JSNA
JOINT STRATEGIC NEEDS ASSESSMENT

Gynaecology Cancers

JSNA Chapter

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Written by Public Health

PUBLIC HEALTH
KINGSTON
Healthier living, happier lives

NHS
Kingston
Clinical Commissioning Group

THE ROYAL BOROUGH OF
KINGSTON
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Overview

Gynaecological cancers are cancers that affect the female reproductive system. They are an important public health issue as they are amongst the most common cancers in the UK and between one-fifth and one-third of them can be prevented by different lifestyle choices such as maintaining a healthy weight and not smoking. As with other health problems the number of new cases of gynaecological cancer and associated deaths are worse in the more deprived areas[1].

There are six types of gynaecological cancers. Nationally, uterine cancer is the most common followed by ovarian, cervical, vulval, vaginal and placental. As placental cancer is very rare it is not discussed here.

In Kingston, 2.1% of total female deaths (2006-2015) are due to gynaecological cancers (Primary Care Mortality Database, 2006 to 2015), with the most common gynaecological cancer being ovarian cancer.

In 2013 a health and wellbeing survey was completed by over 1,800 women with uterine, ovarian and cervical cancer in the UK by women who had mostly had their initial treatment between 1 and 5 years before filling in the questionnaire[2]. These women reported issues such as anxiety, depression, body image issues, urinary and sexual problems and lack of good information and advice about their cancer[3].

Survival rates vary for each of the gynaecological cancers and is dependent on a number of factors such as how advanced the cancer is when it is diagnosed (the stage of the cancer) and the patient's age and general health.

[1] Public Health England. (2014) National Cancer Intelligence Network. Cancer by Deprivation in England Incidence, 1996-2010 Mortality, 1997-2011. Produced in partnership with Cancer Research UK.

[2] NHS England and PHE. March 2015. Living with and beyond womb cancer.

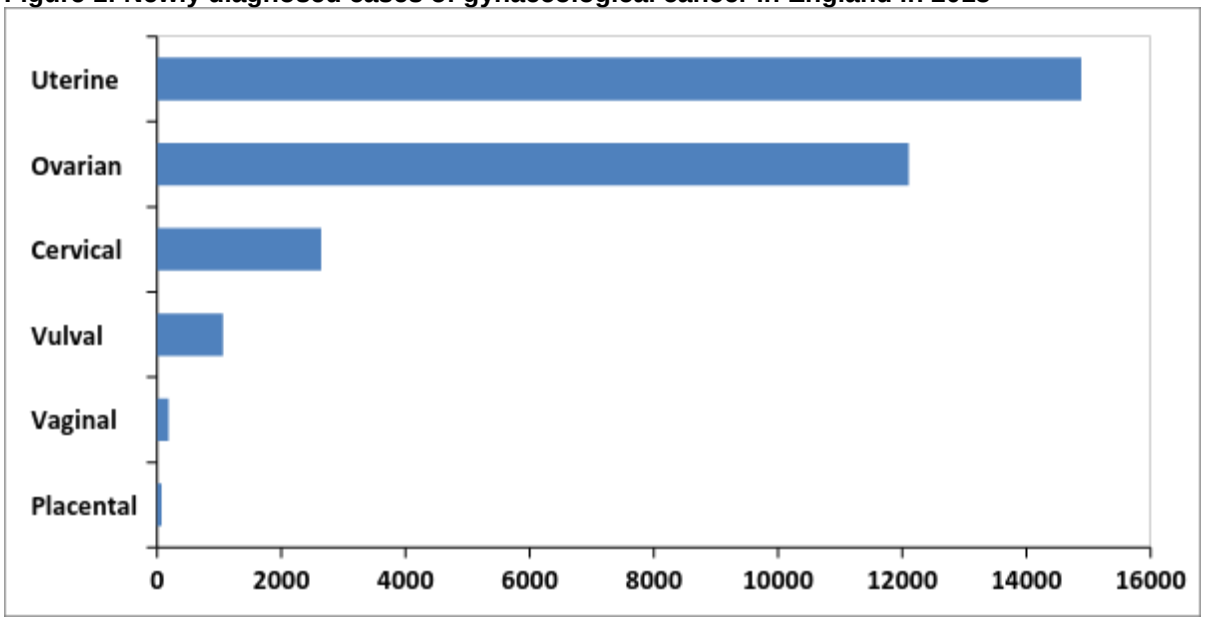
[3] NHS England and PHE. March 2015. Living with and beyond womb cancer.

Introduction

Gynaecological Cancer Incidence

Gynaecological cancer incorporates six types of cancer affecting the female reproductive organs. The most common in the UK being uterine cancer also known as endometrial cancer or cancer of the womb[4]. The second most widespread is ovarian cancer otherwise known as cancer of the ovaries[5]. Cervical is the third most common[6] followed by vulval cancer, vaginal cancer and placental cancer[4] (see Figure 1).

Figure 1: Newly diagnosed cases of gynaecological cancer in England in 2013[7]



Source: ONS Cancer Statistics Registrations, 2013.

Uterine, ovarian and cervical cancer are amongst the top twenty most common cancers in the UK and in the top 10 most common cancers in women[5]. Uterine cancer is the fourth most common cancer in females and ovarian the fifth[5] (see Figure 2).

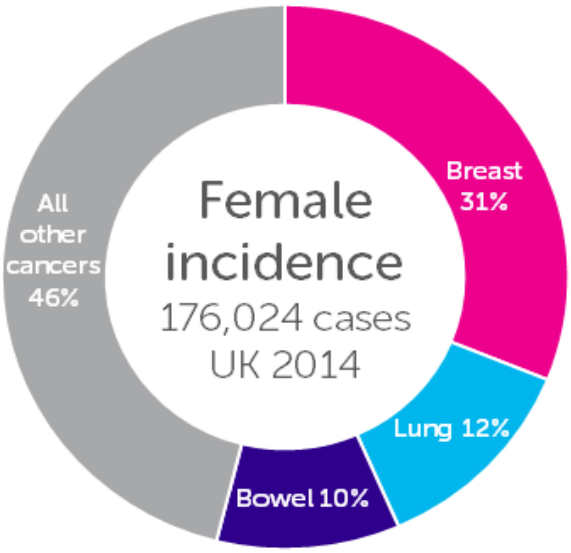
[4] Cancer Research UK. Uterine Cancer Statistics.

[5] Cancer Research UK. Ovarian Cancer Statistics.

[6] Cancer Research UK. Cervical Cancer Statistics

[7] Office of National Statistics. Cancer Statistics Registrations, England (Series MB1), No.44, 2013.

Figure 2: The Three Most Common Cancers in Females, Percentages of All Cancer Cases Excluding Non-Melanoma Skin Cancer, UK, 2014



Source: Cancer Research UK: http://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/common-cancers-compared#heading-Two

Gynaecological Cancer Survival

Overall uterine cancer has the best survival rate with 78% of patients surviving ten years, followed by cervical cancer with 63% of patients surviving ten years and ovarian cancer with 35% of patients surviving ten years[8]. For patients in the UK diagnosed with vulval cancer or vaginal cancer 60% will survive five years or more[9,10].

Gynaecological Cancer Mortality

In 2012 in the UK 4,271 women died from ovarian cancer; 2,025 from uterine cancer; 919 from cervical cancer, 1,203 from vulval cancer and 256 from vaginal cancer[11].

