Learning Notice: 06/18

Circulation date: 4th September 2018

Learning Notice Concerning Triage of Gynaecological Waiting Lists

Actions required By Whom: Hospital Group CEOs, Hospital CEOs and Managers, Clinical Directors, Gynaecology Clinicians in all Directorates and Hospitals.

By When: For **IMMEDIATE ACTION** in Maternity Hospitals and Acute Hospitals with Gynaecological Units/Services. Please ensure that this is brought to the attention of all relevant staff.

Circulation to GPs nationally (through the office of the National Clinical Advisor & Group Lead Primary Care) on an information only basis.

Learning:

Ms. OC met the Minister for Health on the 25th June 2018. She was diagnosed with IIB adenocarcinoma of the cervix in July 2016 and treated with chemo-radiation. Currently a PET scan shows retroperitoneal adenopathy, suggestive of disease recurrence in lymph nodes. A précis of her history is as follows: Ms. OC, age 50, nulliparous, menopause age 43, presented to her GP in July 2015 with vaginal discharge. This persisted despite antibiotic treatment and when she developed abdominal pain a CA125 was normal. In December of 2015 she was referred to hospital with a "heavy pink vaginal discharge and abdominal discomfort". Ms. OC followed up the referral due to progressively worsening discharge and chronic pelvic pain and was advised that she was on a 15 month non-urgent waiting list. Her GP sought an urgent private appointment sooner and in May 2016 she was diagnosed with probable cervical carcinoma, subsequently confirmed. Cervical cytology in 2007, 2011 and 2014 were originally reported as negative.

1. Significant organic symptomology especially when confirmed clinically (*"heavy pink vaginal discharge")* and in post menopausal women needs investigation. When referred to a hospital setting it is important that significant symptomology is triaged appropriately and investigated quickly. Postcoital/irregular bleeding is less likely in adenocarcinoma, possibly due to the location of the disease, high in the endocervical canal[1].

2. The increasing incidence of adenocarcinoma of the cervix (now 15% – 25% of invasive cervix cancer) may be both relative and absolute. Relative in that the cytology screening programme will prevent squamous cancer more efficiently and absolute as the risk factors may be increasing. HPV screening has the potential to prevent adenocarcinoma in more cases than cytology, and is another compelling reason to move to this form of screening as quickly as possible.

3. Both squamous and adenocarcinoma of the cervix are caused by HPV infection. Vaccination against HPV will play a major role in the reduction of all HPV related cancers and every encouragement should be made to achieve high uptake.

4. Despite the current controversy and negativity surrounding cervical screening, adherence to a well resourced, well designed, and well executed screening programme can reduce the incidence of cervical cancer. Clinicians should be cognisant that false negative results are normal in any screening program and **clinical symptoms should take precedence when triaging referrals**. Clinicians should continue to endorse patient engagement with screening programmes.

Ms. O.C.

Dr. Peter McKenna

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1 Shapley M, Jordan J, Croft PR. 2006. A systematic review of postcoital bleeding and risk of cervical cancer. Br J Gen Pract, vol. 56(527), 453-460.

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