

Assessing Gynecology Fast track clinic referrals appropriateness

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Introduction

Gynaecological oncology is a specialised area of cancer care focusing on the diagnosis and treatment of cancers affecting women's reproductive organs. Around 177,000 women are diagnosed with cancer every year.[1] Of those gynaecological cancers (cervix, uterus, ovary, vagina and vulva) accounted for 12%.

The Fast-Track Clinic (FTC) in our hospital looks into urgent referrals made by different specialities. It offers a comprehensive assessment and diagnosis of gynaecological cancers. In these patient referrals, FTC is the first point of contact, providing that they fit the fast-track criteria (Fig 1) for women with possible gynaecological cancer by the GP or radiologist. [2]

More than 9 out of 10 (90%) of gynaecological patients referred to the FTC in the UK do not have cancer. [3] Evidence suggests that large proportion of these patients referred have a benign diagnosis. [3,4] The aim of this project is to evaluate the appropriateness of referrals to the FTC at our hospital and recognize ways to improve efficiency.

Aims

To assess appropriateness of referrals to the fast-track clinic (FTC) and to recognize ways to improve efficiency.

Methods

A retrospective analysis was conducted to examine a cohort of patients who were referred by either the GP or the radiology department between January and June 2021.

A list of patients referred to FTC in our hospital from 11th January to 27th June 2021 (n=146) with a suspected diagnosis of gynecological cancer was obtained from Track Care (electronic appointments system).

Information was collected from Integrated Clinical Environment (ICE) and Clinical Portal regarding the date of first referral, date of first FTC appointment, indication for referral, symptoms, if applicable then biopsy results and final diagnosis. Validation exercise was carried out based on vetting criteria to assess the appropriateness of each of referrals.

Since, the aim of the project was to improve the appropriateness of referrals to FTC, we looked into referee's letter to check medical comments regarding patients. The referral was only counted as validated if the referee's letter commented using the criteria (Fig.1). Information was reviewed twice to prevent data oversight. Validation of referral was further checked by the Lead Cancer clinician.

FAST TRACK CLINIC REFERRAL CRITERIA

- A visible or palpable lesion on the cervix suspicious of malignancy with or without PCB
- A visible lesion on the vulva suspicious of malignancy.
- A palpable pelvic mass that is not obviously fibroids.
- A pelvic ultrasound suggestive of gynaecological malignancy (see previously agreed ultrasound criteria – most of these will be direct referrals from radiology anyway).
- Ascites or malignant ascites with a suspected gynaecological cause.
- The GP ticks 'suspected cancer' on the ERS.

Fig. 1 – Referral Criteria for the gynaecology FTC [2]

Results

A total of 144 patients out of 146 were included in the study who were referred with a suspected diagnosis of gynaecological cancer between 11th January to 27th June 2021.

Overview

- This study demonstrates that about 44% (n=63) of the 144 cases were appropriate for referrals to FTC.(Fig. 2)

