Penile Cancer Guidelines

North West & North Wales Cancer Networks’ Clinical and Referral Guidelines for Penile Cancer

(Diagnosis, Assessment and MDT Discussion)

Final Version 6 (May 2012)

Agreed at the GMCCN Urology CSG 24th April 2012
Agreed by Mr Nigel Parr on behalf of the MCCN Urology CSG, 15th June 2012

REVIEWED BY NIGEL PARR JANUARY 2015
REVIEW JANUARY 2017
Supranetwork Penile Cancer Guidelines

SERVICE OBJECTIVES

The objectives of concentrating this care into the hands of the Specialist Penile Team are:

• To ensure that designated specialists work effectively together in the team such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions.

• To ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision-making and to support clinical governance/audit.

• To ensure that mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.

1 ORGANISATION

1.1 The Supranetwork multidisciplinary team for penile cancer is based upon the specialist urological team at Christie Hospital NHS Foundation Trust.

1.2 The team delivers Supranetwork care to Lancashire & South Cumbria, Greater Manchester & Cheshire, Merseyside & Cheshire and North Wales - a population of 7.8m.

1.3 The team members will deliver all of the care, including local and specialist care, to at least part of their own cancer networks for the local catchment of their host locality.

1.4 For the team to add their full potential value to patient care, the Supranetwork surgical procedures and their immediate post-op care are required to be restricted to certain named hospitals.

• Christie Hospital

1.5 The host hospital for the Supranetwork MDT is Christie Hospital NHS Foundation Trust.
2 PENILE CANCER SUPRANETWORK & SPECIALIST CARE REFERRAL/CLINICAL GUIDELINES

(Clinical and referral guidelines for penile cancer - diagnosis, assessment & MDT discussion)

2.1 Local care is classed as:

The diagnostic process only.

Local care will be carried out by local teams for their catchment. It will also be carried out by specialist teams and the supranetwork team for the local catchment of their host locality.

2.2 Local and specialist care MDTs

Local care
Is any diagnostic procedure only (See section 2.4.4)

Specialist care penile lead:
Lead for an individual network
Manage patients unwilling to travel/infirm
No penile preserving surgery/lymph node surgery
May wish to work within the supra-network centre

2.3 Specialist Supra-Network care (SnMDT) is classed as:

2.3.1 All Resections. All resections should be carried out by the named supra-network hospital specialist team at The Christie NHS FT (see Appendix C).

2.3.2 Radiotherapy and chemotherapy.
Radiotherapy will be carried out The Christie NHS FT, The Clatterbridge Cancer Centre NHS FT and Lancashire Teaching Hospitals NHS Trust.
Chemotherapy will be carried out in appropriate facilities, approved by the SMDT, throughout the Networks.

2.3.3 Specialist care will be carried out by the Supranetwork team members for the local catchment of their host locality.

2.3.4 Specialist care will only be carried out by teams designated as specialist teams within each Network. It will not be delivered by local urology teams in any of the
Networks across the North West and Wales.

2.3.5 All penile cancer cases should be discussed with the Supranetwork team prior to proposed treatment if not referred directly to that team.

2.3.6 The Specialist MDTs will agree a policy whereby patients with early (stage 1) penile cancer should be offered a joint meeting with the surgeon, oncologist and specialist nurse to discuss treatment options prior to deciding which modality of treatment to use.

2.4 Supranetwork Care - Referral to Supra-Network MDT (SnMDT)

Supranetwork care is classed as:

2.4.1 All Resections, including cases needing penile reconstruction or lymph node resection. All resections will be carried out at The Christie. All such operations will be delivered by the Supranetwork team listed in section 6 below.

2.4.2 The treatment planning decisions on patients with penile cancer will be made by the Supranetwork penile cancer team during the regular weekly meetings at The Christie Hospital, as and when those patients are referred.

2.4.3 The Supranetwork MDT at their regular meetings will agree and record patients' diagnosis and subsequent treatment plans. The record should include:

- The identity of patients discussed.
- The diagnosis.
- The multidisciplinary treatment planning decision i.e. to which modalities of Supranetwork or specialist care (surgery, radiotherapy, chemotherapy) they are to be referred for consideration.
2.4.4 **Referral to Supranetwork Team**

Any suspected penile cancer seen by a consultant urologist can be referred without histological diagnosis or staging investigations directly to the department.