Gynaecological Cancer Risk Factors and Prevention

A large proportion of gynaecological cancers are linked to lifestyle factors such as being overweight, lack of physical activity and smoking. The recent introduction of the human papillomavirus (HPV) vaccination will help to reduce cervical cancer, vaginal cancer and vulval cancer.

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[8] Cancer Research UK. 10 Year survival (2010-2011 England & Wales). URL.....

[9] Cancer Research UK. Statistics and outlook for Vulval Cancer.

[10] NHS Choices Vaginal Cancer.

[11] Cancer Research UK.

Uterine cancer

Uterine cancer is also known as endometrial cancer or cancer of the womb. It is the fourth most common cancer in females[5] (see Figure 2). Uterine cancer is most common in women after the menopause. Typical clinical signs and symptoms of uterine cancer include unusual vaginal bleeding or discharge not related to menstruation (periods), pain on urinating, pain during sexual intercourse or pain in the pelvic area[12].

The main risk factors for uterine cancer are increasing age, hormonal factors (high levels of oestrogen), being overweight, not being physically active, diabetes, genetic factors, taking Tamoxifen for breast cancer and hormone replacement therapy (HRT)[13].

Most uterine cancer cases are treated with surgical removal of the womb (hysterectomy) and often removal of the ovaries and fallopian tubes too. Radiotherapy or chemotherapy are also sometimes used before or after surgery. For women who have not yet gone through the menopause and would still like to have children there is a specific type of hormone therapy that may be used instead of surgery. Treatment can cure the cancer if detected in the early stages, or relieve symptoms and prolong life in cancer diagnosed at a later stage.

Women who have had a hysterectomy may find it more difficult to have sex and may also have a reduced sex drive[14].

Ovarian cancer

Ovarian cancer is the fifth most common cancer in women in the UK (see Figure 2). It is most common in women over 50 who have been through the menopause. One in ten cases of ovarian cancer have a genetic link.

Women have two ovaries which release an egg once a month. There are a number of types of ovarian cancer which affect different parts of the ovaries. The symptoms of ovarian cancer can be quite non-specific and therefore similar to other health problems which can make it difficult to detect initially, these include; persistent bloating, pelvic pain, pain in the lower stomach and problems eating.

Ovarian cancer is usually treated with a combination of surgery and chemotherapy depending on the stage at which it is diagnosed. The stage it is at when it is detected also impacts the survival rate. The earlier it is detected the better the survival rate.

Screening for ovarian cancer is only available for women with a strong family history or inheritance of a particular faulty gene.

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[12] National Cancer Institute. General Information about Endometrial Cancer.

[13] Macmillan Cancer Support. Risk factor and causes of womb cancer (endometrial cancer). Accessed

[14] NHS Choices. Uterine Cancer.

Cervical cancer

Cervical cancer is the third most common gynaecological cancer. It is very rare in women under 25 and usually affects sexually active women between the ages of 30 and 45[15]. The NHS Cervical Screening Programme in the UK has led to a reduction in the number of cases of cervical cancer due to abnormal cells being detected earlier and treated.

The cervix is the entrance to the womb from the vagina. Cervical cancer usually has no symptoms in the early stages (occasionally vaginal bleeding can be a symptom) however cell changes on the cervix can be detected at a very early stage by screening with a smear test (see JSNA Chapter on Cervical Cancer Screening).

Cervical cancer is almost always caused by the human papilloma virus (HPV) which is spread through any type of sexual contact with a man or women[16]. Using barrier contraception such as condoms provides some protection against HPV however they are not infallible as the virus spreads through skin-to-skin contact of the wider genital area.
It is hoped through vaccination against HPV that the incidence of cervical cancer will be reduced (see JSNA Chapter on Immunisation). HPV is the cause of 70% of cervical cancer and through early vaccination, before infection is contracted; the aim is to protect these individuals from developing cancer. The vaccination does not stop infection that is already present and so it is important that girls receive this prior to starting sexual contact. The vaccination itself has been shown to reduce persistent infection with HPV 16 or HPV18 by 90%. The UK uses the Gardasil(R) vaccination which also protects against HPV 6 and HPV11, viruses that cause genital warts.

Current evidence shows that the vaccine is effective for a short period of time but there are still further trials needed to determine the full effective life of the vaccination and also to follow the effect of HPV vaccination on the long term rates of cervical cancer as those who have had the vaccination grow older. As with many preventative interventions, the full extent of the vaccination on UK cervical cancer rates will not be seen until the current girls receiving the vaccine pass through the screening process.
Vaccination against HPV is currently offered as part of the UK immunisation programme to women only. There is ongoing debate as to the ethics and effectiveness of vaccination of males in the UK. The vaccine may protect them against external genital cancer[2] this is an area which in future is likely to see further research and discussion as more is learnt about both disease and vaccine.
If cervical cancer is diagnosed early it is usually treated with surgery however it can also be treated with radiotherapy or a combination of the two. The extent of the surgery required depends on how early the cancer is detected. If it is detected late then it may be necessary to remove the womb. Cases of cervical cancer diagnosed at a later stage need to be treated with both chemotherapy and radiotherapy.

[15] NHS Choices Cervical Cancer.

[16] NHS Choices Cervical Cancer.

Vulval cancer

Vulval cancer is a rare type of cancer affecting a woman's external genitalia including the labia minora, labia majora, the clitoris and the Bartholin's glands[17]. It mainly affects women over the age of 65. Vulval cancer is caused by increasing age, infection with the human papilloma virus (HPV), smoking, skin conditions affecting the vulva and vulval intraepithelial neoplasia (VIN) when there are abnormal cells present.

Symptoms of vulval cancer are specific to the area such as a persistent itch, pain, in the area, changes to the appearance of the area such as changes in colour of the skin or thickened patches of skin, unusual growths such as warts, lumps, open sores or moles, burning pain on passing urine, bleeding from the vulva or blood-stained vaginal discharge between periods[18].

Vulval cancer is usually treated with surgery however radiotherapy and chemotherapy can also be used either in combination with surgery or alone if the patient is not well enough to have surgery or if the cancer is diagnosed at a late stage and spread too far to remove it all by surgery[19].

Vulval cancer can be prevented in some people by using a condom during sex to prevent infection with human papilloma virus (HPV), having regular cervical screening, having the HPV vaccination and stopping smoking[20].

Vaginal cancer

Vaginal cancer is a rare type of cancer. It is most often caused by the human papilloma virus (HPV) which is spread through skin to skin contact of the genital area and can be prevented by using condoms and now with the HPV vaccination. The majority of cases (70%) affect women over the age of 60[21]. Women with previous cell changes picked up by a smear test during cervical cancer screening are more at risk.

Vaginal cancer is treated with either radiotherapy, surgery or chemotherapy depending on which part of the vagina is affected with cancer and the stage at which it is diagnosed.

