Endometrial Cancer Suspects

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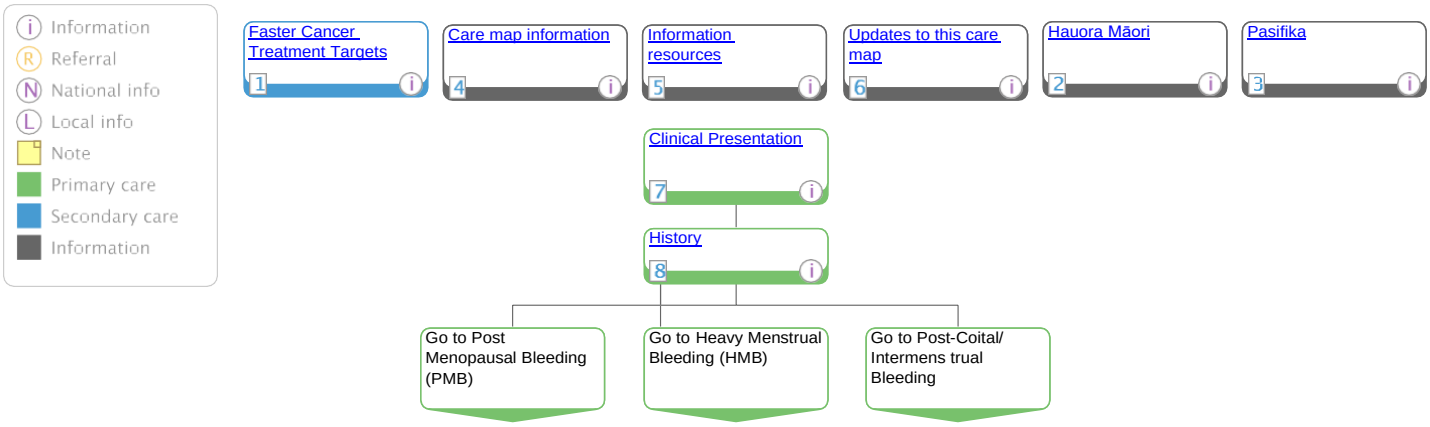

1. Faster Cancer Treatment Targets

Faster Cancer Treatment Targets:

- the Faster Cancer Treatment (FCT) health target builds on the significant improvements that have been made in the quality of cancer services over recent years. It provides a lens across the whole cancer pathway to ensure people have prompt access to excellent cancer services

Faster cancer treatment health target:

- 85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017

For more information:

- view the faster cancer treatment programme

2. Hauora Māori

Māori are a diverse people and whilst there is no single Māori identity, it is vital practitioners offer culturally appropriate care when working with Māori Whānau. It is important for practitioners to have a baseline understanding of the issues surrounding Māori health.

This knowledge can be actualised by (not in any order of priority):

- considering the importance of introductions ('whakawhanaungatanga') - a process that enables the exchange of information to support interaction and meaningful connections between individuals and groups. This means taking a little time to ask where this person is from (Iwi and Hapu) or where they have significant connections to
- acknowledging Te Whare Tapa Wha (Māori model of health) when working with Māori Whānau
- asking Māori clients if they would like their Whānau or significant others to be involved in assessment and treatment
- asking Māori clients about any particular cultural beliefs they or their Whānau have that might impact on assessment and treatment of a particular health issue
- consider importance of whakawhanaungatanga (making meaningful connections) with their Māori client/Whānau
- knowledge of WhānauOra, Te Ara Whānau Ora and referring to Whānau Ora Navigators where appropriate
- having a historical overview of legislation that has impacted on Māori well-being

3. Pasifika

The main Pacific nations in New Zealand are:

- Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau and Tuvalu

Acknowledging general pacific cultural guidelines when working with Pasifika peoples and families:

- cultural protocols and greetings
- building relationships with your Pasifika patients
- involving family support, involving religion, during assessments and in the hospital
- home visits
- contact information

4. Care map information

In scope:

- investigation and management of Post Menopausal Bleeding (PMB), Heavy Menstrual Bleeding (HMB) Post Coital/ Intermenstrual Bleeding and Amenorrhoea to diagnose Endometrial Cancer
- adults over age 18 years

Out of scope:

- diagnosis and management of uterine sarcoma

Definition:

- endometrial cancer:
  - most common type is endometrioid adenocarcinoma, which is composed of malignant glandular epithelial elements
  - clear-cell and serous carcinoma of the endometrium are tumours that are histologically similar to those noted in the ovary and the fallopian tube
  - in approximately 75% of patients with endometrial adenocarcinoma, the invasive neoplasm is localised to the uterus at diagnosis (stage I)
  - PMB – defined as the occurrence of vaginal bleeding 12 months or more after a woman's last menstrual cycle

5. Information resources

Information resources for patients and carers:

- The New Zealand Gynaecological Cancer Foundation
- Cancer Society (NZ)
- Women's Cancer Center of New Zealand
- Gynaecology Cancers - Information for all Women

Information resources for clinicians:

- Cancer Society - Gynaecological Cancer Information
- Ministry of Health High Suspicion of Cancer Definitions
- Reducing cancer inequalities in Māori a priority
- Best practices when providing care to Māori patients and their whānau

6. Updates to this care map

Date of publication: October 2017.
Review in 6 months post publication.