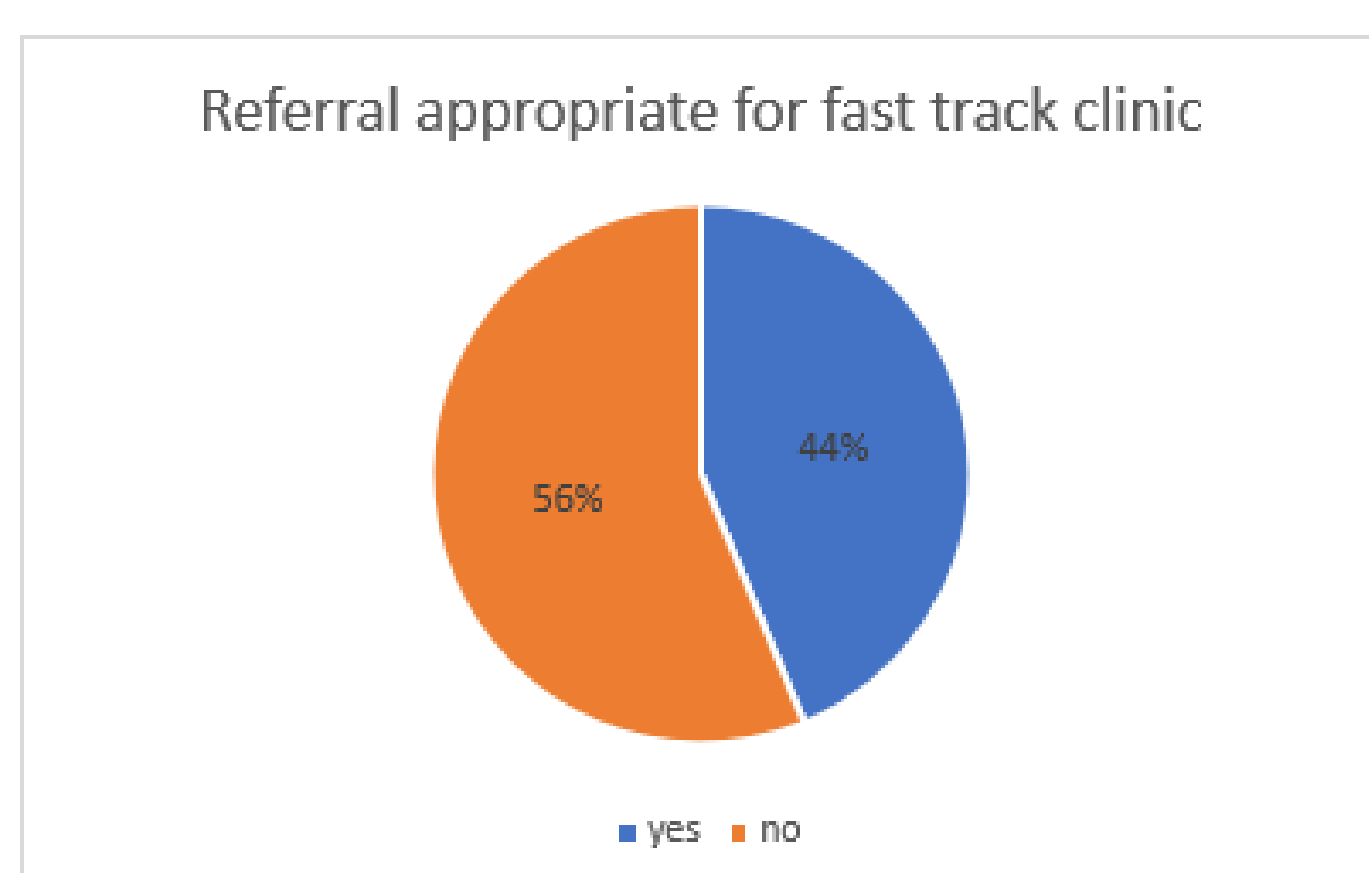


Figure 2 – Percentage of referrals validated for FTCs

Reasons for referral

- In Fig. 3, majority of reason for referral was due to 'other' causes that commonly included, irregular bleeding, raised CA125 blood levels and nausea and vomiting.
- Other reasons as listed in the vetting criteria included, pelvic ultrasound (USS) suggesting malignancy accounting about 30 out of 144 (20.83%), cervix lesion 27 (18.75%), vulva lesion 25 (17.36%), pelvic mass 19 (13.19%) and lastly ascites 3 (2.08%).

