3. Gynaecological

GYNAECOLOGICAL CANCER	
If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
Biopsy-proven or cytology positive gynaecological malignant or premalignant disease[3] or Gestational Trophoblastic Disease	
A visible abnormality suspicious of a vulval, vaginal or cervical cancer (such as an exophytic, ulcerating or irregular pigmented lesion)[4]	
Significant symptoms (including abnormal vaginal bleeding, discharge or pelvic pain) AND Abnormal clinical findings suspicious of gynaecological malignancy (including lymphadenopathy, vaginal nodularity or pelvic induration)[5]	
Post-menopausal bleeding**.** ***(****N.B. High suspicion of cancer may be excluded if physical examination, smear and vaginal ultrasound are normal*[6]*)*	
A rapidly growing pelvic mass or genital lump[7]	
Women with a palpable or incidentally-found pelvic mass (including any large complex ovarian mass >8 cm) UNLESS investigations (ultrasound and tumour markers) suggest benign disease[8]	
Women with a documented genetic risk who have a suspicious pelvic abnormality or symptoms[9]	

[3] Please see National Cervical Screening Programme recommendations for colposcopy referral.
[4] Women with an undiagnosed visible genital abnormality which is not highly suspicious of malignancy should be referred for gynaecological or dermatology review or undergo a biopsy.
[5] Women with gynaecological abnormalities or symptoms may also have gynaecological malignancy and the development of triage pathways is encouraged. Specific consideration includes premenopausal women with abnormal uterine bleeding. Those with persistent or deteriorating symptoms should be reviewed by a gynaecologist. A raised CA125 supports the need for further investigation in woman with persistent pelvic or abdominal symptoms.
[6] Early access to vaginal ultrasound will reduce demand on secondary services. Women without post-menopausal bleeding but with a thickened endometrium should undergo gynae review but are not defined as high risk.
[7] Discernible growth within a 3 month period is normally of concern. Undiagnosed external genital lumps with any discernible growth should normally be reviewed by a gynaecologist and/or biopsied.
[8] The development of referral pathways is recommended to ensure rapid assessment of patients with a pelvic mass, early access to pelvic ultrasound is seen as crucial to this process.
N.B. Suspicion of ovarian malignancy is indicated by metastatic disease, ascites or radiologist's impression, a raised CA125 in a post-menopausal woman or germ cell markers in a woman under 25. The risk of malignancy index (RMI) is utilised to triage patients for subspecialty care.
[9] Usually women with strong family history or known hereditary nonpolyposis colorectal cancer (HNPCC) or BRCA mutations.