Royal United Hospitals Bath GP Guidance for Two Week Wait and Urgent Gynaecology Referrals during the Covid-19 Pandemic

This guidance lays out modifications to the two week way (2WW) referral pathway to RUH Bath gynaecology services in light of the Covid-19 pandemic.

Symptom/ Sign Specific Guidance for GPs

Intermenstrual Bleeding (IMB)

Women should be reassured that IMB is common and symptoms often spontaneously resolve and that underlying cancer is rare.

Where the likelihood of sexually transmitted infection or genital tract cancer is considered negligible, then management options to discuss include:

- Reassurance
- Observation with phone follow up to see if the IMB subsides.
- Change in hormonal contraceptives in current users.
- Trial of hormonal contraceptives in non-users.

Where women are not up-to-date with their smear tests a visual cervical examination in primary care is appropriate. In these patients:

- Perform high vaginal swabs.
- If there is genuine concern about a cervical cancer then refer to RUH on 2WW basis.

If the above has been completed then women should be referred to secondary care for further investigation if:

- Endometrial cancer is suspected because of persistent IMB (i.e. occurring for at least 3 consecutive months) in women over 40 years of age who are not using hormonal contraceptives.

Post coital bleeding (PCB)

Women with PCB should initially be managed by remote communication to:

- Reassure them that a cervical cancer is extremely unlikely if they have an in-date 'normal' cervical screening test.
- Elucidate whether they have any risk factors for or other symptoms of a sexually transmitted disease. If such factors exist, they should be seen in primary care for further investigation and management.
- Women who do not have an in-date negative cervical screening test need to be seen for a speculum examination to exclude cervical cancer.

Abnormal Cervix

If the patients cervix appears suspicious for cervical cancer refer using the 2WW pathway.

Post-Menopausal Bleeding (PMB)

Women with PMB should have a consultation with their GP by remote communication to:

- Confirm the symptom and confirm bleeding is vaginal.
- Confirm that the bleeding is one year after cessation of periods and not due to and increased intermenstrual time period before making a referral.
- Establish if the patient has had a hysterectomy in the past. Women with hysterectomy and no history of genital tract cancer can have topical vaginal oestrogen treatment for 2 months and reassessment. If bleeding continues they can be referred for hospital assessment.
- Establish if the patient is on HRT. Patients on HRT can generally be managed in primary care by stopping the HRT for 6 weeks and then reassessing symptoms. If symptoms have not resolved then patients can be referred via the 2WW pathway. Women should be able to go back on HRT after the social distancing restrictions are lifted.
    - The British Menopause Society has produce guidance on managing unscheduled bleeding within 3 – 4 months of commencing HRT. This includes suggested changes to regimes to control bleeding (https://thebms.org.uk/wp-content/uploads/2020/03/BSGE-document-HMB31.3.20final_.pdf).
- Establish if any vaginal supporting pessaries are in place for prolapse. Examination in primary care to asses for vaginal ulceration from the pessary is an appropriate first management step in these patients. Those with vaginal ulceration from a pessary can generally be managed by temporarily removing the pessary and treating with topical oestrogen.
- Establish recent smear history and if visualisation of the cervix is required.

Once the above steps have been taken and a patient has been identified as having PMB with no clear cause they can be referred using the 2WW pathway.

2WW Referrals for PMB will be triaged by a senior gynaecologist. Initially the focus will be on, as far as possible, maintaining face to face assessment of most patients who require this (Plan A). It is however anticipated that the risk of virus transmission or resource limitation may result in the inability to see many patients face to face. In this situation patients will be triaged according to Plan B below.

Plan A

Patients with unexplained PMB or any high risk factors will be seen, when resources allow, in an enhanced one-stop clinic with facilities of ultrasound scanning, clinical assessment and outpatient hysteroscopy (if required) at the same visit.