7. Clinical Presentation

NB: Māori and Pacific Island women have higher incidences of and mortality from endometrial and cervical cancers (Robson and Harris 2007; Harris et al 2012; McLeod et al 2011)

Clinical Presentation

Patients with endometrial cancer may present with:

- abnormal vaginal bleeding – the most common presentation in 90% of patients [3] – including:
  - post-menopausal bleeding (PMB) [3] – unexplained vaginal bleeding more than 12 months after menstruation has stopped because of the menopause [9]
  - alterations in the menstrual cycle [43]
  - irregular bleeding [43]

- intermenstrual bleeding [43]
- postcoital bleeding [43]
- vaginal discharge [9]
- abdominal or pelvic mass [2]
- abdominal pain [2,9]
- anaemia [9]
- thrombocytosis [9]
- high glucose [9]

Co-morbidities include [45]:

- Lynch syndrome:
  - lifetime risk of endometrial cancer is 40-60%, compared to 3% in the general population
  - increased risk of synchronous endometrial and ovarian cancer
  - families with Lynch syndrome are identified using:
    - the Amsterdam criteria; and
    - the Bethesda Guidelines
  - refer at-risk women for genetic counselling and testing
- Cowden syndrome:
  - lifetime risk of endometrial cancer is nearly 30%
  - no definitive evidence for endometrial screening – suggested options include:
    - annual endometrial biopsies
    - risk-reducing hysterectomy
- Peutz-Jeghers syndrome:
  - increased risk of gynaecological – and other – cancers
  - suggested screening options include:
    - annual Pap smear
    - transvaginal ultrasound
    - cancer antigen 125 measurement

Symptoms of more advanced disease include:

- pelvic or hip pain [2]
- weight loss [2]
- shortness of breath [2]
- cough [2]
- abdominal or leg swelling [2]
- haematuria [9]
- renal failure [2]
- back pain [2]
- bowel syndromes [2]

NB: Only 10% of patients presenting with PMB have endometrial cancer [7].

References:

[2] National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Uterine neoplasms. V.3.2012. Fort Washington, PA: NCCN; 2012.

[3] Colombo N, Preti E, Landoni F et al. Endometrial cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Ann Oncol 2013; 24 Suppl 6: vi33-vi38.

[7] Scottish Intercollegiate Guidelines Network (SIGN). Investigation of post-menopausal bleeding. A national clinical guideline. SIGN Publication no. 61. Edinburgh: SIGN; 2002.

[9] National Collaborating Centre for Cancer (NCC-C). Suspected cancer: recognition and referral. NICE guideline 12. London: NCC-C; 2015.

[43] Fraser IS, Critchley HO, Broder M et al. The FIGO recommendations on terminologies and definitions for normal and abnormal uterine bleeding. Semin Reprod Med 2011; 29: 383-90.

[45] Royal College of Obstetricians & Gynaecologists (RCOG). Management of Women with a Genetic Predisposition to Gynaecological Cancers. Scientific Impact Paper No. 48. London: RCOG; 2015.

8. History

In patients presenting with abnormal and post-menopausal bleeding (PMB), assess [8]:

- the pattern of bleeding:
  - light, intermittent
  - heavy
  - recurrent
  - persisting
- the timing of bleeding [44]:
  - unscheduled vaginal bleeding is a common side effect of hormone replacement therapy (HRT) in the first 3 months of treatment; but
  - should be reported:
    - at the 3-month review appointment; or
    - promptly if it occurs after the first 3 months
- impact on quality of life [38]

Review possible risk factors of endometrial cancer, including:

- age – the probability of endometrial cancer being present in women with PMB increases after age 50 years
- tamoxifen therapy – clinicians should be aware that post-menopausal women receiving tamoxifen therapy, particularly for longer than five years, are at increased risk
- oestrogen-only HRT:
  - abnormal bleeding in post-menopausal women receiving HRT can be caused by any of the following, which should be considered as differential diagnoses:
    - poor compliance, especially related to omission of progestogens
    - poor gastrointestinal (GI) absorption (for oral preparations), eg due to malabsorption symptoms
    - medication interactions
    - coagulation defects
    - other gynaecological disorders
- hereditary non-polyposis colorectal cancer (HNPCC)
- family history of coagulation disorders [38]
- obesity
- diabetes mellitus (DM)
- hypertension
- a past history of hyper-oestrogenism (endogenous or exogenous)
- early onset of menstruation [3]
- late menopause [3]