[17] NHS Choices Vulval cancer

[18] NHS Choices Vulval Cancer

[19] NHS Choices Vulval Cancer

[20] NHS Choices Vulval Cancer

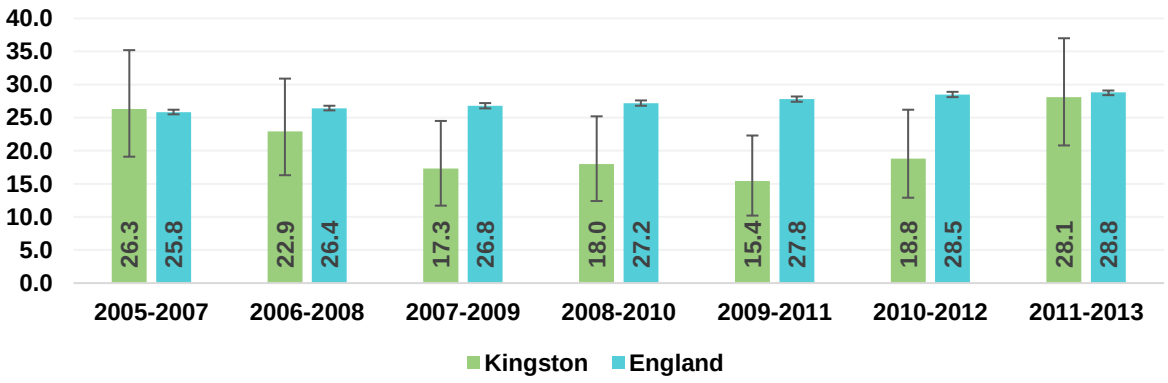
[21] NHS Choices Vaginal Cancer

Local Picture

Incidence

Incidence is the rate of new cases and can give an idea of the demand for initial diagnostic and treatment services.[22]
The incidence of uterine cancer in 2011-13 for Kingston was 28.1 (DSR per 100,000 female population). The Kingston rate was not significantly different from the England average, however, the rates in Kingston have shown considerable variation between 2005-07 and 2011-13.
The incidence of ovarian cancer in 2011-13 for Kingston was 23.0 (DSR per 100,000 female population). The rate in Kingston was not significantly different to the England average of 24.0. The rates in England have not shown a considerable variation between 2005-07 to 2011-13 and the Kingston rates have also been similar between 2005-07 to 2011-13 although there has been some fluctuation through the years.
The incidence of cervical cancer in 2011-13 for Kingston was 11.0 (DSR per 100,000 female population). There has been a steady small increase in the Kingston average from 2005-07 to 2011-13; however this rate was not significantly different to the England average.

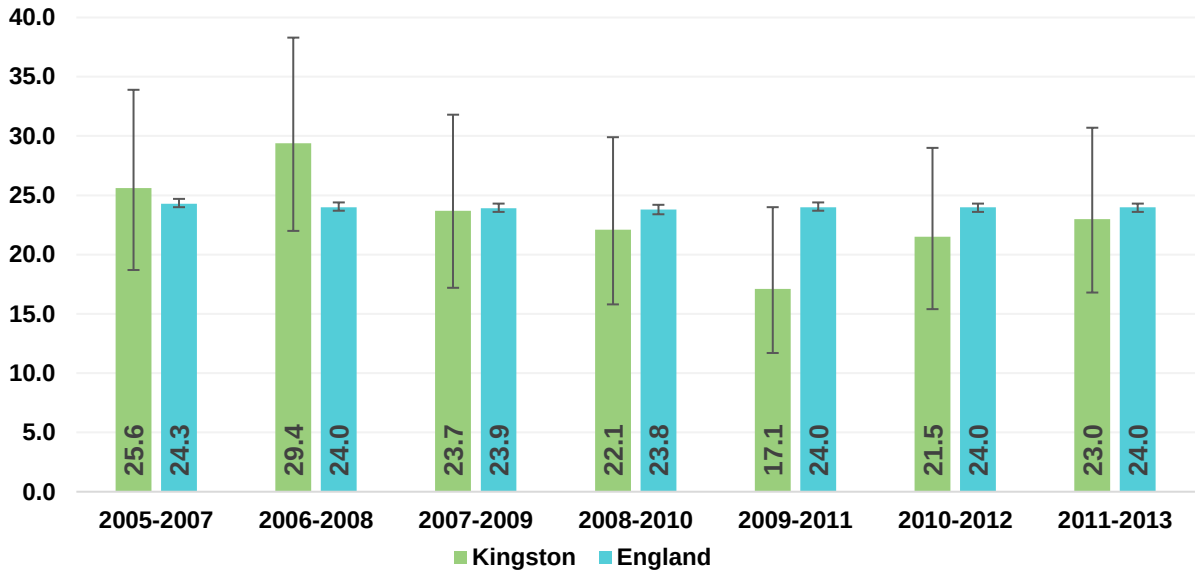
Figure 1: Incidence of Uterine Cancer (DSR per 100,000 female population) in Kingston CCG and England, 2005-07 to 2011-2013



Note: Directly age-standardised (DSR) rates per 100,000 female population were calculated using 2013 European Standard Population up to 90 and over age group

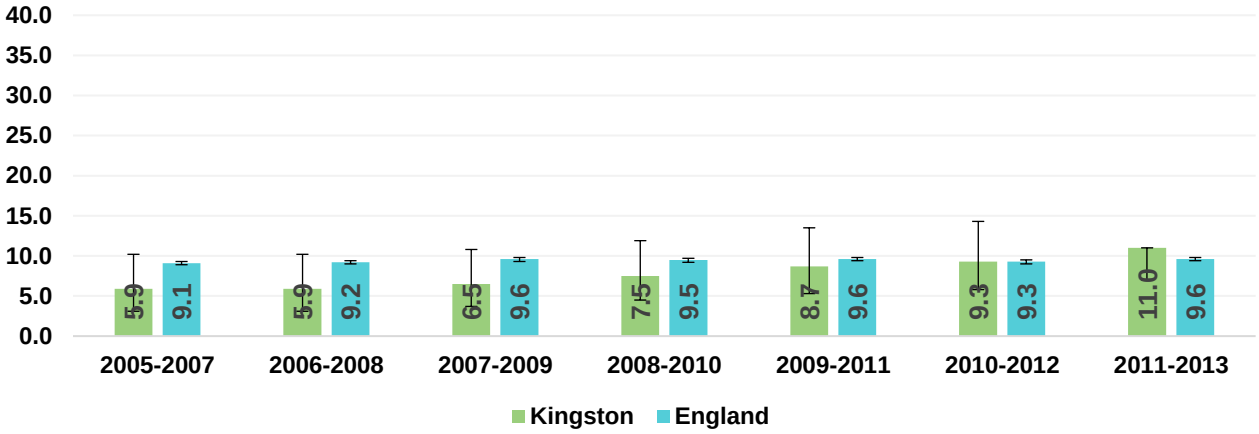
[22] Local Cancer Intelligence. Cancer toolkit. Cancer Incidence in NHS Kingston CCG

Figure 2: Incidence of Ovarian Cancer (DSR per 100,000 female population) in Kingston CCG and England, 2005-07 to 2011-2013



Note: Directly age-standardised rates (DSR) per 100,000 female population were calculated using 2013 European Standard Population upto 90 and over age group
Source: National Cancer Intelligence Network. http://www.ncin.org.uk/profiles/gynae/CCG/atlas.html

Figure 3: Incidence of Cervical Cancer (DSR per 100,000 female population) in Kingston CCG and England, 2005-07 to 2011-2013



Survival

Survival rates are important in giving us an understanding of the success of early presentation / detection as well as the provision of services and difference in these rates could indicate varying clinical practices that need to be looked into.[23]

[23] Local Cancer Intelligence. Cancer Toolkit. Cancer Survival in NHS Kingston CCG

The Kingston survival rates for uterine cancer in 2008-12, shows a one year survival of 91.1 (DSR per 100,000 female population) this is not significantly different to the rates in England which were 90.5. The latest date on three year survival rate at Kingston in 2006-10 was 76.3 again not significantly different compared to the England average of 80.4. The five year survival rate at Kingston in 2004-08 was 76.4 which can be compared to the England average of 75.4 and the two rates were not significantly different.**Error! Bookmark not defined.**

The Kingston survival rates for ovarian cancer in 2008-12, show a one year survival of 87.3 (DSR per 100,000 female population), compared to an England average of 72.5. The one-year survival rates in Kingston are higher than England and the differences are statistically significant. The most recent data on three year survival at Kingston in 2006-10 was 61.1 compared to an England average of 52.2 with no significant difference between the two rates. The five year survival rate in Kingston (2004-08) was 42.8 and was not significantly different compared to an England average at 41.7.