Plan B

This will come into force if the Covid-19 pandemic means the risk of transmission during a visit to the hospital is unacceptably high or if clinic facilities and medical personnel are diverted to other emergency services. There will be a risk of a delay in cancer diagnosis but it is hoped this delay will be small and unlikely affect the stage or prognosis of the cancer.

Face to face assessment of some PMB cases with low risk of cancer may be deferred to 4 or 8 weeks depending on the Covid-19 pandemic status and pressures on hospital services.

Deferred cases may include:

- Women describing period like bleeding with premenopausal symptoms within 5 years of menopause.
- One off short-lasting bleed or blood stained discharge (less than 7 days) or post coital bleeding (PCB). Women with PCB may be asked to refrain from intercourse and to report any further bleeding as vaginal atrophy is a possible diagnosis in these cases.
- PMB in women with supporting pessaries for prolapse (if not assessed in primary care).

Abnormal Vulva/ Vagina

The patients should have a GP telephone consultation in the first instance.

If the patient has known lichen sclerosus or lichen planus consider stepping up emollient and steroid treatment (e.g. daily Dermovate or Nerisone Forte for one month, then every other day for one month and once or twice weekly ongoing) and advise patient initiated follow up. If symptoms persist then consider referral to secondary care.

If concern about vulval/ vaginal cancer on examination then refer using the 2WW pathway.

Symptoms of Ovarian Cancer

Patients with symptoms or signs concerning for ovarian cancer should undergo a Ca-125 blood test with an urgent pelvic ultrasound scan if needed prior to referral to secondary care.

Pre-menopausal patients with simple unilocular ovarian cysts smaller than 5cm in maximal dimension generally do not require referral or follow up as most resolve spontaneously.

Pre-menopausal patients with simple unilocular ovarian cysts between 5cm and 7cm in maximal dimension generally do not require urgent referral and should have a repeat ultrasound in 12 months. These women can be referred via the non-urgent (18 week) pathway and will have appointments scheduled as appropriate after social distancing restrictions are lifted.

If referral is required, patients with complex cysts or post-menopausal patients with ovarian cysts will be triaged by the gynaecology team, usually via telephone. Cases felt to be low risk for malignancy or patients with significant comorbidities may have full review or treatment deferred for 3 to 6 months or until social distancing restrictions are lifted.

General Guidance

Performance status and comorbidities should be included in all 2WW referrals.

Advice and guidance is available via the consultant gynaecologist oncall.

Primary and secondary care need to work together at this difficult time to minimise the risk to patients by avoiding overwhelming the available resources and avoiding unnecessary visits to the RUH Bath. This is best achieved by rigorous risk assessment of urgent referrals.

In all cases an assessment should be made by the GP to establish whether hospital assessment can be deferred for Covid-19 vulnerable patients (e.g. those over 70 years old or with underlying health conditions)

Background to Guidance

The underlying principles for producing this guidance are:

- To reduce the risk of transmission patients should not visit the RUH Bath unless this is absolutely necessary.
- When patients have to visit the RUH Bath the exposure to the hospital should be minimised and one stop assessment and treatment will take place when this is practical.
- Telephone or Video consultations may be used in preference to face to face visits to minimise the risk of transmission.
- No patient should come to the hospital if under quarantine for symptoms or household illness unless it is an emergency.
- In some cases the risk of Covid-19 transmission may be greater than the risk of delayed cancer diagnosis.
- Resource restrictions may require the assessment of some patients to be delayed.
- For as long as is safe and possible best practice standards for the care of patients with suspected cancer will be adhered to.
- Safety netting should be put in place for all for all patients who do not undergo formal review.

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Authors: Jonathan Frost, Nick Johnson, Russ Luker, Shashikant Sholapurkar

Key References

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2. NHS, Clinical guide for the management of cancer patients during the coronavirus pandemic. March 2020
3. Joint RCOG, BSGE and BGCS guidance for the management of abnormal uterine bleeding in the evolving Coronavirus (COVID-19) pandemic. March 2020
4. BSCCP, Colposcopy guidance during COVID 19 pandemic. March 2020