BRITISH GYNAECOLOGICAL CANCER SOCIETY

Virtual Annual Scientific Meeting
13th & 14th May 2021

BGCS 2021 – INVITED PRESENTATIONS

How to set up a HIPEC unit

Professor Donal Brennan
Professor of Gynaecological Oncology
Academic Lead UCD Gynaecological Oncology Group, Dublin, Ireland

Summary of presentation

Overview of the practical steps required to develop a HIPEC program from governance to patient selection and peri-operative protocols

What you need to know (key learning point)

HIPEC should be considered as an adjunct to high quality cytoreductive surgery, it is not a substitute for inadequate surgery. Currently the only indication for HIPEC is at interval cytoreduction in women who have responded to neo-adjuvant chemotherapy and have residual disease < 2.5mm. Any other indication should only be considered within the setting of a clinical trial.

What you need to do (key practice changing points)

Development of a HIPEC unt requires multi-disciplinary collaboration
Focus must be on the quality of cytoreductive surgery

Radiographer challenges and patient experience

Caroline Chapman
Brachytherapy Consultant Radiographer. 17 years experience of working as a Brachytherapy radiographer treating HDR prostate, gynae, GI, skin and breast.

Summary of presentation

This is a brief presentation of the extra considerations and procedures that are required when treating complex gynae interstitial insertions, in particular those with free needles.

Mr Peter Bownes, **Dr Rachel Cooper**

We present the case of a 56 years old woman who had undergone a radical hysterectomy for stage 1B cervical cancer. Histology suggested close surgical margins and she was referred for adjuvant treatment. However the patient delayed her initial consultation and when seen in the clinical oncology clinic she complained of vaginal bleeding and discharge. On examination she was found to have a bleeding irregular area at the vaginal vault, compatible with residual or early recurrent disease. Imaging showed a thickening at the vaginal vault which showed restriction diffusion and correlated with an area of mildly FDG avidity on PET-CT. The patient was treated with chemoradiotherapy to the pelvis followed by a brachytherapy boost to the recurrent disease. We will demonstrate the principles of MRI image guided brachytherapy using the Venezia applicator with vaginal cap and interstitial needles. We will demonstrate the decision process for choosing this applicator, tips for successful insertion and the planning process including the advantages and pitfalls of the Venezia applicator. The principles discussed can be applied to primary vaginal or recurrent endometrial/cervical cancer at a similar site.

Mr Peter Bownes, **Dr Rachel Cooper**

We present the case of a 67 years old woman who had undergone a subtotal hysterectomy for benign disease at age 42 who present with vaginal bleeding and was found to have a biopsy proven SCC of the residual cervical stump. MRI showed a 45 mm tumour, with loss of stromal ring. No nodes and PET scan an intensely FDG avid cervical tumour with no evidence of FDG avid, nodal or distant metastatic involvement. This was therefore staged as FIGO 2B and she was referred to clinical oncology.The patient was referred to clinical oncology. She was otherwise fit or well.

The patient was treated with chemoradiotherapy to the pelvis followed by a brachytherapy boost to the primary disease. The cervical stump was too short for a 4cm central tube and a shorter tube was not available. We will demonstrate the principles of MRI image guided brachytherapy using a ring and interstitial needles as an alternative to the Venezia applicator with vaginal cap and interstitial needles or ring/ovoids with a short central tube. We will demonstrate the decision process for choosing this applicator, tips for successful insertion and the planning process .The principles discussed can be applied to primary vaginal or recurrent endometrial/cervical cancer at a similar site.

Value of surgery in recurrent ovarian cancer
Professor Christina Fotopoulou
Professor Christina Fotopoulou trained in in obstetrics and gynaecology and subspecialized in gynaecological oncology at the Charité University Hospital of Berlin in the surgical and systemic treatment of gynaecological cancer. She is since 2013 a Consultant Cynecological Oncologist at Imperial College London Hammersmith Hospital in London, and is a principal investigator of the Ovarian Cancer Action Research Centre, UK. She also holds a honorary chair in the Gynaecology Dept at the Charite University of Berlin, where she has been the Vice Director of Gynecology, one of the largest reference and accredited centers for gynecological cancer in Europe, as well the Principal Coordinator of the European Competence Center for Ovarian Cancer.
Her principal area of expertise lies in exenterative procedures for advanced forms of pelvic malignancies, in the cytoreductive procedures for primary or relapsed ovarian cancer and the investigation of predictive and prognostic biomarkers of surgical and clinical outcome. Her further area of focus is bioengineering and implementation of novel bioengineering methods in cytoreductive surgery for advanced ovarian cancer.
She has served as the lead of the guidelines group of the British Gynaecological Cancer Society (BGCS) and is at present an elected member of the ESGO- council (European Society of Gynaecologic Oncology) and lead of the ESGO guidelines committee. She is also a member of the German AGO- Ovarian Cancer Steering- and Guidelines Group.
She is on the editorial board and reviewer of numerous international gynaecological and oncological journals and is member of various international oncological committees, including BGCS, ASCO, ESGO, IGCS, ESMO, ENGOT, AGO, SGO and NOGGO.

Summary of presentation
The value of secondary debulking for relapsed epithelial ovarian cancer has changed significantly over the last years. While retrospective data have previously suggested a survival benefit from secondary debulking; prospective data were lacking. We now have the the results of three prospective randomized trials that have all consistently demonstrated a significantly longer remission in selected patients operated tumorfree at relapse versus those with chemotherapy alone. Moreover, it appears that suboptimal/ non tumorfree surgery was associated with worse outcome than no surgery at all. For that reason, the accurate identification of the optimal surgical candidates preoperatively, is of crucial importance in order to direct surgery to those patients who will benefit most. Various predictive algorithms have been developed to select women who are likely to be operated tumorfree, while specialization of centres and surgical and infrastructural expertise appear to be the key of success in every level. In times of rapid advances in the systemic treatment of the disease, it is the package of care, that matters, as is the individualization of treatment, in both surgical and systemic aspects.

What you need to know (key learning point)
- Surgery at relapse is of benefit only in selected patients, who can be operated tumorfree by a specialized team.
- Surgery needs to be consolidated with postoperative systemic treatment
- the disease will still remain chronic

What you need to do (key practice changing points)
- Promotion of specialization of cetres
- Consideration of surgical debulking in patients who fit the profile (length of remission, PS, ascites, residual disease at primary surgery etc)

Key references (papers, websites, guidelines etc)
- Secondary Surgical Cytoreduction for Recurrent Ovarian Cancer.
Coleman RL, Spirtos NM, Enserro D, Herzog TJ, Sabbatini P, Armstrong DK, Kim JW, Park SY, Kim BG, Nam JH, Fujiwara K, Walker JL, Casey AC, Alvarez Secord A, Rubin S, Chan JK, DiSilvestro P, Davidson SA, Cohn DE, Tewari KS, Basen-Engquist K, Huang HQ, Brady MF, Mannel RS.
N Engl J Med. 2019 Nov 14;381(20):1929-1939. doi: 10.1056/NEJMoa1902626.
PMID: 31722153

- Value of tertiary cytoreductive surgery in epithelial ovarian cancer: an international multicenter evaluation.
Fotopoulou C, Zang R, Gultekin M, Cibula D, Ayhan A, Liu D, Richter R, Braicu I, Mahner S, Harter P, Trillsch F, Kumar S, Peiretti M, Dowdy SC, Maggioni A, Trope C, Sehouli J.
Ann Surg Oncol. 2013 Apr;20(4):1348-54. doi: 10.1245/s10434-012-2673-z. Epub 2012 Oct 2. PMID: 23054114

- Update on the secondary cytoreduction in platinum-sensitive recurrent ovarian cancer: a narrative review.
Conte C, Fagotti A, Avesani G, Trombadori C, Federico A, D'Indinosante M, Giudice MT, Pelligra S, Lodoli C, Marchetti C, Ferrandina G, Scambia G, Gallotta V.
Ann Transl Med. 2021 Mar;9(6):510. doi: 10.21037/atm-20-4690.

Interstitial brachytherapy for vulvovaginal cancers

Gerry Lowe and Peter Hoskin
Mount Vernon Cancer Centre

Vulvovaginal cancers present an ideal site for brachytherapy, often in combination with external beam radiotherapy to the primary site and regional lymph nodes. The advantage of brachytherapy in this setting is delivery of a high localised radiation dose with low doses to adjacent vagina, urethra and rectum.

The standard technique uses an interstitial approach with needles or plastic catheters passing through the tumour-bearing region. This will require a general or regional anaesthetic and ultrasound guidance is invaluable in ensuring accurate catheter placement. Catheters should be placed parallel to each other at equal distances trying to avoid convergence or divergence. Vaginal packing is important to displace tissues outside the CTV away from the radiation source. Effective surface fixation is required with a method for catheter position checking between fractions. A urinary catheter is mandatory.

MR-based planning provides optimal definition of the CTV and is compatible with modern brachytherapy planning systems. Implanted markers to define the limits of the GTV may also be valuable when reconstructing on 3D imaging. Planning will be based around the principles of the Manchester or Paris dosimetry systems, but in practice manual or automated optimisation is always used. Dwell times can be upweighted at the ends of loaded sections (Manchester "crossed ends"). If the CTV is small, a balance is needed between excessive "splash" of dose beyond the CTV, whilst avoiding the possibility of geographic miss due to physical uncertainties such as change in CTV size induced by post-procedure oedema. Optimisation may also be constrained by mucosal tolerance.

For a boost after 45-50Gy 18-24Gy will be given in four fractions. As sole treatment for small volume disease 30-36Gy in 6 fractions is used. Patient care is an important consideration during multifraction therapy in which the implant may need to be in place for 4-5 days and the patient will be bed-bound during this time. An enema prior to the procedure and regular loperamide to prevent bowel activity is important. Pain relief should be individualised to the patient's needs, with attention to general discomfort from lying in bed, spinal pain and restlessness. Night sedation is often valuable to minimise disturbance during the night. During this time the patient will be at risk of thromboembolism having an underlying cancer, pelvic disease and immobility. Compression hosiery and prophylactic doses of subcutaneous heparin should be used, omitting the heparin on the evening prior to implant removal.

Following the procedure and implant removal if the treated volume has included the labia and skin then a brisk skin reaction extending to desquamation may occur. Periurethral implants may cause prolonged non-infective urethritis. These should resolve with conservative management. Later complications include vaginal stenosis and urethral stricture. Encouragement to use of vaginal dilators is recommended.

Response rates are high with progression free survival around 70% when brachytherapy is used alone or in combination with external beam radiotherapy.

Follow up of patients on maintenance therapy

Dr Rowan Miller

Dr Rowan Miller is a Consultant Medical Oncologist specialising in gynae-oncology and early phase clinical trials at University College London and St Bartholomew's Hospitals. Her research interests include novel therapies for gynaecological cancer and utilising genomics and biomarkers to guide therapy in patients, particularly in early-phase clinical trials.

Dr Miller completed her undergraduate training at the University of Oxford and clinical training at Guy's and St Thomas' Hospitals, London. She trained in Medical Oncology at University College London and was subsequently awarded a Cancer Research UK Fellowship and attained a PhD from the Institute of Cancer Research. Following her PhD, Dr Miller completed a fellowship at Dana Farber Cancer Institute, Harvard University.

Dr Miller is involved in a number of clinical trials and basic science research projects across the two academic centres. She is a member of the ESMO Personalized Medicine and Translational Research Committee and led their consensus recommendation paper on HRD testing in ovarian cancer.

Summary of presentation

Maintenance therapy is now standard of care for patients with advanced ovarian cancer in the first line setting.

This presentation will review the evidence and guidelines for the follow-up of patients on maintenance therapies.

What you need to know (key learning point)

Are the results of the CA125 follow up trial (MRC, OVO5/ EORTC 55955) still relevant?

Professor Gordon Rustin

Gordon JS Rustin retired from Mount Vernon Cancer Centre in 2018 but continues private practice at Bishops Wood Hospital.

Summary

The MRC OV05/ EORTC 55955 trial investigated the role of CA125 surveillance in patients with a CA125 level within the normal range following platinum-based chemotherapy for epithelial ovarian cancer. If CA125 levels rose to more than twice the upper limit of normal, patients were randomized to immediate or delayed chemotherapy. It enrolled 1442 patients and found that those randomized in the early arm started chemotherapy a median of 4.8 months earlier than those on the delayed arm. There was no difference in survival between the early and delayed arms, with worse quality of life of patients in the early arm.