The Kingston survival rates for cervical cancer in 2008-12, show a one year survival of 94.0 (DSR per 100,000 female population) which is not significantly different to the England average of 87.8. The latest data on three year survival shows a Kingston rate of 76.4 in the year 2006-10, which again is not significantly different to the England rate of 75.9 in the same year. The five year survival data also shows no significant difference in the year 2004-08 between the Kingston rate of 74.5 and the England rate of 70.0.

Table 1: Survival rates for Gynaecological Cancers (DSR per 100,000 female population) in Kingston CCG and England, 2001-05 to 2008-12

		Uterine Cancer			Ovarian Cancer			Cervical Cancer		
		1 year	3 years	5 years	1 year	3 years	5 years	1 year	3 years	5 years
2001 - 2005	Kingston CCG	96.9 (87.0 to 100.3)	84.9 (71.6 to 93.5)	85.0 (70.7 to 94.7)	77.7 (65.1 to 86.4)	58.5 (45.0 to 70.1)	51.6 (38.1 to 63.9)	97.4 (78.6 to 100.4)	84.5 (64.8 to 94.4)	81.9 (61.6 to 93.1)
	England	88.0 (87.5 to 88.4)	78.3 (77.7 to 78.8)	73.9 (73.3 to 74.6)	66.5 (65.9 to 67.1)	46.2 (45.5 to 46.8)	38.1 (37.5 to 38.8)	83.5 (82.8 to 84.2)	71.0 (70.1 to 71.9)	66.7 (65.8 to 67.6)
2002 - 2006	Kingston CCG	93.7 (83.7 to 98.1)	82.1 (69.4 to 90.6)	81.5 (68.1 to 91.0)	72.7 (60.8 to 81.7)	55.0 (42.5 to 66.0)	46.2 (34.0 to 57.8)	89.5 (69.9 to 96.9)	78.9 (57.9 to 90.6)	75.5 (54.2 to 88.4)
	England	88.4 (87.9 to 88.8)	78.8 (78.2 to 79.4)	74.4 (73.8 to 75.0)	67.6 (67.0 to 68.1)	47.2 (46.6 to 47.9)	39.1 (38.5 to 39.7)	83.9 (83.2 to 84.6)	71.5 (70.6 to 72.4)	67.4 (66.5 to 68.3)
	Kingston CCG	91.0 (79.4	77.6 (63.4	74.7 (59.6	75.4 (63.3	53.6 (40.8	45.8 (33.3	84.7 (63.3	77.3 (55.1	73.7 (51.3

2003 - 2007		to 96.7)	to 87.6)	to 86.0)	to 84.2)	to 65.0)	to 57.7)	to 94.4)	to 89.9)	to 87.6)
	England	88.9 (88.5 to 89.3)	79.4 (78.8 to 79.9)	75.1 (74.5 to 75.7)	68.9 (68.3 to 69.5)	48.8 (48.2 to 49.4)	40.6 (39.9 to 41.2)	84.6 (83.9 to 85.3)	72.4 (71.5 to 73.3)	68.4 (67.5 to 69.3)
2004 - 2008	Kingston CCG	91.5 (80.6 to 96.9)	79.0 (65.5 to 88.4)	76.4 (62.2 to 87.0)	75.1 (63.3 to 84.2)	52.6 (40.6 to 63.5)	42.8 (31.2 to 54.2)	80.6 (58.9 to 91.9)	77.5 (55.3 to 90.2)	74.5 (51.8 to 88.5)
	England	89.4 (89.0 to 89.8)	79.7 (79.2 to 80.3)	75.4 (74.8 to 76.0)	69.6 (69.0 to 70.2)	49.8 (49.1 to 50.4)	41.7 (41.1 to 42.4)	85.6 (84.9 to 86.3)	73.9 (73.0 to 74.7)	70.0 (69.1 to 70.9)
2005 - 2009	Kingston CCG	89.2 (77.4 to 95.4)	77.1 (63.3 to 86.9)	/	78.2 (66.3 to 86.5)	54.9 (42.1 to 66.1)	/	84.4 (63.1 to 94.2)	85.4 (63.8 to 95.2)	/
	England	89.7 (89.4 to 90.1)	80.0 (79.5 to 80.5)	/	70.5 (69.9 to 71.0)	51.0 (50.3 to 51.6)	/	86.4 (85.8 to 87.1)	75.3 (74.5 to 76.1)	/
2006 - 2010	Kingston CCG	86.0 (73.0 to 93.4)	76.3 (61.7 to 86.5)	/	79.8 (67.7 to 88.0)	61.1 (47.9 to 72.2)	/	83.8 (61.8 to 93.9)	76.4 (53.6 to 89.5)	/
	England	90.0 (89.7 to 90.4)	80.4 (79.9 to 80.9)	/	71.4 (70.8 to 72.0)	52.2 (51.6 to 52.9)	/	86.8 (86.2 to 87.4)	75.9 (75.1 to 76.7)	/
2007 - 2011	Kingston CCG	86.8 (71.8 to 94.5)	/	/	87.5 (75.6 to 94.1)	/	/	89.6 (70.6 to 96.8)	/	/
	England	90.2 (89.9 to 90.6)	/	/	71.9 (71.3 to 72.4)	/	/	87.1 (86.5 to 87.7)	/	/
2008 - 2012	Kingston CCG	91.1 (78.8 to 96.7)	/	/	87.3 (75.4 to 93.9)	/	/	94.0 (77.5 to 98.7)	/	/
	England	90.5 (90.1	/	/	72.5 (71.9	/	/	87.8 (87.2	/	/

		to 90.8)			to 73.0)			to 88.4)		

Note: Values in brackets denote 95% confidence intervals
Note 2: Directly age-standardised rate (DSR) per 100,000 female population using the 2013. This is a European Standard Population

Mortality

Mortality rates and trends allow us to make judgements about which cancer services need to be targeted to improve survival and they can also inform us about the size of the need for End of Life Care for patients and support for families.[24]

