

Gynaecology Tumour Site Specific Group meeting
Wednesday 12th November 2025
Via Microsoft Teams
13:30 – 17:00

Final Meeting Notes

Present	Initials	Title	Organisation
Hany Habeeb (Chair)	HH	Consultant Gynaecologist	MFT
Michael Mather (Guest Speaker)	MM	Lead Product Manager	AG Health
Hasib Ahmed	HA	Consultant Obstetrician and Gynaecologist	MFT
Suzanne Bodkin	SB	Cancer Service Manager	MFT
Sharon Griffin	SG	Consultant Gynaecologist	MFT
Leeja John	LJ	Gynae FDS CNS	MFT
Zoe Plumb	ZP	Gynae Cancer Support Worker	MFT
Hayley Martin	HM	Macmillan Personalised Care and Support Facilitator	MFT
Karen Flannery	KF	Macmillan Gynae Oncology CNS	MFT
Fay Fawke	FF	Macmillan Deputy Lead Cancer Nurse	DVH
Leanne Warren	LW	NSS / Gynae-oncology CNS	DVH
Hamed Al-Aarag	HAA	Consultant Gynaecologist & Cancer Lead	DVH
Sam Daniels	SD	Gynae Oncology Lead CNS	DVH
Emily Farrell	EF	MDT Co-ordinator	DVH
Louise Sterne	LS	Cancer Support Worker	DVH
Rema Iyer	RI	Consultant Gynaecological Oncologist	EKHUFT
Andy Nordin	AN	Consultant Gynaecologist / Subspecialist Gynae Oncologist	EKHUFT
Rhiannon O'Halloran-Jones	ROHJ	Gynae Oncology Research Nurse	EKHUFT
Emma Martin	EM	Gynae CNS	EKHUFT
Carly Price	CP	Family History and Genetics CNS	EKHUFT
Claire Bingham	CB	Macmillan Personalised Care Facilitator	EKHUFT
Danko Perovic	DP	Gynae Consultant	EKHUFT
Nicola Chalmers	NC	Gynae-Oncology Family History / Genetics Associate Practitioner	EKHUFT
Mohamed Ismail	MI	Gynae Oncologist	EKHUFT
Vicky Morgan	VM	Macmillan Lead Gynae Oncology CNS & SCP	EKHUFT

Justine Elliot	JE	Gynae Oncology CNS	EKHUFT
Gemma Connaughton	GC	Gynae Oncology Support Worker	EKHUFT
Laura Lawrence	LL	Gynae Oncology Support Nurse	EKHUFT
Bana Haddad	BH	Clinical Lead / GP	KMCA
Ann Courtness	AC	Macmillan Primary Care Nurse Facilitator	KMCA
Laura Alton	LA	Senior Programme Manager	KMCA
Emma Lloyd	EL	Cancer Pathways Improvement Project Manager	KMCA
David Osborne	DO	Data Analyst	KMCA
Karen Glass (Minutes)	KG	PA / Business Support Manager	KMCA & KMCC
Colin Chamberlain	CC	Administration & Support Officer	KMCC
Sam Williams	SW	Administration & Support Officer	KMCC
Justin Waters	JW	Consultant Medical Oncologist	MTW & EKHUFT
Andreas Papadopoulos	AP	Consultant Gynaecologist & Gynae-oncology Surgeon	MTW
Stephen Attard-Montalto	SAM	Consultant Gynaecologist & Gynae-oncology Surgeon	MTW
Omer Devaja	OD	Consultant Gynaecologist & Consultant Gynae-oncology Surgeon	MTW
Sasha Humphries	SH	Consultant Radiologist	MTW
Gary Rushton	GR	Consultant Histopathologist	MTW
Amanda Rabone-Young	AR	Consultant Radiologist	MTW
Gemma Hegarty	GH	Consultant Clinical Oncologist	MTW
Diana Frimpong	DF	Pathology Trainee	MTW
Elaine Hales	EH	Clinical Oncology Registrar	MTW
Vickie Gadd	VG	CNS Lead – Gynae Oncology Genetics & Family History Macmillan Clinical Nurse Specialist, Trust Lynch Champion - Endometrial	MTW
Debbie Smith	DS	Gynae Oncology CNS	MTW
Sarah Eastwood	SE	Macmillan Personalised Care Project Manager	MTW
Pollyanna Law	PL	Gynae Oncology CNS	MTW
Gemma Levett	GL	Gynae Oncology CNS	MTW
Lorna Kviat	LK	Consultant Clinical Oncologist	MTW
Marie Arnaez	MA	FDS Nurse Specialist	MTW
Roxanna Dampali	RD	Gynae-oncology Clinical Fellow	MTW
Gaynor Reeve	GR	Macmillan Gynae-oncology CNS	MTW
Apologies			
Kannon Nathan	KN	Consultant Clinical Oncologist and Clinical Director of Oncology	EKHUFT