Any suspected penile cancer or pre-malignant lesion referred to a consultant urologist via a dermatologist or genito-urinary medicine physician with histological diagnosis can be referred directly to the department without further investigation.

Any suspected penile cancer that becomes apparent at the time of a circumcision could be referred directly without histology results.

Any patient with a suspicious but not diagnostic lesion should have a generous deep biopsy for confirmation. Scrapings and/or punch biopsies are not usually adequate in these cases. Patients can be referred to the SnMDT for this; if it is felt it will help the patient pathway.

Patients who are deemed unfit to travel or are unwilling to travel for whatever reason could be discussed directly with the consultant in charge and the supra regional MDT and advice given accordingly.

It is not mandatory to arrange further staging investigations, however if imaging has been performed and/ or arranged this information should be sent with the referral.

The referral should be done by Fax and post. It should include patient details, clinical findings and appropriate histology report if available. The referral should be made directly to one of the Lead Clinicians for Penile Cancer within the Cancer Network.

**Fax Numbers:**
**Christie Hospital NHS Foundation Trust**
0161 446 3352 or 3365

**Wirral University Teaching Hospitals NHS Trust**
0151 604 7481
2.4.5 Upon referral the patient should be seen in an outpatient clinic designated for Penile Cancer. A history and examination will be undertaken followed by an appropriate discussion regarding treatment. The treatment plan will be discussed between surgeon, oncologist, nurse specialist and the patient, and further appointments arranged as necessary. The appropriate Patient information booklets will be offered to each patient.

2.4.6 The patient will be discussed at the SnMDT. The Lead Clinician or designated cover, with the Nurse specialist will co-ordinate the discussion on each case.

2.4.7 The pathology should be reviewed at the SnMDT. Provision to obtain slides will be initiated at the time of receiving a referral. At this point the receiving clinician should inform the SnMDT Pathologist of this need, by fax / letter.

2.4.8 A decision should be made at that SnMDT as to whether the treatment plan is appropriate. The decision of the MDT will be relayed to the patient. If the plan is altered the patient will be informed accordingly.

2.5 Follow up care site

The primary treatment of penile cancer can cause significant psychological distress. In addition, follow-up treatments may be needed. Patients should be followed in a dedicated penile cancer clinic within the Network’s host hospital (in respect of MCCN, patients may be followed up at Arrowe Park, within a designated facility).
3. Diagnosis & Assessment

3.1 Primary lesion
Patients should undergo history and physical examination. This should include medical/surgical history and risk factors. The examination should record:

i. Size
ii. Location
iii. Number of lesions
iv. Morphology
v. Relation to adjacent structures (corpora/urethra)

Cross-sectional imaging (MR with PGE1 or CT)) may be used to assess the lesion and its stage. The purpose is to obtain as much information as possible regarding the grade and stage of the cancer in order to select the most appropriate treatment. Clinical photographs may be taken with patient consent in order to maintain a record of pre- and post-operative appearances and to facilitate audit.

3.2 Regional nodes
Inguinal nodes should be examined carefully. Note:

i. Non palpable nodes. In Intermediate and high risk disease it is appropriate to undertake Ultrasound scan (with Fine Needle Aspiration) and Dynamic Sentinel node biopsy. All centres should be trained in this procedure and be enrolled in the BAUS/RCS Roll Out Programme. Prophylactic groin node dissection is recommended only in mitigating circumstances.

ii. Palpable nodes. On examination note size, position, number, fixation, relationship and oedema. In this scenario histological examination using FNA can be used. In cases where this is negative it can be repeated or excision biopsy can be undertaken. In appropriate cases where there are palpable nodes with negative histology / cytology, these can be re-assessed 4-6 weeks after surgery.
3.3 Distant metastasis

Patients with palpable nodes should undergo MR/CT scan of the abdomen and pelvis in addition to a CXR to assess for distant mets. In patients with bone pain a bone scan is indicated.