A retrospective audit in one centre found 80% of patients choosing not to have routine CA125 follow-up, but routine CA125 use did not change in many centres. The reasons why patients are advised to have routine CA125 measurements will be discussed with explanations as to why this advice is frequently based on erroneous beliefs. It is debatable whether maintenance therapy should be stopped just because of rising CA125 levels. It is unclear whether rising CA125 levels should be a reason for considering second surgery.

Patients entering remission should be told of the potential benefits and harms of routine CA125 follow-up and offered the following options:

1. Not to have routine CA-125 measurements if they are well and have no symptoms suggesting relapse.
2. To continue having CA-125 measurements but not be told the results. This option is particularly useful if they are in a clinical trial or on maintenance therapy.
3. To have routine CA-125 measurements so that they have more warning as to when they might require relapse chemotherapy.

Further requirements to enable safe follow-up of ovarian cancer patients who opt for no routine CA 125 measurements are: 1. A leaflet about follow-up which includes a list of likely symptoms that should prompt an early clinic appointment. (see http://links.lww.com/IGC/A456). 2. Facilities for patients to make urgent appointments. 3. Availability of a support nurse for telephone advice.

Patients need to be told before embarking on CA125 surveillance that it could lead to a worse quality of life with more chemotherapy or surgery than needed, and possibly early discontinuation of maintenance therapy, for no survival benefit.

What you need to know (key learning point)

The MRC OV05/ EORTC 55955 trial showed that routine CA125 measurements did not improve survival and led to a worse quality of life than not having routine CA125 measurements.

What you need to do (key practice changing points)

Patients need to be told of the potential benefits and harms of routine CA125 measurements and given several follow-up options.

Key references (papers, websites, guidelines etc)

Rustin GJS et al. Early versus delayed treatment of relapsed ovarian cancer (MRCOV05/EORTC 55955): a randomised trial. Lancet. 2010;376:1155-1163.

Brachytherapy versus Stereotactic Radiotherapy

Dr Alexandra Taylor.
Consultant in Clinical Oncology Royal Marsden Hospital, UK

Summary of presentation

Stereotactic radiotherapy provides an alternative option to brachytherapy for delivering a high dose boost to disease. Case examples will be presented to demonstrate the potential advantages and disadvantages of SBRT for treating pelvic and vaginal disease.

What you need to know (key learning point)

Stereotactic radiotherapy can enable dose escalation when brachytherapy is not feasible.

Tamoxifen and the LNG-IUS: Friend or foe? The Breast Surgeon's Perspective

Mr James Bristol MD FRCS
Consultant Surgeon Gloucestershire Hospitals NHS Foundation Trust, Genomics Clinical Implementation Lead.
I have been a Consultant Surgeon with an interest in Breast disease for over thirty years, and a former member of the ABS Executive, Guideline writing member etc. The endocrine management of breast cancer has been a long-standing interest, and as such I have been actively involved in clinical trials such as aTTom and ATAC.

Summary of presentation:

Tamoxifen, a non-steroidal selective oestrogen-receptor (ER) modulator, or 'SERM', has been the mainstay of adjuvant endocrine therapy for oestrogen-receptor positive breast cancer (BC) since the early 1990s, as a result of clinical trials which demonstrated a clear survival advantage in treated patients, having previously been shown as an effective endocrine treatment for advanced disease. Aromatase inhibitors (AI) have supplanted its use in many post-menopausal women with ER-positive breast cancer, but Tamoxifen still plays a role in this group. As it has agonist effects on the endometrium it was no surprise to learn that endometrial proliferation was common, resulting in hyperplasia, polyps, and in a small number of cases, endometrial cancer, usually manifest as post-menopausal bleeding. The risk of endometrial cancer is related to both dose and duration of use: randomised trials have indicated a three-five-fold increase in endometrial cancer risk in BC patients receiving Tamoxifen, possibly as high as seven-fold in some groups. Some of this increased risk might have arisen as a result of pre-existing changes in the endometrium, stimulated by the oestrogen-like effect of Tamoxifen.

The levonorgestrel intrauterine system (LNG-IUS) causes profound endometrial suppression.

In users of Tamoxifen, there is evidence to suggest its use leads to a significant reduction in endometrial polyps, and a modest reduction in endometrial hyperplasia; no study has reported any cases of endometrial cancer in these circumstances.

There is no clear evidence to suggest that the risk of breast cancer recurrence is increased, but the number of subjects in existing studies is small, and the studies underpowered. No studies of the deployment of the LNG-IUS alongside Tamoxifen in BC survivors given systemic oestrogen replacement therapy (ERT) have been carried out.

Despite the absence of evidence of harm from the deployment of the LNG-IUD alongside Tamoxifen in BC survivors, there is reluctance among oncologists to sanction its use in these patients. The principal reason for this is fear of provoking BC recurrence, predicated on the known impact of the device on women with no prior history of breast cancer (RR of BC 1.16 - 1.5 for current or recent-users vs non-users, dependent on age), the statement in the manufacturer's insert that it should not be used in BC survivors, and a general view that exogenous sex hormone use in BC patients is risky. It is not clear whether these fears are justified, and they merit further investigation.

The management options for the endometrium in BC survivors on adjuvant endocrine therapy will be discussed, including those having risk-reducing surgery for BRCA variants.

What you need to know (key learning point):

Tamoxifen will continue to have a significant role in the adjuvant, neo-adjuvant, and primary treatment of women with ER-positive breast cancer for the foreseeable future, particularly in those who are pre-menopausal, but also in post-menopausal patients for whom aromatase inhibitors are not tolerated or are otherwise contraindicated. There are no clear protocols for assessment of the endometrium pre- or post-treatment, and there is a significant burden of clinical activity generated as a result of post-menopausal or irregular uterine bleeding requiring investigation. Strategies for reducing this burden have not been worked up to any great extent. The LNG-IUS has the potential to mitigate the agonist effects of Tamoxifen on the endometrium. However, there was a missed opportunity to monitor the effects of the LNG-IUS on the breast when it was introduced, meaning that the optimal management of the endometrium in breast cancer patients receiving Tamoxifen remains unclear.

What you need to do (key practice changing points):

Efforts should be made to personalise the risk/benefit balance for each patient individually in informed discussions with the surgical/oncology teams and the patient, recognising the uncertainties that exist around the choice of pathway that balances endometrial health with breast cancer recurrence risk.

Key references (papers, websites, guidelines etc)

https://associationofbreastsurgery.org.uk/media/332034/abs-endocrine-guidance-2021-v1.pdf
https://associationofbreastsurgery.org.uk/media/64908/11-bms-consensusstatement-the-diagnosis-of-the-menopause-and-management-of-oestrogen-deficiency-symptoms-and-arthralgia-in-women-treated-for-breast-cancer-for-abs-01c.pdf

The conservative management of endometrial cancer

Prof Emma Crosbie

Prof Emma Crosbie is an NIHR Advanced Fellow, Professor and Honorary Consultant Gynaecological Oncologist at the University of Manchester. Her research focuses on screening, prevention and early detection of gynaecological cancers. She is Chair of the NCRI Endometrial Workstream and a member of the NCRI Screening, Prevention and Early Diagnosis Group. She is Chair of the RCOG Academic Board and member of the RCOG Blair Bell Research Society.

Summary of presentation

This presentation will give an overview of the evidence for conservative management of atypical hyperplasia and endometrial cancer for women who prefer to avoid hysterectomy for fertility-sparing or poor surgical fitness reasons. It will describe eligibility, recommendations for treatment, surveillance and follow up, and outcomes from published data and the Manchester clinic.

What you need to know (key learning point)

Progestin is a suitable alternative to surgery for medically unfit women and those wishing to preserve their fertility with atypical hyperplasia and grade 1 stage 1a endometrial cancer so long as the diagnosis is accurate and women are closely monitored during treatment.

What you need to do (key practice changing points)

The conservative management of atypical hyperplasia and endometrial cancer should be managed by a multidisciplinary team of experts that includes a gynaecological oncologist, fertility specialist and anaesthetist. Local teams should build the necessary infrastructure to ensure accurate diagnosis and staging at baseline, followed by careful monitoring during treatment.

Key references (papers, websites, guidelines etc)

Janda M, Robledo KP, Gebski V, Armes JE, Alizart M, Cummings M, Chen C, Leung Y, Sykes P, McNally O, Oehler MK, Walker G, Garrett A, Tang A, Land R, Nicklin JL, Chetty N, Perrin LC, Hoet G, Sowden K, Eva L, Tristram A, Obermair A. Complete pathological response following levonorgestrel intrauterine device in clinically stage 1 endometrial adenocarcinoma: Results of a randomized clinical trial. Gynecol Oncol. 2021 Apr;161(1):143-151.

Westin SN, Fellman B, Sun CC, Broaddus RR, Woodall ML, Pal N, Urbauer DL, Ramondetta LM, Schmeler KM, Soliman PT, Fleming ND, Burzawa JK, Nick AM, Milbourne AM, Yuan Y, Lu KH, Bodurka DC, Coleman RL, Yates MS. Prospective phase II trial of levonorgestrel intrauterine device: nonsurgical approach for complex atypical hyperplasia and early-stage endometrial cancer. Am J Obstet Gynecol. 2021 Feb;224(2):191.e1-191.e15.

Looking back at PORTEC-3, forward to PORTEC-4 and somewhere over the RAINBO

Stephanie de Boer
Radiation Oncologist at Leiden University Medical Centre, the Netherlands.

Summary of presentation

The incidence of endometrial cancer (EC) is rising due to increased population obesity and aging. Adjuvant treatment of EC is currently based on traditional risk factors. The Cancer Genome Atlas defined four molecularly distinct subclasses providing a basis for personalized treatment. For intermediate risk EC, translational analysis in the PORTEC 1 and 2 trial cohorts showed that the integration of these molecular subgroups leads to an improved risk assessment. This is currently being tested in the randomised PORTEC-4a trial, the first clinical trial in which the integration of molecular factors in adjuvant treatment decisions will be determined.
For high-risk EC (HREC), three randomised trials (PORTEC-3, GOG-249 and GOG-258) have published results in 2019. In the PORTEC-3 trial women were randomized to external beam radiotherapy with or without concurrent and adjuvant chemotherapy. The updated survival analysis showed an improvement in failure free survival (12.5%) and overall survival (10%, HR 0.70) favouring chemoradiotherapy. Women with stage III and/or serous EC benefitted most of chemoradiotherapy (absolute OS improvement of 10% and 19% respectively, and FFS improvement of 13% and 12%). Unfortunately, this comes at the expense of increased adverse events and a (transient) impairment of women's quality of life.
Molecular analysis of tumour tissue samples of PORTEC-3 trial participants was performed in 410 cases. The molecular classification had strong prognostic value with a five-year recurrence-free survival of 98% for POLEmut, 72% for MMRd, 74% for NSMP and 48% for p53abn ($p<0.001$). Comparing the two treatment arms, patients with p53abn-HREC benefited from combined chemoradiotherapy (59% vs 36%), while for NSMP-HREC 5-year RFS increased (not significantly) from 68 to 80% with additional chemotherapy. POLEmut-HREC had 97-100% survival in both trial-arms. In contrast, the 5-year RFS for MMRd-HREC showed overlapping curves and chemotherapy seemed not to alter patterns of recurrence and survival.
These results has led to the proposal of the RAINBO-trials program. This is a highly innovative program introducing the molecular groups and additional molecular characteristics into the adjuvant treatment of all women with HREC. This strong international collaboration aims to further improve molecular based precision therapy in patients with HREC.

What you need to know (key learning point)

The introduction of the molecular risk factors in endometrial cancer has changed the landscape and has improved prognostication, treatment selection and response prediction in endometrial cancer.