Louise Black	LB	Macmillan Deputy Lead Cancer Nurse	MFT
Charlotte Wyeth	CW	ST6 - Obstetrics & Gynaecology	MTW
Dawn Langdon	DL	Advanced Nurse Practitioner	Thanet Health CIC

Item		Discussion	Agreed	Action
1.	TSSG Meeting	<p><u>Apologies</u></p> <ul style="list-style-type: none"> The formal apologies are listed above. <p><u>Introductions</u></p> <ul style="list-style-type: none"> HH welcomed the members to today's meeting via MS Teams and the group introduced themselves. HH understands the financial pressures faced but the downside of meeting via Teams is that the meeting loses the personal touch, networking and being able to talk to each other. If you attended the meeting and have not been captured within the attendance log above please contact karen.glass3@nhs.net directly. <p><u>Action log Review</u></p> <ul style="list-style-type: none"> The action log was reviewed, updated and will be circulated together with the final minutes from today's meeting. <p><u>Review previous minutes</u></p> <ul style="list-style-type: none"> There were no objections to the accuracy of the minutes from the previous meeting, which took place on the 7th May 2025 and were signed off as an accurate record of the meeting. 		

<p>2.</p>	<p>USC Gynaecology Referrals Form Proforma</p>	<p><u>Update provided by Hany Habeeb</u></p> <ul style="list-style-type: none"> • HH stated the USC Gynaecology referrals form has been discussed on numerous occasions at the TSSG and CRG meetings. • HH explained the CRG is the Clinical Reference Group and has excellent representation including: <ul style="list-style-type: none"> ○ Rema Iyer – Gynae Oncology surgeon ○ Lorna Kviat – Clinical Oncologist ○ Gary Rushton - Pathology ○ Amanda Rabone-Young - Radiology ○ Sam Daniels – Nursing ○ Sharon Griffin – Consultant Gynaecologist • HH confirmed an agreed template has now been signed off by key stakeholders and is due to be uploaded onto the relevant IT platforms. The next stage is to inform Primary Care so GP’s can start using the new form. • HH presented the new referral proforma, highlighting updates such as the free text area for GP documentation, specific referral criteria for suspected ovarian & endometrial cancers and new ultrasound requirements. • HH acknowledged the largest number of referrals received are for suspected endometrial cancer i.e. unscheduled bleeding whilst on HRT including a link to the BMS guidelines. HH outlined the definition of the menopause for GP colleagues including the comprehensive Menopause Society guidelines. • HH referred to the raised age-dependent CA 125: <ul style="list-style-type: none"> i) > 100 (age </=40) ii) > 50 (age 41–49) iii) > 35 (age >/=50 yrs). 		<p>Presentation circulated to the group on the 10th Dec 2025.</p>
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		<ul style="list-style-type: none"> • HH hoped the additional information on the referral form would significantly reduce the number of referrals due to bleeding on HRT as the majority of these women will not have cancer. • HH stated if any of his patients needed an interpreter or have mobility issues he would set up a double clinic slot. • HH acknowledged that not every form will be 100% perfect and anticipated some teething problems. However, he hoped that using this form would reduce the number of inappropriate referrals received so they could focus on referrals with a higher suspicion of cancer. This would also improve their compliance for the 62-day performance target. • RI confirmed they have already started to receive referrals on the new form at EKHUFT. However, some referrals are being submitted with essential clinical information left blank. RI explained the form's required fields are not technically compulsory, leading to incomplete submissions despite there being clear instructions in place. • LA discussed plans for further educational events and information within the GP bulletins to reinforce the importance of correctly completing the referral forms. LA explained that once the EROS system is fully operational, the referral process will be streamlined, with mandatory fields and prompts to ensure complete submission. There is ongoing work to address current inconsistencies across trusts. • HH stated the importance of Secondary Care and GP's working in partnership and redirecting referrals to alternative pathways ensuring the patient is always put first. • BH advised that if essential information, such as ultrasound reports are missing from referrals, care coordinators should contact the originating practice directly. Targeted education can be provided to specific practices as required. 		
<p>3.</p>	<p>WID-EASY test - detection of Endometrial Cancer</p>	<p><u>Update provided from Michael Mather</u></p> <ul style="list-style-type: none"> • HH introduced MM from AG Health who will be providing an update on the WID-EASY 		<p>Presentation circulated to the group on</p>

