Gynaecological Oncology News

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How urgent is your referral?

Arranging for diagnostic imaging and blood tests in advance can save valuable time

Within the UK, current guidelines suggest that for optimal cancer treatment it should not take more than a month from a patient's initial presentation to the initiation of definitive treatment.

Postmenopausal Bleeding typically is mild and may only present as "spotting" but needs to be surgically explored in every single case. There is no "normal" bleeding after the menopause. Endometrial sampling (Pipelle) or hysteroscopy and D&C are appropriate methods to exclude a malignancy. Endometrioid adenocarcinoma is a rather slowly growing tumour with good prognosis, but uterine papillary serous or clear cell cancers or uterine sarcomas need to be considered aggressive.

If a **Uterine cancer** is confirmed, we will need to determine the extent of the disease. A CT scan of the pelvis, abdomen and chest and a serum CA125 can be organised prior to consultation with a gynaecological oncologist. The accuracy of CT scanning to indicate disease outside the uterus is approx 70% and CA125 has been able to indicate lymph node metastasis with some success. The extent of disease (e.g., absence of disease outside the uterus) will largely determine the aim of treatment, which in most cases will be cure (rather than palliation).

Most patients will require a hysterectomy and the LACE Trial (Laparoscopic Approach to Carcinoma of the Endometrium) comparing laparoscopic with open surgery is well received among patients. Patients enjoy the advantages of laparoscopic surgery and the safety of having surgery as part of a clinical research protocol. Most patients also appreciate the opportunity to contribute to research. Patients who do not wish to participate in research receive the treatment of their choice.

For **Cervical and Vulval cancer** similar principles of referral apply. For both cancers, clinical vaginal examination (speculum) is essential. Suspicious areas should be biopsied. Vulval symptoms (itching) should always trigger a visual inspection of the vulva. Raised or ulcerating lesions must be biopsied. In addition to CT scans, PET scanning is very sensitive (85%) in diagnosing lymph node metastasis from cervical cancer and is usually initiated after referral to a gynaecological oncologist. PET determines if we offer a radical hysterectomy or chemo-radiotherapy for treatment.

QLD Gynaecological Cancer Research Website launched

The Queensland Centre for Gynaecological Cancer (QCGC) Research group has launched its website to keep patients and their families, medical practitioners, and the community informed about groundbreaking gynaecological cancer research projects undertaken in Queensland. The site can be accessed at ***www.gyncan.org***

The website provides up-to-date information on planned, continuing and completed gynaecological cancer research projects and clinical trials. It shares real stories from the staff, patients and families involved in the research as a reminder that the research is about people.

The website also invites support from the community through tax-deductible gifts to help fund the development and implementation of vital research programmes. QCGC Research funds are administered by The University of Queensland, School of Medicine. Being part of QCGC and UQ, my surgery is proud to support research into the causes and better treatments of gynaecological cancer.

Ovarian cancer symptoms typically include bowel (bloating, indigestion) and urinary (frequency) symptoms. They are unspecific but persistence or the combination of these symptoms should trigger diagnostic imaging (Ultrasound, CT scan) and serum tumour markers (CA125, CA19.9, CEA). Patients with suggestions of ovarian cancer (US, CT, tumour markers) should be referred to a gynaecological oncologist immediately. Please advise the patient that she needs to bring the films along to her consultation. Electronic films (discs) sometimes don't work if needed urgently.

Patients with an **Incidental finding of a pelvic mass** on ultrasound will also need serum tumour markers (CA125, CA19.9, CEA) so that we can calculate the risk of malignancy. Please copy me in any blood tests or fax the results to the rooms. Patients with a low risk of malignancy might benefit from a follow-up scan rather than immediate surgery.

Blood thinning medication (Cartia, Plavix, etc) needs to be stopped approx 10 days prior to surgery. I also ask patients to stop fish oil products, glucosamine, garlic and all other herbs known to cause blood thinning in order to prevent secondary (unnecessary) bleeding from surgery.

Please do not hesitate to give me a call if you wish to discuss an aspect of the above or a specific patient with me.
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