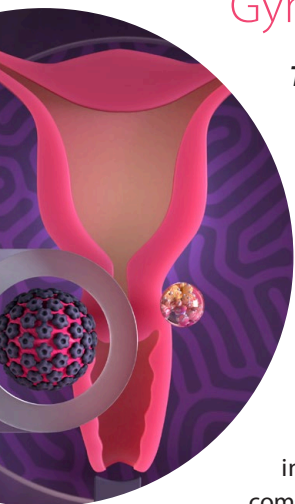


Gynaecological Cancer



The following questions can be used as discussion points for peer groups or self-reflection of practice. The questions relate to the topics within the gynaecological cancer series; it is recommended that the linked articles are read before considering the questions.

Gynaecological cancers make up around 10% of all cancer diagnoses among females in New Zealand; endometrial is the most common, followed by ovarian and cervical. Vulval and vaginal cancers are rare. There are significant ethnic inequities in the incidence of gynaecological cancer, with Māori and Pacific peoples disproportionately affected.

Although many gynaecological cancers cannot be prevented, the cervical screening programme can detect early changes indicative of cervical cancer, HPV vaccination can significantly reduce the risk of cervical, vulval and vaginal cancers and addressing modifiable risk factors such as obesity can reduce the risk of endometrial cancer. The early detection of gynaecological cancers is important as this is generally associated with a good prognosis and high five-year survival rates. Early detection, however, can often be challenging, particularly for ovarian cancer, as symptoms and signs tend to be non-specific and commonly related to another cause, e.g. abdominal or pelvic pain, abdominal bloating or distention, abnormal uterine or vaginal bleeding or discharge, urinary or bowel dysfunction.

The diagnostic workup of a patient with suspected gynaecological cancer typically includes:


- A focused patient history, considering relevant risk factors
- A pelvic examination, including speculum and bimanual examinations (depending on the type of cancer suspected); with cervical screening if due and swabs for sexually transmitted infections, if indicated
- Laboratory tests, depending on individual factors, e.g. full blood count, ferritin, thyroid stimulating hormone, CA 125 (if ovarian cancer suspected)

Further investigations will be initiated, or referrals organised, depending on the type of cancer suspected after examination, e.g. pipelle biopsy and referral for pelvic ultrasound for patients with suspected endometrial cancer, gynaecology referral for patients with suspected vulval cancer. If gynaecological cancer is detected, patients will undergo management in a Gynaecological Oncology centre.

Follow-up and surveillance of patients who have undergone curative-intent treatment for gynaecological cancer is an opportunity to identify recurrence as early as possible, and therefore optimise outcomes. In the majority of cases, gynaecological cancer recurs locally in the pelvic region

within the first two to three years following primary treatment. If identified early, most local recurrences of gynaecological cancers are treatable and potentially curable.


Cervical cancer

 See: **Cervical cancer – early detection and referral**

The risk of cervical cancer is significantly reduced through HPV vaccination and cervical screening programmes, however, there are still an average of 171 females newly diagnosed with cervical cancer each year (from 2015 – 2020) in New Zealand. Upcoming changes to the cervical screening programme in New Zealand in 2023, including moving to HPV primary screening, are predicted to further reduce the burden of cervical cancer.

1. Were you surprised at the high proportion of cervical cancers that can be prevented by prophylactic HPV vaccination? Does this change your perspective on the importance of HPV vaccination, e.g. would you be more likely to use an opportunity within a consultation with a young person to encourage vaccination? Are you aware of what proportion of the eligible patient population at your practice is fully vaccinated against HPV?
2. Māori and Pacific peoples have higher rates of cervical cancer and are less likely to attend cervical screening. What strategies does your practice currently have in place to increase eligible patient's participation in the National Cervical Screening Programme? If none, what sort of things could you do? How do you have a conversation about screening with a patient who is overdue or has never been screened/previously declined?
3. What are your thoughts about the new HPV testing pathway being introduced from July, 2023? Do you think that patients will be more likely to participate with self-testing? Do you anticipate any problems with the new programme? If so, what could be done to mitigate this?
4. In your experience, what symptoms and signs have patients who have been diagnosed with cervical cancer presented with? Would you say that most patients with cervical cancer detected through the cervical screening programme have been asymptomatic?


