## Miss A

- 23y staff nurse
- P/C fainting and dizziness since waking
- Diarrhoea, vomiting and abdominal pain for 2/7

- Admitted to A&E Resus
- BP 87/58, p126, sats 96%(air), RR18, T 37.6˚c
- Treated for dehydration with IV fluids (4L crystalloid) over 4h.
- Failed to respond, abdominal pain and distension



- PT positive
- FAST scan – large amount free fluid

- Immediate transfer to theatre for laparotomy and salpingectomy for ruptured ectopic pregnancy
- 4 units transfusion

- Good recovery
- Discharged home after 3 days

## Ectopic Pregnancy

- Still a leading cause of maternal death
- 1:80 pregnancies, >95% tubal
- Typical symptoms
  - Unilateral pelvic pain, sharp/stabbing
  - Associated with dizziness /shoulder tip pain
  - "prune juice" vaginal loss
- Unusual presentations also fairly common
- Misdiagnosed as gastroenteritis, appendicitis, urinary tract infection or calculi, PID

**Diagnosis and Management of Ectopic Pregnancy** Sivalingam et al; J Fam Plann Reprod Health Care. 2011;37(4):231-240.



## The risk factors for ectopic pregnancy are:

- Previous ectopic pregnancy (odds ratio (OR) 13). Approximately 10% of spontaneous pregnancies after an ectopic pregnancy will be recurrent ectopic pregnancies. One recent study from Denmark suggests this figure is closer to 17%.
- History of PID (OR 7)
- History of infertility or assisted conception (OR 3)
- Conception with IUD in situ (OR 3)
- Smoking (OR 2)
- Conception whilst using POP
- Use of emergency contraception in current pregnancy
- Pelvic or tubal surgery
- Endometriosis

http://www.ectopic.org.uk/professionals/clinical-features/

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## Management of tubal ectopics

- Conservative
  - Low hCG <1500, falling >50% over 48h, asymptomatic, small ectopic on USS, no free fluid
- Medical - Methotrexate
  - Ectopic <3.5cm, hCG<5000, no FH, asymptomatic, no free fluid
  - 10% will require surgery, 70% abdominal pain, resolution may take over 28/7
- Surgical
  - Laparoscopy Vs Open
  - Salpingectomy Vs Salpingotomy

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## Miss B

- 28y
- Diagnosed with missed miscarriage; conservative management
- 6/52 later presented to GP with PT+, no symptoms, no vaginal bleeding
- Serum hCG 98 then 82 after 48h
- GP contacted Gynae for advice - ?further miscarriage or RPOC

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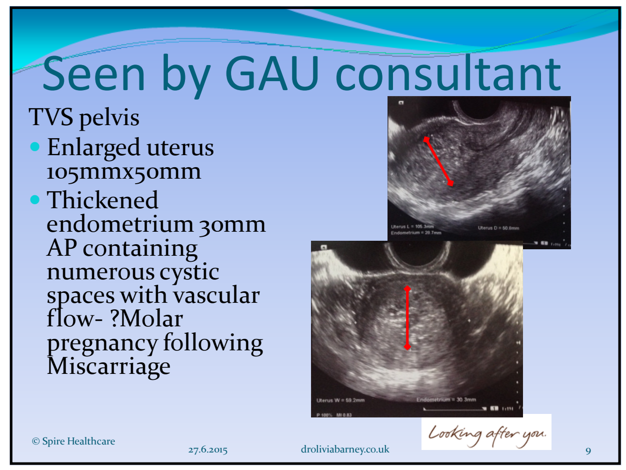

- SERPC recommended – pt DNA'd
- Pt called – explained need for tissue analysis again, SERPC rebooked – patient agreed to attend and said she understood need for histological diagnosis and risk of malignancy (albeit small)
- Pt again DNA'd
- Numerous attempts to call patient – would not pick up call
- GP contacted – would try to see patient



## Gestational Trophoblastic Disease

- Sensitivity of USS is <50% (better for Complete molar)
- Routine histological examination of POC no longer necessary after miscarriage
- Referral for review is recommended if
  - Persistent PVB >3/52,
  - + PT after 3/52
- Do a pregnancy test after any pregnancy if
  - Persistent PVB
  - Symptoms of metastases



