Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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22 December 2021

9(2)(a) [redacted]

RE Official Information Act request CDHB 10773

I refer to your email dated 7 December 2021 requesting the following information under the Official Information Act from Canterbury DHB regarding how referrals for trans vaginal ultrasounds are treated. Specifically:

What priority (urgent, semi urgent, routine, declined) and time frame (in days or weeks) your clinicians would put on the following twelve referral scenarios for a trans vaginal ultrasound from a community GP (under a Covid Level 1 scenario)?

Premenopausal 36 year old women with new onset bowel habit changes and bloating of
A. 1 months duration, normal pelvic exam, negative family history - with CA-125 of 15
B. 3 months duration, normal pelvic exam, negative family history - with CA-125 of 15 (stable)
C. 3 months duration and new onset urinary frequency, normal pelvic exam, negative family history - with CA-125 of 18 (previously 15)
D. 1 months duration, normal pelvic exam, negative family history - with CA-125 of 37
E. 1 months duration, normal pelvic exam, negative family history - with CA-125 of 205
F. 1 months duration, mass on pelvic exam, negative family history - with CA-125 of 205

Post-Menopause 50 year old woman presenting with new bowel habit changes and bloating of
A. 1 months duration, normal pelvic exam, negative family history - with CA-125 of 15
B. 3 months duration, normal pelvic exam, negative family history - with CA-125 of 15 (stable)
C. 3 months duration and new onset urinary frequency, normal pelvic exam, negative family history - with CA-125 of 18 (previously 15)
D. 1 months duration, normal pelvic exam, negative family history - with CA-125 of 37
E. 1 months duration, normal pelvic exam, negative family history - with CA-125 of 205
F. 1 months duration, mass on pelvic exam, negative family history - with CA-125 of 205

We are declining your request pursuant to section 18(g) of the Act as you are asking for opinions and we do not hold any information regarding your questions.

Section 18(g) "….that the information requested is not held by the CDHB and the person dealing with the request has no grounds for believing that the information is either— (i) held by another [agency]; or (ii) connected more closely with the functions of another [agency]."

However, we do note that all these patients would be managed according to the Ovarian Cancer Symptoms pathway as outlined in the Canterbury Community HealthPathways* information. Please refer to **Appendix 1**.

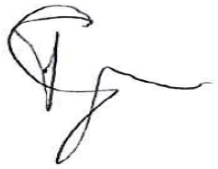
**HealthPathways is designed and written for use during a clinical consultation. Each pathway provides clear and concise guidance for assessing and managing a patient with a particular symptom or condition. Pathways also include information about making requests to services in the local health system.*
Content is developed collaboratively by general practitioners, hospital clinicians, and a wide range of other health professionals. Each pathway is evidence-informed, but also reflects local reality, and aims to preserve clinical autonomy and patient choice. HealthPathways serves to reduce unwarranted variation and accelerate evidence into practice. ***Note:*** *This information is not publicly available.*

Information which is publicly available can be found on the Canterbury HealthInfo website. www.healthinfo.org.nz.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely



Tracey Maisey
Executive Director
Planning, Funding & Decision Support

Community HealthPathways

Ovarian Cancer Symptoms

Red flags

- Genetic risk – strong family history or known HNPCC or BRCA mutation

Background

About ovarian cancer symptoms

About ovarian cancer symptoms

- Ovarian cancer is more common in postmenopausal women.
- The mean age of diagnosis is 65 years.
- The lifetime incidence for women is 1.6%.
- In premenopausal women, ovarian cancer is uncommon but more likely if there is a strong family history of known HNPCC or BRCA mutations.
- Around 10% of ovarian cancer is caused by hereditary cancer syndromes.
- Non-specific symptoms make diagnosis difficult.
- Examination is important as there may be a mass and clinical evidence of abdominal disease.
- Patients with one first- or second-degree relative with ovarian cancer occurring when aged older than 50 years have a 5% lifetime risk, which is slightly increased from the general female population lifetime risk of 1.6%. Patients with known genetic mutations, e.g. BRCA mutation, have a much higher risk.
- There is currently no proven role for Ca125 or ultrasound screening in asymptomatic women.