		<p>endometrial cancer test.</p> <ul style="list-style-type: none"> • MM explained this is a new test that is revolutionising the detection of endometrial cancer and they are currently running 2 service improvement projects / pilots in hospitals within two different Cancer Alliances. • MM highlighted that according to the US, mortality rates for endometrial cancer are increasing particularly within black women. This data has also been supported by an article published in the BMJ in 2024. There are currently long waiting times for hysteroscopies and only 7 out of the 42 ICB's are able to meet the 28-day FDS performance target. The plan is to raise the 28-day performance target from 75% to 80% by March 2026. • In terms of GP referrals, the waiting list for Gynaecology cancer referrals are the highest compared to other tumour types. For the post-menopausal bleeding pathway, the use of sonography is the first line of investigation and around 38% will have a non-conclusive result. • MM described the WID Easy test as an upper vaginal swab detecting DNA methylation associated with endometrial cancer, citing high sensitivity and specificity from pilot studies including the EpiSure Study (at UCLH) and a significant reduction in unnecessary hysteroscopies and biopsies compared to standard imaging pathways. • MM clarified that the test currently requires administration by a healthcare professional, is intended for symptomatic women over 45 and does not replace ultrasound for asymptomatic cases or those with cervical stenosis. • The group discussed the potential of the test to reduce imaging and hysteroscopy burden, concluding that while it may streamline urgent cancer diagnostics, ultrasound remains necessary for identifying other pathologies such as polyps and hyperplasia. • MM stated that lab test results are typically available within 72 hours and economic modelling suggests cost savings per patient, though the test's full impact depends on its placement within the diagnostic pathway and local referral practices. 	<p>the 10th Dec 2025.</p>
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		<ul style="list-style-type: none"> MM reported that some NHS trusts are piloting the test as a first-line investigation, replacing ultrasound in selected cases. MM acknowledged that broader adoption would require further studies, pathway adjustments and ongoing evaluation of clinical outcomes. The group concluded the WID-EASY test would be a good adjunct to the ultrasound but could not replace it at this stage as there is the potential to miss cancers for completely asymptomatic patients and other conditions such as polyps. AN would be keen to reduce the number of hysteroscopies carried out as at 75% are unnecessary. AN suggested the WID-EASY test could be a really positive tool used by clinicians. HH concluded from a personal perspective the ultrasound scan should not be completely eliminated and should remain as the primary test for women with postmenopausal bleeding. There are potentially lots of things they could miss if they do not carry out an ultrasound scan. HH agreed this is promising but it needs more time and careful planning from K&M's perspective. 		
<p>4.</p>	<p>Are the BSCCP Guidelines for CGIN realistic?</p>	<p><u>Update provided by Hasib Ahmed</u></p> <ul style="list-style-type: none"> HH introduced his colleague HA a consultant gynaecological surgeon with vast experience in minimal access and complex gynaecological surgery, endometriosis and cancer. HH explained CGIN (Cervical Glandular Intraepithelial Neoplasia) is a pre-malignant condition of the cervix potentially with a high malignancy and therefore pertinent to this meeting. HA referred to 'Herb Greene' from the National Women's Hospital in Auckland who ran an unethical study called "the unfortunate experiment." He believed that CIS cancer carcinoma in situ would not change to cervical cancer which is completely erroneous. Thereby, treating all of his patients with just surveillance – smears and biopsies. His first cohort of 33 patients in 1966 of which 8 had cancer with a further 30 cancers in the wider group. The detail was published in 1987 and was subject to a judicial enquiry (Cartwright). Greene had retired by this time but his reputation had been destroyed. However, due to Greene they now know the natural history of CIN. HA explained CIN 3 is treated, CIN 1 is observed and CIN 2 can be one or the other depending on the age and fertility aspirations of the patient. 		<p>Presentation circulated to the group on the 10th Dec 2025.</p>

