • Consider chemo.	Node negative: • Limited volume EBRT + BT • Consider chemo
Stage 3B	• EBRT + BT • Consider chemo.	• Limited volume EBRT + BT. • Consider chemo.
Stage 3C1	• EBRT + BT. • Consider chemo.	• Patient individualised EBRT + BT. • Consider chemo.

StageIIIC2	• EBRT + BT. • Consider chemo.	• Patient individualised EBRT + BT. • Consider chemo.

4 Endometrioid endometrial adeno, non-surgical therapy for stage 3, with residual disease or stage 4A disease (advanced risk). Stage 4 disease (metastatic):

Individualised consideration to include EBRT, brachytherapy, hormonal therapy, chemotherapy including neoadjuvant chemotherapy, supportive care.

5 Non endometrioid Histology's:

Chemo:

- Serous carcinomas: any tumour invading myometrium or with any other risk features eg LVSI + should be considered for chemo.
- Carcinosarcomas: any tumour invading myometrium or with any other risk features eg LVSI + should be considered for chemo.
- Undifferentiated carcinomas: should be considered for chemo
- Clear Cell carcinomas: may be offered chemotherapy but are less chemo sensitive.

Radiotherapy:

Histology	Adjuvant Radiotherapy

Serous	As per Grade 3 endometrioid
Carcinosarcomas	As per Grade 3 endometrioid
Undifferentiated Carcinomas	As per Grade 3 endometrioid
Clear Cell Carcinomas	As per Grade 3 endometrioid

6 Concurrent chemoradiotherapy:

Considered if patient has active /residual disease and is fit PS 0-1. Examples include:

- Positive margins (e.g. parametria/ cervical /serosal / vaginal)
- LNs radiologically positive and not dissected
- LN+ve histologically and inadequate harvested

In general use cervix protocol i.e., concurrent cisplatin 40mg/m2 weekly x5.

In this setting of concurrent chemoradiation adjuvant / neoadjuvant chemotherapy can be limited to 4 cycles.

- Adjuvant /neoadjuvant Chemotherapy considered for endometrioid carcinomas if extrauterine disease (stage III or IV). First line chemotherapy is usually carboplatin and paclitaxel.

- Lymph node assessment to be either lymphadenectomy or Sentinel Lymph node assessment.

- Lymph node sampling not encouraged, debulking of enlarged lymph nodes at operation is encouraged but is not considered nodal staging unless patient has had lymphadenectomy

- If formal lymphadenectomy has been performed and the lymph node yield is <6 for each hemi-pelvis there should be consideration of adjuvant treatment based on other risk factors.

SPECIAL CIRCUMSTANCES

MANAGEMENT OF WOMEN WITH SEVERE COMORBIDITY

Severe co-morbid conditions not infrequently complicate the management of women with endometrial cancer. In the case of severe co-morbidity that prevents safe general anaesthesia for abdominal surgery, vaginal hysterectomy alone may be performed under regional anaesthesia with acceptable survival rates. Imaging is required to exclude advanced disease. If there is doubt about the suitability of a patient for surgery, she could be referred early to the centre for further assessment and management.
Radiation alone can be considered for early stage disease where the patient is not fit enough for surgery, but this is associated with an increased risk of intrauterine recurrence. In the event of intra-uterine recurrence following primary radical radiotherapy, treatment options are limited. Hysterectomy should therefore be performed if at all possible. Consideration should be given to the Mirena IUS or Progesterone's.

UTERINE SARCOMA

FIGO staging for Uterine Sarcomas 2009.

Leiomyosarcoma and endometrial stromal sarcoma

- Stage 1 – tumour limited to the uterus.
  - IA < 5cm
  - IB > 5cm
- Stage II – Tumour extends to the pelvis
  - IIA Adnexal involvement
  - IIB Tumour extends to extra-uterine pelvic tissue.

- Stage III Tumour invades abdominal tissues (not just protruding into the abdomen)
  - IIIA One site
  - IIIB > one site
  - IIIC Metastasis to pelvic and/or para-aortic lymph nodes.
- Stage IV
  - IVA Tumour invades bladder and/or rectum
  - IVB Distant metastasis

Uterine adenosarcoma.

