Gynaecological Oncology Services in Tasmania

Service Description & Requirements

Gynaecological Oncology Services are an established and recognized part of Level 6 service provision for Gynaecology in Tasmania. Three extra years subspecialty training is required for specialist certification as a gynaecologic oncologist over and above generalist training in O&G. The centralised model of care of the service in Tasmania would be consistent with models in most other Australian States and Territories (except NT). The present Tasmanian state service is based at the Royal Hobart Hospital (RHH) with weekly outreach outpatient clinics in Launceston serviced by consultants.

The service is small with just over 130 women diagnosed with a gynaecological malignancy in Tasmania each year. It is responsible for the co-ordination and care of women with gynaecological malignancy and has expertise in radical pelvic and abdominal surgery. Additional roles include:

1) Major complex benign gynecological surgery
2) Counseling and surgery for women at high risk of gynaecological malignancies.
3) Expert colposcopic opinion for cervical, vaginal, vulval and perianal disease both for the North, North West and South with monthly multi-disciplinary (MDT) meetings.
4) Management of borderline ovarian tumours
5) Management of women with persistent gestational trophoblastic disease
6) Assistance and advice with complex obstetric surgery (scar ectopics, massive obstetric haemorrhage)
7) Phone advice for gynecologists statewide including emergency intraoperative advice on occasion.

What is the likely future demand for the service?

The number of women with Gynaecological malignancy diagnosed in Tasmania is slowly climbing as a result of:-

a) The increase in numbers of women with endometrial cancer which is strongly associated with obesity
b) Ageing population

Existing Infrastructure support

Inpatient. A “10 bed women’s only” surgical area presently sits within the surgical precinct at the RHH. Nursing support includes a full time gynaecological CNC and a small number of nursing staff with a focus on gynaecology. A surgical high dependency area is utilised by the service, as is ICU.

Outpatient. The gynaecological oncology service shares clinic space at the RHH and the Launceston General Hospital (LGH) with gynaecology. It requires access to an area that allows detailed gynaecological examination, procedures and colposcopy.
The service also shares clinic space in oncology outpatients at the RHH when running combined clinics.

Present Challenges

In the last 15 years the Tasmanian Gynaecological Oncology Service has been confronted with the following challenges:

1) Lack of support for a dedicated clinical female only inpatient facility supporting care for women with gynaecological illness despite good data to confirm individuals undergoing surgery for gender specific problems much prefer a single sex ward. (The Gynaecological Oncology Ward moved numerous times in the last 15 years because of the lack of efficiency of a small unit and a battle each time to keep such an area).

2) Lack of support for continued training of skilled gynaecological nursing staff (most lost because of numerous moves).

3) Lack of clear clinical governance pathways for the service due to lack of a Medical Director of Women’s and Children’s Services since 2006. Small services struggle for representation and their needs are seldom considered a high priority.

4) The LGH Department of O&G have been extremely supportive of the service in the North of the State providing medical, nursing and clerical support. There is no funding or governance around this arrangement although it has worked very well. Support for travel of medical and nursing personal is provided by the RHH.

5) MDT meetings fail to attract oncologists particularly from the north. This occurs because of limited staffing levels of oncologists and also because gynaecological cancers are relatively rare. Oncologists do not have time to attend meetings where only a small number of cases relevant to them are discussed. Over the years the service has tried to get around this by good communication (written and verbal) between specialists.

6) The service has struggled to maintain a high level of care for women because of the challenges mentioned above (No 1-3 & 5). Too much time and energy has been spent on the above issues and this has limited progress.

7) Many women need to travel from the North of the State for surgery in the South. Although women are often facing life threatening illnesses one of their frequent major concerns are the logistics of travel to the south and financial support for their family to stay locally whilst they are inpatients. Present government financial support is inadequate particularly for women requiring longer hospital stays.
8) Lack of availability of prompt access to interventional radiology in the North and North West of Tasmania frequently means women are brought down to the RHH under our care for investigation.

Workforce Requirements

Present Medical and Nursing staffing

The present service is supported by 2 Gynaecological Oncologists, one pelvic surgery registrar who rotates for 3 months of the year with an ITP O&G trainee. Cover for the service and for inpatients involves a 1:2 roster for consultants. The registrar works one 12 hour weekend shift for general O&G every 14 days. Daytime commitments (i.e. long surgeries) for the registrar do not permit regular night cover. After hour cover at a junior level, is provided by registrars on call for the O&G service. They communicate with the on call Gynaecological Oncologist as required.