4. Treatment
4.1 Primary lesion (see Appendix A)

4.1.1 PIN
In penile intraepithelial neoplasia an organ preservation technique is advised and includes

- 5-Fluorouracil (5-FU) cream
- Topical Imiquimod (5%)
- Circumcision
- Glansectomy and reconstruction (+/- graft)
- Glans resurfacing

Other therapies should be done in a trial setting only. Pathological margins should be studied in surgical cases.

4.1.2 Ta-1 G1-2
An organ preserving therapy is recommended. This should be in the form of Wide Local Excision/Circumcision or Glansectomy and reconstruction (+/- graft). Radiotherapy is an option in all patients with lesions less than 4cm. Other therapies should be done within a trial setting only. Pathological margins should be studied in surgical cases.

4.1.3 T1G3, T2>
Partial or total amputation of the penis is recommended. More conservative surgery may be carried out in selected cases e.g. small tumours, unfit patients. Radiotherapy is an option in all patients with a lesion less than 4cm in size.

In patients requiring partial amputation the margin of clearance from the proximal area of induration should be approximately 1cm.

For patients with proximal T2/4 disease a radical penectomy is recommended with the option of delayed phalloplasty.

Chemotherapy should be considered in a trial setting only.
4.2 Regional nodes (see Appendix B)
Regardless of the treatment modality of the primary lesion all patients should undergo lymph node management.

4.2.1 Non palpable nodes
The three risk groups for nodal disease are

i. Low (Tis, TaG1-2 and T1G1) risk less than 2%. In these cases surveillance should be undertaken.

ii. Intermediate (T1G2) risk up to 12%. The risk is greater in cases of lymphatic and vascular invasion and also in those with infiltrative growth patterns. USS +/- FNA and Dynamic sentinel node biopsy should be undertaken, with modified lymph node dissection in positive cases. In negative cases surveillance should be initiated.

iii. High (>T1G3) risk up to 23%. In these cases USS +/- FNA and Dynamic sentinel node biopsy should be undertaken with modified lymphadenectomy in positive cases.

In patients with high surgical risk surveillance may be used.

4.2.2 Palpable nodes
In these cases FNA should be considered. If negative it should be repeated or excision biopsy should be done. In positive cases or concern over palpable nodes, a modified lymphadenectomy should be undertaken

Contra-lateral inguinal regions with no palpable nodes should be assessed as in 4.2.1.

If more than two nodes are found to be positive (across one or both groins) or there is extra capsular disease then the risk of pelvic nodal disease is up to 40%. In this group five year survival may be very poor. A pelvic/abdominal MR/CT scan should be undertaken. In cases where no pelvic nodes are identified then surveillance or pelvic lymphadenectomy (ipsilateral) can be undertaken, although this is controversial and treatment should be considered with in the trial setting. In this setting pelvic radiotherapy is not indicated, but may be given within the trial setting.
Inguinal radiotherapy may be considered in N2-3 patients or N1-3 patients with extranodal spread (especially if associated with a close or positive surgical margin); in selected patients adjuvant EBRT/ChemoRT or Chemotherapy may be offered.

If positive nodes are found at pelvic lymphadenectomy then adjuvant chemotherapy may be considered, preferably with in the trial setting.

In cases of fixed inguinal nodes chemotherapy can be considered followed by lymphadenectomy. Chemotherapy, radiotherapy or chemoradiotherapy may be offered, preferably within the trial setting.

In cases of palpable nodes noted during follow-up then treatment should be directed as above. If there has been a long interval then unilateral lymphadenectomy can be considered, although the risk of bilateral disease can be as high as 30%.

4.3 Distant metastasis
Chemotherapy can be considered and should be case dependent. Treatment with in a trial setting is encouraged. In some cases radiotherapy or chemoradiation may be considered, again this is preferable within the trial setting.

5.0 Follow up
All patients require follow up. This can initially be undertaken at the Supra Network Centre but facilities are in place, to have integrated follow up at local centres (e.g. Arrowe Park).