- Stage I – Tumour limited to uterus
  - IA Tumour limited to endometrium/endocervix with no myometrial invasion.
  - IB ≤ 50% myometrial invasion.
  - IC > 50% myometrial invasion.
- Stage II – Tumour extends to pelvis
  - IIA Adnexal involvement
  - IIB Tumour extends to extra-uterine pelvic tissue.
- Stage III _ Tumour invades abdominal tissues (not just protruding into the abdomen)
  - IIIA One site
  - IIIB > one site
  - IIIC Metastasis to pelvic and/or para-aortic lymph nodes.
- Stage IV
  - IVA Tumour invades bladder and/or rectum
  - IVB Distant metastasis

<u>Uterine sarcoma</u>

Following diagnosis these patients should be referred to the Centre for management.

Careful pathology examination is required to establish the correct diagnosis and determine prognosis and post-operative management. If there is any doubt of the nature of a tumour then a full staging laparotomy should be performed in line with management of Type II disease. Sarcomas generally fall into the following categories:

- Leiomyosarcoma
- Endometrial stromal sarcoma
- Adenosarcoma

Uterine sarcomas are rare, and a definitive diagnosis is usually made following hysterectomy. Endometrial sampling may not diagnose these diseases. Surgery is the mainstay of treatment for all uterine sarcomas. The role of adjuvant treatment in these rare uterine tumours has not been tested in randomized trials but pelvic radiotherapy is usually considered. Treatment decisions following surgery may require discussion with and input from an oncologist with soft tissue sarcoma expertise. The lead oncologist in the network for Sarcoma management is Dr Parikh.
These cases should be referred to the Network Sarcoma MDT for discussion of management. The pathology should be referred to the Network sarcoma team for additional molecular studies where required.

Leiomyosarcoma

Imaging is not reliable in distinguishing leiomyoma from leiomyosarcoma and surgical management must therefore be determined in light of the clinical scenario.

Surgery for leiomyosarcoma comprises TAH/BSO. In the absence of enlarged nodes, routine lymphadenectomy is not usually indicated. Lymph node metastases are uncommon where there is no extra-uterine disease.

Radiotherapy following surgery reduces local recurrence (Grade B).

Endometrial stromal sarcoma (ESS)

Endometrial stromal sarcomas are separated into low grade and high grade tumours using histo-pathological criteria.

Low grade ESS usually behaves in an indolent fashion and usually expresses oestrogen and progesterone receptors. These tumours have a relatively good prognosis following TAH/BSO. Recurrent low grade ESS often exhibits a good response to hormonal treatment.

High grade EES (undifferentiated stromal sarcomas) rarely express oestrogen and progesterone receptors and have a poorer prognosis than low grade ESS.

Chemotherapy is considered following surgery and in cases of advanced disease

Adenosarcoma

Adenosarcomas usually present as polypoid lesions. The risk of lymph node metastasis and the risk of recurrence increase with the proportion of sarcomatous element in the tumour, increased depth of invasion and presence of Lymphovascular space invasion (LVSI).

25-40% women will develop recurrence following TAH/BSO, most commonly in the pelvis or vagina.

FOLLOW UP

The role of routine follow-up for women with completely resected early stage endometrial carcinoma is not well evidenced. Trials addressing the value (or otherwise) of routine follow-up are needed. A suggested follow-up schedule is given below although timing of follow-up visits may be modified according to individual patient circumstances. Patients' views need to be taken into account and it is good practice to discuss discontinuation or continuation of follow-up with individual patients where appropriate. It is acknowledged that it is relatively unusual to detect asymptomatic recurrence in a well patient at routine follow-up. It should be emphasized that patient-initiated attendance with symptoms between routine follow-up visits is more important in the detection of recurrence.

The schedule and nature of follow up should be determined for each individual as defined in the L&SCCN Gynaecology NSSG Follow up Guidelines.

Patients with a low risk endometrial cancer should be discharged at 3 years. Those with a high-risk cancer ie have had adjuvant therapy should be followed up for 5 years & discharged thereafter.

Patients with an intermediate risk can have their follow up individualized as determined at the MDT discussion.

GENETIC COUNSELLING/TESTING

Hereditary endometrial cancer accounts for <5% of all endometrial cancers.

Endometrial cancer is the index cancer in approximately 50% of women Lynch syndrome.