There is a dedicated gynaecological cancer care co-ordinator who has a statewide role and also a CNC in gynaecology based at the RHH. There are a very small number of surgical nursing staff whose focus is gynaecology.

Are there services with key person dependencies that would benefit from clinical redesign to ensure the quality, safety and sustainability of the service?

a) Medical staffing

The present service provided is unsustainable at a consultant level.

A TWO consultant led service is not sustainable for the following reasons:-

1) Onerous on call particularly when leave is taken (1:1)
2) Inability to take leave because of lack of locum availability. Inability to take sabbatical/long service leave and even annual leave for any length of time.
3) Lack of capacity in present system to do much other than pure clinical work, i.e. limited time for administration, research, organizational matters
4) Inevitable burnout of clinicians involved

The present service provided is unsustainable at a consultant level with only 2 specialists. If Tasmania wishes to maintain a comprehensive Gynaecologic Oncology Service then this problem needs to be urgently addressed.

b) Workforce issues- nursing

Maintaining a skilled gynaecological nursing work force has not been seen as a priority by the RHH nursing governance over the last 10 years. There is a need to continue to raise awareness amongst nursing staff of all the challenges women face when undergoing gynaecological illness and surgery.

We have explored the model of a cancer care co-ordinator in the North of Tasmania but believe that the present model of a nurse based in Hobart who travels...
with the team is preferable. This avoids women repeating their story on numerous occasions and the role has focused on providing support for women whilst in hospital and in the community. Email, texting and phone communication is strongly encouraged by the nurse.

Support service requirements

The gynaecological oncology service is supported by specialist anaesthetic, anatomical pathology, & radiology services with regular MDT meetings. It has major links with medical and radiation oncologists in the North & South of the State with clear referral pathways.

The service requires access to both High dependency areas and ICU support on occasion.

The service has close relations with colorectal, urological and plastic surgeons and can call on other specialist teams as required. The service has always had a collaborative approach to care to improve outcomes for women.

Patients frequently have multiple significant co-morbidities and require access to specialist physician and cardiological input.

The last 15 years has seen rapid progress in the understanding of the genetics of many cancers. As an example we now know 15-18% of tubo-ovarian malignancies will be linked to germline BRCA1 or 2 mutations. The service has close ties to the clinical genetics service and has increasingly provided counseling and surgery for women at high risk of gynaecological malignancies.

Future directions for Tasmanian Gynaecological Oncology Service

1) The service model is correct with centralised surgical care. Outreach clinics to Launceston already exist. A Burnie based clinic is not feasible with current medical manpower and may not be practical because of the small number of women likely to benefit.

2) Improving access and refining referral pathways. The service has a strong clinical focus but has lacked resources to develop, plan and educate family practitioners and women about best practice referral pathways.

3) The service already has set referral pathways onwards to a limited number of oncologists (medical and radiation) in the North, NW and South. This concentrates expertise and encourages communication and best practice. A statewide clinical network in gynaecological oncology should be formalized.
4) The service has no means of auditing outcomes for women with gynaecological malignancy or benchmarking against other services. We would very much like to see the development of a state-wide clinical information system to allow this.

5) The majority of States around Australia run a Gestational Trophoblastic Disease registry monitoring BHCG levels post molar pregnancy and post treatment of persistent gestational trophoblastic disease. These registries and usually managed by the Gynaecological Oncology Services and consideration should be given to formalizing pathology review and follow up for women in Tasmania for women who have had molar pregnancies.

Additional comments on Cytology Services in Tasmania

Centralisation of cytology services in the future will become necessary with the move to primary Hr HPV testing instead of cervical cytology (Pap tests) in the near future. At present there is considerable expertise in Hobart both in Private and Public pathology sectors in this area. The Gynaecological Oncology Service runs a monthly MDT meeting and currently receives colposcopy referrals from around the state for review. The management of women is optimised because of this service. We would very much like to maintain this service but this will only occur if expertise is kept in the State and services are centralised.

The service has also put considerable effort into trying to establish a statewide clinical information system for colposcopy that theoretically would link to the Tasmanian Cervical Screening Registry. It has not so far been successful but this would facilitate the service and assist audit and quality assurance.

Testing of pleural and peritoneal fluid for cytology evidence of malignancy and subsequent immunohistochemical testing is frequently a lengthy process in hospitals in the North. Specimens are sent to Melbourne for testing. This often results in significant delays in diagnosis and is unnecessary when such testing is readily available in the south.

Please see the Gynaecology Service response for further information regarding this service.