## Gestational Trophoblastic Disease

- Referral to regional trophoblastic disease centre
- Serial quantitative urine hCG levels (and 1xserum at 3/12)
- Average surveillance about 6 months (hCG <2 at 56/7)
- Must avoid pregnancy
- CAN use hormonal contraception (not IUCD/ IUS)
- MERPC does not appear to affect risk of progression to GTN
- Need short follow up after all subsequent pregnancies

## Gestational Trophoblastic Neoplasia

- Invasive mole
- Choriocarcinoma
- Placental site trophoblastic tumour

- May follow a normal pregnancy, miscarriage or ectopic
- hCG not necessarily high – tends to be lower

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## Red flag symptoms

- In pregnancy
  - Severe intractable vomiting
  - Large uterus
  - PVB
  - Sx of hyperthyroidism
  - Theca lutein cysts
  - Severe early onset PET
- After pregnancy
  - Abnormal bleeding
  - haemoptysis
  - Dry cough
  - SOB / CP
  - Vaginal mass
  - Focal neurology

Mets: Lungs 80% Vagina 30%
Pelvis 20% Brain 10%
Liver 10%

Almost 100% cure rate in UK

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## Mrs C

- 39y biochemist G1 P0
- Low marked abdominal pain (deep central ache) in early pregnancy, no PVB
- GP USS – complex ovarian mass with fetus with FH in left adnexa
- Consultant TV TA USS
- Large multi-septate complex mass below body of uterus. Viable pregnancy within uterine cavity pushed up out of pelvis above the mass. Cervix seen below the mass
- Ovaries not identified
- VE – hard mass - ?degenerating fibroid ?Cervical tumour or ??ovarian mass

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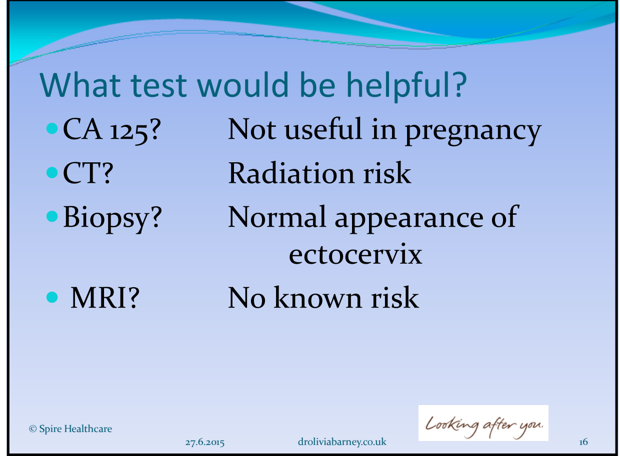


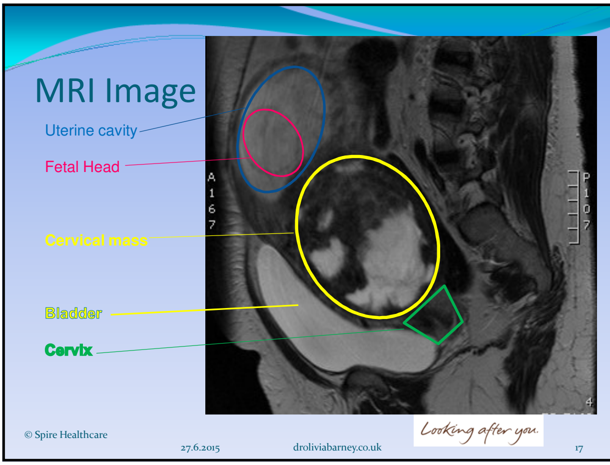


## Pregnancy

- Several admissions with pain due to red degeneration
- Closely monitored through pregnancy
- Numerous discussions regarding possible outcomes: classical caesarean section and hysterectomy
- By term, fetal head below fibroid
- Labour – prolonged second stage – forceps delivery

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## CA125 is not a screening test!