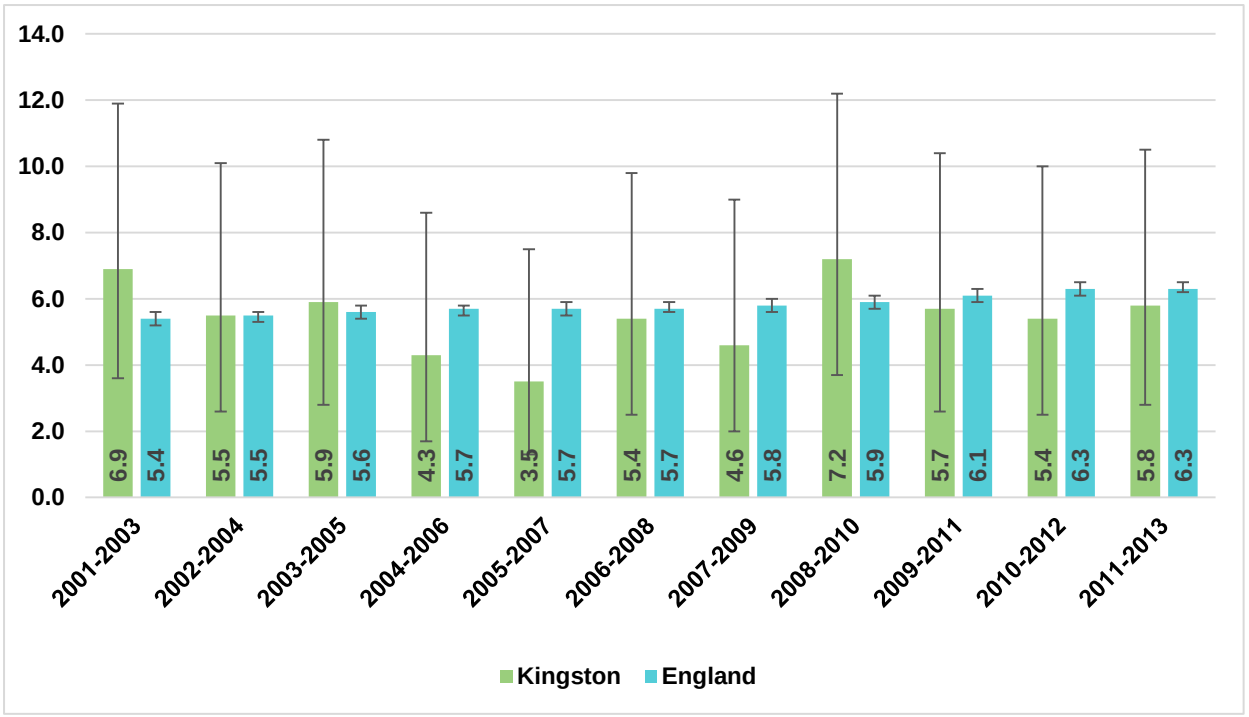
The mortality rate for uterine cancer in 2011-13 was 5.8 (DSR per 100,000 female population) compared to 6.3 per 100,000 in England. There was no significant difference between these figures although there have been variations over the years in the Kingston rate (see Figure 6). **Error! Bookmark not defined.**

The mortality rate for ovarian cancer in 2011-13 was 11.7 (DSR per 100,000 female population) compared to 13.5 per 100,000 in England. There was no significant difference between the Kingston and the England average. Although the figures in 2001-03 and 2011-13 are similar – there has been much variation between the years. See Figure 7.

The death rate for cervical cancer in 2009-13 was 1.9 (DSR per 100,000 female population) compared to 2.9 per 100,000 in England. There has been some fluctuation in the Kingston trend but the figures are not significantly different to the England average. Please note the reporting years for cervical cancer are different to that of ovarian and uterine cancer. See Figure 6.

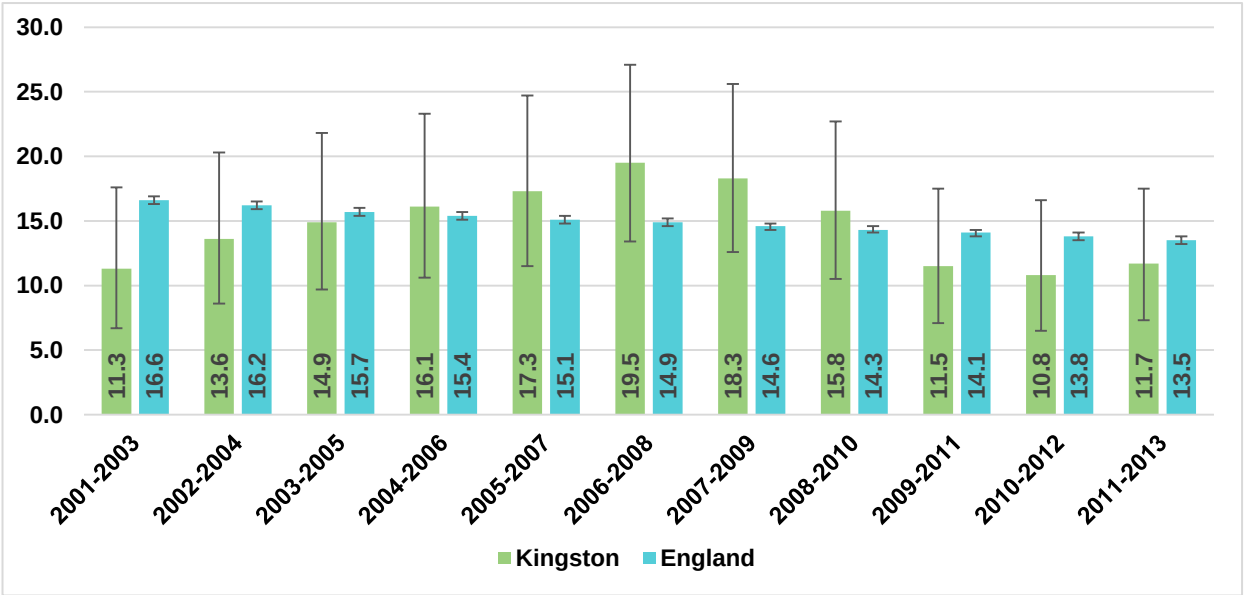
[24] Local Cancer Intelligence. Cancer Toolkit. . Cancer Mortality in NHS Kingston CCG

Figure 4: Mortality from Uterine Cancer (DSR per 100,000 female population) in Kingston CCG and England, 2001-03 to 2011-2013