Assessment

1. Assess possible ovarian cancer if new abdominal or pelvic symptoms are present on a persistent or frequent basis – particularly more than 12 times per month:
    - Persistent abdominal distension or bloating
    - Early satiety or loss of appetite
    - Pelvic or abdominal pain without a known cause

- Increased urinary urgency or frequency
- Irritable bowel symptoms, especially if new onset and aged older than 50 years
- Unexplained weight loss or fatigue
- Postmenopausal bleeding

2. Consider genetic risk.

   Genetic risk

   Patients with one first- or second-degree relative with ovarian cancer occurring when aged older than 50 years have a 5% lifetime risk, which is slightly increased from the general female population lifetime risk of 1.6%. Patients with known genetic mutations, e.g. BRCA mutation have a much higher risk. Ovarian cancer risk is up to 44% with BRCA1 and 17% with BRCA2.

3. Consider a differential diagnosis for other causes of chronic, vague abdominal symptoms, including bowel cancer.

   Differential diagnosis

   Conditions commonly associated with chronic pelvic pain:

   - Gynaecological:
     - Endometriosis
     - Adenomyosis
     - Chronic PID
     - Vulvodynia, vaginismus and sexual dysfunction
     - Pelvic congestion syndrome
   - Adhesions:
     - Endometriosis
     - Previous surgery
     - Pelvic infection
   - Urological:
     - Bladder pain syndrome (formerly interstitial cystitis)

       Bladder pain syndrome

       This was previously called interstitial cystitis.

       It is a chronic bladder condition with pelvic pain, dysuria, urinary frequency, urgency and pressure in the bladder and pelvis, without proven urinary infection or other obvious pathology.

There is no known cause, or consensus on treatment.

Consider:

- MSU.
- urine cytology.
- a bladder diary – advise the patient to include comments about pain.

Management is generally symptomatic and supportive.

Advise the patient:

- to avoid any irritants that may exacerbate symptoms, e.g. caffeine, alcohol, artificial sweeteners, hot pepper.
- that there is some evidence to suggest that certain exclusion diets may help, but it is not conclusive. See Interstitial Cystitis Association – Least and Most Bothersome Foods.
- that there is limited evidence for any oral medications, but medications for chronic pain, e.g. tricyclic antidepressants, could be considered.

See:

- HealthInfo – Interstitial Cystitis
- Patient – Interstitial Cystitis/Painful Bladder Syndrome

- Recurrent UTI

- Gastrointestinal:
  - Irritable bowel syndrome
  - Diverticular disease
  - Coeliac disease
  - Inflammatory bowel disease
- Musculoskeletal:
  - Pelvic floor tension myalgia
  - Coccydynia
  - Fibromyalgia
  - Chronic abdominal wall pain
- Neurological – neuralgia which may be associated with previous surgery
- Psychological:
  - Depression and/or anxiety

- Sexual abuse
- Somatisation
- Opiate dependency

4. Examine the abdomen and pelvis for signs suggesting ovarian cancer, including a pelvic or abdominal mass or ascites.
5. Investigations:
    - Arrange initial blood tests – Ca125, LFT, CBC, CRP, calcium, creatinine, and electrolytes.

      Ca125

      - The sensitivity and specificity of serum Ca125 is limited. Ca125 levels are elevated in approximately 1% of healthy women and fluctuate during the menstrual cycle.
      - Ca125 is also increased in a variety of benign and malignant conditions, including:
          - endometriosis.
          - uterine fibroids.
          - cirrhosis.
          - pelvic inflammatory disease.
          - cancers of the endometrium, breast, lung, and pancreas.
          - pleural or peritoneal fluid due to any cause.
          - pregnancy.
      - Ca125 is most useful in postmenopausal women as there is less risk of false-positive tests.
      - Ca125 is not specific enough to use as a screening tool in asymptomatic postmenopausal women.
      - Serum Ca125 values are elevated in approximately 50% of women with early-stage disease and in more than 80% of women with advanced ovarian cancer.
    - If signs include a pelvic or abdominal mass or ascites, arrange an ultrasound scan within 2 weeks.
    - If no signs, manage according to Ca125 result.

Management

1. If scan is abnormal, e.g. shows ascites or complex cyst, request non-acute gynaecology assessment or seek gynaecology advice. If criteria for high suspicion of gynaecological

cancer are met, select ERMS priority high suspicion of cancer, or write "high suspicion of cancer" on the request. Consider referring the patient to Cancer Support Services.

Criteria for high suspicion of gynaecological cancer

Ministry of Health criteria for determining or confirming the "high suspicion of cancer" flag.