What you need to do (key practice changing points)

Molecular risk factors should be incorporated into clinical diagnostics, treatment decisions and new trials for endometrial cancer
Focus on improving survival and reducing morbidity by selecting effective treatments with less toxicity and avoiding overtreatment and undertreatment

Key references (papers, websites, guidelines etc)

- Stelloo E, Nout RA, Osse EM, Jurgenliemk-Schulz IJ, Jobsen JJ, Lutgens LC, et al. Improved Risk Assessment by Integrating Molecular and Clinicopathological Factors in Early-stage Endometrial Cancer-Combined Analysis of the PORTEC Cohorts. Clinical cancer research: an official journal of the American Association for Cancer Research. 2016;22(16):4215-24.
- de Boer SM, Powell ME, Mileshkin L, et al, PORTEC Study Group; Adjuvant chemoradiotherapy versus radiotherapy alone in women with high-risk endometrial cancer (PORTEC-3): patterns of recurrence and post-hoc survival analysis of a randomised phase 3 trial. Lancet Oncol. (2019) 20, 1273-1285
- Randall M.E., Filiaci V., McMeekin D.S. et al.; Phase III trial: Adjuvant pelvic radiation therapy versus vaginal brachytherapy plus paclitaxel/carboplatin in high-intermediate and high-risk early stage endometrial cancer; J Clin Oncol, 37 (2019), pp. 1810-1818

- Matei D., Filiaci, V., Randall M.E. et al; Adjuvant Chemotherapy plus Radiation for Locally Advanced Endometrial Cancer; N Engl J Med. 2019 Jun 13;380(24):2317-2326
- León-Castillo, A.; De Boer, S.M.; Powell, M.E. et al. Molecular classification of the PORTEC-3 trial for high-risk endometrial cancer: Impact on prognosis and benefit from adjuvant therapy. J. Clin. Oncol. 2020.
- van den Heerik ASVM, Horeweg N, Nout RA et al; PORTEC-4a: international randomized trial of molecular profile-based adjuvant treatment for women with high-intermediate risk endometrial cancer. Int J Gynecol Cancer. 2020;30:2002–2007.

Fertility after endometrial cancer

Dr Cheryl Fitzgerald MRCOG, MD
Consultant in Reproductive Medicine and Clinical Lead for Fertility Preservation Service, St Mary's Hospital, Manchester.

Summary of presentation

Endometrial cancer is a disease increasingly seen in younger women. Historically, the only treatment for endometrial cancer was a hysterectomy (TAH) and bilateral salpingo-oophorectomy (BSO), which is devastating for women whose family is not complete. With the development of more conservative treatment options, some younger women may now be treated in a way which protects their fertility options in the future.
Referral to a fertility specialist must become a routine part of the treatment pathway for women with endometrial cancer.
For women not suitable for more conservative treatment, assessment of ovarian reserve, if low, may enable a woman to accept the recommendation for BSO, there may be an option of oocyte storage before BSO and the woman can discuss the legal, emotional and funding issues around surrogacy.
For women in whom there is the option to consider more conservative treatment, it is helpful to optimise their chance of fertility in the future during this time. Obesity has an extremely detrimental effect on the chance of conception with or without fertility treatment. The woman can use the time during her oncology treatment to reduce her weight, if necessary, to optimise her chance of a pregnancy later and plans can be made to expedite fertility treatment after oncology treatment when appropriate.
Women in this group face significant challenges to achieving a pregnancy and therefore it is essential to offer specialist fertility counselling, should treatment be unsuccessful.

What you need to know (key learning point)

Oocyte storage should be considered for women before BSO if the woman is young, does not have a significantly raised body mass index and has sufficient ovarian reserve.
Weight loss must be encouraged to increase the chance of a future pregnancy.
A holistic approach to patient care must be followed with close collaboration between Reproductive Medicine and Oncology services.

What you need to do (key practice changing points)

Reproductive medicine services should be an integral part of a patient's oncology pathway with patients referred for specialist advice at diagnosis.

Key references (papers, websites, guidelines etc)

Female Fertility Preservation – Guideline of the European Society of Human Reproduction and Embryology 2020

Welcome & Introductions

Hilary Maxwell

With a nursing career spanning 14 years, including several roles as Matron, Hilary is currently a Gynae-Oncology Clinical Nurse Specialist at Dorset County Hospital Foundation Trust. She previously worked for BBC North and was Director at a GP Practice responsible for change, transformation and people management. Her charitable experience includes establishing the Jill Dando Fund with radio and television presenter, Nick Ross and working as Executive Director at The National Endometriosis Society (now Endometriosis UK). Passionate about improving the lives of women with gynaecological cancers, she co-founded GO Girls in 2015, to ensure all women and their families receive grass roots support at every step of their difficult journey. She is also a regular speaker on the international conference circuit on women's health and gynaecological cancers.

She is a member of the British Gynaecological Cancer Society (BGCS) & BGCS Chair of the Nursing Sub-Group
Volunteer of the Year 2019/Charity Today Awards
Oncology Nurse of the Year 2020
In 2020 on International Women's Day, Hilary was awarded a Points of Light award by the Prime Minister, Boris Johnson

https://www.pointsoflight.gov.uk/go-girls/

Summary of presentation

Hilary sets out this year's Nursing Conference Agenda. With a challenging year for all, the BGCS nursing team have crafted an Agenda for a wide variety of Gynae-oncology nurses, both those in specialist roles and those looking after patients on gynaecology wards. The team aim to look at both the wider challenges of COVID 19 on clinical staff as well as some key areas of clinical practice.

What you need to know (key learning point)

The topics should give participants opportunities to listen to key speakers who are experts in their areas of practice, allowing all participants to gain increased knowledge and competence to support their practice.

What you need to do (key practice changing points)

We hope you will join us this year. The BGCS Nursing Conference is an ideal platform on which to grow knowledge and inform whilst connecting with colleagues to share ideas and views.

Key references (papers, websites, guidelines etc)

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Molecular Classification: Towards Personalised Care In Endometrial Cancer
Professor Naveena Singh

Naveena Singh is a consultant pathologist at Barts Health NHS Trust. In addition to participating in the gynaecological pathology diagnostic service at a busy NHS tertiary referral centre, she maintains an interest in teaching and research. She is a member of the transPORTEC research consortium, has held key roles in several clinical trials, has been the chief investigator of multiple collaborative research studies and an invited member of several national and international expert groups (RCPath, NICE, ESMO, ICCR). In addition to over 100 peer-reviewed publications, she has co-authored chapters, invited reviews, and national as well as international guideline documents, including co-authorship of the endometrial carcinoma and other chapters in the World Health Organisation Classification of Female Genital Tumours (2020). She is an invited member of the editorial board of two international journals, the immediate past President of the British Association of Gynaecological Pathologists and current co-chair of the Education Committee of the International Society of Gynecological Pathologists. Her current research interest is centred on the integration of the molecular classification of endometrial carcinoma into routine diagnostic practice.

Summary of presentation

This is a brief presentation on the molecular classes of endometrial carcinoma as defined by the Cancer Genome Atlas (2013). These can be diagnosed through the use of 3 simple tests: immunohistochemsitry (IHC) for mismatch repair proteins, IHC for p53 and mutational testing for the gene DNA polymerase epsilon (POLE). The speaker will consider the impact of this paradigm change (and of not changing practice) and propose an economical way to deliver this testing within the NHS.

What you need to know (key learning points)

- Molecular classification can be delivered economically within NHS:
    - MMR IHC on ALL EC regardless of histotype (NICE, 2020)
    - P53 IHC on all EC (or low threshold)
    - POLE mutation testing on selected cases *where this will affect treatment*
- Molecular classification
    - Does not replace clinico-pathological assessment but improves it
    - Can be carried out on biopsy tissue
    - Enables objective and reproducible diagnosis (inter-observer, inter-lab, biopsy-hysterectomy)
- In terms of risk categorization the numerical impact is modest
- This is a paradigm change and its major impact is in
    - Improving our understanding of endometrial carcinoma
    - Personalised treatment in regard to both conventional treatment and novel strategies

What you need to do (key practice changing points)

- Incorporate molecular classification into your routine practice through:
    - MMR IHC on ALL EC regardless of histotype (NICE, 2020)
    - P53 on all EC (or low threshold)
    - POLE on selected cases *where this will affect treatment*

Key references (papers, websites, guidelines etc)

Kandoth et al. Integrated genomic characterization of endometrial carcinoma. Nature. 2013 May 2;497(7447):67-73. doi: 10.1038/nature12113.
Talhouk et al. A clinically applicable molecular-based classification for endometrial cancers. Br J Cancer. 2015 Jul 14;113(2):299-310. doi: 10.1038/bjc.2015.190. Epub 2015 Jun 30.
Talhouk et al. Confirmation of ProMisE: A simple, genomics-based clinical classifier for endometrial cancer. Cancer 2017; 123(5):802-813. doi: 10.1002/cncr.30496. Epub 2017 Jan 6.
Testing strategies for Lynch syndrome in people with endometrial cancer. Diagnostics guidance [DG42] Published date: 28 October 2020. https://www.nice.org.uk/guidance/dg42

Casey and Singh. POLE, MMR, and MSI Testing in Endometrial Cancer: Proceedings of the ISGyP Companion Society Session at the USCAP 2020 Annual Meeting. Int J Gynecol Pathol 2021;40(1):5-16.
McAlpine et al. Evaluation of treatment effects in patients with endometrial cancer and *POLE* mutations: An individual patient data meta-analysis. Cancer 2021; https://doi.org/10.1002/cncr.33516

Hormone Replacement Therapy after Gynaecological Cancer Treatment

Dr Kathryn Clement
BA (Hons) BM BCh MRCOG MFSRH
Consultant in Sexual and Reproductive Healthcare
The Newcastle upon Tyne Hospitals NHS Foundation Trust
Newcastle Sexual Health Services

Kathryn qualified at the University of Oxford many years ago. She qualified as a Consultant in Sexual and Reproductive Healthcare in April 2013 and was appointed into her consultant post at New Croft Centre, Newcastle upon Tyne later that year. Kathryn is Clinical Lead for Newcastle Sexual Health Services and a member of the General Training Committee for the FSRH. Her special interests at work are care around the menopause, colposcopy and managing impalpable contraceptive implants.

Summary of talk

Advances in the treatment of gynaecological malignancy has resulted in prolonged survival with greater demand from survivors to manage quality of life. Provision of HRT to women following cancer treatment presents a challenge to many healthcare professionals necessitating interpretation of the sparse evidence base, consideration of primary tumour biology, assessment and explanation of associated risk as well as knowledge of available preparations and routes of administration. This whistle-stop tour of HRT aims to outline the evidence, provide a structured approach to assessment, outline prescription principles as well as consider the wider morbidity of menopause and non-hormonal management options.

What you need to know (key learning point)

Understand that the evidence around use of HRT is very poor when it comes to use after cancer treatment and evidence for HRT causing cancer is very complex. However with individualised multi-disciplinary discussion about risks and benefits transdermal HRT may be suitable for some women.

What you need to do (key practice changing points)

The safest HRT is thought to be transdermal estrogen alone but when endometrial protection is required micronized progesterone is considered the preparation with the lowest risks of breast cancer and cardiovascular events.

Key references (papers, websites, guidelines etc)

Richardson A, Ayres J, Cust M, Phillips A The Obstetrician & Gynaecologist 2019;21:291–8.
https://doi.org/10.1111/tog.12607
British Menopause Society and Women's Health Concern Recommendations on HRT in menopausal women. March 2021
Full document available to members – summary on https://thebms.org.uk

Psychological impact of the COVID-19 crisis on women undergoing treatment for ovarian cancer- a longitudinal mixed methods study: Interim update.

Ketan Gajjar

Ketan Gajjar, Consultant Gynaecological Oncologist at Nottingham University Hospital NHS Trust. He received his subspecialty training in Gynae –oncology from Cambridge and has done a fellowship stint in Essen, Germany for advanced ovarian cancer surgery experience. He did his Masters from Lancaster University in the field of Spectroscopy as a novel diagnostic tool for cancer diagnostics. He is continuing to have research interests in his current role as a full time clinician.

Summary of presentation

Introduction

COVID-19 is an unprecedented crisis in modern cancer care. For women diagnosed with ovarian cancer the impact of the crisis on their treatment raises urgent questions about their psychological and supportive care for three reasons: 1) fear of progression is already a primary concern for many patients and may have worsened with treatment disruption; 2) the negative psychological effects of shielding may exacerbate distress; 3) early distress, and encountering more difficulties in treatment are indicators or risk for persistent distress after treatment.

This research aimed to identify how the crisis is affecting the psychological wellbeing of women undergoing treatment for advanced ovarian cancer.

Objectives

- Identify rates of distress in women undergoing or recently completing treatment for advanced ovarian cancer during the COVID-19 crisis, and track how these change over time.
1. Identify unmet informational and emotional support needs.
2. Investigate how are women are coping with their experience of the crisis?

Methods

The design is an exploratory mixed methods prospective cohort study of the psychological adaptation of women with advanced ovarian cancer to the Covid-19 crisis.

Seventy-two women with advanced ovarian cancer were recruited from eight NHS cancer centres in England and Wales, and from an Ovarian Cancer charity and asked to complete questionnaires at 2 month intervals giving 3 data collection points (T0 (study intake), T1 (2 months), T2 (4 months).