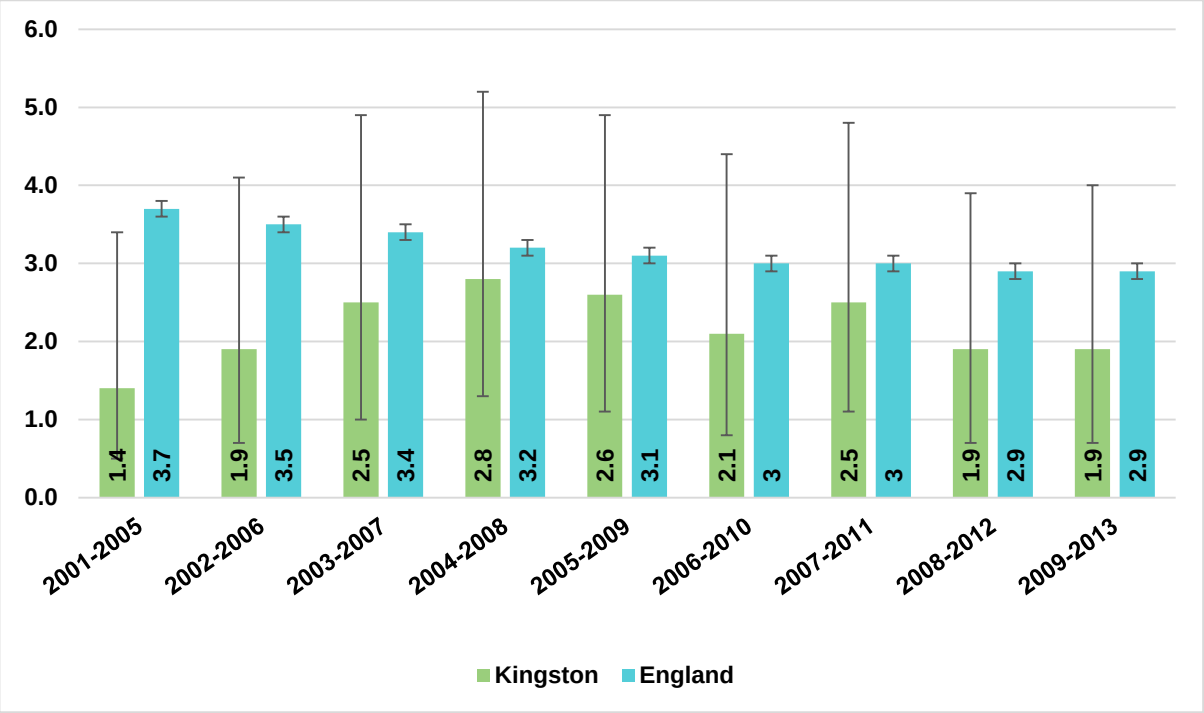
Note: Directly age-standardised rates (DSR) per 100,000 female population were calculated using 2013 European Standard Population up to 90 and over age group
Source: National Cancer Intelligence Network.
http://www.ncin.org.uk/profiles/gynae/CCG/atlas.html

Figure 5: Mortality from Ovarian Cancer (DSR per 100,000 female population) in Kingston CCG and England, 2001-03 to 2011-2013



Note: Directly age-standardised rates (DSR) per 100,000 female population were calculated using 2013 European Standard Population up to 90 and over age group
Source: National Cancer Intelligence Network.
http://www.ncin.org.uk/profiles/gynae/CCG/atlas.html

Figure 6: Mortality from Cervical Cancer (DSR per 100,000 female population) in Kingston CCG and England, 2001-03 to 2011-2013



Note: Directly age-standardised rates (DSR) per 100,000 female population were calculated using 2013 European Standard Population up to 90 and over age group
Source: National Cancer Intelligence Network.
http://www.ncin.org.uk/profiles/gynae/CCG/atlas.html

What Works

The National Institute for Health and Care Excellence (NICE) published guidelines in 2015 entitled 'Suspected cancer: recognition and referral', to assist GPs with recognising patients' symptoms and the clinical signs of cancer with advice on when to refer patients to hospital and which tests to do to enable faster diagnosis and earlier treatment[25]. It contains a specific section dedicated to gynaecological cancer.
The HPV vaccination offered to girls in year 8 of school will help prevent the vast majority of cervical cancer in the future and a large proportion of vaginal and vulva cancer (see JSNA Chapter on Immunisation).

NAEDI initiative
The role of NAEDI was to coordinate and provide support to activities and research that promote the earlier diagnosis of cancer and was an England-based initiative. Download the NAEDI briefing sheet to find out more about the initiative . Although NAEDI has finished Cancer Research UK is continuing activities and research that promote the earlier diagnosis of cancer. The aim is to promote earlier diagnosis of cancer, increasing access to optimal treatment and thereby improving survival rates and reducing cancer mortality through a variety of means. Tackling late diagnosis is a multifaceted challenge and requires action across the whole pathway from public awareness and encouraging people to see their doctor, to supporting GPs and other services so that all patients have timely access to tests, specialist advice and treatment.

Uterine cancer
Recognition and referral
The section on endometrial or uterine cancer in the NICE guidance 'Suspected cancer: recognition and referral' recommends referring women with unexplained post-menopausal vaginal bleeding (12 months after menstruation has stopped because of the menopause) using the suspected cancer pathway referral for a fast track specialist appointment in two weeks.
The guidance also advises GPs to consider a direct access ultrasound scan for women aged 55 and over with unexplained symptoms of vaginal discharge who are presenting for the first time with these symptoms or also have blood in their urine or also have thrombocytosis. Women with blood in their urine and low haemoglobin levels or thrombocytosis or high blood sugar levels should also be referred for an ultrasound scan.

Ovarian cancer
Recognition and referral
The section on ovarian cancer in the NICE guidance 'Suspected cancer: recognition and referral' is taken directly from the NICE guidance on recognising and initial management of ovarian cancer (for women aged 18 and over)[26].

[25] NICE. Suspected cancer: recognition and referral. NICE guidelines [NG12]. June 2015.

[26] NICE. Ovarian cancer: recognition and initial management. NICE guidelines [CG122]. April 2011.

It advises GPs to urgently refer to hospital all women with excess fluid or a mass in the pelvis or abdomen.
For women with persistent symptoms of bloating, feeling full, loss of appetite, pelvic pain, abdominal pain or increased urinary urgency or frequency it advises GPs to carry out a blood test (CA 125) and if this is raised then arrange an ultrasound scan of the abdomen and pelvis. If there are any concerns about ovarian cancer following the ultrasound the women should be referred to the hospital for further investigation.
The guidance also suggests carrying out these same tests in women with unexplained weight loss, tiredness, changes in bowel habit or in any woman over 50 with symptoms suggestive of irritable bowel syndrome (IBS).
Women not suspected of having ovarian cancer but whose symptoms persist or become more frequent are advised to return to their GP.

Cervical cancer
Recognition and referral
In the 2015 NICE guidance 'Suspected cancer: recognition and referral' it recommends a suspected cancer pathway referral for a fast-track appointment in two weeks for women where the appearance of their cervix is consistent with cervical cancer.

Vulval cancer
Recognition and referral
The 2015 NICE guidance 'Suspected cancer: recognition and referral' section on vulval cancer advises GPs to consider a suspected cancer pathway referral for a fast-track appointment in two weeks for women with an unexplained vulval lump, ulceration or bleeding.

Vaginal cancer
Recognition and referral
The 2015 NICE guidance 'Suspected cancer: recognition and referral' section on vaginal cancer advises GPs to consider a suspected cancer pathway referral for a fast-track appointment in two weeks for women with an unexplained palpable mass in or at the entrance to the vagina.

Current Services

There a number of routes patients with symptoms of gynaecological cancer may take within the health care system before they are diagnosed, such as via their GP, via A&E, via an outpatient appointment for another health problem or as an inpatient for another health problem. Patients are advised to visit their GP if they have concerning symptoms.

Prevention Services

There are a variety of programmes available in the Royal Borough of Kingston to help people adopt more healthy lifestyles. These include increasing physical activity, stopping smoking, reducing obesity and encouraging a healthy diet all of which help prevent gynaecological cancer.
The HPV vaccination offered to girls in year 8 of school will help prevent the vast majority of cervical cancer in the future and a large proportion of vaginal and vulva cancer (see JSNA Chapter on Immunisation).

Uterine cancer
It is estimated that over a third of uterine cancers in the UK are linked to lifestyle factors such as being overweight or obese, lack of physical activity (4%) and hormone replacement therapy (1%).