A screening test should be:

- ✓ Cheap
- ✓ Easy to perform
- ✓ Minimal discomfort
- ✓ Reliable (same result every time)

- ✗ Valid
  - Sensitivity 72%
  - Specificity 78%
  - PPV 72%
  - NPV78%

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## What causes a raised CA125?

**Non-malignant**
- Benign ovarian tumours
- PID / Salpingitis
- Pregnancy
- Periods
- Fibroids
- Endometriosis
- Ascites
- Inflammation
- Diverticulosis
- Pleural disease
- Pericardial disease
- Pancreatitis
- Heart failure

**Malignant**
- Ovarian cancer 80% (**late non-mucinous ovarian epithelial cancer**)
- Uterine cancer
- Pancreatic cancer
- Stomach cancer
- Colon cancer
- Rectal cancer
- Intra-abdominal mets (e.g. breast)

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## When is CA125 useful?

- When you have identified a cyst on scan
  - Post menopausal complex cysts and simple cysts >2cm
  - Premenopausal complex cysts or simple cysts >7cm
    - (also check LDH, αFP and hCG under 40y)
- Monitoring levels during treatment to assess response

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## USS instead?

- Not perfect either
- Some /many ovarian cancers are likely to be tubal in origin so scan may be negative in early disease
- So far no evidence that any screening is useful in reducing morbidity or mortality
- Annual screening in high risk women has not proven useful (UKFOCCS 1)
- Current trials looking at 4 monthly screening (UKFOCCS 2)
- Must consider the negative impact of screening (emotional, impact of unnecessary intervention)



## UKFOCSS Inclusion Criteria - High Risk Families

http://www.uhb.nhs.uk/Downloads/pdf/CancerPbOvarianCancerFamilialRisk.pdf

Practitioners may choose to refer patients to the UHL Genetics Unit in the following circumstances:

- 1 ovarian cancer and one breast cancer (at <50y) in first degree relatives
- 1 ovarian cancer and 2 breast cancers (at <60y) in first degree relatives
- 2 or more cases of ovarian cancer in first degree relatives
- 1 ovarian cancer and 3 colorectal cancers (1 at <50y) in first degree relatives
- A documented mutation of a predisposing gene
- Where there are three or more first degree relatives, with other gastrointestinal renal, urinary tract, uterine or ovarian cancer at any age.
- Where there are three or more relatives with a combination of cancers of breast, ovary, prostate, pancreas, melanoma or thyroid.
- Individuals with an Eastern European/Jewish origin who do not meet the above criteria could still be considered because of their increased risk of BRCA1 and BRCA2 mutations.

A High risk individual is a first degree relative of affected members in such families. Evidence of paternal transmission also acceptable.

Must be 35 years or older for screening.



## Red flag symptoms

- Stage 1 (30%, 90% FYS)
  - Pain in the lower abdomen or side
  - Bloated, full feeling in the abdomen
- Stage 2 (4%, 40% FYS) or 3 (40%, 20% FYS)
  - Irregular periods or PMB
  - Abdominal/Back pain
  - Urinary frequency
  - Constipation
  - Pain during sex
  - A swollen abdomen
  - Feeling of fullness or loss of appetite
- Stage 4 (15%, 5%FYS) -as for stage 2/3 plus:
  - Tiredness
  - N&V
  - SOB

→ USS, CA125, CT

## Miss D

- 32y Asian woman
- BMI 34
- Referred to infertility clinic after 4y trying
- 3 periods in 4y
- PMHx - diet controlled type 2 DM
- DHx - nil
- SHx - NAD

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## USS

- AV normal uterus with irregular, thickened, cystic endometrial echo, ET 22mm
- Left ovary contained 15 peripheral immature follicles, 12.3cc
- Right ovary contained 12 peripheral immature follicles, 11.7cc
- Small amount of free fluid

- Δ Δ - ?endometrial polyps, ?endometrial hyperplasia and meets Rotterdam criteria for PCOS