Questionnaire Measures

1. Hospital Anxiety and Depression Scale
2. Brief Illness Perception Questionnaire
3. Brief COPE
4. Fear of Progression Questionnaire, short form
5. Supportive Care Needs Survey, short form
6. PTSD Checklist - Civilian

Fifteen participants also completed semi-structured interviews about their experience of the crisis. These interviews will be transcribed verbatim and analysed using thematic analysis.

Interim findings

There were high rates of anxiety and depression reported at T0 with just over 50% of the sample reporting levels of symptoms above the cut-off for caseness for anxiety and depression. Rates of fear of progression (FoP) at T0 were comparable to rates for women with ovarian cancer reported in the research literature prior to the crisis, with 25% of the sample reporting moderate FoP and 8% reporting high FoP.

A large number of unmet information and emotional support needs were reported - the most common were help with:

- keeping a positive outlook
- uncertainty about the future
- lack of energy
- being unable to do what you used to do

- worry that the results of treatment are beyond my control

Further analysis plan
The paper will report further analyses of changes in measures of distress over time, predictors of high distress and draw on insights from the analysis of interview data.

What you need to know (key learning point)
The unmet information and emotional support needs in patients undergoing treatment for advanced ovarian cancer during covid-19 include keeping a positive outlook, uncertainty about the future, lack of energy, being unable to do what you used to do and worry that the results of treatment are beyond my control.

What you need to do (key practice changing points)
Clinicians should work towards developing support frameworks to address these unmet needs irrespective of pandemic settings.

The Impact of the COVID-19 Pandemic on Gynaecological Cancer Surgery. Update from the COVIDSurg-Cancer: An International Multi-Centre Cohort Study

Dr Elaine Leung
Dr Elaine Leung, NIHR Academic Clinical Lecturer (Gynaeoncology), the University of Birmingham.

Elaine (@elaineleung) relocated to Birmingham in Spring 2020 to strengthen her translational research portfolio in human ovarian cancer immunology. She has expertise on the influence of immunity on cancer outcomes and effectiveness of oncolytic viral therapies. Her current research programme focuses on the mechanistic importance of chemokines and their implications on immunotherapies in ovarian cancer.

Elaine is a member of the international steering committee (Gynaeoncology) of the COVIDSurg-Cancer study. She is also the site principal investigator of this study at the Pan Birmingham Gynaecological Cancer Centre.

Summary of presentation

The COVID-19 pandemic has resulted in significant number of elective surgeries being delayed or cancelled worldwide. COVIDSurg-Cancer (Gynaecological Cancer) is an international prospective multi-centre study to investigate the impact of this pandemic on cancer surgery. The latest descriptive analysis of outcomes will be presented on behalf of the steering committee.

What you need to know (key learning point)

- COVIDSurg-Cancer is one of the largest prospective multi-centre studies investigating the impact of the COVID-19 pandemic on the delivery of elective surgeries[1]
- The risks of pulmonary complications in this group were positively associated with the regional incidence of COVID-19 infections, which could be reduced by COVID-19-free surgical pathways and vaccinations[2,3]
- The collaboration has connected gynaeoncologists worldwide, with the potential to encourage future research

What you need to do (key practice changing points)

- Minimise the additional risks of surgery during the pandemic by maintaining COVID-19-free surgical pathways[2]
- Encourage patients to be vaccinated against COVID-19 infections when the vaccinations are offered to them[3]
- Engage with this network of gynaeoncologists to further improve the care of women with gynaecological cancers worldwide[4]

Key references (papers, websites, guidelines etc)

1. COVIDSurg-Cancer webpage: https://globalsurg.org/cancercovidsurg/
2. Glasbey JC, Nepogodiev D, Simoes JFF, et al; COVIDSurg Collaborative. Elective Cancer Surgery in COVID-19-Free Surgical Pathways During the SARS-CoV-2 Pandemic: An International, Multicenter, Comparative Cohort Study. J Clin Oncol. 2021 Jan 1;39(1):66-78.
3. COVIDSurg Collaborative, GlobalSurg Collaborative. SARS-CoV-2 vaccination modelling for safe surgery to save lives: data from an international prospective cohort study, *British Journal of Surgery*, 2021. https://doi.org/10.1093/bjs/znab101.
4. For further information, please email: gocovidsurg@gmail.com

United Kingdom COVID and Gynaecological Cancer Study (UKCOGS)

Prof Ranjit Manchanda

Ranjit Manchanda is a Professor at Wolfson Institute of Preventive Medicine, Barts CRUK Cancer Centre, QMUL, and Consultant Gynaecological Oncologist at Barts and the Royal London Hospital, London, UK. His research interests are focused around Targeted Precision Prevention. This includes population-based germline testing, mainstreaming genetic testing and precision medicine approaches for risk prediction, stratification, and targeted screening & cancer prevention. He has a keen research interest in health economic issues related to his areas of research. He is the Principal Investigator on the PROTECTOR trial, PROMISE Pilot study, GCaPPS trial, RRESDO, SIGNPOST, DETECT and UKCOGS studies. He is co-Lead for the Cancer Prevention Theme at the Barts CRUK Cancer Centre. He is the Specialty Research Lead for Gynaecological Cancer, NIHR North Thames CRN; and the Integrated Academic Training Programme Director, London Specialty School of Obstetrics & Gynaecology, Health Education England. He is a member of number of other advisory bodies and oversight committees.

Summary of presentation

The COVID-19 pandemic has led to a global crisis disrupting most health systems and economies worldwide. COVID-19 has affected many areas of healthcare, including a major impact on cancer care. The UK has taken multiple steps to mitigate the impact of COVID-19, including public lockdowns, self-isolation, shielding of high-risk individuals, an increase in hospital beds and ITU capacity and recently a vaccination drive. Both routine non-urgent patient care activity and urgent care activity have been reduced. Besides there has been a fall in the number of patients seeking care. There has been significant service reconfiguration, and changes to cancer care as a result of the COVID pandemic. Additional factors/stresses have included staff sickness, staff redeployment, reduced theatre availability, supply chain shortages (including PPE), reduced hospital visits, remote consultations and offsite working. Mitigation strategies have included changes to surgical plans, and systemic chemotherapy plans, deferred surgery, treatment delays, introduction of regimens requiring less-frequent administration and hypofractionated radiotherapy. MDT throughput and decision making has changed.

The UK COVID and Gynaecological Cancer Study (UKCOGS) is a national audit of gynaecological oncology MDT outcomes across 50 cancer centres and units across the UK. It aims to (a) evaluate the changes to MDT decision making for gynaecological cancer, and patients' outcomes across the UK in response to the COVID-19 pandemic; (b) document the structural and logistic changes implemented across Gynae-oncology cancer centres/units in response to the COVID-19 pandemic. Preliminary review of MDT data from >10,000 patients discussed across cancer MDTs between 1/3/20 to 28/2/21 will be presented. Data will be presented from two UK surveys sent to all BGCS members between 29/04/20 and 15/05/2020 and between 26/3/21 and 19/4/21 during the COVID surge. Survey data captures changes to logistics, structure, capacity, staffing and changes to working practices implemented.

What you need to know (key learning point)

UKCOGS is a national audit of gynaecological oncology MDT outcomes across the UK.

What you need to do (key practice changing points)

Mitigation strategies to address the impact of COVID19 and plan for the recovery need to be devised.

Key references (papers, websites, guidelines etc)

www.ukcogs.org.uk

Do we really need to think about HRT?

Miss Rachel O'Donnell

Rachel graduated from Edinburgh Medical School in 2005 before joining the Edinburgh Obstetrics and Gynaecology program in 2007. In 2011 she headed south to join the team at the Northern Gynaecological Oncology Centre and went on to complete her PhD in translational ovarian cancer research in 2016. Rachel completed subspecialty Gynaecological Oncology training and was awarded a NIHR Clinical Lectureship in 2016 before being appointed in 2020 as Lead GynaeOncologist at the Newcastle Upon Tyne Trust and Honorary Senior Clinical Lecturer at Newcastle University. Alongside her clinical roles Rachel is Trust lead for Undergraduate quality for Newcastle University and leads a programme of research across the Translational and Population Health Sciences Institutes.

Summary of presentation

This brief presentation sets the scene describing the prevalence of menopausal symptoms for women with gynaecological malignancy as well as the potential impact on their quality of life. We briefly summarise a small qualitative pilot study looking at the anxieties and confidence levels in some of the stakeholder professional groups contributing to follow up care for women after treatment for a gynaecological malignancy.

What you need to know (key learning point)

- Prevalence of menopausal symptoms is high but potentially under recognised
- Impact can be significant for women putting pressure on community professionals to provide solutions
- There are high levels of anxiety and low levels of confidence in providing HRT or its alternatives identifying an area of unmet need.

What you need to do (key practice changing points)

- What are your follow up pathways?
- Who are the professional groups involved?
- Can they access specialist support for management of menopause?
- What is the impact of a poorly managed menopause on survivorship?
- Did we consider and discuss this as part of treatment decision making?

- Do we need a BGCS consensus statement to support our specialist services and allied professionals?

Key references (papers, websites, guidelines etc)

None available!

BRCA and HRD testing update
Professor Rachel Butler

Aims
To increase knowledge about access to testing for homologous recombination deficiency in patients with ovarian cancer.

Background
Tumours with defects in homologous recombination repair are unable to recognise and repair double-stranded DNA breaks. Patients with these tumours are sensitive to treatment with PARP inhibitors (SOLO-1 and PAOLA-1). Patients with ovarian cancer are now eligible for analysis of the BRCA1 and 2 genes and for Homologous Recombination Deficiency (HRD) to identify those individuals most likely to benefit from treatment with PARP inhibitors.

Methods
Methods for the analysis of BRCA1 and 2, and HRD will be described. Sample pathways will be discussed for access to genomic testing, via the Genomic Laboratory Hubs (GLHs). This will include the interpretation of genomic results.

NHS Cancer Plan 2021

Rob Gornall
Gynaecological Oncology Consultant Gloucestershire Hospitals NHSFT 2001- Medical Director 3 Counties Cancer Network 2008-2015, Clinical Lead West Midlands Cancer Alliance 2015-

Summary of presentation

The NHS Cancer programme leads the delivery of NHS Long Term Plan setting out a new ambition that by 2028 the proportion of cancers diagnosed at stage 1 and 2 will rise of just over half to three quarters of cancer patients. By 2028 55,000 people each year will survive their cancer for at least 5 years after diagnosis. The focus on earlier and faster diagnosis aims to expand access to diagnostics through rapid diagnostic centres and community diagnostic hubs measured through the introduction of a new 28 day faster diagnosis standard. Emphasis is given to developing personalised care and improvements in follow up pathways. Integration of molecular diagnostics into mainstream medicine will further drive patient centred care

The Covid Pandemic Restrictions have since provided great challenges to cancer services with cessation of screening programmes and patient diagnostic pathways. Greater collaboration across provider organisation and the establishment of cancer treatment hubs has provided opportunities to look at solutions at wider system levels. This is reflected in the 2021-22 planning guidance which focuses on restoration and recovery of services as STP/ emerging ICS footprint level.

What you need to know (key learning point)

The immediate focus is to return the number of people waiting for longer than 62 days to the level saw in February 2020 and meet the increased levels of referrals and treatment required to address the shortfall in number of first treatments by March 2022.

What you need to do (key practice changing points)

Underpinning the restoration and recovery planning remains the drive to achieve earlier diagnosis by focusing on innovative solutions to delivering care and using new commissioning frameworks to reduce inequity of access and improve outcomes. The formation of operational delivery networks for radiotherapy services and implementation of radiology and pathology networks with reforms of multidisciplinary team working will facilitate planning of services over larger footprints for some specialised services.

Mr Andy Nordin

The Ovarian Cancer Audit Feasibility Pilot is jointly funded by The British Gynaecological Cancer Society, Target Ovarian Cancer and Ovarian Cancer Action and is being delivered by analysts at the National Cancer Registration and Analysis Service, part of Public Health England. The initial pilot ran for two years, and a 12 month extension has recently been agreed to take the project through until June 2022. The main outputs of the project are the "profile" report which details incidence, survival and mortality, and the "treatment" report which analyses rates of chemotherapy and surgery. Both reports, available to download from the gynae cancer hub (http://www.ncin.org.uk/OCAFP), demonstrate significant regional variation throughout England. Granular data by Trust of diagnosis is available for teams to review on the password-protected CancerStats2 website. A report analysing regional variation of "short term morality" is currently being prepared for publication, and preliminary data should be available for presentation at the BGCS conference. In addition to updating profile and treatment analyses, the project extension will enable detailed analysis of regional variation in surgical practice, including surgical radicality and outcomes. However, this work is dependent on completeness of performance status and residual disease COS-D data fields, and MDTs are encouraged to retrospectively ensure compete data capture for these data fields for all cases diagnosed during 2017, 2018 and 2019 before this phase of the project commences in July 2021.