		<ul style="list-style-type: none"> • The most important change of untreated CIN 3 to cancer would be: <ul style="list-style-type: none"> i) 16% at 10 years ii) 25% at 20 years iii) 31% at 30 years • HA referred to the screening programme and George Papanikolaou who developed the stain used for smears in 1923. In the UK smear tests were started in the 1960's with a national recall system developed in 1988. In 2003 liquid cytology was introduced and moved to primary HPV screening in 2019/20 which is more sensitive to both CIN and CGIN. The introduction of the cervical screening programme has reduced the incidence of cervical cancer by 50%. The mortality from cervical cancer has reduced by 75%. The effect on squamous cell cancer has been profound. However, the rates of adenocarcinoma are unchanged. • HA reviewed the natural history of Cervical Intraepithelial Neoplasia (CIN) and CGIN, emphasising the differences in progression, the limitations of HPV testing for CGIN and the importance of individualised treatment, including a low threshold for hysterectomy when the family is complete. • HA explained that currently 70% of cervical cancer is prevented by the screening programme and many cancers are due to the lack of a smear test. If there were 100% smears delivered, 83% of cervical cancer would be prevented. The government pledge is to be zero new cases of cervical cancer by 2040. There was a rollout of HPV vaccination for girls aged 12-13 in 2008 and in 2019 rollout to boys aged 12-13. • HA presented audit data from two cohorts, comparing compliance with excisional biopsy depth standards, MDT discussion and follow-up protocols, noting that achieving recommended excision depths (especially in women over 50) was often not feasible, though complete excision was still frequently achieved. The audit revealed variable compliance with national standards, particularly regarding excision depth and follow-up, leading HA to recommend that management should be tailored to individual patients rather than strictly adhering to arbitrary depth measurements. • HA explained that clinicians often balance the risk of bleeding and fertility preservation 		
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		<p>when determining excision depth and that real-world practice may differ from guideline expectations due to patient-specific factors and procedural risks.</p>		
<p>5.</p>	<p>Key updates from trusts</p>	<p><u>Update from DGT – provided by Hamed Al-Aarag</u></p> <ul style="list-style-type: none"> • The triaging system continues to work well and was presented at the previous TSSG by SD. • More rapid access clinics are in place and they are able to see a patient within one week of referral. • They have no staffing or capacity issues at this time. • A new Consultant has been appointed who will be supporting the rapid access clinics. <p><u>Update from MFT – provided by Hany Habeeb</u></p> <ul style="list-style-type: none"> • They are four Consultants down which is impacting their colleagues who are having to cover extra clinics and on-call. There are plans to advertise for these posts with two adverts on NHS jobs and two to follow. They hope to be back to full complement by Feb 2026. • The team continue to triage all referrals. Hasib Ahmed is leading on a triage audit together with Leeja John (FDS Nurse) which is due to be presented imminently. • MFT are meeting the 28-day FDS target but are struggling to achieve the 62-day standard. • There are pressures within pathology and radiology services which is affecting their performance alongside other factors – multiple diagnostics / MDM discussions. <p><u>Update from EKHUFT – provided by Andy Nordin</u></p> <ul style="list-style-type: none"> • Doing well in terms of their 62-day performance for Gynae but are struggling with their 28-day FDS standard. • Their main issue relates to patients who are bleeding on HRT which is swamping their rapid access clinics. Utilising the WID-EASY test would definitely help reduce the number of hysteroscopies. • Charlotte (Wyeth) has joined EKHUFT as a General Obstetrician Gynaecologist to support the gynae-oncology team. She will lead on the high-risk obstetric surgical part of the service. • AN asked if there was an accredited gynae oncologist who would like to work at EKHUFT as there will be an upcoming position next year as he is planning to retire. 		