- Biopsy-proven or cytology positive gynaecological malignant or premalignant disease, or gestational trophoblastic disease.
- Visible abnormality suspicious of a vulval, vaginal, or cervical cancer, e.g. exophytic, ulcerating, or irregular pigmented lesion.
- 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.
- Postmenopausal bleeding. High suspicion of cancer may be excluded if physical examination, smear, and vaginal ultrasound are normal.
- Rapidly growing pelvic mass or genital lump.
- Patients with a palpable or incidentally found pelvic mass (including any large complex ovarian mass larger than 8 cm) unless investigations (ultrasound and tumour markers) suggest benign disease.
- Patients with a documented genetic risk who have a suspicious pelvic abnormality or symptoms.

2. If there are no signs, manage according to Ca125 results and whether the woman is premenopausal or postmenopausal:

    - Premenopausal women

      Premenopausal women

      For premenopausal women with elevated Ca125 (even when Ca125 greater than 200 units/mL), benign conditions are the most likely cause.

      Manage investigation results for possible ovarian cancer in premenopausal women:

      1. If serum Ca125 is less than 35 units/mL, assess for other causes of symptoms. If no other causes are evident after full assessment, advise the patient to return if symptoms increase or are persistent.
      2. If Ca125 greater than 35 units/mL but less than 200 units/mL, in the presence of normal clinical findings, repeat serum Ca125 in 6 weeks' time. If this is repeatedly high or climbing, arrange ultrasound scan. The patient is eligible for publicly-funded radiology. Once scan result is obtained, seek gynaecology advice.

3. If Ca125 decreases by any amount in the 6 week time frame, reassure the patient that this is not ovarian cancer and advise there is no need for further investigation unless symptoms deteriorate.
4. If Ca125 greater than 200 units/mL, arrange ultrasound scan.The patient is eligible for publicly-funded radiology. Once scan result is obtained, seek gynaecology advice.
5. If unsure of the management of the Ca125 result or the scan result, seek gynaecology advice.

- Postmenopausal women

  Postmenopausal women

1. If serum Ca125 less than 35 units/mL, assess for other causes of symptoms. If no other causes are evident after full assessment, advise the patient to return if symptoms increase or are persistent. Reassess and arrange ultrasound scan.
2. If Ca125 greater than 35 units/mL, arrange ultrasound scan. The patient is eligible for publicly-funded radiology. If the scan is abnormal, request non-acute gynaecology assessment.
3. If Ca125 greater than 35 units/mL and scan is normal, seek gynaecology advice.
4. If unsure of the management of the Ca125 result or the scan result, seek gynaecology advice.

3. If known genetic mutation, persistent symptoms, no signs, and investigation results do not meet criteria for referral, seek gynaecology advice.

Request

- If scan is abnormal, e.g. shows ascites or complex cyst, request non-acute gynaecology assessment or seek gynaecology advice. If criteria for high suspicion of gynaecological cancer are met, select ERMS priority high suspicion of cancer or write "high suspicion of cancer" on the request. Consider referring the patient to Cancer Support Services.

  Criteria for high suspicion of gynaecological cancer

  Ministry of Health criteria for determining or confirming the "high suspicion of cancer" flag.

  - Biopsy-proven or cytology positive gynaecological malignant or premalignant disease, or gestational trophoblastic disease.
  - Visible abnormality suspicious of a vulval, vaginal, or cervical cancer, e.g. exophytic, ulcerating, or irregular pigmented lesion.

- 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.
- Postmenopausal bleeding. High suspicion of cancer may be excluded if physical examination, smear, and vaginal ultrasound are normal.
- Rapidly growing pelvic mass or genital lump.
- Patients with a palpable or incidentally found pelvic mass (including any large complex ovarian mass larger than 8 cm) unless investigations (ultrasound and tumour markers) suggest benign disease.
- Patients with a documented genetic risk who have a suspicious pelvic abnormality or symptoms.

- Request non-acute gynaecology assessment or seek gynaecology advice after ultrasound pelvis result is obtained if:
  - initial Ca125 is 35 to 200 units/mL in premenopausal women and repeat Ca125 (6 weeks) is high or climbing.
  - Ca125 is greater than 200 units/mL in premenopausal women.
  - Ca125 is greater than 35 units/mL and scan is normal in postmenopausal women.
- If unsure of the management of the Ca125 result or the scan result, seek gynaecology advice.
- If known genetic mutation, persistent symptoms, no signs, and investigation results do not meet criteria for referral, seek gynaecology advice.