Mainstreaming genomics in cancer care

Amanda Pichini

Amanda completed her Master of Science in Genetic Counselling at the University of Toronto. Since moving to England in 2014, Amanda has been working with the Bristol Regional Clinical Genetics Service, providing genetic counselling to patients and families with a wide range of conditions. Amanda was the Lead Genomics Practitioner for the West of England Genomic Medicine Centre, which facilitated enrolment of patients to the national 100,000 Genomes Project. She is currently working with Health Education England's Genomics Education Programme, providing subject matter expertise to develop competency frameworks and resources to support healthcare professionals that will be involved in requesting genomic testing. Amanda supports trainees with clinical rotations and research projects, and is passionate about educating healthcare professionals to support the integration of genomic medicine into mainstream healthcare.

Summary of presentation

Building on current medical practice, genomic medicine highlights unique considerations for patient care, including addressing needs of the wider family, the complexity and uncertainty of genomic information, and data sharing protocols. England is implementing a national Genomic Medicine Service leading to the utilisation of genomic testing across a growing number of specialties. This has resulted in a requirement for workforce development and service transformation, to embed genomic testing into mainstream patient pathways where it would support their ongoing care.

This presentation will highlight somatic and germline testing of the *BRCA1* and *BRCA2* genes as an example of mainstreaming genomics in cancer care in the South West of England. The success of a mainstreamed service is crucially dependent on working effectively as a multi-disciplinary team, including Clinical Genetics, Genomic Laboratory and cancer clinical services. Mainstreaming is also underpinned by education to upskill healthcare professionals who will need to understand the implications of genomic testing. We will therefore also discuss different educational tools and modes of delivery, including resources developed by Health Education England's Genomics Education Programme, which can be used to ensure a high quality and sustainable Genomic Medicine Service.

What you need to know (key learning point)

Mainstreaming genomic testing in cancer clinical services requires a multi-disciplinary approach to consider the pathway, educational and patient needs in order to deliver an effective service.

What you need to do (key practice changing points)

Consider whether you have gaps in your knowledge about genomics and what you can do, or who you can speak to (e.g. colleagues at a local, regional or national level), to ensure that you can support your patients to access genomic testing.

Key references (papers, websites, guidelines etc)

British Gynaecological Cancer Society/British Association of Gynaecological Pathology consensus for germline and tumour testing for BRCA1/2 variants in ovarian cancer in the United Kingdom: https://www.bgcs.org.uk/wp-content/uploads/2020/09/BGCS-BAGP-070920-final-v1.pdf

Genomics Education Programme – Competency Frameworks: https://www.genomicseducation.hee.nhs.uk/consent-a-competency-framework/

Genomics in the NHS – e-Learning for HealthCare: https://www.e-lfh.org.uk/programmes/genomics-in-the-nhs/

Genetic testing in ovarian cancer – information from Eve Appeal: https://eveappeal.org.uk/inherited-risks/ask-eve-genetic-testing-in-ovarian-cancer/

Lynch Syndrome and Gynaecology Cancer testing Update

Neil Ryan PhD MRCS (Eng) FHEA RAMC
Specialty Registrar in Obstetrics and Gynaecology, Severn Deanery, Bristol, UK
Honorary Clinical Lecturer, The Academic Women's Health Unit, Translational Health Sciences, Bristol Medical School, University of Bristol, Bristol, UK

Abstract

Lynch syndrome is an inherited autosomal dominant condition that predisposes carriers to a myriad of cancers; namely colorectal, endometrial and ovarian cancer. Lynch syndrome is thought to affect 1 in every 280 people of which 95% are unaware of their diagnosis. This is critical as colorectal and gynaecological cancers are preventable through chemoprevention, colonoscopic surveillance and risk reducing surgery. However, if people are unaware they have Lynch syndrome, they cannot access these measures.

Around 3% of endometrial and colorectal cancers are related to Lynch syndrome. Routine testing of colorectal cancer has been recommended by The National Institute of Institute for Health and Care Excellence (NICE) since 2017. Not including endometrial cancer in their guidelines meant women were potentially disadvantaged; endometrial cancer is often their sentinel neoplasm and therefore a crucial diagnostic opportunity. Women are likely to survive their endometrial cancer, however if not diagnosed with Lynch syndrome, could go on to develop a lethal colorectal cancer. Furthermore, cascade testing of relatives could identify healthy carriers before they develop cancers enabling them to be enrolled in preventive strategies. Finally, identifying cancer with mismatch repair deficiency enables potential treatment with checkpoint inhibitors. These factors were explored in the PETALS study and its publication led to NICE recommending universal Lynch syndrome testing in endometrial cancer in 2020. Testing in ovarian cancer remains of uncertain value.

Identifying Lynch syndrome carriers before they develop gynaecological cancer presents a challenge. Clinicians must be mindful of the need for family planning given the recommendation for risk reducing surgery. Furthermore, women with Lynch syndrome may request referral to fertility services as to explore preimplantation diagnosis or to overcome the effects of previous treatment. Lifestyle advice so as to reduce general cancer risk is recommended, however the evidence for its effectiveness in Lynch is unclear. It is also not clear if surveillance for gynaecological cancers is of benefit despite many with Lynch syndrome seeing it as beneficial. The use of hormonal prophylaxis for gynaecological cancers in Lynch syndrome carriers is not supported by any trial data although there is mechanistic evidence for its use. All these uncertainties have led to inconsistencies in the care provided for women with Lynch syndrome. Only through onward and robust research can these clinical conundrums be addressed and gynaecological care for women with Lynch syndrome be improved.

What your anaesthetist is thinking

Dr Owen Bodycombe
Consultant in Anaesthesia and Pain Medicine Gloucestershire Hospitals NHSFT

Summary of presentation

Bariatric anaesthesia for the non-anaesthetist. Intraoperative respiratory physiology and pre-op assessment of the bariatric patient.

What you need to know (key learning point)

Intraoperative ventilation of the morbidly obese patient
Risk assessment in the pre-operative assesment

What you need to do (key practice changing points)

Understand changes to respiratory management in the obese surgical patient. Apply different risk scores in the high risk surgical patient.

Update from the NCRI Ovarian Workstream
Dr Rebecca Bowen

Summary of presentation
A brief review of the current ovarian cancer trials portfolio, the impact of the results of recent portfolio studies on standard of care and new ovarian cancer trials plus reference to the negative impact of the COVID-19 pandemic on the recruitment to cancer trials in the UK

What you need to know (key learning point)
Majority of interventional trials in the portfolio involve either PARPi or immunotherapy or a combination of both

What you need to do (key practice changing points)
We would encourage you to get involve in Gynae cancer research at your centre and to contact us if you require any further information or help with this.

Key references (papers, websites, guidelines etc)

https://www.ncri.org.uk › groups › gynaecological-group

Hysteroscopy: Making the cancer diagnosis

Professor T Justin Clark

Prof Clark is a Consultant Gynaecologist at the Birmingham Women's and Children's Hospital and is an Honorary Professor of Gynaecology at the University of Birmingham. He is the President of the British Society for Gynaecological Endoscopy. His clinical and research interests are in the diagnosis and treatment of abnormal uterine bleeding, pelvic pain and endoscopic surgery. He has helped pioneer ambulatory gynaecological intervention. He has published widely, holds over £9 million in research grants and is an Editorial Board member of the British Journal of Obstetrics & Gynaecology

Summary of presentation

The presentation will cover the organisation of diagnostic services for suspected endometrial cancer and the evidence supporting best diagnostic work up; specifically the role of outpatient testing with ultrasound, hysteroscopy and endometrial sampling. Practical aspects of fundamental importance to delivering a successful service will be explored, particularly in relation to the conduct of outpatient hysteroscopy / directed biopsy, optimising patient experience, consent, choice and the findings of a major national survey of >5500 outpatient hysteroscopic diagnostic and therapeutic procedures. The talk will also cover controversies such as decision making with non-diagnostic biopsies, investigation of women on HRT, after endometrial ablation etc. and practical 'tips and tricks' such as how to undertake procedures successfully in complex patients.

What you need to know (key learning point)

- Clinical factors such as obesity, diabetes, nature of PMB, time since menopause etc. need to be integrated with findings from outpatient tests to improve diagnostic accuracy
- Outpatient hysteroscopy is integral to the diagnostic work up of PMB and suspected endometrial cancer
- 50% of women who have an endometrial thickness >4mm and a benign endometrial biopsy have an endometrial polyp, of which 6% have atypical endometrial hyperplasia or cancer
- Blind D&C should be consigned to history
- Outpatient hysteroscopy with blind or directed biopsy is highly acceptable and services are highly valued

What you need to do (key practice changing points)

- Review your PMB diagnostic pathways and ensure in keeping with current evidence-base
- Invest in outpatient hysteroscopic services to allow speedy diagnosis and adherence to best practice to optimise patient experience
- Audit PMB services annually e.g. using the BSGE outpatient hysteroscopy patient survey
- Audit outpatient hysteroscopy services against the soon to be released updated joint RCOG / BSGE GTG 59 "Best Practice in Outpatient Hysteroscopy" guidelines
- Consign D&C to history

Key references (papers, websites, guidelines etc)

- Cooper NA, Barton PM, Breijer M, Caffrey O, Opmeer BC, Timmermans A, Mol BW, Khan KS, Clark TJ. Cost-effectiveness of diagnostic strategies for the management of abnormal uterine bleeding (heavy menstrual bleeding and post-menopausal bleeding): a decision analysis. Health Technol Assess 2014;18:1-201
- Clark TJ, Cooper NAM, Kremer C. Best Practice in Outpatient Hysteroscopy. Best Practice in Outpatient Hysteroscopy: Green Top Guideline 59. RCOG/ BSGE Joint Green Top Guideline. RCOG 2011 [https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg59/]
- Cooper NA, Clark TJ, Middleton L, Diwakar L, Smith P, Denny E, Roberts T, Stobert L, Jowett S, Daniels J; OPT trial collaborative group. Outpatient versus inpatient uterine polyp treatment for abnormal uterine bleeding: randomised controlled non-inferiority study. BMJ. 2015 Mar 23;350:h1398. doi: 10.1136/bmj.h1398.
- Smith PP, Middleton LJ, Connor M, Clark TJ. Hysteroscopic morcellation compared with electrical resection of endometrial polyps: a randomized controlled trial. Obstet Gynecol 2014;123:745-51.
- Smith PP, Kohle S, O'Connor S, Clark TJ. Vaginoscopy Against Standard Treatment: a randomised controlled trial 2019;126:891-899.

- van Hanegem N, Breijer MC, Slockers SA et al. Diagnostic workup for postmenopausal bleeding: a randomised controlled trial. BJOG 2016 https://doi.org/10.1111/1471-0528.14126
- Clark TJ. Hysteroscopy is needed in the diagnostic workup of postmenopausal bleeding. BJOG 2016;124:241 https://doi.org/10.1111/1471-0528.14128
- Mahmud A, Smith PP, Clark TJ. Benchmarking services in Outpatient hysteroscopy (OPH): a quality improvement project. EJOG 2021;259:211-221 DOI:https://doi.org/10.1016/j.ejogrb.2021.01.028

NCRI Endometrial Workstream Updates

Professor Emma Crosbie

Prof Emma Crosbie is an NIHR Advanced Fellow, Professor and Honorary Consultant Gynaecological Oncologist at the University of Manchester. Her research focuses on screening, prevention and early detection of gynaecological cancers. She is Chair of the NCRI Endometrial Workstream and a member of the NCRI Screening, Prevention and Early Diagnosis Group. She is Chair of the RCOG Academic Board and member of the RCOG Blair Bell Research Society.

Summary of presentation

This presentation will provide updates of the NCRI Endometrial Workstream. It will highlight progress in three key areas: 1) DEveloping Tests for Endometrial Cancer deTection (DETECT study); 2) Proportion of Endometrial Tumours Associated with Lynch Syndrome (PETALS study); and 3) MIrena for the Reduction of Endometrial Neoplastic Abnormalities (MIRENA study). These areas of early detection, screening and non-surgical management of endometrial cancer are all strategic priorities for the workstream.