5.1 Primary Tumour
5.1.1 Conservative surgery
Should be as per nodal status – see below

5.1.2 Partial Penectomy/Radical Penectomy
Should be as per nodal status – see below
5.2 Nodes

5.2.1 cN0
for Low Risk disease as 5.1.1

4 monthly for years 1 - 2
6 monthly for years 3 – 4
Annually thereafter

for Intermediate Risk & High Risk (after sentinel node biopsy or surveillance):

- 2 monthly for year 1 - 2
- 3 monthly for year 3
- 6 monthly for year 4 – 5
- Then annually

Length of follow up should be:
For low risk, at least 5 years
for intermediate risk, at least 5 years
for high risk, at least 10 years

5.2.2 cN+

This should be guided by the individual patients’ risks and comorbidities. Some patients may be followed up as part of a trial protocol.

5.2.3 CIS

In patients where CIS has been found on circumcision and clinical follow-up is indicated this should be on a 3 monthly basis for 6 months, then 6 monthly up to year 3. Self-examination should be encouraged between visits. Suitable patients may be discharged with advice regarding self-examination at 1yr rather than 3yrs of follow up.
6 SUPRANETWORK MDT CORE MEMBERSHIP

6.1 The group of people comprising the Core Membership are the surgeons operating on the named hospital sites together with the health professionals who work in the MDT membership roles with them.

<table>
<thead>
<tr>
<th></th>
<th>Christie</th>
<th>Wirral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urological Surgeons*</td>
<td>Mr Vijay Sangar Mr Maurice Lau</td>
<td>Mr Nigel Parr</td>
</tr>
<tr>
<td>Clinical Oncologists</td>
<td>Dr Tony Elliott</td>
<td>Dr Peter Kirkbride</td>
</tr>
<tr>
<td>Medical Oncologists</td>
<td>Dr Michael Leahy</td>
<td>Dr Helen Innes</td>
</tr>
<tr>
<td>Histopathologists</td>
<td>Dr Jonathan Shanks Dr N Dalal</td>
<td>Dr Ranjala Seneviratne</td>
</tr>
<tr>
<td>Radiologists</td>
<td>Dr Ben Taylor Dr Bernadette Carrington</td>
<td>Dr David Hughes</td>
</tr>
<tr>
<td>Urology Nurse Specialists</td>
<td>Jane Booker Sharon Capper</td>
<td>Beverley Rogers</td>
</tr>
<tr>
<td>MDT coordinator</td>
<td>David Bowerman</td>
<td>Graham Totty</td>
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<td>EXTENDED MEMBERS</td>
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<tr>
<td>Palliative Care</td>
<td>Richard Brennan</td>
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<tr>
<td>representative</td>
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<tr>
<td>Plastic/reconstructive</td>
<td>Gary Ross David Mowatt</td>
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<tr>
<td>surgeon</td>
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<tr>
<td>Psycho-oncologist &amp;</td>
<td>Tarnya Hawthorne Josie Butcher</td>
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<td>Psycho-sexual</td>
<td></td>
<td></td>
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<tr>
<td>counselling</td>
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</table>

*Any consultant in the supranetwork catchment area of the MDT who is responsible for performing lymph node dissections and/or penile reconstruction should be a core member of the supranetwork penile cancer team.

6.2 The MDT will nominate one of the members of the core or extended team as the person responsible for ensuring that service improvement is integrated into the functions of the MDT.

6.3 A member of the Core Penile Cancer Team will be an extended member of the Skin MDT.
7 **AUDIT AND DATA COLLECTION**

7.1 During the year prior to the peer review visit the penile cancer team with all its referring teams should have carried out, as one of the agreed network audit projects, the following:

7.2 An audit of cases over the previous year, diagnosed with penile cancer by its referring teams, and its own cases.

7.3 Cases referred for specialist care and Supranetwork care should be audited for consistency with the network penile cancer guidelines (defining specialist and Supranetwork care for the network). The audit should also ascertain whether all cases diagnosed with penile cancer were discussed with the Supranetwork team prior to referral or to proposed specialist care.

7.4 The Supranetwork MDT will provide the total number of the following procedures performed for penile cancer by the team and by individual surgeons during the year prior to being reviewed.

   i) Penile reconstruction procedures.
   ii) Lymphadenectomies.

These will be presented at an annual meeting of the Supranetwork MDT.