Women with Lynch syndrome have a 40-60% lifetime risk of developing endometrial cancer and are likely to develop another Lynch syndrome-associated cancer within 11 years of their index cancer. Currently prophylactic hysterectomy is the only proven method of preventing endometrial cancer in affected women.

Recognition of women with Lynch syndrome is important as it enables them and their families to undergo genetic counselling and to receive appropriate screening for bowel cancers.

The following women are more likely to have Lynch and should be referred to the Clinical Genetics team for further discussion/ counselling and testing for Lynch if appropriate:

- Any woman with an endometrial cancer diagnosed at the age of 45 or less.
- A patient with endometrial cancer under the age of 60 and the following family history:
    1. A further case of endometrial cancer in a primary degree or secondary relative under the age of 65.
    2. A primary degree relative with bowel cancer under the age of 50.
    3. Two close relatives with bowel cancer under 60 on the same side of the family.
    4. Two close relatives on the same side of the family with ovarian or bowel cancer where the bowel cancer is under 60.

RECURRENT DISEASE

For patients who develop pelvic recurrence following surgery, radiotherapy may be given with curative intent. Imaging of the abdomen and pelvis and chest x-ray should be carried out to assess disease extent. The prognosis is far more favourable for central mucosal disease. Patients are offered pelvic radiotherapy followed by vault caesium treatment.

Extra-pelvic recurrence or recurrence following adjuvant radiotherapy should be considered for chemotherapy which will usually be carboplatin/paclitaxel or single agent carboplatin. Response rates of 50% have been reported with paclitaxel containing chemotherapy with a modest survival benefit noted on addition of paclitaxel to platinum-based chemotherapy in a phase III trial.
Hormonal treatment, usually with high dose progestogens Medroxyprogesterone acetate or megestrol acetate) can be used for women with recurrence. Responses are seen more frequently in women whose index tumour contained oestrogen and progestogen receptors (usually G1/2 tumours). G3 tumours and non-endometrioid tumours often lack hormone receptors and these tumours are less likely to respond to progesterone. Although some women have prolonged responses, median length of response is usually reported as 10 months.

AREAS OF RESEARCH AND DEVELOPMENT

The L&SCCN Gynaecology NSSG and Gynaecology Specialist MDT keep an up to date record of clinical trials open to recruitment on the NCRI research portfolio. A quarterly report is presented to the L&SCCN Gynaecology NSSG on research activity available for gynaecological cancers.

Consideration should be given to recruiting all patients with a recurrence of disease to national trials.

End of Life Pathway

The WHO describes palliative care as 'the active, holistic care of patients with advanced, progressive illness'.[1]

The hub of any patient's medical health is the GP, they are in an ideal position to provide and coordinate this care for a number of reasons:

- they have long-established relationships with their patients which are so important at this critical time in a patient's life
- they are used to dealing with co-morbidity and uncertainty

- they are trained to treat patients holistically which is central to the palliative care approach.

GPs have to be able to provide high quality, equitable care, and to work together effectively with specialist teams if they are to provide the best primary palliative care for all who require it.

There is an increasing imperative to be able to recognise the needs of all patients nearing the end of their lives, not just those with cancer, and to be able to extend some of the developments in care provided for cancer patients to those with other illnesses, which constitute 75% of all deaths. A large proportion of patients receive news of palliative disease which will lead to end of life from the secondary care and steps need to be put in place to ensure provisions are met, this becomes more relevant when the time frame for commencing end of life provision is approximately one year before death i.e. at the time of advancing disease.

Proactive end of life care

In order to provide optimal care for any patient nearing the end of their life, i.e. not just in the terminal or dying phase, but in their last year, we need to be able to do three things:

- identify where a patient is on their illness trajectory – do they have years, months, weeks or days to live? This then allows proactive management, calmer planning and less 'fire-fighting' crisis management
- assess their needs, and those of their family/carers, in the light of their advance care plan
- plan (using a management plan) and then provide their care according to the patient's preferences and varying needs, at different times.

A key point is for all hospital and hospice clinicians who recognise that a patient may be in their last year of life to notify the patient's GP and recommend that the patient is added to the palliative care register. The basis for this lies in the End of Life Care Strategy.

End of Life Care Strategy

The strategy was developed over a period of a year by an advisory board led by Professor Mike Richards and six working groups, consulting over 300 stakeholders. It became apparent that a whole systems approach was required. Accordingly, the Strategy strongly recommends that a care pathway approach should be followed both for care and the commissioning of end of life care.