The main preventative actions to reduce risk of uterine cancer are to be physically active and maintain a healthy weight. Physical activity is protective against uterine cancer[27] as is having a healthy body weight. Cancer Research UK advises doing 30 minutes of moderate exercise five times a week. There are six healthy lifestyle services in Kingston helping people be more physically active such as 'Get Active Exercise Referral', 'Walk for Health', Parkrun, 'Fit as a Fiddle', 'Active Gardening' and 'Cycle Kingston'. To find out more about each of these there is a Healthy Lifestyle helpline on 0800 028 8694, an email address healthy.lifestyles@kingston.gov.uk and a website http://www.kingston.gov.uk/info/200312/being_active.

See physical activity section of the JSNA

Ovarian cancer
Over a fifth of ovarian cancers in the UK are linked to lifestyle factors including smoking (3%), some types of hormone replacement therapy (1%), and certain occupational exposures (less than 1%)[28]. One in ten ovarian cancer cases has a genetic link.

Kick It is a free stopping smoking service available in Kingston. See also the council website. and the smoking section of JSNA. People are four times more likely to quit smoking with the

[27] Cust AE. Physical activity and gynaecologic cancer prevention. Recent Results Cancer Res. 2011;186:159-85.

[28] Cancer Research UK. Ovarian Cancer Risk Factors.

help of a stop smoking service. Clinics are available in GP surgeries, local pharmacies, Kingston Guildhall and Surbiton Health Centre providing advice on which medications can help you quit and support with changing your behaviours.

Cervical cancer

Almost all cervical cancer cases in the UK is linked to human papillomarvirus (HPV) infection which can be prevented with the HPV vaccination. Condoms can also help prevent HPV infection. Smoking and human immunodeficiency virus (HIV) are also associated with cervical cancer because they are related to HPV infection. Cervical cancer screening is also important to prevent cervical cancer.

Vaginal and vulva Cancer

In the UK almost two thirds of vaginal cancer cases and two fifths of vulva cancer cases are caused by HPV infection[29,30]. Stopping smoking can reduce your risk of vulval cancer[31]. Kick It is a free stopping smoking service available in Kingston.

Screening Services

Uterine cancer screening

There is currently no screening test available for uterine cancer that is accurate and reliable enough to detect uterine cancer in the general population. Women at higher risk of uterine cancer are those with a family member who has Lynch syndrome or hereditary non polyposis colon cancer (HNPCC). Women at a higher risk of uterine cancer are advised to keep aware of symptoms and may be offered vaginal ultrasound scans and hysteroscopies.

Ovarian cancer screening

There is currently no national screening programme for ovarian cancer as there is no test reliable enough to pick up ovarian cancer at an early stage, however women at high risk of ovarian cancer can have either a blood test for CA125 or a transvaginal ultrasound[32]. Research published in 2015 by University College London has suggested that new ways of looking at changes in CA125 may prove more accurate for detecting ovarian cancer at an early stage[33].

Women are considered to have a higher than average risk for ovarian cancer if they have two or more relatives on the same side of the family diagnosed with ovarian or breast cancer under the age of fifty[34]. Between one in four and one in five women diagnosed with ovarian cancer have an inherited tendency to develop the disease[35].

The three main options to reduce the risk of ovarian cancer are: screening, risk-reducing surgery and/or prescription of the combined contraceptive pill.

[29] Cancer Research UK. Vaginal Cancer Risk Factors.
[30] Cancer Research UK. Vulval Cancer Risk Factors.
[31] NHS Choices Vulval Cancer Risk Factors.
[32] Cancer Research UK. Ovarian Cancer Screening.
[33] NHS Choices. New test could improve diagnosis of ovarian cancer.
[34] Cancer Research UK. Ovarian Cancer Screening.
[35] Ovarian Cancer National Alliance.

Women who think they are at increased risk of ovarian cancer should talk to their GP who can refer patients to a genetics service (also known as family cancer clinic). Women deemed at high risk are put on the UK Familial Ovarian Cancer Registry and offered counselling about their options such as regular tests or surgery.

Cervical cancer screening
All women aged between 25 and 64 are invited for cervical screening at their GP. See JSNA Chapter for Cervical cancer screening.

Vulval cancer and vaginal cancer screening
There is no screening programmes for vulval cancer or vaginal cancer however the vulva and vagina are routinely examined during a cervical screening test. Women should visit their GP if they notice any changes to their vagina such as growths, nodules, bumps or sores (ulcers).

Primary Care Services

GPs are trained at recognising symptoms of gynaecological cancer and making appropriate referrals to hospital for patients with concerning clinical signs and/or symptoms. There are 26 GP practices in the Royal Borough of Kingston.

Kingston has a Macmillan GP to enhance clinical liaison for cancer services.

Secondary Care Services

Patients living in Kingston can be referred for management of their suspected cancer to either Kingston Hospital in Norbiton, the Royal Marsden Hospital in Fulham, St Georges hospital in Tooting or Queen Mary's Hospital in Roehampton.

The Sir William Rous Unit provides cancer services at Kingston Hospital. The cancer services available from Kingston hospital include inpatient surgery, day case surgery and chemotherapy treatments. Kingston Hospital provides Cancer Information Prescriptions for patients. There are Information Prescriptions available for uterine cancer, ovarian cancer, cervical cancer, vulval cancer and vaginal cancer provided by the NHS Choices website.

Kingston Hospital has a Cancer Services User Group for patients and carers to share their experiences.

Kingston Hospital's gynaecology service provides emergency and planned care and both outpatient and inpatient services. There are Rapid Access Clinics to fast track assessment for women who have been referred by their GP with possible gynaecological cancer in order

to diagnose or rule out cancer as soon as possible. Kingston Hospital aims to give patients an appointment within two weeks of receiving the referral from the GP[36].

These Rapid Access Clinics are accompanied by an ultrasound service with the aim of providing ultrasounds to patients on the same day as the clinics.

Further investigations such as a CT scan or MRI we be conducted if cancer is found, followed by agreeing a treatment plan with the patient and the healthcare team.

Occasionally treatment for patients in Kingston with gynaecological cancer needs to be undertaken at The Royal Marsden Hospital which is a world-leading cancer centre specialising in diagnosis, treatment, care, education and research.

Nurse staffing levels on the gynaecology ward in Kingston Hospital (the Isabella ward) are between 96% and 102% as of October 2015[37].

End of Life Care

An End of Life Care Steering Group was set up in Kingston in 2013 to ensure good quality end of life services for people locally. A key feature of this work is the 'Co-ordinate My Care' electronic record for end of life care patients in order to provide better coordination between GPs, in hospital and in care homes[38].
Over a third of people in Kingston die in their usual place of residence[39] which is the preference of two-thirds of the population[40].
Kingston Hospital has a Palliative Care Team which strives to achieve the best quality of life for patients with life-limiting cancer as well as support their families. The Hospital Palliative Care Team provides advice on managing difficult symptoms and support for psychological, spiritual, social and practical issues. Kingston Hospital also has a social worker for cancer and palliative care and a Hospital Cancer Counsellor. There is also a Macmillan Cancer Information and Support Centre in Kingston Hospital.
The Royal Borough of Kingston has a Community Palliative Care Team and a number of local hospices, with the main hospice provider being the Princess Alice Hospice in Esher.
The CareWatch Kingston and Merton Palliative Care Service also provide support in meeting patients' end of life needs.