8 **ANNUAL MEETING**

8.1 During the year prior to peer review, the Supranetwork penile cancer MDT will have held a meeting at which at least one core member of the team met with at least one core member of each of its referring teams to review all the cases during the previous year diagnosed as having penile cancer by its referring teams, and its own cases. At the meeting they should have ascertained:

   • whether all cases were discussed with them prior to referral or to proposed specialist care and
   • whether referrals for specialist and Supranetwork care were consistent with the network guidelines

8.2 The Annual Meeting will also be used to discuss, review, agree and record operational policies.
8.3 The Supranetwork penile cancer team may arrange more regular meetings (4 – 6 monthly) to facilitate research and audit.

9 TRIALS

9.1 The Supranetwork MDT will maintain a list of approved trials to which each Network agrees to enter patients.

9.2 The Supranetwork MDT will ensure that mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.
Appendix A – Penile Cancer Primary Treatment

Penile Cancer Diagnosed/Suspected

- sMDT Clinical Assessment (MR/CT/CXR in advanced/selected cases if accurate staging at this point is felt necessary)

Primary Surgery as indicated

- **Tis/PIN**
  - 5-FU Imiquimod
  - Circumcision
  - WLE
  - Glansectomy + reconstruction
  - Glans resurfacing

- **Ta-1 G1-2**
  - Circumcision
  - WLE
  - Glansectomy +/- reconstruction
  - Partial penectomy
  - EBRT/Brachytherapy

- **T1G3, ≥ T2**
  - Partial penectomy
  - Radical Penectomy glansectomy
  - +/- reconstruction
  - EBRT

In all Surgical Cases reconstruction should always be considered at the time of surgery.
In radical penectomy delayed phalloplasty should be an option.

WLE = wide local excision; EBRT = external beam radiotherapy; 5-FU = 5-fluorouracil
Appendix B - Lymph Node Assessment & Treatment

**Primary Tumour Stage**

- **Low Risk**
  - Tis
  - Ta G1-2, T1G1
  - Non-palpable Inguinal nodes
  - Surveillance

- **Intermediate Risk**
  - T1G2
  - Palpable Inguinal Nodes
  - MR/CT Scan & CXR
  - Nil other metastasis
  - FNA/Excision biopsy

- **High Risk**
  - ≥ T1 G3
  - Non-palpable Inguinal nodes
  - Other metastasis present
  - Consider Chemo or EBRT or ChemoEBRT or Inguinal Node dissection

**EBRT** = External Beam radiotherapy
**DSNB** = Dynamic Sentinel Node Biopsy
**FNA** = Fine Needle Aspiration
**ML** = Modified Lymphadenectomy
**RL** = Radical Lymphadenectomy

*Each groin should be taken as a separate entity and treated according to the guidance.*
## Appendix C

<table>
<thead>
<tr>
<th>Trusts included within MDT</th>
<th>Local MDT Name &amp; Hospital Base of MDT</th>
<th>Specialist MDT Name and Hospital Base</th>
<th>Catchment Population</th>
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</thead>
<tbody>
<tr>
<td>Pennine Acute Trust</td>
<td>Pennine Acute Royal Oldham Hosp</td>
<td>North East Sector Urological Cancer Specialist MDT</td>
<td>744,000</td>
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<tr>
<td>Central Manchester and Manchester Children’s Trust</td>
<td>Central Manchester and Manchester Children’s Manchester Royal Infirmary</td>
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<td>225,000</td>
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<td>Bolton Hospitals NHS Trust</td>
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<td>Salford Urological Cancer Specialist MDT</td>
<td>276,000</td>
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<td>Wrightington, Wigan and Leigh NHS Trust</td>
<td>Wrightington, Wigan and Leigh Royal Albert Edward Infirmary</td>
<td>Salford Royal Hospital</td>
<td>302,000</td>
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<td>Salford Hospitals Hope Hospital</td>
<td>Salford NHS Foundation Trust</td>
<td>243,000</td>
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<tr>
<td>University Hospital of South Manchester NHS Trust</td>
<td>University Hospitals of South Manchester Wythenshawe Hospital</td>
<td>South Manchester Urological Cancer Specialist MDT</td>
<td>146,000 + 224,000 Total = 370,000</td>
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<tr>
<td>Trafford Healthcare NHS Trust</td>
<td>* NB Trafford patient flows are currently being reviewed and may change during 2012-13</td>
<td>Hospital</td>
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<tr>
<td>Stockport Foundation Trust Tameside &amp; Glossop Trust</td>
<td>Stockport Foundation Trust - Stepping Hill Hospital</td>
<td>University Hospitals South Manchester NHS Foundation Trust</td>
<td>290,000 + 233,000 Total = 523,000</td>
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<td>East Cheshire Macclesfield General</td>
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<td>Mid Cheshire Trust</td>
<td>Mid Cheshire Leighton Hospital</td>
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<tr>
<td>Local MDT Name &amp; Hospital Base of MDT</td>
<td>Catchment Population</td>
<td>Penile Cancer Specialist MDT</td>
<td>Total Catchment Population</td>
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<tr>
<td>Greater Manchester &amp; Cheshire Cancer Network Local Urology MDTs</td>
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*Joint, single Supranetwork MDT with Wirral Hospitals NHS Trust. Operating site at Christie.
All hospitals within the Penile Cancer Network are listed below:

