Gynaecological Cancer Services
Follow Up Guidelines

Follow up of gynaecological cancer patients has two distinct aspects:

- Assessment and management of physical and psychological morbidity following primary treatment
- Prompt detection of recurrent disease in order that treatment may be initiated as early as possible

The following guidelines have been developed by the Gynaecological Cancer Clinical Network Group (CNG) in order to ensure consistency in the quality of care and level of access that patients receive within the network during follow up. Recommendations are based on evidence relating to clinical need and patient preference and support the sector model of MDTs within Merseyside and Cheshire comprising unit and centre teams.

These follow up guidelines form part of the gynaecology oncological guidelines formally adopted in June 2005 and submitted as evidence for peer review. Network follow up guidelines will be reviewed in light of national guidance as this becomes available.

1. Recommendations for each treatment pathway are outlined in the attached algorithm.

Routine follow up should continue for three years after treatment as follows:

- 6 weeks post treatment – holistic assessment
- Every 4 months for first two years
- Every 6 months for third year

There will be certain exclusions depending on patient need (for example those with persistent disease or side effects of treatment) and patients in clinical trials.

2. Ideally, patients should be seen by the clinical team responsible for treating them as follows:

- Surgery only – local follow up where surgery has been undertaken, within the local gynae-oncology clinic.
- Adjuvant chemotherapy/radiotherapy – follow up to alternate between the local gynae-oncology clinic and medical/clinical oncologists (at the sector oncology clinic).
- Chemotherapy or radiotherapy – patients should be seen by the medical or clinical oncologist for the first two years at the sector oncology clinic and then alternate with the gynae-oncologist at the local hospital.
- Palliative care – patients with advanced disease should be referred on to local teams in line with agreed pathways. Patients should be referred back to the MDT if further input is required.

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3. Once follow up is complete, patients should be discharged by the clinician who sees them in clinic.

4. All women should be offered a single holistic assessment by the Clinical Nurse Specialist 6 weeks after completion of treatment. This will normally take place at the hospital where primary treatment is undertaken and will include assessment of physical, psychological, social, sexual and spiritual aspects. This will be supported by written information appropriate to need.

5. The Clinical Nurse Specialist will remain the main point of contact for the patient throughout the pathway and will have close links with primary care practitioners to ensure that they can access services for any problems or symptoms that may develop after treatment. Patients who experience problems should be re-referred by their GP.

6. The patient should be given some choice in their place of follow up i.e. some may opt for follow up in the referring local clinic rather than the cancer centre.

7. These guidelines are not intended to be prescriptive as it is not possible to cover all clinical presentations. Exceptional cases should be discussed and have their follow up strategies agreed at the MDT.

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Next Review Date : This document will be updated with the introduction of Stratified Follow Up