Ovarian cancer

 See: **Ovarian cancer – early detection and referral**

Ovarian cancer is the second most common gynaecological cancer in New Zealand after endometrial cancer, with an average of 371 females newly diagnosed each year (from 2015 – 2020). Ovarian cancer can be challenging to diagnose as there is no reliable screening test and symptoms may be subtle and non-specific. Diagnosis at an early stage offers a significant survival benefit. Clinicians should be alert for potential symptoms of ovarian cancer and have a low threshold for initiating further investigations.

1. Symptoms and signs of ovarian cancer are often non-specific and commonly encountered in primary care. How do you differentiate the cause of these symptoms and what is your threshold for suspecting ovarian cancer, e.g. presence of risk factors, new or worsening symptoms, symptoms without a likely explanation?
2. In your experience, how common is the cause of ovarian cancer a hereditary cancer syndrome? What is your approach to the management of a patient at high risk of ovarian cancer, e.g. a patient with a BRCA mutation?
3. Referral for an urgent pelvic ultrasound is generally the first-line investigation for a patient with suspected ovarian cancer. How achievable is this in your region for the patient to have an ultrasound within two weeks? In your experience, what is the typical timeframe from pelvic ultrasound referral to completion, report and review?


Endometrial cancer

 See: **Endometrial cancer – early detection and referral**

Uterine cancer is the most prevalent gynaecological cancer in New Zealand, with an average of 627 females newly diagnosed each year (from 2015 – 2020). Endometrial cancer accounts for the majority of uterine cancer diagnoses. Excessive exposure to endogenous or exogenous oestrogen unopposed by progesterone is aetiologically linked to most endometrial cancers. Obesity is one of the most significant risk factors with an estimated six out of ten diagnoses of endometrial cancer attributed to this.

1. Prior to reading this article, were you aware of the extent of the disparity for Māori and Pacific peoples in terms of endometrial cancer? What about the significant link between obesity and endometrial cancer? How do you balance educating patients about risk factors and encouraging a healthy lifestyle with positive messaging that focuses on the benefits of early detection?
2. What symptoms and signs would make you suspicious of endometrial cancer? Have you had any patients recently who have been diagnosed with endometrial cancer; if so, what were their symptoms and signs? Is awareness of symptoms and signs of endometrial cancer something you discuss regularly with patients?
3. Is training for pipelle biopsy available in your area? If you have received training, how confident are you in performing a pipelle biopsy? If you do not have training, is there a clinician who can perform the procedure at your practice? If not, who do you refer to and what is the typical wait time?

Vulval and vaginal cancer

 See: **Vulval cancer – early detection and referral** and **Vaginal cancer – early detection and referral**

Vulval and vaginal cancers are the least common types of gynaecological cancer in New Zealand. Most vulval cancers are squamous cell carcinoma and are usually related to high-risk HPV infection or vulval inflammatory disorders such as lichen sclerosus. The majority of primary vaginal cancers are also squamous cell carcinoma; however, these are rare. Instead, most cancers affecting the vagina are secondary, involving metastases from another site such as the cervix.

1. Have you ever had a patient diagnosed with vulval or vaginal cancer, and if so, what were the symptoms or signs that made you suspect it? Have you ever identified a suspicious vulval or vaginal lesion as an incidental finding?
2. Before reading this article, were you aware of the increased risk of vulval cancer associated with lichen sclerosus? Thinking back to if there was a time when a patient of yours was diagnosed with lichen sclerosus, did you discuss vulval cancer risk? What, if any, surveillance or follow-up plan was put in place?
3. When the cervical screening programme changes to HPV testing with the option of self-testing, how do you think this will affect opportunistic detection of lesions or other abnormalities? In your experience, do patients tend to notice lesions themselves first anyway?

Follow-up and surveillance

 See: **Gynaecological cancers – follow-up and surveillance**

Follow-up and surveillance of patients who have undergone curative-intent treatment for gynaecological cancer is an opportunity to identify recurrence as early as possible, and therefore optimise outcomes. Most cases of recurrence occur within two to three years post-treatment and patients are generally symptomatic; patients must be encouraged to seek advice if symptoms occur between scheduled follow-up appointments.

1. Are you currently involved in the management of any patients post-treatment for gynaecological cancer? If so, what is your role?
2. Were you surprised that evidence shows that most patients experience gynaecological cancer recurrence within two to three years post-treatment? Is this generally the case in your experience? Were you aware that vulval cancer may recur at a much later time than other gynaecological cancers?
3. In your experience, how do you find patients cope after having treatment for gynaecological cancer and being faced with the potential for recurrence? What strategies have you found successful at improving the mental health and wellbeing of these patients? Do you have any support groups in your area that you recommend?