<table>
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<th>Organisation</th>
<th>Address</th>
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<tbody>
<tr>
<td>Pennine Acute Hospitals NHS Trust (North East)</td>
<td>Westhulme Avenue</td>
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<td></td>
<td>Oldham</td>
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<td></td>
<td>Lancashire OL1 2PN</td>
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<td>Pennine Care NHS Trust</td>
<td>225 Old Street</td>
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<td>Ashton-under-Lyne</td>
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<td></td>
<td>OL6 7SR</td>
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<tr>
<td>Bolton, Salford &amp; Trafford Mental Health NHS Trust</td>
<td>Bury New Road</td>
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<td>Prestwich</td>
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<td></td>
<td>Manchester M25 3BL</td>
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<td>Royal Bolton Hospital</td>
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<td>North West Ambulance Service NHS Trust</td>
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<td>&amp; Mersey Area Office</td>
<td>Belmont Grove</td>
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<td></td>
<td>Liverpool L6 4EG</td>
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<tr>
<td>North West Ambulance Service Great Manchester Area</td>
<td>Bury Old Road</td>
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<tr>
<td>Offices</td>
<td>Whitefield Road</td>
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<tr>
<td></td>
<td>Manchester M45 6AQ</td>
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<tr>
<td>Cumbria &amp; Lancashire Area Office</td>
<td>Lancashire Area Office</td>
</tr>
<tr>
<td></td>
<td>449 – 451 Garstang Road</td>
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<tr>
<td></td>
<td>Broughton</td>
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<tr>
<td></td>
<td>Preston</td>
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<td>Lancs PR3 5LN</td>
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<td>Trust Name</td>
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<tr>
<td>Calderstones NHS Trust</td>
<td>Mitton Road Whalley Clitheroe Lancs BB7 9PE</td>
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<tr>
<td>Lancashire Teaching Hospital NHS Foundation Trust</td>
<td>Royal Preston Hospital Sharoe Green Lane Fulwood PRESTON PR2 9HT</td>
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<tr>
<td>Trafford Healthcare NHS Trust</td>
<td>Moorside Road Urmston Manchester M41 5SL</td>
</tr>
<tr>
<td>Wrightington, Wigan &amp; Leigh NHS Trust</td>
<td>The Elms Royal Albert Edward Infirmary Wigan Lane Wigan WN1 2NN</td>
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<tr>
<td>Salford Royal Hospitals NHS Foundation Trust</td>
<td>E2, Hope Hospital Stott Lane Salford M6 8HD</td>
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<tr>
<td>Central Manchester &amp; Manchester Children’s University Hospitals NHS Foundation Trust</td>
<td>Cobbett House Manchester Royal Infirmary Oxford Road Manchester M13 9WL</td>
</tr>
<tr>
<td>Tameside &amp; Glossop Acute Services NHS Trust</td>
<td>1st Floor, Darnton Building, Darnton Road Ashton under Lyne OL6 9RW</td>
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<td>University Hospital of South Manchester NHS Foundation Trust</td>
<td>Wythenshawe Hospital Southmoor Road Wythenshawe Manchester M23 9LT</td>
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<tr>
<td>Manchester Mental Health &amp; Social Care NHS Trust</td>
<td>Chorlton House 70 Manchester Road Chorlton Manchester M21 9UN</td>
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<tr>