What you need to know (key learning point)

1) Novel non-invasive endometrial cancer detection tools are in development and offer hope for the triage of symptomatic women in primary care; 2) The PETALS study has directly informed new NICE Guidance (DG42), published in October 2020, that all women with endometrial cancer be screened for Lynch syndrome; 3) Weight loss achieved during intrauterine progestin treatment of atypical hyperplasia or grade 1 stage 1a endometrial cancer can improve response rates and offer a suitable alternative to surgery for medically unfit women and those wishing to preserve their fertility.

What you need to do (key practice changing points)

1) Screen all your endometrial cancer patients for Lynch syndrome. It will enable women with Lynch syndrome to reduce their future cancer risk through aspirin chemoprevention and bowel surveillance. It will also enable cascade testing of at risk family members. Further, it will support the molecular classification of endometrial cancers to enable personalised adjuvant treatment decisions and suitability for immunotherapy in relapse. 2) Address risk factors and treat obesity during conservative management of atypical hyperplasia or grade 1 stage 1a endometrial cancer to improve outcomes.

Key references (papers, websites, guidelines etc)

O'Flynn H, Ryan NAJ, Narine N, Shelton D, Rana D, Crosbie EJ. Diagnostic accuracy of cytology for the detection of endometrial cancer in urine and vaginal samples. Nat Commun. 2021 Feb 11;12(1):952.

Ryan NAJ, McMahon R, Tobi S, Snowsill T, Esquibel S, Wallace AJ, Bunstone S, Bowers N, Mosneag IE, Kitson SJ, O'Flynn H, Ramchander NC, Sivalingam VN, Frayling IM, Bolton J, McVey RJ, Evans DG, Crosbie EJ. The proportion of endometrial tumours associated with Lynch syndrome (PETALS): A prospective cross-sectional study. PLoS Med. 2020 Sep 17;17(9):e1003263.

https://www.nice.org.uk/guidance/dg42

The Day I was asked to Clean the Toilet

Hilary Maxwell

With a nursing career spanning 14 years, including several roles as Matron, Hilary is currently a Gynae-Oncology Clinical Nurse Specialist at Dorset County Hospital Foundation Trust. She previously worked for BBC North and was Director at a GP Practice responsible for change, transformation and people management. Her charitable experience includes establishing the Jill Dando Fund with radio and television presenter, Nick Ross and working as Executive Director at The National Endometriosis Society (now Endometriosis UK). Passionate about improving the lives of women with gynaecological cancers, she co-founded GO Girls in 2015, to ensure all women and their families receive grass roots support at every step of their difficult journey. She is also a regular speaker on the international conference circuit on women's health and gynaecological cancers.

She is a member of the British Gynaecological Cancer Society (BGCS) & BGCS Chair of the Nursing Sub-Group
Volunteer of the Year 2019/Charity Today Awards
Oncology Nurse of the Year 2020
In 2020 on International Women's Day, Hilary was awarded a Points of Light award by the Prime Minister, Boris Johnson

https://www.pointsoflight.gov.uk/go-girls/

Summary of presentation

COVID 19 has had a huge impact, at many levels, on clinical care. Hilary takes a lighter look at how COVID 19 has challenged clinicians in unusual and unexpected ways including a non-Trumpian use of bleach.

What you need to know (key learning point)

COVID 19 has brought strength and stresses to many teams: we learn lessons to inform future waves of the virus and how to work effectively with each other.

What you need to do (key practice changing points)

We hope you will join us this year. The BGCS Nursing Conference is an ideal platform on which to grow knowledge and inform whilst connecting with colleagues to share ideas and views.

Key references (papers, websites, guidelines etc)

NA

GROINNS V-II/III

Maaike Oonk

Gynaecological oncologist in the University Medical Centre Groningen, the Netherlands, since 2014. O&G, Program director, for region North-East of the Netherlands. Principle investigator in GROINSS-V studies and (co)chair of national and international guideline committees.

Summary of presentation

I will start with shortly looking back to the GROINSS-V I study. After that, the latest results of GROINSS-V II will be discussed. I will finish with introducing GROINSS-V III.

What you need to know (key learning point)

- All patients with SN metastases need additional treatment, irrespective of size of metastasis
- For SN metastases ≤ 2mm, radiotherapy is a safe alternative to lymphadenectomy, with less treatment-related morbidity
- Radiotherapy is not a safe alternative for patients with SN-metastases > 2mm
- In GROINSS-V III patients with SN macrometastases will be treated with chemoradiation instead of lymphadenectomy

What you need to do (key practice changing points)

- Strictly adhere to the criteria for sentinel node biopsy in order to prevent groin recurrences, which are hard to treat and often fatal
- Give adjuvant treatment for all patients with SN metastases (also those with only isolated tumour cells)

Key references (papers, websites, guidelines etc)

- Van der Zee AG, Oonk MH, de Hullu JA, et al. Sentinel node dissection is safe in the treatment of early-stage vulvar cancer. J Clin Oncol 2008.
- Oonk MH, van Hemel BM, Hollema H, et al. Size of sentinel-node metastasis and chances of non-sentinel-node involvement and survival in early stage vulvar cancer: results from GROINSS-V, a multicentre observational study. Lancet Oncol 2010.
- Te Grootenhuis NC, van der Zee AG, van Doorn HC, et al. Sentinel nodes in vulvar cancer: long-term follow-up of the Groningen International study on sentinel nodes in vulvar cancer (GROINSS-V) I. Gynecol Oncol 2016.
- Oonk MH, Planchamp F, Baldwin P, et al. European Society of Gynaecological Oncology Guidelines for the management of patients with vulvar cancer. Int J Gynecol Cancer 2017.

Medical management of low grade serous ovarian cancer

Ms Susana Banerjee

Dr Susana Banerjee MBBS MA FRCP PhD is a Consultant Medical Oncologist and Research Lead for the Gynaecology Unit at the Royal Marsden, London, UK. She is also Reader in Women's Cancers at the Institute of Cancer Research. Dr Susana Banerjee serves on the European Society of Medical Oncology (ESMO) Executive Board as Director of Membership. She was the Track Chair for Gynaecological Cancers at ESMO Congress 2018 and Scientific Co-Chair for ESMO Asia 2018. She is Chair of the ESMO Gynaecological Cancers Congress 2021.

Dr Banerjee is an author of over 130 peer-reviewed publications (*including New England Journal of Medicine, Journal of Clinical Oncology, Lancet Oncology, Annals of Oncology*) and is actively involved in clinical trials and translational research. Dr Banerjee is UK Chief Investigator and Principal Investigator at the Royal Marsden for multiple national and international clinical trials. She is Global Lead of two international collaborative group trials in rare gynaecological cancers including the ENGOT-ov60/NCRI/GOG-3052 RAMP 201 phase II trial in low grade serous ovarian cancer.

Summary of presentation

Low grade serous ovarian carcinoma (LGSOC) is a rare gynaecological cancer with distinct pathological, molecular and clinical features. The response rates with traditional systemic treatments such as chemotherapy are low and there continues to be an unmet need to improve clinical outcomes. LGSOC is characterised by alterations in the MAPK pathway. Targeted therapies have shown promise in this disease with MEK inhibitors at the forefront. Recently, two randomised trials of MEK inhibitors specifically in recurrent LGSOC have been reported. As a result, MEK inhibitors are entering clinical practice (eg trametinib in England via the Cancer Drugs Fund during COVID-19 period). The preliminary results of the ongoing FRAME phase I study of the dual RAF/MEK inhibitor and FAK inhibitor has shown encouraging responses-particularly in KRAS-mutated LGSOC. This has led to the international phase II ENGOT-ov60/NCRI/GOG-3052/RAMP 201 trial. The latest progress in targeted therapy approaches in low grade serous ovarian cancer, potential biomarkers and current clinical trial options will be presented.

What you need to know (key learning point)

- Chemotherapy and hormonal therapy are standard of care options
1. MEK inhibitors eg trametinib are active in LGSOC
2. Clinical trials in LGSOC are available eg ENGOT-ov60/NCRI/GOG-3052/RAMP 201

What you need to do (key practice changing points)

1. MEK inhibitors eg trametinib, should be considered an option for recurrent LGSOC
2. Consider clinical trials to access targeted therapies

Key references (papers, websites, guidelines etc)

1. Grisham, Monk, Banerjee et al. MILO/ENGOT-ov11: Binimetinib Versus Physician's Choice Chemotherapy in Recurrent or Persistent Low-Grade Serous Carcinomas of the Ovary, Fallopian Tube, or Primary Peritoneum. Journal Clin Oncol 2020 Nov 10;38(32):3753-3762
2. Gershenson, Miller, Brady et al A Randomized Phase II/III Study to Assess the Efficacy of Trametinib in Patients with Recurrent or Progressive Low-Grade Serous Ovarian or Peritoneal Cancer. ESMO 2019
3. A Study of VS-6766 v. VS-6766 + Defactinib in Recurrent Low-Grade Serous Ovarian Cancer With and Without a KRAS Mutation https://www.clinicaltrials.gov/ct2/show/NCT04625270

ESMO-ESGO-ESTRO guidelines for the management of endometrial cancer
Professor Emma Crosbie

Presenter (name and short bio)
Prof Emma Crosbie is an NIHR Advanced Fellow, Professor and Honorary Consultant Gynaecological Oncologist at the University of Manchester. Her research focuses on screening, prevention and early detection of gynaecological cancers. She is Chair of the NCRI Endometrial Workstream and a member of the NCRI Screening, Prevention and Early Diagnosis Group. She is Chair of the RCOG Academic Board and member of the RCOG Blair Bell Research Society.

Summary of presentation
This presentation will provide updates on the management of endometrial cancer following publication of the 2020 ESMO-ESGO-ESTRO guidelines. This talk will focus on staging, molecular classification, testing for Lynch syndrome, surgery and fertility-sparing management of endometrial cancer. Adjuvant treatment and the management of advanced and recurrent disease will be covered in the second talk of this series.

What you need to know (key learning point)
Screening for Lynch syndrome and the molecular classification of endometrial cancer is now mainstream and will direct a personalised approach to the management of endometrial cancer.

What you need to do (key practice changing points)
Ensure your current practice is evidence based and in line with international recommendations. Engage with and recruit to clinical trials on the NCRI portfolio to drive innovation and improvements in patient care. Attend NCRI Endometrial Workstream meetings – held 6-monthly – to find out what's happening and how you can get involved.

Key references (papers, websites, guidelines etc)
https://ijgc.bmj.com/content/ijgc/31/1/12.full.pdf

Notes from a pathologist
Dr Raji Ganesan

Summary
The fifth edition of the WHO classification of tumours of the female genital tract was published in September 2020. In this volume tumour types include, in addition to clinical features, epidemiology, aetiology, pathogenesis, histopathology; diagnostic molecular pathology, staging and prognostic/ predictive information. The 'notes from a pathologist' starts with a brief summary of the salient changes in this volume.

This will be followed by two illustrative case reports to discuss new approaches to diagnosis of endometrial cancers and sarcomas of the female genital tract.

Immunotherapy toxicity

Nikki Hunter
Clinical Nurse Specialist for Immunotherapy Renal & Skin Team
Royal Marsden Hospital NHS Foundation Trust

Nikki Hunter is the Immunotherapy Clinical Nurse Specialist at the Royal Marsden NHS Foundation Trust. Her role covers educating, advising, and supporting all patients receiving immunotherapy, their caregivers, and all clinical teams. She runs pre-treatment patient education, and well-being seminars, as well as organising study days on immune-related adverse-event management (at RMH). In 2017 Nikki launched the Immuno-oncology Nurses Forum, providing education and networking opportunities to all nurses (ANP, CNS, AOS and Research) across tumour groups.

Following a BSc in anthropology, and master's degrees in medical anthropology, and the sociology of death and dying, she has a particular interest in cultural understandings of well-ness and illness, and the problems of liminality and survivorship for immuno-oncology patients.

Summary of Presentation

My presentation will be a brief overview of Immunotherapy toxicities, anticipating and recognising the multiplicity of side effects; auto-immune adverse events (irAE) and potentially overlaying presentations. Anticipating, recognising and supporting patients and caregivers through their therapeutic pathways; whilst emphasising the importance of timely communication of any variance and response to irAES and accurate documentation.

MDTs- time for a change?

Benjamin Lamb

Ben Lamb is a Consultant Urological and Robotic Surgeon at the Department of Urology, Cambridge University Hospitals NHS Foundation Trust. Ben is Urology MDT Lead and Cancer Lead at CUH NHS FT, and Chair of the East of England Cancer Alliance MDT Transformation Committee. Ben gained a PhD in improving cancer MDTs at Imperial College London in 2012, and since then has been involved in research to understand and improve MDTs. Ben has written and presented work on decision making, non-technical skills, and leadership in MDTs. Ben enjoys teaching medical students, doctors and allied healthcare professionals on communication skills, MDT improvement and urological cancers.