		<ul style="list-style-type: none"> • RI referred to the newly introduced proforma (in May) developed for their 28-day rapid access clinic patients. The proforma is available on Sunrise so clinicians are able to complete the form rather than dictating a letter. This is essential as it captures performance status, BMI and also importantly if the patient needs to stay on the pathway. • AN referred to ongoing meetings regarding the Women’s Health Hubs so they are able to appropriately manage the cases of women with abnormal bleeding on HRT. The current service is not fit for purpose and overloads their diagnostic service. AN added the Women’s Health Hubs are only currently funded until March (2026) so he is hopeful there will be further future permanent funding in place to set up the appropriate pathways. • HH agreed and stated the importance of these women not needing to come into Secondary Care and should be cared for by GP’s. HH has only seen one case in 20-years who had cancer whilst on HRT. • AN stated the ideal triage would be for women bleeding on HRT to be referred to the Women’s Health Hubs for an HRT discussion, WID-EASY test to exclude cancer and to be managed appropriately by HRT professionals. This would ensure they would only receive referrals with a high conversion rate to cancer. <p><u>Update from MTW – provided by Steve Attard-Montalto</u></p> <ul style="list-style-type: none"> • As a trust and not just within Gynae they have met all three performance targets for 2025 apart from August. • Their main issue was within the breast service in particular histopathology and radiology delays. • For 28-day performance, MTW are at ~78% currently and hope to increase to 80% imminently. • In terms of delays within Gynae this is due to the large number of referrals for bleeding on HRT. There are also delays for day case hysteroscopies which is impacting their 28-day FDS target. • A letter has been developed for patients referred on a 2ww pathway. They will have an outpatient hysteroscopy and if it is a normal result they should be taken off of the cancer pathway. RI explained a patient cannot be taken off of the 28-day pathway only the 62-day pathway until the patient has received the results letter stating all results are clear of suspected cancer. HH felt that was an organisation issue as this was not the same for the 		
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		other trusts and he felt it should be discussed further at EKHUFT.		
6.	Performance data	<p><u>Update provided by David Osborne</u></p> <ul style="list-style-type: none"> • K&M has the highest 62-day performance (84.3%) in England and is the seventh highest alliance for the 28-day FDS. • EKHUFT (91.5%) and MTW (88.5%) are performing very highly for the 62-day performance with MFT the lowest at 51.1%. In terms of FDS DVH is the lowest at 48.2% with the other trusts being close to the England average. • DO navigated through the live Gynae cancer dashboard and highlighted specific areas including: <ul style="list-style-type: none"> i) Waiting times from referral to specific milestones (median days) ii) Investigation indicators – histopathology turn-around times iii) Treatment indicators • DO explained the relationship between the route to diagnosis and outcomes in the gynae pathway with many cases being diagnosed via the USC route. A substantial number are diagnosed through emergency presentation with only 35% being diagnosed at stage 1 or 2 and with much lower survival rates. The data presented demonstrates the need to look towards more screening. • Cervical screening – coverage has been falling year on year and is lower in deprived areas. However, coverage increased in the most deprived quintile in 2024. • HH suspects the variation in 62-day compliance across the trusts particularly at DVH and MFT is due to diagnosis and treatment taking place on two different sites creating unavoidable delays. However, for EKHUFT and MTW this takes place on one site only. • JW asked DO if it would be possible to break down the data for the Gynae cancers into the 		Data pack circulated to the group on the 10 th Dec 2025.

