

# Womb cancer stats reveal treatment variation across England

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Cancer doctors have a set of treatment guidelines to refer to, which ensure they give their patients the best care. These guidelines are put together by experts and are shaped by research.

But sometimes the research just hasn't been done to give doctors the information they need or interpretation of the research is tricky. And a new study points to this being the case in [womb](#) cancer, indicating that the treatment guidelines doctors refer to need to be reviewed.

Around 9,300 people are diagnosed with womb cancer in the UK every year, with the latest figures showing that in the last decade the number of women diagnosed has increased by almost a quarter. This has been linked to rising obesity levels, as womb cancer is probably the type of cancer most closely linked to being overweight or having obesity.

With more and more women being diagnosed with womb cancer, we need to make sure doctors are prepared. That's where our statisticians come in.

Working in partnership with Public Health England, they've looked at an incredibly detailed set of data of how womb cancer is treated in England for the first time. It outlines all the different types of treatment that 27,719 women with womb cancer had between 2013 and 2016. And they teamed up with Dr. Andy Nordin, a consultant gynaecologist from Queen Elizabeth The Queen Mother Hospital in Margate in Kent, also working with PHE, who helped them pick out the most relevant and

useful info from the numbers.

"We have shown the real-life situation in the England," says Nordin.

"That depending on where you're treated, for the same disease you could be offered a different treatment from someone else in another hospital."

## **The dilemma faced by gynae doctors**

But this isn't a reflection on the doctors that treat womb cancer. Instead it brings to light a very fragmented research picture and unclear guidelines that are open to interpretation.

The most common treatment is surgery. "Pretty much every patient with a womb cancer diagnosis will be advised to have a hysterectomy, removing the womb, tubes and ovaries," says Nordin. "There's no debate about that. Hysterectomy will cure the disease for the majority of women."

But the next treatment steps are where it gets murky.

"There is a debate over whether [lymph nodes](#) should also be removed so we can then test them in the lab to see if the disease has spread outside the uterus."

If cancer cells are found in the lymph nodes, then patients may need radiotherapy in their pelvic area to mop up stray cancer cells. Research suggests this reduces the chance of the cancer coming back in that part of the body.

But it's a tricky task because doctors are constantly having to weigh up benefit and risk.

"Around one in 10 women will have womb cancer cells in their lymph

nodes," says Nordin. Which means nine in 10 women may have had an unnecessary addition to their surgery.

And lymph node removal can cause debilitating and life-long side effects.

"We know that lymph node removal makes the operation take longer and there are potential complications afterwards including swelling of the leg."

And even though a clinical trial found there was no difference in the survival between the women who did and didn't have lymph nodes removed, current guidelines state that lymph nodes should to be taken out and analysed to effectively stage the disease.

"A lot of hospitals continue to recommend taking out lymph nodes for higher risk patients to help them decide if a backup radiotherapy should be given," says Nordin.

But in the majority of cases we don't know if this procedure is causing more harm than good. And according to our new paper, doctors around the country seem to disagree who should get what.

"You might be offered the removal of the lymph nodes in one centre and a patient with the same disease in another might not," says Nordin. In another instance, patients might be recommended to have radiotherapy at one hospital, but just surgery in another.

The paper also suggests that a number of cancer clinics use the results from lymph nodes to work out who should have radiotherapy. But this isn't always the case.

Nordin thinks that if a doctor thinks the patient might be able to avoid

radiotherapy, which also comes with life-long side effects, then removing the lymph nodes to double check the cancer hasn't spread may be a justifiable move.

"Because then the patient can make an informed decision about whether to have radiotherapy depending on whether their lymph nodes tested positive for cancer or not."

But the jury is still out.

## **'Practicing-changing' data**

Nordin is quick to stress that these stats don't suggest which decision is best.

"It just shows that there is a huge variation in practice across the country and when you have huge variation in management that identifies that changes need to be made."

"Nobody is setting out to harm patients," says Nordin. "Decisions are made because they believe it will give them the best chance of being cured and at the same time minimise the long-term side effects."

He hopes the clinical community use this new insight, as well as emerging technologies, to agree on the best way to treat patients based on the evidence at hand.

## **Quality of life after cure**

Fortunately, the majority of womb cancer patients are diagnosed early enough for their cancer to be cured. Womb [cancer](#) is most common in women ages 70-75 who have gone through the menopause and so any

bleeding they experience sends them straight to their GP for further tests.

"Because of the nature of the disease the womb is surround by tough muscle which forms a barrier around the disease, so it takes time for the tumour to work its way through and spread," says Nordin.

Which may help to explain why 95 out of every 100 women in the UK survive their [womb cancer](#) for 5 years or more. But doctors are still making treatment decisions that will impact patients for the rest of their lives without clarity.

"This paper has an important message for the clinical community to digest and for NHS England to consider," says Nordin. "It's a really unique opportunity. If we want to improve practice, then we need to act on all this fantastic data that we're collecting."

Provided by Cancer Research UK

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