Summary of presentation

MDT working has improved standards in cancer care. Evidence is accumulating of what makes MDTs work well, and of interventions that can improve quality. Over time, however, the workload of MDTs has increased, and the sustainability of the current model is uncertain. To improve the effectiveness and efficiency of cancer MDTs, national guidance recommends streamlining MDT meetings according to clinical complexity and guidelines. More recently, however, the Covid-19 pandemic has had a profound effect on the way teams in healthcare interact, including MDT meetings. The longer-term impact of these changes is unknown. In this presentation I will explore how the existing knowledge-base and resources can help MDTs to improve their effectiveness. In addition, I will feed-back on the results of a survey of MDTs, which included many BGCS members, regarding the impact of Covid-19 on MDT working.

What you need to know (key learning point)

- MDT working has improved the delivery of cancer care.
- Streamlining of MDT meetings is recommended to improve effectiveness and efficiency.
- Changes to MDT working should be evidence based to assure quality.
- Evidence-based tools are available to support MDT transformation.
- Covid-19 has resulted in changes to MDT working that may have a lasting impact.

What you need to do (key practice changing points)

- Implement streamlining recommendations as per NHSEI guidance.
- Utilise existing resources to implement streamlining in a scientific manner.
- Undertake regular audit of MDT processes and outcomes to sustain quality improvement.

Key references (papers, websites, guidelines etc)

- Evidence based tools to support MDT improvement. MDT-brochure-V.2.pdf (canceralliance.co.uk)
- A review paper detailing strategies that have been successful in improving MDT working. Successful strategies in implementing a multidisciplinary team working | JMDH (dovepress.com)
- Resources for MDT transformation from the East of England Cancer Alliance. MDTM transformation :: East of England Cancer Alliance
- NHS England and Improvement guidance on streamlining MDTs. Streamlining (england.nhs.uk)
- A report detailing the characteristics of an effective MDT. MDT Development (ncin.org.uk)
- Report by Cancer Research UK on the status of MDTs in the UK. MEETING PATIENTS' NEEDS (cancerresearchuk.org)

Title of Presentation

Dr Melanie Powell

Dr Melanie Powell is a Clinical Oncologist at St Bartholomew's Hospital, London. She trained in oncology at The Royal Marsden , Mount Vernon and The Middlesex Hospitals, and was awarded a radiobiology MD for research involving the modification of oxygen levels and blood flow in tumours. She is actively involved in clinical research with a focus on improving outcomes for women with gynaecological cancers and has been Chief Investigator on 2 CRUK studies. She is a founder member of the International TRANSPORTEC consortium which has led the way in bringing molecular profiling of endometrial cancers to the clinic setting.

Summary of presentation

A Risk based approach to adjuvant treatment for endometrial cancer has become standard practice. Tumour stage, depth of myometrial invasion, grade, cell type, presence of LVSI and older age have been the main determinants of risk of relapse. However, a new molecular classification has been developed which, together with clinical data published over the past 3 years, has allowed the risk groups to be redefined. This has been incorporated into the recently published ESGO-ESTRO-ESP endometrial cancer guidelines which will be summarised and discussed today.
What you need to know (key learning point)
The new risk groups for adjuvant treatment of endometrial cancer and management options

What you need to do (key practice changing points)

Download and read the guidelines

Key references (papers, websites, guidelines etc)

Concin,N, Matias-Guiu,Vergote,I, et al ESGO/ESTRO/ESP guidelines for the management of patients with endometrial carcinoma Int J Gyn Cancer 2021;31:12-39

Evidence based surgical practice.

Presenter Jane M Blazeby

Jane M Blazeby is Professor of Surgery at the University of Bristol and an Honorary Consultant Surgeon at University Hospitals Bristol NHS Foundation Trust. She studied Medicine at the University of Bristol and undertook higher surgical training in the South West of England. Jane was a practicing upper gastro-intestinal cancer and general surgeon until 2018. Academically she has had a long-standing interest in patient centred surgical care and standards of surgery. Jane developed and validated an international portfolio of patient reported outcome measures which are widely used in clinical trials in surgical oncology. She collaborates with surgeons, methodologists, trialists and patient partners to design and deliver randomised controlled surgical trials and she is extending interests into early phase work. She enjoys embedding methodological research into the trials and investing in future leaders. She mentors and supports consultant surgeons, methodologists and academic trainees to become chief and principal investigators and associate principal investigators.

Jane directs the Bristol Centre of Surgical Research. The Centre includes the Surgical Innovation theme of the Bristol Biomedical Research Centre and Royal College of England Surgical Trials Centre. The MRC ConDuCT-II Hub for Trials Methodology Research was hosted in the Centre. Jane is Chief Investigator of the NIHR HTA By-Band-Sleeve study in bariatric surgery and a co-investigator (supporting the CIs) of 10 HTA trials. She is a member of the executive committee of COMET (Core Outcome Measures in Effectiveness Trials), the IDEAL Collaboration and the MRC Trials for Research Methodology Partnership. She is an NIHR Senior Investigator. Her vision is to see surgical practice to be based on high quality evidence and for surgeons to participate in the creation of that evidence so that they understand it and implement findings in clinical practice.

Summary of presentation

Large scale pragmatic surgical trials are possible. Minimising selection and ascertainment bias is especially important. Although surgeons have preferences for treatments, it is possible to randomise into trials, gain confidence and clinical equipoise. The TIME and ROMIO trials in minimally invasive oesophagectomy will be described to illustrate how trials influence practice. The talk will conclude that more (bigger) and better trials are needed with strong clinical leadership, and good team working with efficient clinical trials units. Fundamental to success is widespread engagement across all clinical centres to optimise learning.

What you need to know (key learning point)

Collaboration is the new competition.

What you need to do (key practice changing points)

Engage and recruit into NIHR clinical trials.
Support trainees to do likewise.

Key references (papers, websites, guidelines etc)

https://www.bristol.ac.uk/population-health-sciences/centres/surgical-research/

Bristol Centre for Surgical Research | Bristol Medical School: Population Health Sciences | University of Bristol

COVID19: Fallout and Recovery

Dr Melissa Girling
Macmillan Clinical Psychologist joined the Counselling and Psychology Service in the Dorset Cancer Centre at Poole Hospital in February 2020. I lead the team and provide a clinical psychology service to patients, their families and staff in the Oncology and Palliative Care Services. Prior to this, I worked in Adult Mental Health holding posts in both primary and secondary care in West Midlands and across the county of Dorset since gaining the Doctorate in Clinical Psychology from the University of Birmingham in 2008.

Summary of presentation

The impact of COVID 19 on health services has been immense. The toll on the health and wellbeing of staff has been unprecedented. As we begin to enter a phase of recovery it remains important that we remain active in managing stress, to reduce burnout amongst a weary staff population. A Compassionate Mind perspective is introduced along with practical strategies to reduce stress and burnout amongst healthcare professionals.

What you need to know (key learning point)

Strategies to prevent and reduce stress and burnout amongst health care professionals.

What you need to do (key practice changing points)

Improve self-compassion through awareness and practice.

Key references (papers, websites, guidelines etc)

Eriksson, T., Germundsjo, L., Astrom, E. & M. Ronnlund (2018). Mindful self-compassion training reduces stress and burnout symptoms among practicing psychologists: A randomised controlled trial of a brief web-based intervention. Frontiers in Psychology, 9, 1-10.
Neff, K. (2021). Test how self-compassionate you are. Self-compassion. https://self-compassion.org/test-how-self-compassionate-you-are/
Williams, R., Murray, E., Neal, A & Kemp V. (2020). Top Ten Messages for Supporting Healthcare Staff During the COVID-19 Pandemic. RCPsych Publications, 2020.

Design considerations of surgical trials

Allan Hackshaw

Allan Hackshaw is Professor of Epidemiology & Medical Statistics at University College London, and Director of the Cancer Research UK & UCL Cancer Trials Centre. He has 30 years' experience in the design, conduct and interpretation of clinical trials, observational studies and systematic reviews/meta-analyses; including surgical phase III trials in oral, endometrial and thyroid cancer. He has published over 190 peer-reviewed articles and is first author of 5 textbooks including those on clinical trials.

Summary of presentation

This talk will provide an outline of some key design issues associated with modern surgical trials in oncology. These are: (i) clear definition of the research question and justification for a proposed design, (ii) the choice of primary outcome measure (overall survival versus disease free survival), and (iii) choosing an appropriate non-inferiority margin when the trial aims to show that two interventions (one or both surgical) have similar efficacy.

What you need to know (key learning point)

That design features of surgical trials can have a direct impact on their results and therefore if/how they can be used to change practice.

What you need to do (key practice changing points)

Look at papers on surgical trials that completed and how their design features helped to changed practice, but also those that failed to complete and see if any of the reasons were associated with the design.

Key references (papers, websites, guidelines etc)

Cook et al. IDEAL framework for surgical innovation 3: randomised controlled trials in the assessment stage and evaluations in the long term study stage. IDEAL Group.BMJ. 2013;346:f2820. doi: 10.1136/bmj.f2820

The Challenges of Surgical Trials

Prof Sean Kehoe
Gynaecological Oncologist, Senior Research Fellow , St Peters College Oxford. Lead Clinical for the Oxford Gynaecological Cancer Centre. Chair of the FIGO Cancer Committee, Council Member of the BGCS, Trustee and Head of Medical Advisory Board OVACOME.

Summary of presentation

The presentation will cover the specific challenges and obstacles which surgical trials face. This will incorporate development of trials, the requirement and risks involved in a new 'surgical technique' trial, some ways to address specific situations, and where surgeons biases exist – and possibly why!. Also a structure to facilitate surgical trials will be presented, and where assistance is available to assist in trial development.

What you need to know (key learning point)

The processes involved in a trial
Surgeons potential biases and why they may occur
The main barriers to trials
The IDEAL Collaboration.

What you need to do (key practice changing points)

Consider where you may be biased – confirmation bias for example.
Consider where Surgical trials would be of value.
Do you tend to support and recruit to surgical trial or not?

Key references (papers, websites, guidelines etc)

McCulloch P, Kaul A, Wagstaff GF, Wheatcroft J.Tolerance of uncertainty, extroversion, neuroticism and attitudes to randomized controlled trials among surgeons and physicians. Br J Surg. 2005 Oct;92(10):1293-7
Patrick L Ergina et al. BMJ 2013;346:bmj.f3011
www.ideal-collaboration.net

The LACC Study: Experiences from a Surgical Trial
Dr Pedro Ramirez

The design, implementation, accrual, and ultimate completion of a prospective randomized surgical trial is associated with numerous challenges and detailed strategies are required in order to successfully complete such trial. There are several key basic elements that provide the broad initial foundation for such trial and these include rationale for scientific question, implications on clinical practice, time-frame relevance, and realistic projections for completion. In addition, to the scientific and logistical feasibility of proposing a large, multi-institutional trial, investigators must assure that there will be adequate funding to support the trial throughout the anticipated projection of the study. Resources will need to be appropriately allocated for a number of critical elements that support the trial. These include, but not limited to, research personnel support, institutional approval processing fees, protocol translation and certification fees, auditing and monitoring expenses, and per-patient accrual fees.

A multi-institutional collaboration is critically important to the success of a prospective trial. This will require investigators to seek support of institutions that are committed to the principles of the trial and the scientific question in order to provide swift initiation of the trial as well as consistent and equitable accrual to the study. Contracts must be established and agreed upon prior to initiation of the study, including a confidentiality agreement, as well as an authorship agreement. Centers must be selected based on patient volume, surgical expertise, and prior experience in surgical trial conduct. Data quality is a key component, therefore, there must be confirmation of internal quality control and appropriate database capabilities. Monitoring of each site and auditing of the data throughout the life of the study is a key component.

Once the study is implemented it is essential to assure that there are no protocol violations and that data entry is maintained and up to date. Periodic meetings with the Data Safety Monitoring Committee assure that trial conduct is appropriate and that no patients are harmed by the interventions proposed in the study. In addition, challenges and unexpected circumstances related to the trial, as well as updates on clinical relevance of the study question are addressed.

Upon trial completion, it is essential that involved institutions are aware of data freezing and analysis. It is equally essential to assure that data is up-to-date, accurate, and complete prior to statistical analysis initiation. Finally, it is essential that all authors review results of the trial, are provided ample opportunity to comment on the final manuscripts of the trial, and that there is agreement regarding selection for journal for submission.