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[37] NHS Choices. Kingston Hospital. Nurse staffing levels. Gynaecology.

[38] Royal Borough for Kingston. Annual Public Health Report 2013. Older people in Kingston Living Well in Later Life.

[39] Royal Borough for Kingston. Annual Public Health Report 2013. Older people in Kingston Living Well in Later Life.

[40] British Social Attitudes survey published May 2013.

The range of organisations providing end of life care, advice and support for patients, families and carers locally is covered in detail in the 2013 Kingston Annual Public Health Report. See Chapter 4.6 for more information.

Community Voice

It is fundamental to assess patient experience of cancer care services to ensure patient satisfaction and high quality healthcare provision.

In 2014 Kingston Hospital published the results of their latest annual cancer patient experience survey run in 2013 in line with the National Cancer Patient Experience Programme[41]. The survey included adult patients aged 16 and over with a primary diagnosis of any cancer who had been admitted to Kingston Hospital as an inpatient or as a day case patient. 175 patients took part in the survey (a response rate of 63% compared to a national response rate of 64%).

The results of the survey were overall positive with over four fifths (85%) of patients rating care as 'excellent' or 'very good' overall. Over three quarters (79%) of patients reported that they were seen as soon as necessary and 84% of patients felt their health got better or remained the same whilst waiting.

The vast majority of patients (84%) felt staff gave a complete explanation of the purpose of the test with 86% of patients feeling staff explained what would be done during the test and 75% of patients reported being given a complete explanation of test results in an understandable way. 87% of patients felt they were told that they had cancer in a sensitive manner.

Nearly all (82%) of patients reported being given a choice of different types of treatment and 69% of patients definitely felt involved in decisions about their care and treatment. 97% of patients reported that staff had told them who to contact if worried after discharge.

The survey however showed 54% of patients reported being definitely told about treatment side effects that could affect them in the future. Less than half (41%) of hospital staff gave patients information on getting financial help. Only two thirds (66%) of patients' families definitely had an opportunity to talk to the doctor. Under two thirds (61%) of patients reported being able to discuss worries or fears with staff during their visit. Finally less than a fifth (17%) of patients were offered a written assessment and care plan.

Regrettably too few patients with gynaecological cancers responded to this survey to evaluate responses specific to these patients.

The Kingston Hospital Friends and Family Test for the gynaecology ward (Isabella ward) from December 2014 to June 2015 had a positive response with between 92.4% and 100% of patients recommending this service.

[41] Quality Health on behalf of NHS England. September 2014. The National Cancer Patient Experience Survey. Kingston Hospital NHS Foundation Trust.

The South West London Cancer Awareness Measure Survey in 2010 conducted by Ipsos MORI[42] showed that almost two thirds of Kingston residents when unprompted were aware that an unusual lump or swelling is a warning sign of cancer however less than a quarter of Kingston residents were aware of the other warning signs of gynaecological cancer: bleeding, persistent unexplained weight pain, unexplained weight-loss and loss of appetite. These proportions increased markedly when residents were prompted on these questions. The survey showed that less than a third of Kingston residents were neither aware that HPV infection is the main risk factor for cervical cancer nor that the age that women were first invited for cervical screening.

A Living with and beyond womb cancer survey of over 600 women in England in 2003 showed that almost all women were treated with surgery (96%) and 91% stated their cancer had fully responded to treatment[43]. 40% of women reported suffering from aches and pains in their muscles and joints and 61% reported passing urine more frequently with 59% reporting having to hurry at least a little bit to get to the toilet when they feel the urge to pass urine. On a seven point scale with one being very poor and seven being excellent over 80% of women rated their overall health, as well as their quality of life, as a 5 or above.

[42] Ipsos MORI. October 2010. Baseline Assessment of Gynaecological Cancer. South West London Cancer Network. NHS Wandsworth. National Cancer Action Team.

[43] Public Health England. NHS England. 2015. Living with and beyond womb cancer.

Recommendations

Kingston Public Health, Royal Borough of Kingston

1. Increase local awareness for risk factors of symptoms for gynaecological cancer. (The South West London Cancer Awareness Measure (CAM) Survey showed that South West London residents have lower levels of awareness than residents elsewhere in the country.)

2. Continue to promote the message that 'prevention is key'. In particular promoting physical activity, maintaining a healthy weight, reducing alcohol intake, stopping smoking and ensuring uptake of the HPV vaccine. These all reduce the risk of gynaecological cancer.

3. Continue to provide lifestyle services to aid the local population to be physically active, lose weight, stop smoking and reduce alcohol intake.

Kingston Clinical Commissioning Group (Kingston CCG)

4. Work to implement improvements to areas of weakness identified by the 2014 Kingston Hospital National Cancer experience survey which highlight the need for better communication between professionals and patients.

5. Audit local GP practices against the 2015 NICE guidance 'Suspected cancer: recognition and referral' for gynaecological cancer.

6. Continue to address all issues raised by the NAEDI initiative

7. Current providers should undertake interventions to address the issues raised by the health and wellbeing survey of women with gynaecological cancer in 2013 (Living with and beyond womb cancer").

Kingston Health and Wellbeing Board

8. Focus gynaecological cancer prevention efforts on hard to reach groups.

9. Ensure marginalised groups have equal access to gynaecological cancer healthcare services.

Glossary

DSR: Directly age-standardised rate

Gynaecological cancer: types of cancer affecting the female reproductive organs.

Uterine cancer: cancer of the womb. It is also known as endometrial cancer.

Ovarian cancer: cancer of the ovaries.

Cervical cancer: cancer of the cervix at the entrance to the womb from the vagina.

Vulval cancer: cancer affecting a woman's external genitalia including the labia minora, labia majora, the clitoris and the Bartholin's glands.

Vaginal cancer: cancer of the vagina.

Incidence: is a measure of the occurrence, rate, or frequency of a disease or medical condition in a specific population in a specified period of time (i.e. the number of new cases during a certain time period).

Survival rate: the expected duration of time until death.

Mortality rate: A measure of the number of deaths in a given population in a specific time period. Also known as death rate.

Screening: a method of identifying the probable presence of an undiagnosed disease in people without signs or symptoms, which triggers a full diagnostic process to ascertain if the disease is truly present.

Other Needs Assessments

Screening for Cervical Cancer. Joint Strategic Needs Assessment for Kingston 2010-11

Cancer Needs Assessment. Joint Strategic Needs Assessment for Kingston 2010-11

Useful Links

National Cancer Intelligence Network

National Cancer Intelligence Network, General gynaecological cancer resources

NHS Cervical Screening Programme

National Cancer Strategy

National Awareness & Early Diagnosis Initiative for England

Cancer Statistics ONS

Local Authority Health Profiles

Cancer research UK: cancer survival by age, cancer survival by ethnicity

NCIN Outline Uterine Cancer Report

Help and Information

Cancer Research UK, Women's cancers (gynaecological cancer)

NHS Choices, Womb (uterus) cancer

NHS Choices, Ovarian cancer

NHS Choices, Cervical cancer

NHS Choices, Vulval cancer

NHS Choices, Vaginal cancer

NHS Choices, Information Prescription Service

Kingston CCG Website

Macmillan Cancer Support

Marie Curie

NHS Inform, Palliative Care Zone

NHS Choices, Guide to Care and Support

Womb cancer organisations