		<p>different tumour types – ovarian, endometrial, cervical, vaginal, vulval as the nuances of the behaviour of the pathways would be quite different between them. DO admitted he has looked at this previously and it is hard to split the data at the investigation stage due to the small number of cases but this is doable for 62-day as the cancer has been diagnosed.</p> <ul style="list-style-type: none"> • RI mentioned at EKHUFT they see between 500-600 patients per month which is double patients seen at MTW and four times at MFT so they are doing very well for their 28-day target under the circumstances. <p><u>How to sign up to the Cancer Pathways and Cancer in Primary Care Dashboards</u></p> <ul style="list-style-type: none"> • Register for access to Kent and Medway ICB Power BI reports by completing the form at https://forms.office.com/r/svyPSvktHw. • Email David.Osborne11@nhs.net to inform him that you have completed the form for access to the dashboard. It can take up to a week for the ICB to grant access. • Once access has been granted, you can access the dashboard at https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e. Click on the KM ICB Main app and you will see Cancer in Primary Care and Cancer Pathways listed on the left-hand menu. 		
<p>7.</p>	<p>Discussion points / challenges / future agenda items</p>	<ul style="list-style-type: none"> • EM highlighted that the KMCC Pathway of Care documents have been out of date for some time and asked if there were any plans for them to be updated or if they can be republished with current dates. • AN stated they should be reviewed on a 3-yearly basis and presumed they do not reflect current practice. There are no details on immunotherapy or maintenance therapies for ovarian cancer. <p>Action – Hany suggested they discussed the PoC documents at the next CRG meeting and agreed to delegate individuals including oncologists to update these historic documents</p>		<p>EL / CRG</p>

		<ul style="list-style-type: none"> JW mentioned from the oncological treatment perspective they update the NOG guidelines regularly so the overarching guidelines could refer to the NOG document directly. 		
<p>8.</p>	<p>CNS updates</p>	<p><u>MFT update</u></p> <ul style="list-style-type: none"> Paracentesis - Rocket Drain pathway SOP - in progress. Hope to update further by the end of the year and will share the details in due course. Padlets – ZP explained this is an online platform for patients created by HM which reduces the paperwork and provides all aspects of information including details of any wellbeing events. <p><u>EKHUFT update</u></p> <ul style="list-style-type: none"> 1 CNS is on maternity leave and this is being covered by the other CNS's. Continue doing PIFU and are no further forward with end of treatment summaries. Family History and Genetics – progressing well with all training now completed. <p><u>MTW update</u></p> <ul style="list-style-type: none"> Providing education to female sixth form students (16 – 18-year-olds) – raising awareness and signs & symptoms of gynaecological cancers and the cervical cancer screening programme. Face to face HNA clinics have been set up for those patients who would prefer an assessment to be in-person with the majority preferring via telephone. Stage 2 of the transformation process is ongoing and is due to finish at the beginning of 2026. Implementing a patient satisfaction and feedback survey about the robotic surgery. Most of the CNS team have now completed the level 2 psychological training provided by Clare Reeder. <p><u>DVH update</u></p> <ul style="list-style-type: none"> SD has also completed the level 2 psychological course. LS and LW are also due to complete 		

		<p>the training when the next course becomes available.</p> <ul style="list-style-type: none"> • Nothing further to update. 		
<p>9.</p>	<p>Research update</p>	<ul style="list-style-type: none"> • DETECT 2 Study Progress: CP described the DETECT 2 study at East Kent, which compares genetic testing at home versus in hospital for ovarian and endometrial cancers. All eligible patients are offered participation, but uptake is low and aligns with national figures. • EORTC Module Recruitment: AN reported completion of recruitment for the Vulval module (phase four) with approximately 35 patients, as well as significant contributions to phase three of the hereditary predisposition syndromes questionnaire and phase one of the ovarian EORTC OV 28 redo, highlighting active involvement in ITC Quality of Life group research projects over the past year. • Site Selection and Study Closures: RI shared that their site was selected for two gyne-onc CTIMS studies: Blue Star (endometrial, PI Kannon Nathan) and Trevi (ovarian, PI Justin Waters). She also noted closure of the EORTCVU 34, OV 28, and Protector studies, the latter focusing on prophylactic salpingectomy prior to oophorectomy in premenopausal women. • Protector Study Phase Two: RI explained that phase one of the Protector study, led by Ranjit Manchanda at Barts, has closed, and phase two is nearly ready to open with patients already lined up for recruitment. The study aims to prevent tube ovarian cancers in high-risk premenopausal women. • West Kent Trial Openings: LK announced a new trial opening in West Kent for metastatic endometrial cancer with mismatch repair proficiency, and plans to open the Tropicana study investigating circulating HPV DNA in cervical cancer patients undergoing chemo-radiation. <p><u>Update for EKHUFT - provided by Rhiannon O'Halloran-Jones – via email</u></p> <ul style="list-style-type: none"> • We have one currently actively recruiting study: <ol style="list-style-type: none"> i) Detect 2, which is looking at a direct to patient app for genetic testing for those diagnosed with bowel, womb and ovarian cancer. (RI is PI) 		<p>Circulated to the group after the meeting</p>