All investigators considering a prospective randomized trial should be encouraged to consider numerous obstacles and barriers including study equipoise, variations in patient population, lack of funding for surgical trials, slow accrual during initial phase of the trial, potential protocol violations, authorship conflicts, issues of data monitoring and auditing, and ultimate implications of trial findings. It is essential to maintain focus and direction as to the importance and relevance of the study and to assure ethical conduct and sound principles of scientific investigation.

Radiotherapy: Managing Consequences for Patients - the Short & Long Term Impacts
Dr Rachel Wilkinson
Dr Wilkinson has been a Consultant Clinical Oncologist at University Hospitals Dorset for 18 months, since the completion of her specialist training in the Peninsula Deanery. She specialises in the treatment of gynaecological and breast cancer.

Summary of presentation
Radiotherapy is an integral part of treatment for patients with gynaecological cancer. It is offered in the adjuvant setting, to reduce the risk of local recurrence and in the curative setting, in terms of definitive chemoradiotherapy for cervix cancer. It is also given in the palliative setting to alleviate symptoms of cancer. In this talk we will consider the short and long term impacts of radiotherapy for patients in regards to early and late side effects of treatment, and explore how these side effects are managed in clinical practice.

What you need to know (key learning point)
Treatment with radiotherapy to the pelvis can result in side effects. Careful clinical assessment allows us to identify these side effects. Effective management can positively impact on quality of life.

What you need to do (key practice changing points)
Be awareness of possible side effects of radiotherapy and their management .

Key references (papers, websites, guidelines etc)
https://www.cancerresearchuk.org/about-cancer/cervical-cancer/treatment/radiotherapy

Transitioning to End of Life: Management of Patients & Their Families

Dr Paul Barker
Dr Paul Barker is a Palliative Care Doctor at Weldmar Hospicecare In patient Unit in Dorset.

Summary of presentation

A philosophical treatise on the relationship between suffering and dying and why end of life conversations are so important.

What you need to know (key learning point)

1) Most people wish to talk about coming to the end of life and palliation
2) Often it is the message that is 'malignant' and impeccable communication is all important
3) Suffering and dying are often perceived as inter-related but usually are not
4) Advance Care Planning provides control and hope for our patients

What you need to do (key practice changing points)

Never be afraid to communicate messages however difficult the information might be. Advanced communication skills courses are excellent ways of understanding our communication styles.
Learn about advance Care Planning and your role in facilitating this
Liaise with your local palliative Support Services and see what's available for your patients.

Professor Luis Chiva

Radical hysterectomy has been the treatment of choice for early cervical cancer for years.

In 2018, Dr. Pedro Ramirez published the LACC clinical trial that showed decreased survival in patients undergoing minimally invasive surgery for cervical cancer.

This study has shown a tremendous impact on the management of this disease in recent years.

However, in the international scientific community, multiple questions have arisen regarding the causes of these results.

Our group developed a retrospective observational study, the SUCCOR trial, that included 1152 patients undergoing radical hysterectomy in Europe for 1B cervical carcinoma.
This study's results have revealed the risk factors associated with a decrease in disease-free -survival and overall survival when operating by minimally invasive surgery.

Our presentation shows how the uterine manipulator, surgical protective maneuvers to avoid tumor spread, and previous conization significantly modify the management of patients with early cervical cancer due to minimally invasive surgery.

Therefore, we show an algorithm that allows us to select patients for minimally invasive surgery.

Besides, we have conducted a recent survey among members of the ESGO that shows this society's perspective regarding the current situation of early cervical cancer treatment.

The RACC-trial

Dr Henrik Falconer

Associate Professor Henrik Falconer is Head of Gynecologic oncology at Karolinska University Hospital, Sweden. Dr Falconer's research is currently focused on cancer epidemiology and clinical trials in robotic surgery. He is the Principal Investigator for the international RACC-trial (Robot-assisted Approach to Cervical Cancer). Dr Falconer has been working with many aspects of robotic surgery for more than 10 years and has a special interest for education and surgical efficiency. Dr Falconer regularly runs courses in robotic surgery and has been lecturing on several international conferences. Dr Falconer is a council member of SERGS and a member of the EURACAN steering committee.

Summary of presentation

The RACC-trial is an ongoing, international multicentre RCT exploring the oncologic safety of robot-assisted radical hysterectomy for early-stage cervical cancer. The presentation gives an overview of the trial, describes key differences compared to previous trial(s) and current status.

What you need to know (key learning point)

Current accrual status of the RACC-trial

What you need to do (key practice changing points)

Contact the speaker if you have interest to join the trial!

Key references (papers, websites, guidelines etc)

Falconer H, Palsdottir K, Stalberg K, Dahm-Kähler P et al. Robot-assisted approach to cervical cancer (RACC): an international multi-center, open-label randomized controlled trial. Int J Gynecol Cancer. Int J Gynecol Cancer. 2019;29(6):1072-1076

www.racctrial.org

The Robot vs Open surgery in Cervical Cancer (ROCC) trial

Mario M Leitao Jr MD, FACS, FACOG
Attending Surgeon
Division of Gynecology, Department of Surgery
Director, Minimal Access and Robotic Surgery Program, Dept of Surgery
Director, Gynecologic Oncology Fellowship Program
Memorial Sloan Kettering Cancer Center
Professor, Weill Cornell Medical Center

Summary of presentation

There is a need for validation of the LACC trial findings which were unexpected. Many issues regarding the LACC trial have been identified. We have been developing another randomized controlled trial – ROCC trial. This trial will randomize 840 patients with the same inclusion criteria as the LACC trial. The ROCC trial has addressed the many concerns of the LACC trial. Preoperative MRI is required for all cases. Transcervical uterine manipulators will not be allowed. Tumor containment prior to colpotomy in all cases is required. There will be close follow-up postoperatively with CT imaging and physical exams. The trial has 3 interim analyses built in to address safety and futility. The ROCC trial has received funding and will run through the US-based cooperative trial group GOG Partners.

What you need to know (key learning point)

We will present concerns of the LACC trial and provide details of the upcoming ROCC trial

What you need to do (key practice changing points)

Assess whether the ROCC trial may be something that is compatible with your practice and to offer your patients.

Mr Andy Nordin

Following the publication of the LACC and SEER papers, the BGCS approached NCRAS with a request for an analysis of English cancer registration data to compare outcomes for minimal access surgery (MAS) and open (laparotomy) radical hysterectomy for cervical cancer. This was performed by linkage of HES and COS-D cancer registration data. The analysis was completed by senior NCRAS analysts and epidemiologists, and a PHE report was published in association with the BGCS in May 2019. Women resident in England with early stage cervical cancer (FIGO stage IA2, IB, IB1) treated surgically by radical hysterectomy during 2013-2016 formed the analysis cohort. Overall survival and time to death where applicable were based on NCRAS data with ONS mortality file linkage. All patients were followed up to end of 2017 (follow-up range 129-1824 days, median 1116 days, mean 1109 days). In the study cohort of 929 women, 564 (61%) were treated by the MAS approach, and 365 (39%) by open surgery. The use of MAS increased from 48% in 2013 to 74% in 2016. There was little difference between the MAS and the open surgery groups. Unadjusted Cox regression analysis indicated evidence for variation in overall survival by surgical approach, with the MAS group having a hazard ratio value of 3.3 (p=0.009). In multivariate Cox regression analysis adjusting for diagnosis year, age, socio-economic status, Charlson comorbidity score, stage at diagnosis, English region, Route to Diagnosis, and adjuvant treatment status, the difference in overall survival between the two surgical approach groups remained, becoming slightly larger (hazard ratio value of 4.0, p=0.007). In the context of overall excellent prognosis (4.5-year overall survival being 93.1% for MAS cohort and 97.2% for open surgery cohort), surgical approach was associated with overall survival, with women treated with MAS radical hysterectomy having inferior survival than those treated with open radical hysterectomy. Since the PHE report was published, the histopathology reports of all 929 cases have been analysed, and the cause of death for each case of mortality is being reviewed. The preliminary results of these additional analyses will be available for presentation at the BGCS conference.

In January 2021, NICE published the Interventional Procedures Guidance 686 “Minimally Invasive Radical Hysterectomy For Early Stage Cervical Cancer” (www.nice.org.uk/guidance/ipg686). This guidance states that minimally invasive radical hysterectomy should not be used for tumours 2 cm or above, and that as evidence on efficacy for tumours smaller than 2 cm is inconclusive MAS radical hysterectomy for tumours smaller than 2 cm should only be used in the context of research. This guidance will be discussed in the context of the NCRAS pathology data.

Managing Cancer Patients in the Digital Age - New Ways of Working & the Digital Recovery Agenda
Abigail Orchard
Lead cancer nurse and Advanced nurse practitioner in acute oncology

Summary of presentation
Managing Cancer Patients in the Digital Age - New Ways of Working & the Digital Recovery Agenda
The COVID pandemic has forced many hospitals to change the way they deliver Some of their services. Historically, the NHS has not always been at the forefront of digital advances, however covid has seen a rapid change in this area of healthcare
During this session, there will be an exploration and critique of the digital technology used to support follow up and surveillance of people affected by cancer.
There will be a focus on remote monitoring, including digital patient portals, video supported outpatient appointments and the delivery of psychological support services using digital technology.

What you need to know (key learning point)
The types of digital technology used to support healthcare
Benefits of digital technology
Disadvantages of digital technology

What you need to do (key practice changing points)
Consideration of implementation of these technologies within other healthcare settings

Key references (papers, websites, guidelines etc)
NHS Improvement (2016) Innovation to implementation: Stratified pathways of care for people living with or beyond cancer. A 'how to guide'. https://www.england.nhs.uk/wp-content/uploads/2016/04/stratified-pathways-update.pdf
Video consultations in secondary care https://www.england.nhs.uk/outpatient-transformation-programme/video-consultations-in-secondary-care/

Impact of the LACC on Standard of Care
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The Laparoscopic Approach to Carcinoma of the Cervix (LACC) trial is a prospective randomized trial comparing open vs. minimally invasive radical hysterectomy in patients with early-stage cervical cancer. Its primary aim was to evaluate disease-free survival. A total of 319 patients were assigned to minimally invasive surgery and 312 to open surgery. Of the patients who were assigned to and underwent minimally invasive surgery, 84.4% underwent laparoscopy and 15.6% robot-assisted surgery. The two groups were similar in histologic subtypes, the rate of lymphovascular invasion, rates of parametrial and lymph-node involvement, tumor size, tumor grade, and the rate of adjuvant therapy. The rate of disease-free survival at 4.5 years was 86.0% with minimally invasive surgery and 96.5% with open surgery. Minimally invasive surgery was associated with a lower rate of disease-free
survival than open surgery (3-year rate, 91.2% vs. 97.1%; HR, 3.74). In addition, minimally invasive surgery was also associated with a lower rate of overall survival (3-year rate, 93.8% vs. 99.0%; HR, 6.00). Subsequent data was published on the comparison of complication rates between the open and minimally invasive surgery. The data on adverse events showed that the incidence of intraoperative and postoperative adverse events associated with minimally invasive versus open radical hysterectomy for early stage cervical cancer was similar. Subsequently, we also published on the comparison of QoL between the two groups. Eligible patients completed validated QoL and symptom assessments (SF-12, FACT-Cx, EQ-5D, and MDASI) before surgery and at 1 and 6 weeks, and 3 and 6 months after surgery (FACT-Cx was completed for 54 months after surgery). In that study, there was no difference between the open and minimally invasive surgery groups at any time point on any of the six composite scores for the four instruments. At 6 weeks after surgery, both groups exhibited a significant reduction in the physical component score of the SF-12, indicating worsening of QoL, and the reduction was greater in the open than in the minimally invasive surgery group. The two groups did not differ with respect to change scores for any of the other QoL measures at 6 weeks or 3 months after surgery.
In summary, the LACC Trial showed a higher rate of recurrence and worse disease-free survival for patients undergoing minimally invasive radical hysterectomy when compared to the open approach with no difference in complication rates or quality of life between the two surgical approaches. As a result of this study, and numerous others that have been published following the publication of the LACC trial, the following guidelines and societies have changed their recommendation in favor of open radical hysterectomy for the surgical management of patients with early stage cervical cancer. These include the National Comprehensive Cancer Network, the European Society of Gynecologic Oncology, the European Society of Medical Oncology, and the International Federation of Gynecology and Obstetrics (FIGO).