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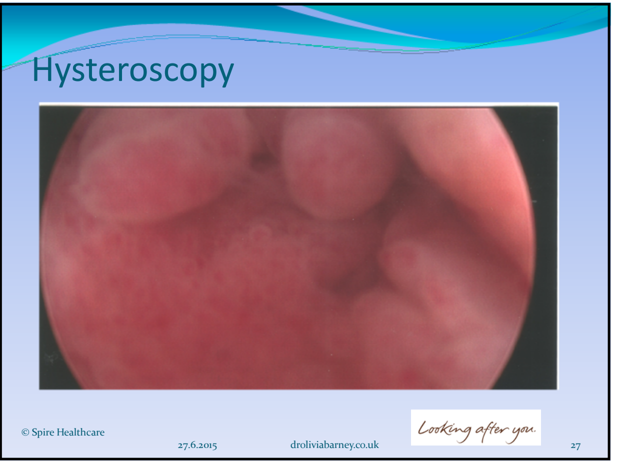
## Hysteroscopy



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Myosure
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Histology
Grade 1 endometroid adenocarcinoma
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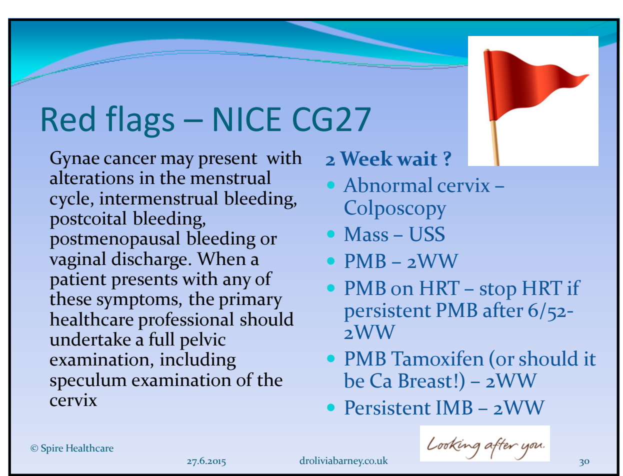
Red flags – NICE CG27
Gynae cancer may present with alterations in the menstrual cycle, intermenstrual bleeding, postcoital bleeding, postmenopausal bleeding or vaginal discharge. When a patient presents with any of these symptoms, the primary healthcare professional should undertake a full pelvic examination, including speculum examination of the cervix
2 Week wait ?
Abnormal cervix – Colposcopy
Mass – USS
PMB – 2WW
PMB on HRT – stop HRT if persistent PMB after 6/52- 2WW
PMB Tamoxifen (or should it be Ca Breast!) – 2WW
Persistent IMB – 2WW
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## Who should you refer?

- Post menopausal bleeding;
- Post menopausal bleeding and taking tamoxifen;
- Unscheduled bleeding on HRT;
- Persistent intermenstrual bleeding with negative pelvic examination;
- Thickened/abnormal endometrium on an ultrasound scan;
- Suspected endometrial cancer
- Premenopausal abnormal bleeding

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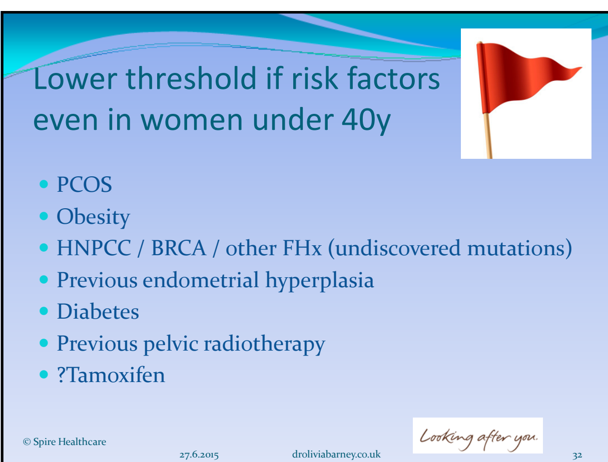

## Summary

- Ectopic until proven otherwise
- GTD can follow any pregnancy – ectopic, miscarriage or delivery of a baby
- Is CA125 really a valid screening test?
- Endometrial pathology can be seen under 40y

OUT TO LUNCH

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