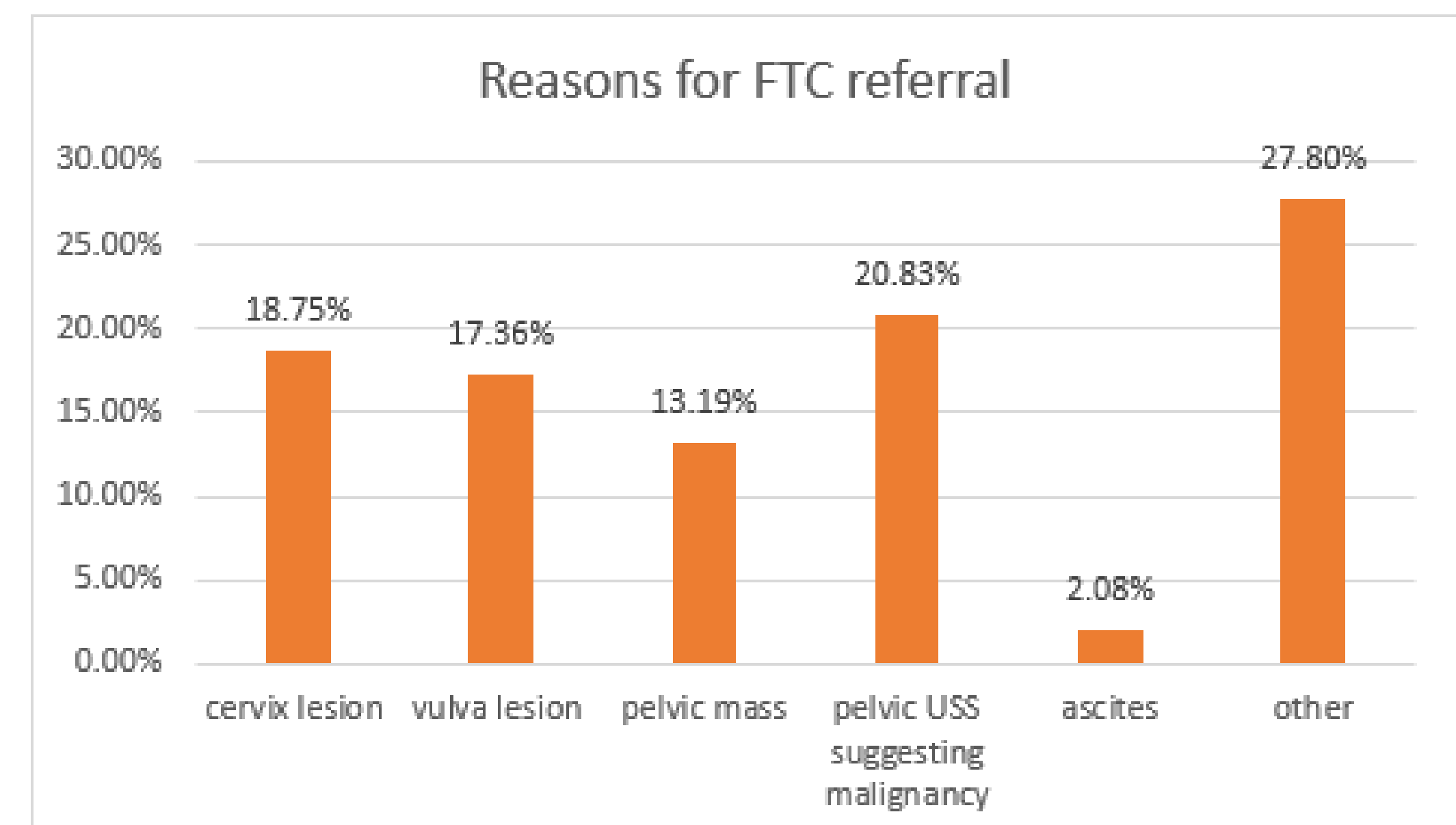


Figure 3 –Percentage of patients for referred for various reasons to FTC

Final Diagnosis

- The majority of women seen in the FTC had benign pathology (fig.4 - 75%; n=108).
- In Fig.4, about 7 cases (4.86%) were cervical cancer, 4 (2.78%) vulval cancer, 8 (5.56%) ovarian cancer, 0 uterine cancer, 3 (2.08%) CIN and 2 (1.39%) VIN. 12 (8.33%) cases were included as 'other'. These included lung, colorectal, breast, pancreatic cancer.