		<ul style="list-style-type: none"> • We have five studies pending go ahead, that we will hopefully open soon: <ul style="list-style-type: none"> i) Protector Arm 2 - surgical trial for people at increased risk of ovarian cancer, where they can self-select one of the following: ii) Risk-Reducing Salpingo-Oophorectomy; Risk-Reducing Early Salpingectomy with Delayed Oophorectomy; or no surgery (control) (RI is PI) iii) QLG RISK 3 - Development of an EORTC questionnaire for individuals at risk for a Hereditary Cancer Predisposition Syndrome: the EORTC QLQ-HCPSxx (Phase 3) (AN is PI) iv) Bluestar CTIMP Puxitatug Samrotecan (AZD8205) Monotherapy vs Chemotherapy in B7-H4-selected Endometrial Cancer (KN is PI) v) Trevi CTIMP AZD5335 vs. Mirvetuximab Soravtansine in FRα-high and AZD5335 vs. Chemotherapy in FRα-low Platinum-resistant Ovarian Cancer (JW is PI) • We have closed two studies - VU34 and OV28 - this year with excellent recruitment numbers. • Please contact me if anyone has any questions or wants to discuss anything: r.ohalloran-jones@nhs.net <p><u>Update from MTW – provided by Debbie Webber – via email</u></p> <ul style="list-style-type: none"> • We currently have no Gynae studies open at MTW, Protector is currently on hold by the sponsor. • However, we are literally days away from opening TROFUSE at MTW – PI Dr Lorna Kviat which is an A Phase 3 Randomized, Open-label, Multicenter Study to Compare the Efficacy and Safety of Sacituzumab Tirumotecan in Combination with Pembrolizumab Versus Pembrolizumab Alone as First-line Maintenance Treatment in Participants with Mismatch Repair Proficient Endometrial Cancer (TroFuse-033/GOG-3119/ENGOT-en29). 		
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<p>10.</p>	<p>Next steps and meeting close</p>	<p><u>Cancer-related Fatigue Management film animation – details provided by Claire Mallett after the meeting</u></p> <ul style="list-style-type: none"> • The video, created by a dedicated team of clinical nurse specialists, cancer support workers and allied health professionals, offers practical advice and emotional support to help patients and their families better understand and manage one of cancer’s most common and disruptive side effects. It can also be a valuable resource for professionals working with cancer patients. You can watch the video on the Kent and Medway Cancer Alliance website – www.kentandmedwaycanceralliance.nhs.uk/cancer-related-fatigue • Listen to Dr Jonathan Bryant, GP and Kent and Medway Cancer Alliance Clinical Lead talk about the film, in an interview with Sophie Sutton, on BBC Radion Kent Make a Difference - Radio Kent - Listen Live - BBC Sounds (around 1:42). • Limbo land - patient experiences of uncertainty and cancer A series of films of capturing personal cancer experiences, including professional perspectives on roles and support available limbo land - personal cancer experiences Cancer Alliance • HH personally thanked both Rema Jyothirmayi and Andy Nordin for all their hard work and support as they are both due to retire before the next Gynae TSSG meeting. AN is yet to decide whether he comes back after a 6-month sabbatical on a part time basis. HH wished both RJ and AN all the best and he has enjoyed working with them both for many years. They will be sorely missed and are exemplary colleagues. 		
<p>11.</p>	<p>Next Meeting Date</p>	<ul style="list-style-type: none"> • Wednesday 13th May 2026 – 13:30 – 16:30 – venue TBC. 		<p>KG has circulated the meeting date – venue TBC</p>