<td>The Christie Hospital NHS Foundation Trust</td>
<td>Wilmslow Road Withington Manchester M20 4BX</td>
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| Royal Liverpool & Broadgreen University Hospital NHS Trust | Prescot Street  
Liverpool L7 8XP |
|----------------------------------------------------------|------------------|
| Aintree University Hospitals NHS Foundation Trust        | Aintree House  
Longmoor Lane  
Liverpool  
Merseyside L9 7AL |
| Mersey Care NHS Trust                                    | 8 Princes Parade  
Princes Dock  
St Nicholas Place  
Liverpool L3 1DL |
| Wirral University Hospital NHS Foundation Trust          | Arro...  
Arro...  
Upton  
Wirral CH49 5PE |
| Cheshire & Wirral Partnership NHS Trust                  | Trust Board Offices  
Upton Lea Resource Centre  
1st Floor  
Liverpool Road  
Chester CH2 1BQ |
| Countess of Chester NHS Foundation Trust Hospital        | Health Park  
Liverpool Road  
Chester CH2 1UL |
| The Clatterbridge Cancer Centre NHS Trust                | Clatterbridge Road  
Bebington  
Wirral CH63 4JY |
| Walton Centre for Neurology & Neurosurgery NHS Trust     | Lower Lane  
Fazakerley  
Liverpool L9 7PJ |
| Liverpool Heart and Chester Hospital NHS Trust           | Thomas Drive  
Liverpool L14 3PE |
| Alder Hey Children’s NHS Foundation Trust               | Alder Hey Hospital  
Eaton Road  
Liverpool L12 2AP |
| Southport & Ormskirk Hospital NHS Trust                 | Southport & Formby DGH  
Town Lane  
Kew, Southport |
<table>
<thead>
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<th>Trust Name</th>
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<td>Blackpool, Fylde &amp; Wyre Hospitals Trust</td>
<td>Blackpool Victoria Hospital Whinney Heys Road Blackpool FY3 8NR</td>
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<td>University Hospitals of Morecambe Bay</td>
<td>Westmorland General Hospital Burton Road Kendal LA9 RG</td>
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<td>North Cumbria Acute Hospitals NHS Trust</td>
<td>Cumberland Infirmary Carlisle CA2 7HY</td>
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<td>Cumbria Partnership NHS Trust</td>
<td>The Carleton Clinic Cumwhinton Drive Carlisle CA1 3SX</td>
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<td>East Lancashire Hospitals NHS Trust</td>
<td>The Royal Blackburn Hospital Haslingden Road Blackburn Lancashire BB2 3HH</td>
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<td>Leighton Hospital Middlewich Road Crewe CW1 4QJ</td>
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<td>East Cheshire NHS Trust</td>
<td>Macclesfield District General Hospital Victoria Road Macclesfield SK10 3BL</td>
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<td>Warrington and Halton Hospitals NHS Foundation Trust</td>
<td>Lovely Lane Warrington Cheshire WA5 1QG</td>
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<td>St Helens &amp; Knowsley Hospitals NHS Trust</td>
<td>Whiston Hospital Prescot Merseyside L35 5DR</td>
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<td>5 Boroughs Partnership NHS Trust</td>
<td>Hollins Park House Hollins Lane Winwick Warrington WA2 8WA</td>
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<td>Liverpool Women’s NHS Foundation Trust</td>
<td>Crown Street Liverpool L8 7SS</td>
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<td>Wrexham Maelor Hospital</td>
<td>Croesnewydd Road Wrexham LL13 7TD</td>
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<tr>
<td>Bangor Community Hospital</td>
<td>Castle Street Bangor BT20 4TA</td>
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<tr>
<td>North West Wales Hospital</td>
<td>Ysbyty Gwynedd Penrhosgarnedd Bangor Gwynedd LL57 2PW</td>
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