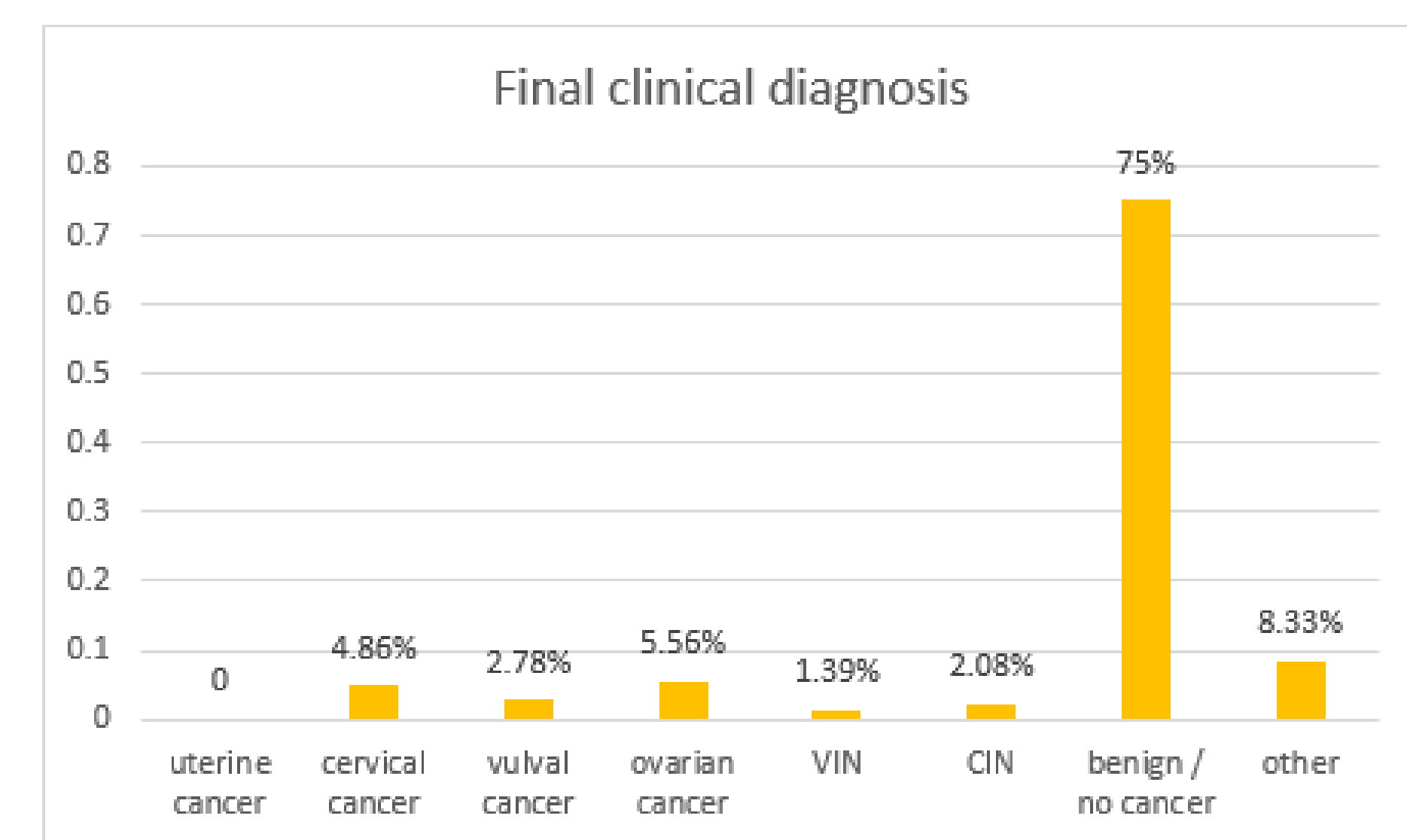


Fig.4 – Percentage of patients for each final clinical diagnosis

Discussion

The FTC purpose is to detect and diagnose cancers promptly, with the aim of saving more lives. A National audit report identified wide variation in urgent GP referral rates in different areas across England.[5] The degree of variation in referral between practices would vary as it depends on cancer incidence rate, cancer risk profile and different use of diagnostic tests. The criteria (Fig.1) provided is a guideline to aid a GP to make the best judgment depending on each individual case.[2] As noticed in the results, most of the referral's reasoning was classified 'other' thus highlighting that the doctor used their clinical assessment to see if an urgent referral is needed (Figure 3 - 27.8%).

There is a significant difference in the proportion of inappropriate referrals between individual referral pathways. The majority of inappropriate referrals were for long-standing symptoms like post-coital bleeding, intermenstrual bleeding and chronic pelvic pain. Many referrals regarding cervical cancer suspension were due to abnormal appearance of the cervix. Organizing educational workshops can be helpful where specialists could be guided better on how to identify insidious lesions or which investigations they should organize when referring to FTC.

It is difficult to ascertain the reasons for the inappropriate referrals to FTC. Most GPs' referrals had mentioned cancer antigen 125 (CA125) and c-reactive protein (CRP). Along with this, ultrasound and CT imaging were also commonly indicated when investigating under FTC referrals. The role of serum biomarkers (CA125) as part of the International Ovarian Tumor Analysis (IOTA) study had shown a limited role in the diagnosis of ovarian pathologies in premenopausal women.[6]

Using the IOTA classification, doctors can identify adnexal masses if they are benign and malignant using simple descriptors and rules. Both rules and descriptors had high sensitivity and specificity ranging from 85 -99 and 69-96 respectively. [6]

Conclusion

Our project has identified that service improvement needs to utilise FTC resources effectively. Few of the services improvements initiated following this project are refining referral criteria, educating the vetting team, modification of reporting of ovarian masses and flagging of referrals to cancer specialities when needed.