Assessing abnormal bleeding in women using HRT:

- enquire whether bleeding pattern is abnormal:
  - unscheduled bleeding is the term used to describe:
    - breakthrough bleeding occurring in females on cyclical HRT
    - any bleeding in females on tibolone (Livial)
    - any bleeding in females on continuous combined HRT (can take up to 6 months for amenorrhoea to develop)

- for sequential regimens abnormal bleeding may:
  - be heavy or prolonged at the end of or after the progestogen phase
  - occur at any time (breakthrough bleeding)
- for continuous combined regimens abnormal bleeding may occur after:
  - the first six months of treatment
  - amenorrhoea has been established
- assess for any other related symptoms or contributory factors associated with endometrial cancer
- consider using the following questions in the assessment:
  - when does bleeding occur with respect to the oestrogen and the progestogen phase?:
    - women on sequential regimens should ideally not experience withdrawal bleeding before completion of the progestogen component of the preparation
  - how long does the bleeding last and how heavy is it?
  - was there a period of amenorrhoea before HRT was started?
  - is there a problem that suggests poor compliance?
  - is there a reason to suspect poor GI absorption?

NB: There is no evidence of an increased risk of endometrial cancer in women using combined HRT.

References:

[3] Colombo N, Preti E, Landoni F et al. Endometrial cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Ann Oncol 2013; 24 Suppl 6: vi33-vi38.

[6] Contributors representing the National Cancer Action Team; 2010.

[7] Scottish Intercollegiate Guidelines Network (SIGN). Investigation of post-menopausal bleeding. A national clinical guideline. SIGN Publication no. 61. Edinburgh: SIGN; 2002.

[8] PRODIGY. Gynaecological cancer - suspected. Version 1.0. Newcastle upon Tyne: PRODIGY; 2005.

[38] National Institute for Health and Clinical Excellence (NICE). Heavy menstrual bleeding: full guideline. Clinical guideline 44. London: NICE; 2007.

[44] National Institute for Health and Care Excellence (NICE). Menopause: diagnosis and management. NICE guideline 23. London: NICE; 2016.

Endometrial Cancer Suspected

Provenance Certificate

Overview | Editorial methodology | References | Contributors | Disclaimers

Overview

This document describes the provenance of the Sub-region Districts (MidCentral, Whanganui and Hawke's Bay District Health Boards) Endometrial Cancer Suspected Pathway.

The purpose of implementing cancer pathways in our Districts is to:

- Reduce barriers so that all people with cancer are able to access the same quality care within the same timeframes, irrespective of their ethnicity, gender, locality or socio-economic status
- Achieve the faster cancer treatment (FCT) health target – 85% of patient receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90% by June 2017
- Implement the national tumour standards of service provision, developed as part of the FCT programme, to support the delivery of standardised quality care for all people with cancer
- Improve equity along the cancer pathway
- Clarify expectations across providers
- Improve communications and follow up care for cancer patients

To cite this pathway, use the following format:
Oncology/Oncology/Endometrial Cancer Suspected

Editorial methodology

This care map was based on high-quality information and known Best Practice guidelines from New Zealand and around the world including Map of medicine editorial methodology. It has been checked by individuals with front-line clinical experience (see contributors section of this document).

Map of Medicine pathways are constantly updated in response to new evidence. Continuous evidence searching means that pathways can be updated rapidly in response to any change in the information landscape. Indexed and grey literature is monitored for new evidence, and feedback is collected from users year-round. The information is triaged so that important changes to the information landscape are incorporated into the pathways through the quarterly publication cycle.

References

This care map has been developed according to the Map of Medicine editorial methodology. The content of this care map is based on high-quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience. This sub-region version of the evidence-based, practice-informed care map has been peer-reviewed by stakeholder groups and the CCP Programme Clinical Lead.

[2] National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Uterine neoplasms. V.3.2012. Fort Washington, PA: NCCN; 2012.

[3] Colombo N, Preti E, Landoni F et al. Endometrial cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Ann Oncol 2013; 24 Suppl 6: vi33-vi38.

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[8] PRODIGY. Gynaecological cancer - suspected. Version 1.0. Newcastle upon Tyne: PRODIGY; 2005.

[9] National Collaborating Centre for Cancer (NCC-C). Suspected cancer: recognition and referral. NICE guideline 12. London: NCC-C; 2015.

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[45] Royal College of Obstetricians & Gynaecologists (RCOG). Management of Women with a Genetic Predisposition to Gynaecological Cancers. Scientific Impact Paper No. 48. London: RCOG; 2015.

Contributors

MidCentral DHB's Collaborative Clinical Pathway editors and facilitators worked with clinical stakeholders such as front-line clinicians and pharmacists to gather practice-based knowledge for its care maps.

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Disclaimers

Clinical Board Central PHO, MidCentral DHB

It is not the function of the Clinical Board Central PHO, MidCentral DHB to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.