**New Look 2 WW Gynaecology Referral Form – Cancer Exclusion Service**

In recent months there has been a significant upsurge in the number of women being referred onto the 2 WW Gynaecology pathway with post-menopausal bleeding who are still on HRT.

There has also been a large number of women who have been referred without being examined, have not had bloods taken or the results of a pelvic USS reviewed and attached to the 2 WW referral form.

Our aim is to help all those referring under the 2WW pathway to provide the relevant necessary information to streamline the care of patients being referred. This is a gentle reminder and we ask you to:

1. **Examine the patient**. Inspection and bimanual examination to look for causes of the bleeding, including taking a smear ***if it is due/overdue***. During Covid the absolute requirement for examination was wavered by secondary care, but as we have returned to seeing patients in primary care this must be done ***before*** referring the patient. Examination will help determine which Gynae 2 WW pathway to refer the patient onto if they have symptoms/PMB/PCB.

If there is a cervical lesion the patient should be referred to colposcopy via the 2 WW form.

If a vulval or vaginal lesion is present then those pathways should be chosen on the 2 WW form.

Without examination in primary care the incorrect 2WW Gynaecology pathway may be chosen causing the patient to have unnecessary investigations which can lead to a significant delay in getting a diagnosis in secondary care if there is an underlying cancer present. The bloods and pelvic ultrasound will also guide which 2 WW pathway to refer the patient on to, as an ovarian mass or thickened endometrium will mean different pathways are followed.

1. **Order and review the results of appropriate blood tests**. These tests are listed on the 2WW referral form and since August 2022 Ordercomms has specific tabs for the bloods which can be requested at the click of a button.



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| **Test group** | **Patient Sex** | **Screenshot** |
| Gynaecology 2WW (<40 years old) | F |  |
| Gynaecology 2WW (≥40 years old) | F |  |
| Gynaecology 2WW (non-ovarian) | F |  |

1. **Stop the HRT for women on HRT with PMB if they have been on HRT for more than 6 months**. The HRT needs to be ***stopped for 6 weeks*** to see if the bleeding settles. If bleeding continues after 6 weeks off HRT, then a 2 WW Gynae referral is appropriate. If the USS is performed whilst the patient is still on HRT, or has not stopped it for 6 weeks or more, the endometrium is highly likely to be ≥4 mm so should not be done at that time. If the patient is still on HRT when scanned this can result in them having unnecessary endometrial sampling/hysteroscopy which is putting them at increased risk as these investigations are invasive.

If the bleeding returns after restarting HRT (which will most likely be due to insufficient suppression of the endometrium by the progestogen component of the HRT chosen), please consider adjustments to HRT as indicated in the table below.

Advice on complex cases can be sought from the Somerset NHS Menopause Service (contact details are available on TeamsNet under both the ‘Gynaecology’ and ‘Women’ sections). A detailed letter can be sent for Advice and Guidance but please note this service is a limited resource and is unable to give urgent advice.

1. **Review the USS result** – this is essential, as it tells you the endometrial thickness and whether there is any ovarian pathology. The cut off for a referral being accepted is an endometrial thickness of ≥4mm (when not on HRT). If the endometrial lining is thinner than 4mm then the referral will not be accepted by secondary care, as the chance of having endometrial cancer is < 0.1%. Triage by secondary care will now be stricter and a letter explaining why the referral has not been accepted will be sent back to the referrer (in line with the 2WW Lower GI letters that are currently sent out by the Colorectal Hub if a 2 WW lower GI referral is declined). Safety-netting patients in primary care is vital at this stage (see section (5) below). If the endometrium is <4mm PMB will most likely be due to other common causes, eg vaginal atrophy, which should be treated in primary care and the patient should not be referred.
2. **Continuous/recurrent vaginal bleeding (not on HRT at all) following a reassuring scan** For bleeding > 3 months but < 12 months after a reassuring USS please repeat the USS and re-examine the patient. If no obvious non-cancerous cause for the bleeding is seen then make a 2 WW Gynaecology referral via C the Signs/eRS regardless of the endometrial thickness. There is a new box to tick on the new 2 WW referral form for these patients.
3. Heavy perimenopausal bleeding < 50 years – as before, please ask for A&G via ERS.
4. Anyone not meeting the NICE NG12 2WW referral criteria (as detailed on the 2 WW Gynaecology referral form on C the Signs), but who has risk factors for endometrial cancer, should be referred urgently by letter via eRS to Gynaecology or Gynaecological Oncology. Risk factors include:
   1. one major risk factor from: BMI >40; Lynch syndrome; tamoxifen; unopposed oestrogen use (not including vaginal oestrogen)
   2. two or more minor risk factors from: BMI >30; diabetes mellitus; hypertension; liver disease; PCOS.
5. **For those without risk factors for endometrial cancer please optimise HRT**. This advice has been jointly written by the Gynaecology Team at Musgrove and Dr Juliet Balfour (GP with special interest in treatment of the Menopause, who runs the Somerset NHS Menopause Service) in line with current national guidelines. The current advice is as follows:

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| **OPTIONS FOR OPTIMISING HRT TO REDUCE UNSCHEDULED BLEEDING:**   1. Mirena IUS (supplement with additional progestogens such as norethisterone, Provera,   Utrogestan if already in situ)  2. Utrogestan:   1. increase if fibroids, BMI>30 or high dose oestrogen i.e. 200 mg if continuous /   300 mg if sequential  b) change from daily to days 1-25 if using continuous 200 mg already  c) discuss switching from oral to vaginal use (same capsule, dose and regime) - off licence)   1. Switch to an equivalent androgenic progestogen (e.g., Elleste duet, Kliofem /Kliovance, Evorel conti / sequi)     4. Switch to sequential HRT for 6-12 months if the patient is on continuous combined HRT  5 Add in norethisterone, Depo-Provera or POP  6. Consider reducing the dose of oestrogen if indicated  NB oral oestrogen and norethisterone not suitable for those with risk factors for thrombosis |

The Somerset Wiltshire Avon and Gloucester (SWAG) Cancer Alliance endorses the information contained within this comms, it is being implemented by multiple systems and it is in line with national guidelines (*NICE guidance for Suspected Cancer* (NG12) and *British Gynaecological Cancer Society (BGCS) Uterine Cancer Guidelines: Recommendations for Practice)*. Discussions are currently underway nationally about the pros and cons of stopping HRT for women with PMB, and it is anticipated that a Consensus Statement, based upon best practice, will be issued in the autumn which may change the 2 WW Gynaecology pathway in the future.

There is now a new-look 2 WW Gynaecology Referral Form on C-the-Signs which reinforces this good practice.

In the autumn we will be running education events in conjunction with SGPET for Gynaecological Cancers and will be offering training for bimanual and pelvic examination techniques, in the same way as we did for the very well received digital rectal examination (DRE) training, which we provided for allied health professionals and GPs wishing to refresh their skills and knowledge across Somerset last year.