Key Steps

Identification of people approaching the end of life, and initiating discussions about preferences for end of life care;

Care planning: assessing needs and preferences, agreeing a care plan to reflect these and reviewing these regularly;

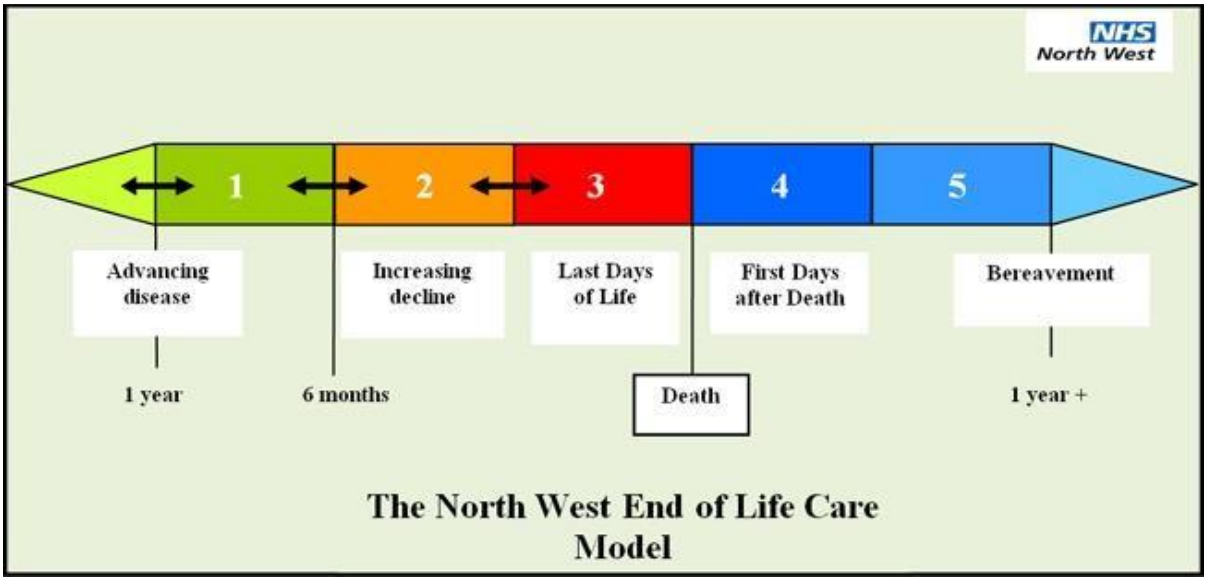
Coordination of care;

Delivery of high-quality services in all locations;

Management of the last days of life;

Care after death; and

Support for carers, both during a person's illness and after their death.



The story of a patient's health from diagnosis of a life-limiting illness can be seen with this model. The model comprises five phases as described below with some examples of practice highlighted.

1. Advancing disease – timeframe: 1 year or more.

Example of practice required -the person is placed on a supportive care register in General Practitioner (GP) practice/care home. The person is discussed at monthly multidisciplinary practice/care home meetings.

2. Increasing decline – timeframe: 6 months [approximate].

Example of practice required -DS1500 eligibility review of benefits, Preferred Priorities for Care (PPC) noted, Advance Care Plan (ACP) in place and trigger for continuing healthcare funding assessment

3. Last days of life – timeframe: last few days.

Examples of practice required - primary care team/care home inform community and out of hours services about the person who should be seen by a doctor. End of life drugs prescribed and obtained, and Liverpool Care Pathway (LCP) implemented.

4. First days after death – timeframe: first few days.

Examples of practice required include prompt verification and certification of death, relatives being given information on what to do after a death (including D49 leaflet), how to register the death and how to contact funeral directors

5. Bereavement – timeframe: 1 year or more.

Examples of practice required include access to appropriate support and bereavement services if required.

As health professionals working within gynae oncology, we treat patients who fit all parameters of the end of life scale, what is required of us is to be aware of whereabouts on this scale our patients fit and advise the GP, District Nurses, Macmillan Nurses accordingly so they can be transferred as appropriate to the primary care end of life register so all their needs can be anticipated and met at the primary level.

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